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The uneven “mainstreaming” of migration-related diversity in French healthcare education and training

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Processes developing global flows of capital and commodities also increasingly restrict the circulation of people, including by managing their inclusion or exclusion in foreign job markets. In the European Union (EU), where shifts in borders in the 2000s have created new barriers for non-EU citizens and workers, a growing literature has explored labour market and educational opportunities and impediments for a group whose skills and qualifications may be thought to travel easily: healthcare workers. This article seeks to explore a particular case, France, and the French healthcare system, which, despite shortages, depends less on foreign healthcare workers than many other countries in the global North. It asks whether and how the French healthcare system “mainstreams” migration-related diversity by promoting better inclusion for workers qualified outside the EU. Results are based on content analysis of a desktop study of policy documents and 18 semi-structured interviews with policy, employment, education, and training stakeholders conducted between May 2024 and May 2025. Interviewees’ accounts highlight the complexities of policy choices and the competing nature of the goals between which they are required to navigate and arbitrate. The article concludes that the uneven development of the French regulatory framework defining how workers born or trained outside the EU access healthcare work, as well as the multiplicity and autonomy of employment stakeholders, create conditions likely to promote the temporary or permanent downward mobility of these workers. These tendencies also often leave the onus for professional integration on migrant workers, rather than on sectoral stakeholders.

KEYWORDS

France, healthcare work, migration, recognition, training

1 Introduction

Following the COVID-19 crisis, the role international migrant workers play in the systemic resilience of many healthcare systems was identified as a significant topic of interest, with differences observed between countries in the global North (Anderson et al., 2021). The French healthcare system, with its 18.1% of foreign doctors in 2020/21 and 6.2% of foreign-born nurses, appears to rely less on foreign health training systems than other members of the Organisation of Economic Cooperation and Development (OECD), which, on average, employ foreigners in 27.9% of doctors’ posts and 17.6% of nurses’, respectively (OECD, 2025). Research indicates that migrant workers from outside the European Union (EU) are over-represented compared to EU migrant and non-migrant populations in essential services in

France (Broberg et al., 2025). However, in many medical and paramedical¹ occupations, the French national statistics institute highlight that the proportion of immigrants from outside the EU is less than or almost equal to their proportion in the total working population (7.9%): in 2019, 3.1% of midwives, nurses, and other paramedical professionals were from outside the EU, compared with 7.7% of nursing assistants and 8.0% of doctors (INSEE, 2019).

In 2015, it was estimated that 5.3% of the French population worked in the healthcare sector (Chevreul et al., 2015, p. xxiii), which in 2022 employed 3.39 million people (DREES, 2024), while 366,424 independent professionals are in private practice.² This sector is nonetheless characterised by long-standing labour shortages,³ for three main reasons: firstly, increases in population caused by positive birth rates and people living longer; secondly, cuts to health budgets which make recruitment harder; and third the medical profession's dominance and its wish to limit the number of doctors trained (Sirna, 2021, p. 12). In a healthcare sector with many professions for which the "access, scope of practice or title is regulated by law,"⁴ training and education are key sites for regulating employment. However, little scholarship explores links between labour shortages and perceptions and mechanisms of inclusion of international migrants in the workforce, through education, training and skills recognition processes.

This article seeks to explore the role of employment, education, and training policy in organising the inclusion of migrants trained or qualified outside the EU in the French health system through two main research questions: (1) To what extent do employment, education and training and migrant integration policies promote or facilitate access to healthcare education and training for migrants, particularly among healthcare professionals who have already qualified or trained abroad and (2) What inequalities and disadvantages do sectoral stakeholders identify for migrants in health education and training and to what extent do they consider these should be maintained or mitigated?

To answer these questions, we present the results of a qualitative study carried out between March 2024 and May 2025 as part of the Skills4Justice research programme, funded by Horizon Europe, which explores the education, training, and labour market inclusion of

non-EU migrants. Primary data were collected through a desktop study and 18 in-depth stakeholder interviews, and the content analysed based on relevant themes. This research hopes to shed new light on the governance of migration and education regimes in an increasingly globalised health sector. Inclusion of workers from outside the EU in the French workplace has been found to be negatively affected by inequalities between EU citizens and non-EU citizens, uneven recognition of degrees and diplomas, differential socialisation in French, and racial and religious discrimination (Vallot, 2024, pp. 147–148). This article will, therefore, consider stakeholder engagement with questions around legal and regulatory frameworks for inclusion of migrants qualified or trained outside the EU in the healthcare workforce, recognition of qualifications and access to training and education.

This article is organised into four parts. In Part 2, the theoretical and conceptual framework of our analysis will be presented, followed by the methodology used to collect data (Part 3). In Part 4, we will expose the results of our year-long qualitative study. Then, in Part 5, we will discuss and analyse the effects of the categories of difference that healthcare education and training policy create.

2 Theoretical, conceptual, and analytical background

2.1 "Mainstreaming": a concept grounded in complexity theory

A body of work has built up in recent years examining French policy towards migrant work and the treatment of migrant workers by employers and labour market stakeholders. Authors concur that French immigration policy, influenced by European trends, has taken an economically utilitarian turn which, by increasing border controls and renewing of policy production around guestworker-like temporary statuses, creates a hierarchy of rights and reinforces labour market segmentation (Terray, 1999; Potot, 2013; Veron, 2024). Skills evaluation and development are henceforth tied up with issues of migration control (Iskander, 2007). This body of scholarship links into research on bordering processes, where concepts of inclusion and exclusion have been used to explore the filters that determine differential migration workforce participation and outcomes (Fedyuk and Stewart, 2018; Mezzadra and Neilson, 2013). The concept of integration/*intégration*, on the other hand, has, in France, as elsewhere,⁵ long come under intense academic scrutiny for its normative implications and the politically charged and one-sided way it is used in much public discourse and policy (Lapeyronnie, 2003). Critical literature on French "integration" policy and its implementation highlights its role in the "othering" of migrants, by making their "integration" a social and legal obligation, the forms of which are defined by the state (Gourdeau, 2015). The introduction of a new and more centrally run immigrant integration framework in 2007, aimed

1 The French Public Health code (*Code de la santé*) defines three types of healthcare professions: medical professions, which include the doctors, dentists, and midwives who possess prescriptive capacities; paramedical professions, which concern care occupations such as nurses, nursing assistants, ambulance drivers, or medical laboratory technicians that carry out prescriptions under medical supervision; and pharmaceutical professions.

2 Over 30 professions are authorised to work independently in private practice including doctors, nurses, dentists, mid-wives, physiotherapists, speech therapists, etc.

3 In a 2021 report, the Health Ministry highlighted that if current trends continue, medical and pharmaceutical coverage in France will decline over the next few years and will only stabilise in the mid-2030s (Anguis et al., 2021). It also estimates that 80,000 extra nurses, on top of those it already predicts will train and graduate in France, will be needed to satisfy the care needs of an ageing population (Parent, 2024). For nursing assistants (*aides-soignants*), in 2024, 69.4% of recruitment projects nationally had difficulties finding the right applicant [see France Travail (2024). *Besoins en Main d'Œuvre*, Available at: <https://statistiques.francetravail.org/bmo/bmo?graph=4&in=4&le=0&tu=10&pp=2024&ss=1>].

4 This is the definition of regulated professions given on the European Commission's European Skills, Competences, Qualifications and Occupations (ESCO) website. Available at: <https://esco.ec.europa.eu/en/about-esco/esco-pedia/escopedia/regulated-professions> (Accessed September 15, 2025).

5 As Adrian Favell pointed out in his commentary on William Schinkel's "Against 'immigrant integration': For an end to neocolonial knowledge production" (Schinkel, 2018), "residual talk today of 'national integration' – particularly of the integration of 'immigrants' into given 'national' societies – is therefore normative not analytical or empirical sociology" (Favell, 2019: para. 7).

at non-EU citizens for 5 years after the obtention of their first residence permit, is also judged to have weakened the public integration infrastructure available after this period and disempowered third sector stakeholders (van Breugel and Scholten, 2017). Avoiding the pitfalls of the concept of integration, recent scholarship has instead emphasised the multiplicity of actors in both public and private domestic spaces who contribute to defining the “hospitality” extended to migrants (Agier and Le Courant, 2022). Equally, work on the diversity of political configurations and mobilisations of actors involved in local governance in cities (Michalon and Lacroix, 2025) and rural areas (Verove, 2023), reveals the spatial inequalities which can support or hinder migrants’ job market and social inclusion.

To explore connectedness between migration, education, and training policies and job market inclusion at the sectoral level, this article proposes to foreground the concept of “mainstreaming.” The concept of “mainstreaming” is rooted in complexity theory, most prominently developed by Beck (1992), which considers societies as operating on complex global systems, “consisting of a large, often indeterminable, number of factors that are interdependent and that interact in a variety of ways” (Scholten and Schiller, 2025, p. 1791). Steve Vertovec laid out the implications of this theory for the governance of human diversities. Through the concept of superdiversity, he highlighted that social and economic outcomes are affected by ever more complex intersectionalities, which go beyond questions of class, gender and race to take in nationalities, identities, legal status, languages, sexualities, social networks, religions, health, mobilities, lifestyles, and educational and professional subjectivities and experiences, among many others (Vertovec, 2007). Mainstreaming is a concept designed to explore social complexities from a governance perspective by asking how far public policy succeeds in taking diversity into account. Developed around issues of gender equality (Verloo, 2005) before expanding to other topics such as disability, special needs, the environment or migration-related diversity, “mainstreaming” questions the “gradual embedding of former target group specific policies into a generic cross-sectional and often also multi-level approach” (van Breugel and Scholten, 2017, p. 514). It also allows researchers to explore shifts from a state-centric form of policy intervention to a more “polycentric” approach articulating European, national and local levels, and bringing together a broad, actively engaged network of state and non-state stakeholders around the issues in question (van Breugel and Scholten, 2017; Scholten and Schiller, 2025). The concept, therefore, seems particularly appropriate for our study, which seeks to question stakeholders who, by virtue of their strategic positions in the health sector, influence education policies and policy implementation affecting non-EU immigrants’ access to and participation in the health workforce but who do not necessarily see themselves as having a role in migrant “integration” policy.

2.2 Migration and healthcare workers: lessons from the literature

The migration of health workers is an area of significant interest to international and French researchers across health, social science, and management disciplines. Underpinning economic development and human wellbeing in both “source” and “destination” countries, the health sector provides a site for observing how public authorities exploit the specific opportunities to “manage” international mobility that the regulation of health professions affords them (Bach, 2006). Internationally, scholarship has questioned whether international

health workforce mobility promotes international brain drain or brain exchange (for example, Bach, 2006) and demonstrated how individual migrants bear the burden of knowledge transfer policies (for example, Öhlander et al., 2020). A central question for migrant healthcare workers is the renegotiation of symbolic capital, social status and knowledge, in a new context where they may be faced with “limits regarding the acknowledgement of their seemingly transnational competences and diplomas” (Boström and Öhlander, 2015, p. 41). Recent work has also examined international partnership schemes aimed at training workers from the global South to work in European countries, such as Germany (Hillmann and Handayani, 2025).

French social science literature on migration and employment in the health sector is characterised by an academic interest in the medical professions and particularly doctors (Hounsou, 2014; Cottureau, 2015; Mendez and Merzouk, 2020). This reflects a policy imbalance cultivated since the 1970s, when hospitals were authorised to respond to staff shortages by recruiting foreign, and particularly, non-EU doctors (Cottureau, 2015; Sirna, 2020), who were granted a temporary authorisation to practice. Several papers from the 2000s examine important policy changes, such as the law voted in the 1930s to condition the practice of medicine and dentistry on French nationality (Noiriel, 2004),⁶ and its suppression in 2009 (Hatzfeld et al., 2009). Since 2009, the nationality of the qualification counts more than the nationality of the worker: to work in regulated professions in healthcare in France, candidates must process a state-mandated diploma or degree (*Diplôme d’Etat français* or *DE*) delivered by the Ministry of Health (Hatzfeld et al., 2009). Several authors highlighted how legislation driven by anti-discrimination obligations and/or European integration has shifted the boundaries of inclusion in the health workforce. From 1975 onwards, successive European legislations and most recently the 2005 and 2013 European Directives on Recognition of Professional Qualifications have provided the framework for the automatic recognition of regulated medical and paramedical qualifications obtained within the EU, thus creating different categories of foreign degree holder in France: those qualified in an EU country, and those qualified outside the EU (Cottureau, 2015, p. 15)⁷. However, in France, Cottureau highlighted some international links that have earlier roots than the EU, such as the long-standing arrangement with the Saint-Joseph University in Beirut, which is the only structure outside of France authorised to grant the French state-mandated nursing diploma (Cottureau, 2015, p. 84).

In this context, Marc-Olivier Déplaud asks whether the xenophobia that motivated the 1930s laws also explains more recent policy

6 French medical students protested against the “competition” represented by their foreign counterparts, obtaining in 1892 the right to a separate degree, and later, the adoption of bills barring foreigners (1933) and then naturalised foreigners (1935) from practising medicine in France (Noiriel, 2004, pp. 66–67).

7 Transposition of the Professional Qualification directive into French law does not seem to have led to fully automatic recognition for EU healthcare qualifications: holders of a qualification obtained in the EU who wish to register in France are required to follow a specific procedure to obtain a licence to practice (*autorisation à exercer*) in the relevant occupation, granted by a committee (a *commission d’autorisation d’exercice—CAE*) in the case of medical applicants or the decentralised government department for the economy, work, labour and solidarity (*DREETS*). If the training applicants have received is very different from French training or if the practice of the profession in France involves acts that are not practiced in the EU country of qualification, compensatory measures, involving adaption lasting up to three years, can be required.

decisions affecting doctors qualified outside the EU (Déplaudé, 2011). He concludes that supposing xenophobia of certain elites to be the only explanation runs the risk of masking other social logics that can produce and perpetuate discrimination towards foreigners (Déplaudé, 2011, p. 230). He also argued that recent policy thinking on better inclusion of non-EU doctors hired on derogatory and temporary statuses is influenced by questions of equity with doctors trained through the French system. French-trained doctors have, until very recently, had to go through two competitive exams: first, to enter the second year of medical training, success at which depended on a quota system (*numerus clausus*), then to enter the third cycle of training. New procedures introduced in the 2000s have therefore required doctors qualified outside the EU who wished to become fully authorised to practice in the French system to rank at a skills verification test (*épreuve de vérification des compétences* or *EVC*), for jobs that are also subject to a quota system (Déplaudé, 2011, p. 231). Thousands of medics qualified outside the EU are nonetheless employed by hospitals at lower salary rates than their French and EU qualified counterparts while they take and pass the *EVC*, which can take several years (Sirna, 2020). Francesca Sirna underlined the gender implications of this system, where the lengthy timeframes and uncertainty of requalification particularly affect women juggling both productive and reproductive work (Sirna, 2020).

Also, Hatzfeld et al. underlined the paradox that the French government's "chosen immigration" policy aimed at skilled or highly skilled workers, launched in 2007, includes no official inducements for medical and paramedical staff qualified outside the EU to apply to work in France (Hatzfeld et al., 2009). Private arrangements certainly exist, particularly for doctors (Hatzfeld et al., 2009) who, in the absence of national schemes, represent an "invisible" pillar of the French system (Cottureau, 2015, p. 1). Before they are granted full authorisation to practice, these medics are now widely known as *PADHUEs* (*praticiens à diplôme hors Union européenne*) (Cottureau, 2015). Only a small number of researchers have focused on paramedical professions, such as nurses (Hatzfeld et al., 2009; Sirna, 2020), who must retrain to obtain the *diplôme d'état*: nursing studies last between 3 years for a nursing qualification and 5 years for an advanced practice qualification (although exemptions from some modules of study are authorised by the regional directorate for work on a case by case basis). Sirna highlighted that the nurses she interviewed had often previously qualified as doctors outside the EU but were hired as nurses in France for lower wages (Sirna, 2020, p. 41).

3 Methods and materials

3.1 Research protocol

The study design identified two main research tools to explore firstly, education, training, and employment policy for non-EU migrants in healthcare; and secondly, the perceptions and activities of relevant stakeholders: a desktop review and in-depth interviews with employer, political, education, or third-sector stakeholders.

Firstly, a desktop review of policy reports and other material sought to build up a picture of the French health sector's recent history as regards the employment, education, and training of workers from other countries, of the legislative and regulatory framework and policy developments affecting them and of the activity of varied

stakeholders to change and/or implement this. To this end, the desktop review took in legislation passed since the late 2000s defining criteria for eligibility to work in health professions and statistical material from French national statistics offices (INSEE, INED). We also studied reports pertaining to foreign workers, students and skills needs, produced by the relevant government ministries or departments (health, higher education, labour, and interior), public advisory and strategic institutions (Hauts conseils, *France Compétences*, *France Stratégie*), and public agencies implementing work and immigration policy (*France Travail*, OFII). At the international level, we considered EU legislation and publications by international organisations such as the World Health Organisation (WHO), the International Labour Organisation (ILO), and the OECD. Added to this corpus were other materials produced by national and regional employment and trade union stakeholders, which included press statements containing references to medical and paramedical professionals from other countries, the results of surveys carried out by bodies representing employers or professionals, trade union newsletters, and statistics and employers' human resource department publications.

Secondly, 18 semi-structured interviews lasting between 45 min and 1 h 30 min were carried out in French with 25 representatives of employer, political, education, or third-sector organisations who either work in the healthcare sector or whose expertise directly pertains to health work and workers. The aim of these interviews was to understand these stakeholders' representations of the health sector's need to employ and train workers from outside of France and the steps their organisations have taken to facilitate this. In most of the 18 organisations who contributed to our study, we spoke to only one stakeholder, but in others, two or three professionals with different expertise and responsibilities answered our questions, to give us as broad a perspective as possible. This explains why the number of participants is slightly more than the number of interviews.

Two open-ended interview guides were designed for different types of stakeholders. Employment and political stakeholders were asked questions around four main themes: perceptions of labour shortages in the health sector and/or organisation and strategies implemented to minimise them; representations of the education and training system and its capacity to train sufficient health sector workers; perceptions of the need to recruit workers from abroad in their sector and of issues associated with this; and collaborations with companies or educational organisations outside of France to promote international mobility. The second interview guide, aimed at educational and third-sector stakeholders, also covered four areas: descriptions of programmes their organisation runs, funding and recent organisational evolutions; perceptions of training needs in the health sector and of the adequacy of education and training provision; inclusion of migrants from outside of Europe in their programmes and student/ trainee needs; and participation in international cooperation programmes. Participants were also asked to describe the role and activities of the organisation they worked for, and its place in the health ecosystem. Additional information was also collected online about the size and history of the organisations involved.

We also attended two health sector professional forums and one round table event on refugee inclusion in healthcare, where we were able to talk informally with healthcare stakeholders and where field notes were made.

The Community of Universities Angers-Le Mans ethics committee approved the interview-based study in late April 2024. Participation

was based on informed consent. All participants were provided with written information about the research project, how data would be used, anonymisation and their right to modify or withdraw data they had contributed. To fluidify exchanges and relations, we chose not to ask for signed consent. Instead, a double consent mechanism was used in which participants' written agreement to participate was obtained *via* e-mail and their oral consent was later requested again at the beginning of the interview. After the interview, we also provided participants with anonymised transcripts of the interview, which they could alter or withdraw if they wished. No participants chose to do this.

3.2 Sampling and data analysis: adaptations and surprises in data collection

Participants were recruited for semi-structured interviews using a purposive sampling technique designed “to select respondents that are most likely to yield appropriate and useful information” (Kelly, 2010, p. 317). Initial plans were to target national-level stakeholders in order to gain an overview of labour shortages and strategies to address them, but this design had to be adapted to the characteristics of the French employment market, and the health sector in particular. In France, a relatively significant autonomy is devolved to professional “branches,”⁸ sectors, employers, and higher and further education establishments. National and regional public organisations attached to the health and education ministries regulate qualifications and professions, aided by professional “orders” governed by private law but accepting a public service remit. However, healthcare establishments are managed autonomously, and human resource management is decentralised, with only the recruitment of hospital medical staff, medical teaching staff, and directors of healthcare structures managed centrally by the Health Ministry's agency for human resources, the *Conseil national de gestion* (or *CNG*), in concertation with healthcare establishments and regional health agencies. Students of medicine, dentistry, and midwifery are attached to one of 45 public university health faculties, as are pharmacy students. Paramedical training centres, including 326 institutes for training of nurses (*IFSI*) and approximately 450 institutes for training of nursing assistants (*IFAS*), are spread out across local areas, in both public and private training organisations. In this context of multi-level and multi-stakeholder governance, we sought to triangulate data by diversifying the participating stakeholders based on the level they worked at, and speaking both to organisations representing healthcare workers politically, as well as to national and local employer and training organisations.

Between May 2024 and March 2025, we requested interviews from over 90 targeted individuals and organisations, with only 25 stakeholders replying positively in the health sector. This response rate is perhaps unsurprising in a short-staffed sector where professionals are often time-poor and where the political context is marked by a troubled national debate over questions of immigration, particularly before and during the passing of a new immigration law in January

⁸ French occupation “branches” or “*branche professionnelle*” refer to professional fields that bring together companies and employers from the same sector of activity and subject to the same collective labour agreement (“convention collective”) or equivalent public sector agreement regulating labour rules (wages, leave, and contracts). Within a professional field, other stakeholders, such as employers' organisations and trade unions, are involved in the joint administrative of the main social dialogue and relations bodies.

2024. It perhaps also reflects the deep roots of universalist ideology in French society where there tends to be “a general distrust of policies that target a particular group over others” (Escafré-Dublet, 2014, p. 7). Moreover, with regulation defining who can work in the French healthcare workforce currently in flux, the framework and processes governing the access of foreigners or people trained abroad to healthcare work seem to be a grey area that only stakeholders with a certain interest for or experience of the question wished to be questioned on. Our sample of participants is therefore a particularly knowledgeable one in a wider context in which these inclusion measures seem to be less well known.

Our 25 interviewees' institutional roles are presented in Table 1. As interviewees' participation was on the basis of their role representing an organisation, we do not include personal details such as age and gender.

Limitations of the stakeholder study lie in the small number of political and trade union representatives. We sought to compensate for this by monitoring the main political actors and trade unions' online publications.

TABLE 1 Breakdown of participant stakeholders' institutional affiliations.

Level	Type of organisation	Number of participants (25)
Organisations with a national scope	Ministry of Health	1
	National professional bodies representing different healthcare professions	4
	National non-profit professional training structure	1
	Non-profit health provider and employer	1
	NGOs involved in supporting migrants to move into healthcare work	5
	Public structure providing international degree and diploma recognition	1
Organisations with a regional or local scope	University hospital training structures involved in employing training doctors in hospitals	5
	Regional branch of a federation representing non-profit health employers	1
	FE Paramedical Training School	5
	University French language school	1

Transcripts were made of interviews, with stakeholders described only by their professional functions and organisations only by the type of activity, to avoid participants being identifiable when citations were used. Recordings and transcripts of interviews were kept on the University of Angers secure server. To analyse data, transcripts were read in depth and coded manually based on the main themes of the interview guides. Thematic findings from interviews were compared and, when needed, contextualised through comparison with the desk-top study findings.

4 Results

4.1 Economic and sectoral context

In a healthcare sector with high levels of work/study alternance during training, opportunities and imperatives to train are developed, discussed, and defined across diverse policy settings, which are not limited to education and training forums but also include employment and third-sector stakeholders. Holding positions of responsibility in a sector with longstanding labour shortages which elude simple solutions, the stakeholders interviewed for this study navigate and arbitrate complex social situations daily. The first part of this section analyses stakeholders' perceptions of the economic and sectoral backdrop in which thinking about migration mainstreaming takes place, while the second part presents stakeholders' knowledge about the regulatory framework determining inclusion measures for workers and trainees trained or qualified outside the EU.

4.1.1 Labour shortages and care standards: interconnecting challenges for stakeholders

All informants highlighted that the health sector is beset by shortages and has difficulties both attracting students and trainees and keeping qualified workers. However, they also note significant variations in perceptions of shortages and reasons for these between urban and rural areas, regions, and in different types of health establishments. An employment director for a national network of private non-profit health establishments described how difficult it is to recruit permanent staff when agency work is more profitable and allows greater flexibility for nurses and nursing assistants in France's larger metropolises. In contrast, to ensure staff supply in rural areas, they had to work with staff and local authorities, by focusing on the details of workers' needs, particularly lower-paid ones:

So it's true that in these structures, we try to encourage carpooling, try to adapt schedules to public transport timetables, try to work with local authorities to see how we can improve things. In any case, it really depends on your socio-professional category⁹ [translation].

⁹ Interview with the employment director of a national network of non-profit health establishments on 19 August 2024.

Most of our informants believed the education and training system did not produce sufficient healthcare workers in France. Perceptions of working conditions and the social status of caring professions were identified by our informants as a key factor limiting the expansion of student and trainee numbers. Representatives of a nursing assistant training centre reported students on their very first work placement being courted by employers who also put pressure on the training centre to make sure students enter the job market quickly:

They call us up and say 'What are you doing with your students? Where are your students who have left the school?'¹⁰ [translation].

Although it seems easier to determine shortages at the level of individual health establishments or organisations, interviewees' uncertainties about shortages echo recent policy documents that consider tools to estimate healthcare human resource needs to be insufficiently precise (HCAAM, 2022, 2024). Certain policy documents highlight how difficult it is to define needs for workers as recent reforms redefine the activity and scope of competences across different professions, and as telemedicine, demographics, and climate change remodel the healthcare landscape (CNOM, 2024). Indeed, most informants were involved in piloting or adapting to reforms engaged since 2019 that have sought to boost the numbers of healthcare trainees and graduates and to reconfigure responsibilities or create new professions in order to free up medical time.¹¹ One of the most prominent measures was the 2019 removal of the "numerus clausus," which had, since the 1970s, limited the number of medical and pharmaceutical students who could go into the second year of study. Greater flexibility was also developed in medical training pathways, partly in an attempt to stem the flow of prospective students training elsewhere in the EU (Lenesley et al., 2021). Despite these reforms, our interviewees highlighted that other factors, inbuilt into the education and training infrastructure, inhibited significant increases in student numbers. Because of insufficient funding and the high levels of work/study alternance, the public or publicly funded training structures that carry out most education and training lack both teachers and professional workplace supervisors for student interns, which limits opportunities to increase staff supply to healthcare establishments. As a doctor coordinating training for medical interns in a university hospital put it:

If I had plenty of teachers and plenty of internship supervisors, yes, the hospital departments have plenty of places¹² [translation].

Moreover, stakeholders highlighted concerns about the loss of trained personnel to countries bordering France with higher salaries,

¹⁰ Interview with staff at a training establishment for nursing assistants on 17 July 2024.

¹¹ New professions, such as specialised administrative professionals (*assistants médicaux*) or advanced practice nurses (2018) have been created or skilled up. Similarly, the reform of the nursing profession adopted in June 2025 broadens the skills and duties and increases the autonomy of nurses, who will now be able to perform certain procedures and duties previously reserved for doctors, such as issuing death certificates and prescribing some medication based on a nursing diagnosis.

¹² Interview with a doctor and researcher coordinating training for interns in a university hospital, 22 August 2024.

such as Switzerland, as well as to Québec: the one bilateral agreement organising the mutual recognition of diplomas obtained outside of the EU for certain regulated professions, including doctors and nurses, was signed in 2010 between France and Québec.

4.1.2 Stakeholder perceptions of a complex and uneven framework for including workers qualified outside the EU

Despite identifying the difficulties faced by the French education and training system to provide sufficient healthcare workers to meet the country's needs, few interviewees openly evoked recruitment abroad, or the development of international skills or work partnerships as a way of reducing shortages. Recruitment of workers trained abroad seemed to be viewed, or at least treated, as an outcome of workers' choices to look for work after moving to France, rather than the result of official schemes to attract them. A recent 2022 poll of private health establishments moreover determined that only 6% of respondents recruited staff with qualifications gained abroad as a strategy to reduce personnel shortages (*Observatoire de l'OPCO Santé, 2022, p. 11*). This muted approach to foregrounding migrants in the workforce is prolonged by the paucity of statistics characterising the migration-related diversity of workers. Major employers and employers' federations do not publish statistics on the nationality of their staff. While the internationalised HE sector provides numbers of international students in health studies (future doctors, dentists, pharmacists, midwives, and nurses), the absence of variables on nationality or origin and the lack of national statistics for the FE and professional training sector (*Lendaro, 2011*) mean national migration-related data is not available for paramedical trainees, apart from nurses. However, bodies representing certain key professions (medicine, dentistry, pharmaceuticals, nursing, and physiotherapy), known as "Orders," who play a role in guaranteeing patient safety and professional skills, have started to quantify the number of people qualified abroad who apply to register to practice in their profession in an effort to better understand medical and paramedical demography. Migration-related data is therefore unevenly produced: more is known about medical and pharmaceutical trainees, students, and staff than their paramedical counterparts.

Despite this statistical opaqueness, mainstreaming has moved on from the state described in the literature (see Section 2.2). Stakeholders highlighted a changing regulatory context that they have to adapt to. Post-COVID, "a single route" to full medical practice in metropolitan France was defined in 2023 for holders of a non-EU medical qualification. This route, as in the past (see Section 2.2), requires successful candidates to rank at the highly selective skills and language verification competitions (*EVC*) in order to be eligible for one of a limited number of posts, before undergoing a compensatory two-year skills consolidation course, involving internships in relevant hospitals departments and re-enrolling for ongoing professional training in the health faculty. Certain stakeholders identified, however, two exceptions to this procedure. Firstly, for non-refugee candidates, the *EVC* is a competition, the success of which depends on both their ranking compared to other candidates and the number of positions available, while for refugees, the *EVC* is an exam in which the aim is to obtain over 50%. Secondly, considerations about unmet skills needs have shifted attitudes in much less wealthy parts of France, which struggle to attract health professionals, such as French Guiana, Mayotte, Martinique, Guadeloupe, and Pierre et Miquelon, where a procedure

was adopted in 2024 to allow non-EU medical professionals working in hospitals to present an application to a committee rather than go through the *EVC*. To facilitate access to the healthcare job market, accelerated compensatory training to obtain an equivalent qualification to a French nursing diploma has also been put in place for non-EU medical graduates, while non-EU qualified nurses can sometimes obtain partial recognition of their skills as a nursing assistant by applying to regional authorities (*DREETS*).

Stakeholders interviewed nonetheless pointed out difficulties with the current framework for the inclusion of workers and students qualified outside the EU in the healthcare sector, highlighting how these difficulties varied according to the origin and profession of migrants. Although the number of posts made available to *PADHUEs* through the *EVC* scheme has increased significantly in recent years, some stakeholders highlighted dysfunctions in the competitive exam, with results being delayed by up to 6 months at 2 days' notice in 2021 and 2023, thereby denying those who were ranked and obtained a post several months' work at a higher salary. In February 2025, a hunger strike was initiated by one *PADHUE* trade union after the 4,000 new posts announced by the French government in 2024 for candidates who passed the *EVC* were reduced. As reported in other scholarship (*Cottureau, 2015*), our informants largely recognised how difficult the inclusion processes were for medical professionals qualified outside the EU, with several qualifying them as examples of "administrative mistreatment."

For nurses, the requirement is to requalify by retraining for a full 3 years (with some exceptions and exemptions possible on a case-by-case basis). Because of this, one interviewed hospital's attempts to recruit non-EU-trained workers failed due to the limits of the regulatory framework:

To my knowledge, it is not possible to hire a nurse with a qualification from outside the European Union. This is simply because there is no system in place, as there is for *PADHUEs*, to validate their skills¹³ [translation].

Interviewees identified that, for medical and paramedical professionals who qualified outside of the EU, (at least temporary) skills devaluing is built into the system by the processes of professional regulation. As one Ministry of Health interviewee put it:

Nurses are generally recruited as nursing assistants in France, and not as nurses at all, except in extreme situations¹⁴ [translation].

Third-sector organisations have begun to provide specific support for professional inclusion in the health sector, often located in areas such as Paris, characterised by high levels of labour shortages and high concentrations of migrants, including recent migrants. The representative of one non-profit federation of health providers described how their organisation had decided to put in place a special training

¹³ Interview with a specialist doctor and *PADHUE* supervisor, periphery hospital, 27 August 2024.

¹⁴ Interview with a technical expert working for the Health Ministry, 16 December 2024.

scheme, complete with language classes, psychologists, social workers and core training to satisfy needs identified among migrant workers:

Our role is also to accompany them, because these are people who have lived through things that are complex and difficult in their country of origin. In addition to managing these complex things, we must also know how to explain to them that, in France, they have to start all over again¹⁵ [translation].

Refugees can face particular difficulties in having their qualifications recognised and finding positions in healthcare, due to their lack of professional network and, in some cases, because they were unable to bring their diplomas and education credentials with them to France. One advocacy lead for an NGO, which decided to develop a specific programme for refugees wishing to work in healthcare, as well as to support peer-to-peer initiatives by refugees themselves, said:

The refugee healthcare professionals who came to see us, who were struggling to find their way and ... It's been about two years since we decided to launch this programme to try to help them, because we really couldn't find anyone else who could support them¹⁶ [translation].

They explained that while refugee medics and pharmacists can go through the *EVC* examination process, because they are outside the competitive exam, they have no guarantee that an actual position is waiting for them after they pass, which would then allow them access to the skills consolidation course and a permanent post. Moreover, refugees who left their country of origin during their medical studies can find it difficult to re-enter medical studies in France at the same level or at a lower level because of the handful of places available to them.¹⁷

Recruitment of all foreign, particularly non-EU, healthcare students into long health studies, the cost of which is still at least partly borne by the state, appears to be limited. In 2022–2023, only 23,002 international students (8% of all international students, who themselves represent 13.7% of the total student population) studied health (medicine, dentistry, pharmaceuticals, midwifery, and nursing), of which 47% were from North Africa (see [Campus France, 2024](#)). International cooperation schemes exist to allow foreign medics to train in a speciality in France, although many of these courses do not provide certification that allows holders to work in the French system. Schemes for medics seem more numerous than those available for nurses, despite nursing being a university subject leading to a bachelor's degree since 2009. For foreign healthcare students, then, selection and differentiation by skill sets and qualifications reinforces other forms of social selectivity at the border ([Bréant, 2018](#)). It should be noted that to facilitate access to university for refugees and asylum seekers, third-sector and university actors have brought together funding to cover course fees for a “Bridging” university diploma (*DU Passerelles*), created in 2019, which provides French lessons and personalised signposting services and facilitates access to

grants and housing. In this way, NGOs' work highlights the “incomplete” and differential nature of mainstreaming in the health sector.

Stakeholders' accounts and perceptions show that mainstreaming of migration-related diversity has occurred for medical and pharmacy training and, to a lesser extent, for paramedical training. However, they also suggest an asymmetry in the priority given to migration “mainstreaming” by and within different professions. In a healthcare sector that acknowledges the existence of labour shortages, education credentials and their recognition are considered to play a pivotal role in ensuring patient safety and controlling the quality of care. For professionals qualified outside the EU, however, the rigid regulatory framework designed to test their skills devalues their previous qualifications and pushes them towards further education and training if they wish to remain in the sector at an equivalent level. In the next part, we will consider to what extent different actors perceive the need to reform this framework to facilitate greater and swifter inclusion.

4.2 Mainstreaming and perceptions of migration-related diversity at different levels of healthcare governance

The many layers of governance of health, HR, and education policy make it a highly relevant area to explore the polycentric mainstreaming of migration-related diversity in France. In a globalised sector, national policies regarding healthcare staff and training are affected by international diplomacy and policy work in disparate areas such as education, international development, industry, and commerce. France's global health strategy for 2023–2027, for example, indicates support for multilateral and bilateral HR initiatives abroad and affirms its wish to encourage international partnerships and cooperation as well as “international mobility for students, healthcare professionals and scientists in order to share best practices and encourage reciprocal skills and knowledge building” ([Ministry of Europe and Foreign Affairs, 2023](#), pp. 26–27). It also reiterates its commitment, as part of its global health action, to the WHO Global Code of Practice on the International Recruitment of Health Personnel, a voluntary code approved by WHO member states in 2010 which, amongst others, lists countries that should not be targeted when actively recruiting health or care professionals ([Ministry of Europe and Foreign Affairs, 2023](#), p. 27). However, state-level diplomatic commitments do not fully determine labour market and education opportunities for non-EU migrants in a healthcare sector where multiple stakeholders at different levels discuss, negotiate, and arbitrate processes for including workers in health work. In our interviewees' accounts, sometimes competing policy and/or moral goals (care standards, a shared skills foundation for healthcare staff, and social justice for migrants and non-migrants) create complex dilemmas regarding the inclusion of different groups in healthcare professions. In this section, we consider stakeholders' perceptions of these different imperatives and their strategies for balancing them, according to their organisations' interests and to their representations of migrant workers.

4.2.1 Stakeholder perceptions of mainstreaming dependent on their organisations' interests

As developed in Section 4.1, policy developments for health professionals trained abroad are ongoing but have also been highly

¹⁵ Interview with the head of paramedical training at a national non-profit federation of health providers, 2 July 2024.

¹⁶ Interview with Advocacy and fieldwork lead, NGO for refugees, 28 October 2024.

¹⁷ Interview with Advocacy and fieldwork lead, NGO for refugees, 28 October 2024.

uneven. Non-EU doctors and medical professionals have been recognised at the highest levels as mainstays of the health system (Drexler, 2024), and they are the subject of recurrent mobilisations by trade unions representing them. As recognised by an interviewee from the Health Ministry, this preference is partly determined by government's public policy focuses:

The central issue, however, concerning the migration of doctors outside the European Union, is indeed discussed very, very regularly, even several times a day, and in any case, is the subject of a number of discussions, whether directly by the ministerial office or by the central administration services.¹⁸ [translation].

While underlining the dominance of medical concerns in policy hierarchies, this interviewee nonetheless also explained that for nurses, the government had been asked by some major employers to think about “the possibility of building agreements, partnerships and cooperation with countries outside the European Union in particular, such as in North Africa.”¹⁹ The French state has a dominant role in the regulation of medical professions and immigration, capable of legislating on the conditions of practice of the regulated professions and negotiating bilaterally and multilaterally. However, in this stakeholder's account, the state's role appears to be that of a broker balancing the demands of different actors within the health sector to develop an inclusion framework for migrant workers that responds to economic needs but also is attentive to the specificities of different professions.

Disparate attitudes to migration mainstreaming within professions then become particularly significant. Our interviews suggest stakeholders' specific sphere of competence and influence and the interests of their own organisations determine the extent to which they engage with the idea that the regulatory framework needs to be modified to facilitate the access of non-EU qualified healthcare professionals to work and training. For example, two national-level non-state professional bodies, representing the pharmaceutical professions and the nursing profession respectively, diverged in their strategies for creating greater opportunities for migrant professionals. Both highlighted the relatively small numbers of migrant workers in their professions, as well as the shortages in their sector. However, these two bodies represented professions which in total numbers (regardless of the origin of the qualification) are very different: 73,600 pharmacists practiced in France in 2022, compared to 637,644 nurses in 2023. The potential for including new workers is therefore very different.

On the one hand, a professional body representing pharmacists and pharmacy workers underlined that policy procedures and compensatory measures initially designed to include non-EU doctors were too restrictive for the pharmaceutical professions, which includes medical biologists, pharmacists in a dispensary, pharmaceutical technicians and industry pharmacists. Declaring that they were concerned about the unequal effects of existing inclusion measures, stakeholders interviewed were working closely with government to adapt the current legislative framework to find ways to open up the EVC and skills

consolidation training pathway to more non-EU qualified pharmacists and pharmaceutical workers:

Until now, the system was designed in such a way that when you were a pharmacist from outside the European Union, the knowledge assessment tests and the subsequent skills consolidation programme were solely for hospital use. This meant that a certain number, a large number of pharmacists, who came from community pharmacies or from industry, could pass the knowledge assessment tests, but they were not suitable. The internship that the CNG or the ARS [regional health agency] could then assign them as a skills consolidation programme was again hospital-based and had nothing to do with what they had done. If someone left their country who had worked for 20 or 15 years in their country in a pharmacy, but had not worked in a hospital, nothing has been adapted to them. Today, since 1 January 2025, we have been working on adapting these measures²⁰ [translation].

They also criticised the unfairness of current rules based on nationality, which they had asked the government to change to allow non-EU citizens with a qualification obtained elsewhere in the EU to work in France (and thereby ensure equality with EU citizens). Throughout the interview with these representatives, their focus was largely on adjusting the current system to create fairer conditions for migrants already in France, rather than on increasing flows from abroad into the profession.

In contrast, a representative of a professional nursing body revealed that the French government had consulted their organisation about the idea of developing a partial practice procedure for nurses trained outside the EU, which would enable them, like medics, to work as nurses while they retook their French *diplôme d'état* exams. The interview with the representative of this body took place shortly before the finalisation of legislation granting a larger scope of practice and greater autonomy to nurses, who had previously been more dependent on medical prescriptions for certain acts. In this context, in the name of defending both the value of the French nursing qualification and weaker health systems which might be affected by brain drain, this representative resisted the idea that nurses qualified outside of the EU might work in the French health system without first validating all the modules required for the French *diplôme d'état*:

I know that we, personally, like many European countries, are extremely concerned about a kind of global movement among leaders who seem to believe that, regardless of the level, we need manpower, and lots of it. And that is not at all the policy we advocate. We believe that we must not distort the nursing profession as it exists in Europe, that we have skills and that we are fighting for recognition of our autonomy, our professional added value and our contribution to the health system. In France, there is a shortage of doctors, so they are proposing alternative solutions with cooperation protocols and delegations at certain levels of activity. We are not at all in favour, like some examples we hear of, of going to India to recruit or even train professionals who will then be sent abroad to come here, and even on the level, I would say... [...] Ethically speaking, I find it very shocking to

¹⁸ Interview with a technical expert working for the Health Ministry, 16 December 2024.

¹⁹ Interview with a technical expert working for the Health Ministry, 16 December 2024.

²⁰ Interview with three representatives of a national professional body representing pharmacists and pharmacy workers, 24 February 2025.

go and recruit young people... In fact, we are going to recruit brains and arms in countries that need them themselves and that have an insufficient number of nurses in their own countries²¹ [translation].

This interviewee further backs up their argument by referring to a particular type of worker (a mother from a poorer war-torn country) that might be particularly negatively affected by attempts to attract more foreign nurses to France:

Speaking of ethics, I was in contact with [a colleague in Lebanon] at the time of the [2025] crisis, and when the effects of the war were felt, many Lebanese nurses emigrated to France, and we had a lot of them in eastern France. They [plural female pronoun used in the French] came to work all alone to earn French salaries which aren't that great, but anyway, they were sending all their salary to Lebanon. [...] So that's where, on an ethical level, I have a problem. I mean, she didn't have enough people in her hospitals. And [we] had the Lebanese nurses²² [translation].

This stakeholder highlights both economic and moral stakes of the dilemmas faced by their organisation on the question of opening up nursing to non-EU qualified professionals. Faced with socially complex situations, stakeholders are brought to choose between different moral arguments (such as “brain drain” or “brain waste”) and often base their thinking on representations of a specific group of migrants. These examples also show that multiple national-level, non-state stakeholders contribute to thinking about bordering processes that affect the regulatory framework determining which health professionals trained outside the EU can access work and/or the training required to validate their previously acquired qualifications in France. In the next section, we will consider how the perceptions and choices of local-level stakeholders implementing this framework can affect education and training opportunities for non-EU migrants.

4.2.2 Differential local implementation of the regulatory framework and its effects

Despite the multistakeholder policy work carried out over recent years to simplify the policy framework, our results suggest that a high degree of discretionary power and autonomy among employment, education, and training stakeholders reinforces differential inclusion processes for professionals who qualified outside the EU and who seek use their skills in the French health workforce. Inequalities across regions, timeframes of access to education and training and the willingness of individual or collective stakeholders to engage with mainstreaming processes to facilitate them are key factors determining their impact.

Disparities in care provision and coverage between regions, as well as between cities and rural areas, are often at the heart of policy conversations and statistical production on skills shortages in French healthcare. The spatial distribution of non-EU healthcare workers suggests employers and education stakeholders engage with these skills shortages in different ways. While metropolises like Paris, Lyon, and Marseille that have greater care needs also have large concentrations

of foreign healthcare workers, rural and underserved areas have, in certain cases, also turned to non-EU workers to maintain care levels (Cottureau, 2015). However, local dynamics affect engagement with the recruitment and (re-)training of healthcare professionals qualified outside the EU. For example, one hospital group's HR development representative explained informally that his group has no formal policy on hiring professionals qualified abroad, despite having some *PADHUEs* in their ranks, as these types of recruitments and retraining are deemed too complicated from a financial and HR point of view.²³ In contrast, we met a peripheral hospital in an underserved rural area in another region that had developed a clear policy of recruiting *PADHUEs* from France and from abroad and had increased its medical staff from 100 to 150 in this way, enabling it to open new services for patients. Its strategy involved providing attractive conditions for working while preparing for the *EVC*, then supporting those who ranked through compensatory training measures. Again, representations of social justice affect stakeholders' engagement in support of these measures. The interviewee at this hospital went on to justify their personal decision to assist their *PADHUE* colleagues by citing their own and other French colleagues' international experiences:

If a French person has the right to say I want to go somewhere else and I'm going to Canada or Switzerland, why shouldn't a Malian or a Brazilian have the right to say I want to go to France? So the idea is not to systematically bleed healthcare systems that are already in dire straits. But if individual people want to move and we need them, I'm not shocked²⁴ [translation].

Differences in the ways medical workers qualified outside the EU are able to request retraining after the *EVC* also exist, depending on local factors. Doctors teaching in a university hospital and in charge of coordinating training programmes for *PADHUEs* highlighted that health planning stakeholders at the regional level did not always help them make sense of institutional demands and standardised agreements to facilitate contractualisation between training partners. One stated that the decision to help *PADHUE* doctors retrain through the skills consolidation pathway and find internship supervisors had been theirs alone, as *PADHUEs* were considered “surplus” students, on top of their usual quota of students coming through the French system, that teaching supervisors could reject, ignore, or accept:

I've been given no assignment to look after the *PADHUEs* who are on our territory, but I don't think that, humanly speaking, it's legitimate to [refuse] them, given the career paths we've described. [...] But in any case, for me, there's no level to support these students²⁵ [translation].

One NGO supporting refugee doctors explained that part of their advocacy role is to find university doctors in hospitals who can mediate with colleagues to develop new posts and training opportunities and influence employers' perceptions of the transferability of skills.²⁶

²³ Notes from observations at a professional salon, Paris, 20 May 2025.

²⁴ Interview with a specialist doctor and *PADHUE* supervisor, periphery hospital, 27 August 2024.

²⁵ Interview with a doctor and researcher in charge of training junior doctors at a university hospital, 22 August 2024.

²⁶ Interview with Advocacy and fieldwork lead, NGO for refugees, 28 October 2024.

²¹ Interview with a representative of a professional nursing body, 15 May 2025.

²² Interview with a representative of a professional nursing body, 15 May 2025.

In these examples, migration mainstreaming processes appear dependent on the willingness of staff in key positions in the health system to enable workers to retrain.

Regional disparities and inequalities also appear in the question of the time needed for professionals qualified outside the EU to retrain. Several stakeholders interviewed gave examples of how the lack of or uncertainty around institutional mechanisms for the implementation of the regulatory framework could hold up the process of retraining and revalidating qualifications. Some interviewees pointed out delays maintain a cheaper, more precarious and more available workforce within a hospital system racked by shortages. On the other hand, without disavowing the need for regulators to carry out on checks on skills, other stakeholders highlighted the practical mechanisms that lengthened the process both of carrying out these checks and of adapting skills through education and training. One issue is the time required for the training system to adjust provision to care organisations' and healthcare workers' needs. A representative of a professional body for nurses pointed this out:

So we have a real problem in France with adapting nurses who come from abroad, unlike some countries that have set up proper adaptation programmes, etc. We are not very advanced in this area. For example, a nurse who needs to take additional modules has to wait for these modules to be offered at the IFSI (nursing training institutes) in order to take them. They are not designed specifically for them²⁷ [translation].

Despite potential delays, institutional responsibility for providing core professional training for employees seems relatively clearly signposted. Responsibility for French language learning seems less so, however. For many regulated professions, a high intermediate level of French (B2 on the Common European Framework of Reference for Languages) is required to retrain and work. Outside of the language provision provided through the major integration stakeholders, such as the *Office Français d'Immigration et d'Intégration*, which only concerns basic and low intermediate levels of French (A1.1 to B1), or the university few providers offered funded language classes at B2 levels and above. Classes run by volunteers in NGOs, or paid for with individual training credits built up by already employed workers, are often the only possibilities for those wishing to learn higher-level French in a collective setting, without paying a private company or tutor.

5 Discussion

Scholarship has highlighted that antagonistic forces drive debates around access to education: "Education is [...] a bordering practice. Institutionalised systems of education are invariably tied to the interests of the nation state and are at the same time spaces and places essentially characterised by the coming together of people" (Gerrard and Sriprakash, 2018, p. 107). Policy dilemmas around migrant inclusion have equally been linked to sometimes apparently contradictory global and domestic social justice goals. These translate "the inherent tension between liberal commitments to universal values and human rights and the necessarily particularistic pursuit of the common

interests of a country's citizens and residents to the neglect of outsiders" (Schmid et al., 2025, pp. 30–31). In this article, we have sought to explore the mainstreaming of migration-related diversity and, more specifically, the inclusion of healthcare professionals already trained and/or qualified in non-EU systems, in French healthcare work through retraining. We have shown that mainstreaming does not just depend on state-level policy activity but also on key stakeholders at all levels of the health system. While we have analysed stakeholders' perceptions and choices at multiple levels, the difficulties we experienced in persuading employment and government-level policy stakeholders to participate in the study limit certain conclusions, for example, around the granting of work permits to healthcare workers. However, this reticence to participate is in itself interesting, as it suggests that policy dilemmas, resistance or advocacy on this issue are partly expressed, negotiated and dealt with behind closed doors, between health, education and immigration policy actors. Indeed, it highlights the role that the regulation of employment, education, and training in certain professions plays in "migration management" (Bach, 2006), which remains a discretionary state prerogative. One of the findings of this study has been the uncertainty and difficulties stakeholders feel in identifying political leverage that would enable them to make a change in the domain of migrant inclusion.

French policy on migrant labour market inclusion develops in a specific national context. In their 2017 article, van Breugel and Scholten highlighted that the French tradition of universalism, with the emphasis it puts on the individual relationship to the state and its refusal to recognise officially ethnic groups, means France has a long history of "colourblind" approaches that "have much in common" with the principles of governance mainstreaming (van Breugel and Scholten, 2017, pp. 516–517). The absence of migration data in employers' human resource statistics, for example, can be partially understood in light of this tradition, which could also explain the low rates of stakeholder participation in this study. However, the French policy tradition, like other European countries, is also based on a model conceived of "as people leaving one country to arrive in another country where they were subsequently 'integrated' into the container-like national social system" (Schneider, 2025, p. 189). Inversely, the stakeholders interviewed have to grapple with the implications of working within a national policy system, while being themselves very often involved in European or international policy forums, such as the WHO. Their accounts and our desktop and literature study revealed enmeshed policy forums and interests that affect national policy. "Mainstreaming" of migration-related diversity in France has been pushed forward by European education and anti-discrimination agendas, which have shifted borders to access to French healthcare work: the border for immigration control and for both access to higher education and professional training and the recognition of educational credentials has moved to the EU (Cottreau, 2015). Borders are not, however, applied in the same way to all those non-EU citizens who wish to cross them.

This article has shown policy mainstreaming developments for health professionals trained abroad to be ongoing but also highly uneven, with policy work focused more on medical and pharmaceutical professionals. We have argued that this can be explained partly by state-level preferences but also by the way migration inclusion dilemmas are arbitrated at the level of professional bodies and other sectoral actors. Processes of "mainstreaming" migration-related diversity have developed in ways that defer non-EU qualified professionals' equality of status by bringing them back into education before they can fully

²⁷ Interview with a representative of a professional nursing body, 15 May 2025.

requalify. This choice seems to have been made to satisfy concerns about care standards by ensuring non-EU healthcare workers go through professional training (and language exams) designed to socialise them within the French health education system, build a skills base shared with others in their profession and reinforce employers' trust in their skills. For the medical profession, it has previously been concluded that "the decisions taken about doctors with non-EU degrees do not represent a simple recording, at state-level, of a consensus expressed with the medical profession. These decisions have been the result of struggles between actors with different interests, the result of which has depended on unequal power relationships between these actors and the opportunities offered to them by society to support their positions" [translation] (Déplaudé, 2011, p. 230). We can prolong this analysis to the relationships between professions: the continuing dominance of the medical professions in health policy forums partly explains the need expressed by some representatives of the nursing profession to defend the value of the French nursing qualification, including by opposing partial practice measures for nurses qualified outside of the EU.

Hierarchies between professions could also be a partial explanation for the policy focus on mainstreaming in the medical and pharmaceutical professions. But the gender implications of these policies and their implementation should also be explored, despite being largely absent from interviewees' accounts. Though the demographics of the medical and pharmaceutical professions are less male dominated than in the past (50% of doctors are women in 2021—Anguis et al., 2021), the choice to focus less on opening the nursing professions to migrant workers could be analysed through the lens of traditional male breadwinner models: are nurses, who are predominantly female, seen less as a demographic of a work-related immigration requiring professional integration measures?

Our results also suggest that mainstreaming of migration-related diversity is incomplete, as van Breugel and Scholten conclude in their analysis of more global French policy (2017). However, by highlighting struggles for influence and different positioning by policy actors, we suggest that mainstreaming can never be fully complete until migrants are offered full equality with non-migrants. The mainstreaming observed through our study appears jagged and uneven, transcended by logics of social and professional differentiation and selectivity. Skill levels, educational background, and socioprofessional background provide a launch point for gatekeepers managing external and internal borders to judge the legitimacy of applications to cross these borders. However, several corollary effects of this approach can be observed. Difficulties placed in front of non-EU professionals wishing to use and validate their health qualifications in France can be understood first as a way of managing the mobility of health professionals, by discouraging or limiting individual or collective initiatives to move to France outside of partnerships and cooperations. Secondly, they represent a way of managing the social and professional expectations of qualified migrants by deskilling them as they cross the border. By devaluing their educational and professional credentials, procedures for accessing the healthcare workforce can encourage professionals to accept either downward social mobility or disadvantageous working conditions, at least while their qualifications are revalidated, and sometimes after that. Our results suggest that immigration control combined with the internal borders we have described creates within the French health service a group of overqualified workers whose downward mobility, if they remain within the health service, ensures

healthcare establishments can employ workers with higher levels of training and ability on certain subjects than the employer has paid for.

The literature has explored the effect on migrant integration of "increasingly complex stratifications of legal statuses [...] driven by a perceived need to defend the national resources of welfare systems and labour markets, creating differential entitlements for migrants to access education, welfare benefits and, dependent on their route, the right to work" (Oliver and Hughes, 2018, p. 130). However, the impact of the diversification of stakeholders involved in migrant governance on this stratification, on social and professional mobility and on skills mismatch has not been fully explored. Our interviewees give the point of view of sectoral stakeholders tasked with finding ways of adapting their sector to greater social complexity. Our results suggest that the multiplicity and relative autonomy of employment, education, and training stakeholders in the French system can reshape and sometimes reinforce or mitigate the differential inclusion outlined in the legal framework regulating how non-EU citizens and those trained and qualified outside of the EU access healthcare work in France. In a system in which many HR and training decisions are pushed down to hospitals, universities and training centres, the argument in favour of mainstreaming migration-related diversity by developing more inclusive measures has to be fought and won in multiple arenas again and again.

The complexity of definitions and borders in the policy framework for including non-EU workers and students also has the effect of individualising trajectories and implementation of frameworks and diminishing the potential for forming groups of migrants to participate in social dialogue and bargaining. As is shown by the existence of "PADHUE" doctors' trade unions, the development of a political framework to allow their integration into the health service also established the conditions for contesting this framework by forging a clearly defined group of workers with similar interests. This process is much less visible for other professions, such as nursing, where foreign or non-EU-trained professionals are considered in the system as individuals, not as collectives. In line with van Breugel and Scholten's results, we can underline that in the context of the French healthcare, in most cases, the "burden or obligation to integration is clearly placed one-sidedly with migrants and their individual responsibility to integrate, and 'fit into the mainstream'" (van Breugel and Scholten, 2017, p. 523).

6 Conclusion

This article examined how French health education and training policy stakeholders perceive and promote the job market and educational inclusion of migrants already trained and qualified outside the EU. It drew on the content analysis of a corpus gathered through a desktop study and 18 in-depth semi-directive interviews with employment, policy, education and training stakeholders to analyse multi-stakeholder governance of the health sector. Although limits to our study exist, caused by difficulties engaging policy stakeholders, this article reveals a system of inclusion that delays or blocks equal treatment with French-trained professionals by pushing migrants towards retraining and requalification. The shift from French national borders to EU borders that occurred in the late 2000s and impacts the delivery of visas, professional recognition of qualifications, education, and

training, has contributed to structuring uneven development and the differential implementation of the regulatory framework determining migrant inclusion in the health sector. On the one hand, interviewees were faced with the complexity of an education and training system limited in its capacity to renew a healthcare workforce perceived to be beset by shortages. On the other hand, stakeholders interviewed revealed that change depends on organisations that hold different positions on how best to defend professionals' interests and provide care. While some actors voluntarily alter their professional practices to better include migrant colleagues, others prefer to maintain the status quo or hesitate to engage with the question.

The concept of mainstreaming recognises migration-related diversity as having complex links to social and economic outcomes and that solutions to improve these outcomes cannot be isolated into a single policy domain (van Breugel and Scholten, 2017, p. 514). Mainstreaming was chosen as a conceptual basis for this article as it provides space to ask how multiple stakeholders at different levels of governance prioritise or promote better inclusion of migration-related diversity. Moving on from national analyses of mainstreaming trends (van Breugel and Scholten, 2017; Escafré-Dublet, 2014), we focused more specifically on one sector to highlight the multiplicity of actors involved in inclusion processes and the social complexity and ethical dilemmas they faced, as they navigate their role in maintaining care standards, ensuring sufficient staffing levels and responding to domestic and global justice claims. The autonomy of different actors and the variety of attitudes to migrant inclusion show mainstreaming to be a process that is jagged, uneven, and dependent on both the varied interests of policy, employment and education actors and their differing perceptions of the needs of the sector, professions, and migrant workers. As such, mainstreaming appears to be a constantly ongoing process instead of one that may one day be complete.

Data availability statement

The datasets presented in this article are not readily available because access to data is restricted as interview texts, despite being anonymised, could mean participants were identified. Requests to access the datasets should be directed to Joanne Walker, Samuel Delépine, Jaoven Launay skills4justice.esoangers@contact.univ-angers.fr.

Ethics statement

The studies involving humans were approved by Comité d'éthique de la Recherche (CER), COMUE Angers-Le Mans. The studies were conducted in accordance with the local legislation and institutional requirements. Written informed consent for participation was not required from the participants or the participants' legal guardians/next of kin because a formal written consent form was considered by the research team as detrimental to the fluidity of relations with participants before and during the interviews. Written consent was obtained in that participants all replied positively by e-mail to requests to participate in the research after having been provided with written information concerning their right to not participate, or change any data given to us at a later date. This information was reiterated during

interviews. Oral consent was obtained in all cases and recorded in most cases. Recordings were retranscribed and sent by e-mail to participants to check if they wished to change anything.

Author contributions

JW: Conceptualization, Data curation, Formal analysis, Methodology, Resources, Validation, Writing – original draft, Writing – review & editing.

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Conflict of interest

The author(s) declared that this work was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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The author(s) declared that Generative AI was not used in the creation of this manuscript.

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