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International Mobility of Nurses from Kerala (India) to the EU: Prospects and Challenges with special reference to the Netherlands and Denmark

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Abstract

The estimated six million nurses and midwives in the WHO European Region are inadequate to meet current and projected future needs. In several of the EU countries, expected shortages are accentuated by the fact that the health workforce is ageing and a growing proportion of workers will retire soon. These countries are diversifying strategies to remedy shortages. At the governmental level, the EU countries seek to minimize migration from developing countries citing 'ethical' concerns about shortages at the source. However, nurses from developing countries including India remain a potential source of supply that has been tapped by the EU countries from time to time. In this context, this paper examines the prospects for the migration of nurses from Kerala to the EU and the challenges in this regard. The state of Kerala is of interest because of its history of migration of nurses to Europe, its strengths in education and its health sector achievements. The paper takes up the cases of two EU countries – the Netherlands and Denmark – to understand better the challenges to the mobility of nurses to the EU. The Netherlands and Denmark have recruited small numbers of Indian nurses and operation theatre assistants in the recent past. Both countries are contending with present and future shortages of nursing staff, yet there is a discernible mismatch between their immigration policies with respect to nurses and the demands of hospitals / employers. In this context, sporadic network driven migration of nurses mostly from Kerala has registered greater success but there has been less space for the evolution of a coordinated approach to migration from India i.e., between governments, recruiting agencies and employers. To study the policy context for the migration of nurses from non EU countries in the Netherlands and Denmark and the experiences of nurses, the paper uses material generated through interviews conducted in October 2012 with a cross section of stakeholders in these countries. The paper also evolves recommendations to enable a mutually beneficial and planned mobility of nurses to the EU.

Keywords: *India, European Union, Mobility of Nurses, Migration Policy*

1. Introduction

The international mobility of nurses has grown significantly in recent decades in response to globalization and supply-demand dynamics. It has been facilitated by enhanced connectivity including better flow of information, communication and reduced costs of travel. There is an increased demand for well trained nurses in the developed regions of the world today because of an aging population, the increased prevalence of chronic diseases, shortages of primary care physicians, and the use of nurses in managing complex clinical cases (Gostin, 2008:1828). The impact of ageing is being felt also in terms of a shortage of health personnel. The health workforce in OECD countries is ageing i.e., a growing proportion of health workers are now in their 50s or early 60s and may be expected to retire soon. However, shortages in health care staff are a global problem that also reflects inequalities in the fight against diseases. Reflecting the disparity between developed and developing countries, the Americas region (North and South combined) has only 10 per cent of the global burden of disease yet accounts for more than 50 per cent of the world's financial expenditures on health and employs 37 per cent of the global health workforce (WHO, 2006).

Developed countries have employed several strategies to address shortages in nurses. These include cutting down on the staffing requirements of hospitals on the one hand and increasing training and retention of nurses at home, enhancing productivity of existing nurses and adopting a more efficient skill mix on the other hand. Recruitment of foreign trained nurses has been an important strategy to address shortages. Increasingly, however, it is viewed with concern by some developed countries and framed, in this light, as a short-term solution. The view that international recruitment of foreign health professionals exacerbates the shortages in developing countries has been emphasized in recent years through international guidelines and national directives on "ethical recruitment."[1] Nonetheless, the aspiration to migrate is evident at a personal level and in national programmes of training and "labour export" by countries like the Philippines.

[1] Policies to encourage periodic return or circular migration among the highly skilled have also been proposed to address the concerns over shortages caused by emigration of health workers from developing countries. They include temporary employment visas, grant of multi-year visas, guarantees of readmission, recognition of dual citizenship and partnership agreements providing for financial incentives. See (AP-MagNet, 2012)

Nurses may migrate for reasons that cut across demand side and supply side contexts. Indian nurses look for overseas opportunities because of the lack of opportunities for professional growth and skill development at home and because of poor working conditions and poor quality of training. But they also aspire to work and live overseas. Besides, migration also depends upon portability of skills, recognition of qualifications, social networks and active recruitment (Dussault et al, 2009: 22). In this context, language may play an important role in determining a destination (Buchan, 2002) as also geographic proximity to the proposed migration destination (Silva & Fernandes, 2008).

Not surprisingly then, among the industrialized regions, North America (the USA and Canada), the UK, Ireland and Australia are reckoned as important and even preferred destinations of Indian nurses. If the scarcity of nurses in the developed regions has led to large scale migration from the global south since the 1990s, India or more precisely the state of Kerala has been a source of nurses for the West and the Middle East since the 1960s. Movement from Kerala gained momentum in the 1970s, with the oil boom in the Middle East. Since then nurses from Kerala have established a reputation for mobility across the world and are ubiquitous in hospitals across India.[2] Yet we neither have definitive estimates of the quantum of their movement nor a sufficient explanation for the remarkable foothold they have gained in the nursing profession. Malayalee Christian nurses began to migrate to Europe in the 1960s, much before the recent shortages, and have built up strong social networks in some of these countries. However, their numbers vary significantly across the EU countries.

Given that the estimated six million nurses and midwives in the WHO European Region are inadequate to meet current and projected future needs, there are significant prospects for mobility of nurses from India. Kerala with its long history of the migration of nurses, strengths in higher education and health sector achievements is a useful context for investigation of the prospects for the mobility of nurses. While emigration of nurses from Kerala to Australia, USA and to the Gulf region has been studied, there is a knowledge gap in understanding the migration

[2] Impressionistic estimates suggest that 80 % of nursing staff in Hyderabad hospitals are from Kerala (The Hindu, June 9, 2012) as are 60 to 70 % in Bangalore (Bageshree, 2012) and close to 80 per cent of nurses in Delhi and Pune (Nair, N, 2011). Half the nurses in a sample of 40 aspiring migrants in a hospital in Delhi studied by Khadria (2004) were from Kerala. More than half the sample of 448 nurses drawn from several hospitals in Delhi was from Kerala (Thomas, 2006: 279). The migration of nurses from Kerala to distant parts of India and overseas has been the subject of numerous media reports (See Nair, N., 2011, Rosen, 2006, George, 2012).

experience and the profile of the nurses in EU countries. Research suggests that the emigration of nurses from Kerala including to Europe is largely personal and network-driven (Walten-Roberts, 2010: 208). A study of the key enablers and barriers to the mobility of Indian nurses to Europe from a transnational perspective is therefore timely in the light of the looming healthcare workers' crisis in Europe.

The paper is divided into eight sections including the introduction and conclusion. The following section elaborates on the objectives and methodology. Section III provides an overview of the patterns of migration, locates the migratory disposition of nurses from Kerala in the social context of early mid twentieth century and examines supply side issues in contemporary Kerala. Section IV introduces the policies followed by EU countries with regard to the international recruitment of nurses. This is followed in Section V by an overview of the scale of migration of nurses from India / Kerala to European countries and the factors affecting current flows. Section VI maps the policy matrix prevailing in the selected EU countries: the Netherlands and Denmark and the challenges to the mobility of foreign-trained nurses in these countries. Material from interviews conducted with stakeholders in these countries forms the core of this section. Section VII engages with the perspectives of internationally recruited nurses from India with reference to the larger literature and interviews with nurses from Kerala who had migrated recently to Denmark. Section VIII gives the conclusions and recommendations.

2. Methodology

This paper is an effort to understand the prospects for the mobility of nurses from Kerala (India) to the EU countries, in view of policy related considerations in the EU countries and the history and practice of mobility of nurses from Kerala. In order to obtain specific and relevant information in this regard, the Netherlands and Denmark were selected for more detailed investigation. Both countries will experience shortages owing to their demographic profile. Parts of these countries already experience the burden of rising costs of elderly care and a retiring health work force. Denmark and the Netherlands were selected also because of a labour mobility partnership that has been negotiated with the former and ongoing negotiation on a human resources mobility partnership with the latter. Apart from relying on appropriate secondary sources of information for this paper, field work was conducted in the Netherlands and

Denmark.[3] The authors' conducted interviews with a cross section of stakeholders in Denmark and the Netherlands between 1st and 8th October 2012. Prior to the field visit, we identified the stakeholders in Denmark and the Netherlands on the basis of their role in the regulation of nursing standards, qualifications, registration and establishing procedures for immigration and work in the EU.[4] We also made an effort to contact service providers, particularly hospitals and nurses, and groups working to protect the interests of nurses.

The aim of the field investigations was to identify the interests and conflicts if any involved in the recruitment and mobility of foreign nurses. We conducted semi structured interviews with the relevant government agencies, industry bodies, employers' organizations, nurses associations, consulting, recruitment firms and research organizations. In this process we developed and used guidelines with open ended questions for each respondent. We interviewed 21 persons in Denmark and the Netherlands.

In Denmark we interviewed representatives of the National Board of Health; the Danish Agency for Labour Retention and International Recruitment; Elderly Care, Management for Health & Care, City of Copenhagen; the retired head nurse of a hospital that had recruited Indian nurses and two of the nurses who had been recruited by the hospital and a job consultant who was involved in the recruitment of Indian doctors to Denmark. We also had discussions with scholars of migration from the Danish Institute of International Studies and the Danish Research Centre for Migration, Ethnicity and Health, Department of Public Health, Copenhagen University.

In the Netherlands, we spoke to Senior Policy Advisors, Ministry of Social Affairs and Employment; Senior Policy Officer, Immigration and Naturalization Service, Ministry of Interior; and Coordinator Labour Policies, Ministry of Health, Welfare and Sport. We also interviewed a representative of the Nurses Association and senior consultant at a management consultancy firm that was commissioned a report on international migration of health care workers by the Ministry of Health in the Netherlands. We also had discussions with a senior scholar of migration studies and a researcher at the Faculty of Law, Maastricht University. We also interviewed a nurse in Pala (Kottayam District, Kerala) who had returned in early 2012 after five years of service in Denmark.

[3] The field visit was supported by the India Centre for Migration, New Delhi.
[4] This was done in association with Ms Karolina Batcho, the EU Local Coordinator for the study, who also conducted a preliminary literature review of five EU countries and helped set up the interviews.

3. International Mobility of Nurses from Kerala

3.1 Scale and composition of migration

Recent surveys affirm the domination of overseas migration of nurses from India by Malayalee Christian women but the nursing student body in Kerala is much more diverse today than it was previously. Hindus and Muslims together comprised close to half of at least one large sample of nursing students in recent years and the proportion of Hindus intending to migrate was only a little less than the proportion of Christians (Walton Roberts, 2010: 9). The social composition of aspiring migrants among Indian nurses too is becoming more diverse. The intention to migrate is notable among Punjabis nurses.[5] Known for their strong migratory disposition, the people of Punjab have built social networks across Europe and North America. Unlike migration from Kerala, migration from Punjab has been led by men, but recently women nurses have also entered into the OECD countries (Sharma, The Sunday Tribune, 2005).

Currently the major destinations of Indian nurses are the Gulf countries and the OECD. An estimated 60,000 Indian nurses, predominantly from Kerala, are in the Gulf countries (Percot, 2006), where programmes of nationalization of the workforces pursued since the 1980s have not stemmed the flow in any serious way.[6] It is also apparent that Malayalee nurses are showing increasing interest in the OECD countries. Most nurses under the jurisdiction of the Kerala Nursing Council head for English-speaking destinations: 38% of Kerala´s nurses work in the US, 30% in the UK, 15% in Australia, and 12% in the Gulf (Lum, 2012).Outflows in a single year may be quite large when as in the past decade there was significant global demand for nurses and co-ordination of movement. The State Medical Council Registrar's Office reported in 2003 that more than 14,000 qualified nurses from the State had cleared their certificates to leave for the U.S., Canada, England and Australia. Notably 30 percent of them were said to belong to the

[5] Whereas 73 % of Malayalam speakers desired to migrate as compared to 63 % of the sample, 50 % of Sikhs aspired to migrate as did 48 % of Hindus even as the Christians registered the highest proportion of aspiring migrants (Thomas, 2006: 281).

[6] In 2011, the Kerala Government had talks with the UAE government about streamlining recruitment of nurses from Kerala to overcome shortages in the UAE on account of an increase in health providers (Saberi, Kerala tackles Nurse Recruitment Racket, Sept 17, 2011). The Ministry of Health in Kuwait recruited 1000 nurses from India in September 2011. In May 2012, Saudi Arabian Health Ministry officials were in Delhi, Hyderabad and Kochi to recruit nursing staff. In the case of Saudi Arabia, the Overseas Development and Employment Promotion Council (ODPEC) - the Government of Kerala manpower recruitment company -- had invited 3000 nurses for the interview to Kochi (Saudi Arabia to recruit nurses from Kochi, *Times of India*, May 28, 2012). A later report said over 600 nurses had been recruited (Abdullah Al-Qahtani, MoH Foreign nurses with 10 years' service to lose jobs, Saudi Gazette).

State Health Service. The Registrar, Kerala State Medical Council was quoted as saying, "[e]veryday, on an average, 100 attestations are issued to nurses seeking employment abroad' (Pazhanilath, 2003).

Recent outflows of nurses to the Gulf countries and the OECD from the major recruiting hubs in India have been significant.[7] Indian nurses are a growing presence in the OECD countries in the past decade. In 2000, India ranked sixth in terms of origin countries of nurses in the OECD countries with 22,786 nurses in the region, far below the Philippines, the leading exporter of nurses (Dumont and Zurn, 2007: 212). Since then, however, India became the principal supplier of nurses to the UK and Ireland, the third largest source of internationally educated nurses (IEN) in the US and the third and fourth largest supplier of nurses respectively to New Zealand and Canada. India accounted for 10 % of IEN in the US in 2008 (US Human Resources and Service Administration, 2010) and 5.3 % of the foreign trained workforce in Canada in 2005 (compared to 30.3 % from the Philippines) (Kumar and Simi, 2007: 29).[8] Australasia too is the destination of a growing number of Indian nurses in the last decade.[9] Since 2003-04, India has been third among the top source countries of foreign nurses entering New Zealand, after the UK and the Philippines. The annual registration of nurses trained in India increased from almost none in 2000 to 100 in 2005 (Zurn and Dumont, 2008: 37). In the past three years, a total of 1003 Indian nurses registered in New Zealand.[10]

3.2 Historical Perspective on the Mobility of Nurses from Kerala

Nurses from Kerala were pioneers in opening up a new avenue of employment for migrants in Europe, the US and the Gulf and in taking up the position of the main breadwinners of their families. As their husbands and family began to follow them overseas, they reversed the gender pattern of migration. In the early phase, Bombay was the launching pad for nurses seeking to go to the Gulf countries, the US and East Africa.[11] Movement to the Gulf countries since the 1950s

[7] It is estimated that 10,000 nurses may have migrated from New Delhi in the two years prior to the study, mostly to the US, as compared to 11,000 from Bangalore and 7,000 from Kochi to the Gulf and the OECD countries (Khadria, 2007).
[8] See Appendix A for the growth of IENs from India since the 2000s and the rise in aspirations among Indian nurses to go to the USA in the numbers of nurses attempting and succeeding in the qualifying examinations.
[9] See Appendix A for the increase in the share of foreign trained nurses in Australia and New Zealand.
[10] This comprised 318 in 2009-2010, 331 in 2010-2011 and 354 in 2011-2012 (Nursing Council of New Zealand, 2012).
[11] The husband of a nurse, who had gone to work in Kuwait in 1959, recalled that several Syrian Christian men in Bombay had been recruited by the Kuwait Oil Company at the time opening up a route for migration to Kuwait.

was linked to the relative ease in getting jobs "because the process did not include sponsorships and tests. Typically recruiters from countries like Kuwait or Saudi Arabia would hold interviews in India and pay all travel expenses for those selected to work" (George, 2005: 53). The Gulf countries do not offer permanent residence but remunerative salaries made them appealing. The US has been open to foreign nurses since it relaxed its immigration laws in 1965. US hospitals conducted recruitment campaigns for nurses in the Philippines and in India because of critical shortages of nurses in the 1960s and 1970s, arising from the expansion of medical coverage and the decline in women attending American nursing schools (Williams, 1996: 15). Nevertheless, India was among the smaller source countries during the period. Of the foreign nurses newly registered in the US in 1972, 14 percent were from India, Korea, Thailand and the Caribbean put together (Mejia, 1978).

Nurses from Kerala have been working in the European countries since the 1960s, yet, with the exception of the UK and Ireland, there is scant literature on this migration stream. About 6000 Indian nurses, mostly Catholics from Kerala, went to work in Germany in the 1960s to help meet shortages of health staff there (Gottschlich, 2012: 2). These nurses went to work mostly in Catholic hospitals and homes for the elderly. Hospitals in Vienna recruited nurses from Kerala in the early 1970s through a Catholic order 'the Queen of the Apostles' founded in Vienna in 1923 for missionising in India (Hintermann and Reegar, 2005: 64). Christian nurses from Kerala have been working in Italy since at least the late 1960s (Gallo, 2005). Their presence has also been noted in Switzerland. The network of the Catholic church as well as personal and social networks were critical in initiating and sustaining this migration. Recently too in the context of the slowing down of migration because of the economic crisis, the Catholic Church set up a help desk to help trained nurses looking to migrate to the European countries (UCA News, January 11, 2013). Individual initiative too was important in opening up channels of migration a typical instance being that of a Malayalee student in Vienna, Mr. Kizhakkekara, who got a 'letter of goodwill' signed by the former Vienna town Councilor for Public Health declaring that the city of Vienna 'will employ Indian nurses as far as possible' (Hintermann and Reegar ,2005: 64). Networks of family, community and nursing schools channeled information and provided a sense of security to potential migrants. The development of social networks enabled Malayalee nurses

The sister of the nurse who too was a nurse had preceded her to Kuwait. (Personal conversation between one of the authors and the daughter/niece of two nurse siblings, who had migrated in the late 1950s)

to respond to recruiting drives with alacrity, where women from other states may have been more circumspect.

3.2.1 Shaping a Migratory Disposition

The social environment in Kerala enabled the migration of women as nurses. Kerala had a significantly better nurse-people ratio compared to India even at the time of independence. The princely rulers of Travancore had patronized public health giving it a central place in public policy, which may have provided conditions that were conducive to drawing a wider cross section of women into the provision of public health than in British India. Kerala inherited the significant public health achievements of the state of Travancore in 1956 and took steps to remedy the neglect of Malabar under British rule. The ratio of nurses to people improved from 1: 26770 in 1951 to 1: 5190 in 1983 (Jeffrey, 1992: 194).[12] In the early decades of independence, nursing schools made efforts to expand demand for nursing education, recruiting students under a bond system that gave them stipends but obligated them to work for a specified period after training (George, 2005: 41). Thus, families incurred little or no expense for training a nurse. But by the mid twentieth century the perception that nursing was not a desirable profession for women had taken root (Abraham, 2004: 19, George, 2005, Aravamudan, 1975). The work of nurses involved taking care of patients, requiring physical contact with men, close interaction with male doctors and working on night shifts, which raised the suspicion that nurses could easily flout sexual norms. Derogatory references to nursing as 'dirty work' implicated the perception that nurses could easily transgress gender and sexual norms but also that nursing involved 'menial' work (George, 2000, Aravamudan, 1975).

Christian families were no less affected by stigma on nursing than others nor distinguished by a discernible preference for nursing as an occupation. In the first half of the twentieth century, population pressure arising from a high growth rate of population had motivated the Syrian Christians to search for alternative livelihoods.[13] Migrating in large numbers to land abundant

[12] The nursing profession in India was in a state of acute neglect at independence. Taking note of the ratio of 0.23 nurses for 10,000 people, the Bhore Commission underlines the need to address the neglect of nurses in India in order to attract more people to the profession.

[13] With a higher fertility rate than other communities, the Syrian Christians share of the population of the state increased from about 10.5 % to 13 % between 1901 and 1941 (Zachariah, 2001: 10-16).

regions in the east and north of Kerala, they created a recent history of movement.[14] The Syrian Christian community and church supported this movement and sought to legitimize it through public discourse that made way for a new social imaginary (Varghese, 2007: 517-18). These material conditions enabled the development of a migratory disposition among the Syrian Christians and enabled women to claim new kinds of spaces, breaking out of older norms of work and mobility. Because of the increase in the size of families, nursing jobs were expected to provide relief when it came to paying dowries. In this context, the legitimacy provided by the intervention of the Catholic Church could have been crucial in promoting aspirations among Christian women to study nursing and to take up overseas jobs.

The migration of nurses from Kerala to Europe was embedded in the network of the Catholic Church. This provided a sense of legitimacy for migration (Goel, 2008). However, even where the church was not active in recruiting, a Roman Catholic destination was perceived as safe for Catholic women. This was the case with migration to Italy (Lum, 2012). At the destination, the church assisted in shaping community 'infrastructure', which is critical to the settlement of a migrant community. In Germany, it helped to sort out problems in families and supported journals that discussed issues confronting the Diaspora (Goel, 2008). The church was an important part of the social context of the migrants: "The real basis of Malayalee social life are their Churches, which serve as a meeting point for their particular religious orientation within the complex world of Keralite Christianity" (Gottschlich, 2012: 24). Malayalees are known for their involvement in building a rich associational life. "Indian associations play a negligible role in facilitating the integration of Indians in Italy, due to low involvement in their activities. The Malayalees are more active in the field of associations, with three associations, based in Rome, Milan and Genova respectively, that organize cultural events" (Lum, 2012). The arrival of Malayalee nurses in Germany in the 1960s has been linked to the establishment of "more and more clubs, societies, and associations" by Indians (Gottschlich, 2012: 10).[15]

But these nurses, reared in patriarchal social and family contexts in Kerala, were pitted into a struggle against existing norms about work, mobility and sexuality of women. It has been observed that migrant nurses adhered to the patriarchal gender division of labour within the

[14] This movement altered drastically the demographic composition of erstwhile Malabar between 1931 and 1951 and also the spatial and occupational profile of the Syrian Christians (Varghese, 2007).
[15] Germany has many Malayalee organizations and even an umbrella organization - the Union of German Malayalee Associations (Goel, 2008).

household (George, 2005; Chakravarthy and Nair, 2010). Even so, overseas employment generated the promise of increased wealth, better conditions of work and prospects for professional improvement but also of the possibility of untold freedom, travel and adventure. Eventually, an overseas job became the means for young women to reclaim respectability and gain recognition within the sending community.[16] Their success was framed in terms of the rewards that migration could fetch for the community – remittances and sponsorships for family members. Women migrants paid for socially acceptable marriages for themselves and/ for other girls in their families through dowries which otherwise would have been out of reach.[17]

3.3 Supply-side Concerns

At present India is way below the WHO benchmark for nurses and midwives. The adjusted ratio for India was 2.4 nurse-midwives for 10,000 people in 2005. By the same criteria, India had less than one nurse per allopathic doctor, where a higher ratio is desirable because nurses deliver services at lower cost than doctors (Rao M. et al, 2011: 3, 4).[18] Recently, health experts have pointed out that India faces a 40 to 50 % shortage of nurses (Indian Express, March 29, 2012). With more than 2000 nursing schools and colleges in 2007, India was turning out more than a lakh of nurses annually. In 2010, the numbers of nursing schools and colleges had increased to over 3000 (Table 1). However, the country also loses a significant proportion of the nurses it trains as, according to one source, over 20% of the annual turnover of student nurses headed for foreign shores every year (Sinha, 2007). Further, the distribution of nurses is highly skewed towards the southern and northeastern states and towards the urban areas. Kerala has over 16 nurse-midwives for 10,000 people (Rao K. et. al., 2012). In 2010, the government took a number of steps to increase the scale of training nurses in the country – giving approval to set up 260 government nursing schools at the district level, permitting married women to join nursing

[16] Overseas nurses are now being recognized as an important factor that enabled the Catholic community in Kerala to overcome economic hardships and survive agrarian crises (Secretary of the Syro Malabar Church Laity Commission, UCA News, January 11, 2013).

[17] Gallo (2005) provides illustrations of how the first generation of migrant women to Italy, who feared ostracism because they had left the convent, sought re-entry into their families by sponsoring the dowries and migration expenses of their nieces at home.

[18] Owing to problems with the data on nurse availability in India, Mohan Rao et al have computed the ratio using the Census 2001 adjusted for population growth to 2005 and NSSO, 2005. These have been adjusted for qualifications as reported data on occupation alone could be misleading. The Nursing council of India does not maintain a live register, hence its data on registered nurses does not account for those who have retired, died or otherwise quit the profession.

courses and lowering the eligibility criteria for admission to diploma and degree by 5% (TOI, May 12, 2010). However, a sudden increase in educational institutions has led to serious concerns about preparedness and the quality of training.

3.3.1 Nursing Education

Between 2004 and 2010, the number of institutions offering B.Sc. nursing grew six times and institutions offering General Nursing and Midwifery (GNM) diploma courses grew by three times (see Table 1 below). Alongside there has been a decline in the long established concentration of nursing institutions in southern India. The decline was sharp for institutions offering graduate nursing programme – from 78 % in 2004 to 60 % in 2010 – than those offering GNM courses. Nursing institutions have grown noticeably in Madhya Pradesh, Maharashtra, Punjab and Rajasthan (table not shown).

Table1: Distribution of Nursing Educational Institutes in India according to Course in selected States

States	2004		2007		2010	
	B. Sc.	GNM	B. Sc.	GNM	B. Sc.	GNM
South India (SI)						
Karnataka	67	154	285	458	311	520
Andhra Pradesh	39	91	167	222	211	244
Tamil Nadu	36	54	80	122	131	164
Kerala	5	74	83	172	97	218
Total	147	423	615	974	750	1146
All India total	187	684	833	1597	1244	2028
Proportion in SI	78 %	62 %	74 %	62 %	60 %	57 %

Source: http://www.indiannursingcouncil.org/, accessed January 21, 2013

Table 2 shows that the overwhelming majority of seats in GNM (93%) and B.Sc. nursing (88%) courses are in the private sector. Private institutions accounted for all the B Sc courses started since 2001 and 73 % of GNM courses started since 1991. The same pattern has been observed in the country as a whole - 88% of GNM courses in 2006 were in the private sector (Rao M. et al. 2011: 7). Increasingly the OECD countries are beginning to insist on a bachelor's degree as the minimum qualification for entry into nursing and the pattern of increase in courses in northern India and in the private sector may reflect the aspiration to cater to the overseas market for nurses.

Table 2: Nursing Institutions in Kerala according to Period of Establishment and Course

	General Nursing and Midwifery				B Sc. Nursing			
	Government		Private		Government		Private	
Year	No	Seats	No	Seats	No	Seats	No	Seats
Upto 1960	3	110	3	120	0	0	0	0
1961-1980	7	179	34	1329	1	75	0	0
1981-1990	1	30	19	695	2	120	0	0
1991-2000	2	46	65	1896	6	300	0	0
Since 2001	5	100	85	2205	2	120	84	4515
Total	18	465	206	6240 (93%)	11	615	84	4515 (88%)

Source: compiled from data in http://www.keralanursingcouncil.org, accessed October 2012

3.3.2 The Supply of Nurses in Kerala

Since 2011, nurses from private hospitals across Kerala have been going on strike demanding better compensation and working conditions. In 2012, the state government appointed a committee, headed by Dr Balaraman, to inquire into the issues raised by the striking nurses. Nurses reported to the Balaraman Committee that some of the up market private hospitals in the city paid them Rs.1,500 -1,750 and paid the tutors in the nursing college run by the hospital Rs.3,000 (The Hindu, Feb 9, 2012). *The unrest directed attention to the large numbers of nurses currently available for employment. In 2011 alone as many as 27, 250 nurses with GNM diploma or graduate (B. Sc.) nursing qualifications registered with the Kerala Nursing and Midwives Council (KNMC), including 9155 from nursing schools in the state and the remaining from other states, particularly Karnataka* (Maya, 2012). This may have set the stage for 'massive exploitation and human rights violation within the workforce'.[19] The exponential growth of nursing education has been linked to a decline in the quality of education. A survey showed that 61% of nursing colleges in the country were unsuitable for teaching, with an acute shortage of faculty and facilities (GOI, 2005 cited in Rao M. et al., 2011: 7). The situation is said to be particularly bad in Karnataka where many new nursing schools lack clinical facilities (Rao, M. M. 2012). Nursing professionals in Kerala point out that a section of nurses trained in Karnataka are particularly ill-qualified and prey to private hospitals who recruit them as 'trainees' for little or no wages and put them to work for 12 or 15 hours (Maya, 2012).

[19] Prasannakumari, Deputy Director of Nursing Education, was the convener of a committee studying the nursing sector (Maya, 2012).

The situation in Kerala is too complex to be characterized as simply one of abundance of nurses. On the one hand, students succumb to the bond system prevalent among private institutions because of the high demand for nursing education. Private hospitals attached to nursing institutions have a reservoir of trainees and students, requiring clinical practice, who are used as the 'major workforce'. On the other hand, a significant section of newly educated nurses are looking to gain the experience that is necessary to apply for overseas jobs. 'We swallow the abuse and break our backs doing tough 16-hour shifts just to obtain that one-year experience certificate from the hospital… We do it because it's our only ticket to leave the country forever' (a nurse from Kerala cited in George, 2011). And many students finance nursing education with bank loans, which need to be repaid at the end of the course.[20] These factors have heightened the pressure on newly educated nurses to work at low pay and under harsh conditions. It has been reported that even government hospitals in the country are increasingly employing nursing staff on contract rather than filling in vacancies for full time staff (Kurup, 2012). Trainee nurses loathe the bond system but the efforts of nurses' associations to do away with it have not borne fruit so far. [21]

4. EU Policy Perspectives on International Nurse Recruitment

4.1 Shortages in the EU

Demographic projections suggest that shortages in health care staff in Europe will increase in the next few years owing to either a shrinking pool of young cohorts or an ageing/retiring workforce. For instance, UN population projections (using a medium fertility assumption) suggest that in Europe the population in the age group 15-24 will decline by about 25% between 2005 and

[20] In Kerala, private nursing colleges charge around 72,000 rupees a year for the four-year BSc degree. Beena Bhasan, president of Kerala Trained Nurses Association and principal of a private nursing college in central Kerala is quoted as saying that 90 % of students in the college, mostly from lower middle-class families take loans to pay the fees (George, 2011).

[21] The Balaraman Committee made a string of recommendations including a minimum basic pay of Rs. 12900/ for a staff nurse and decreed illegal by INC norms, the bond system, which required nurses to work for a year or more in the hospital attached to their nursing school, or the practice of appointing nurses as trainees without adequate compensation. However, nurses continue to go on strike periodically as the state government has not implemented the recommendations.

2025.[22] In this context, a rising proportion of young people will have to enter the health profession, if current training rates are to be maintained (OECD, 2008: 20).

Rising incomes, new medical technology, increased specialization of health services, and population ageing are pushing up demand for healthcare workers in OECD countries. In response, there was a prolonged growth in physician and nurse density in OECD countries in the 1970s and 1980s, but the growth rates have slowed sharply since the early 1990s. Cost-containment policies, such as control of entry into medical school, and closure of hospital beds in the case of nurses, may explain much of the slowdown. In addition, trends such as the growing feminization of the physician workforce, higher rates of part-time working and early retirement are also likely to have reduced hours worked by the average health personnel (OECD, 2010: 4).

Forecasting future shortages is a challenge in view of the difficulties of incorporating changes in productivity, yet a number of countries have published projections of demand and/or supply for health professionals. The 'Wanless' report estimates that the demand for nurses in the UK will increase by about 25% between 2005 and 2020. In 2006, the U.S. Health Resources and Services Administration (HRSA) estimated that the nation's nursing shortage would grow to more than one million nurses by year 2020.[23]

Strategies of OECD countries to cope with shortages include: reducing hospital beds and some of their accompanying nurses, because of increasing day-case treatment, reducing the length of stay and the discharge of long-stay patients to residential homes and domiciliary settings. Increase in domestic training has been recommended but the duration of training is a stumbling block in meeting short term demand. Other suggestions are to improve retention through better workforce organization and management, to attract back those who have left the health workforce; to adopt a more efficient skill mix (e.g., by developing the role of advanced practice

[22] In Japan, numbers in this population group will decline by about 20% and in Korea by 33% over the same period. However, in Australia, Mexico and New Zealand numbers will remain almost constant and in the United States, these are expected to increase by over 8%.

[23] In the report titled What is Behind HRSA's Projected Supply, Demand, and Shortage of Registered Nurses?, analysts show that all 50 States in the U.S. will experience a shortage of nurses to varying degrees by the year 2015. On March 9, 2012, the U.S. Bureau of Labor Statistics (BLS) reported that job growth in the healthcare sector was outpacing the growth realized in 2011, accounting for one out of every 5 new jobs created this year. Hospitals, long-term care facilities, and other ambulatory care settings added 49,000 new jobs in February 2012, up from 43,300 new jobs created in January. As the largest segment of the healthcare workforce, it is likely that RNs will be recruited to fill many of these new positions. The BLS confirmed that 296,900 jobs were added to the healthcare sector in 2011. www.bls.gov/news.release/empsit.nr0.htm

nurses and physicians' assistants); and iv) improving productivity (e.g., through linking payment to performance) (OECD, 2008: 19, 39).

4.2 *Policies on the Migration of Health Workers*

Migration programmes in most OECD countries do not target health professionals specifically. However, general migration schemes may provide simplified procedures to facilitate the recruitment of health workers, notably at the local or regional level. Australia and New Zealand grant special points for health professionals in their permanent migration programmes. This facilitates the immigration of health workers but only to a limited extent. In the United States, H1-B visas are available for most health professionals.[24]

In European OECD countries, work permits may be available for skilled immigrants and are generally granted for a limited period. These permits may be conditioned on a labour market test (*i.e.*, checks that there are no EU residents available to fill the position). Nonetheless, in most countries there are conditions under which the labour market test may be waived. This is the case in the United Kingdom, Belgium, Ireland, Denmark, the Netherlands or Spain for occupations on the shortage list. In these countries, health professionals are or have been included in the shortage lists.

A few OECD countries have bilateral agreements for the international recruitment of health professionals. Bilateral agreements maybe organized at the regional level as is the case in Italy, where several provinces have signed protocols with provinces in Romania to train and recruit nurses. In Europe, the United Kingdom is the only country which has made intensive use of bilateral agreements and memoranda of understanding with non-OECD countries for international recruitment of doctors and nurses. It has signed a memorandum of understanding with India in 2002.[25]

International organizations, NGOs as well as the OECD countries stress ethical concerns about migration contributing to 'critical' shortages in the developing regions of the world. The WHO code is an expression of this concern. The concerns over ethical recruitment have increasingly been targeted towards "healthcare exporters" such as the Philippines that have a history of

[24] In 2005, about 7,200 initial requests were approved for medicine and health occupations including 2,960 for physicians and surgeons. This corresponds to an increase of about 55% as compared to 2000 (OECD, 2008: 30).
[25] It has an agreement with South Africa on reciprocal educational exchange of health care concepts and personnel (2003), and a Protocol on Cooperation in Recruiting Health Professionals with China (2005).

deliberately producing health workers for exports.[26] Recent evaluations have shown that this export strategy has negative consequences, reducing their populations' access to services and lowering the quality of training (Brush & Sochalski, 2007).

The recent fluctuation in the inflows of nurses to the UK from Asia is the consequence of the explicit policy change towards self sufficiency (Mathias et al, 2011: 56). The UK government formulated a code of ethical recruitment in 2001, aimed at protecting health systems in developing countries from the brain drain triggered by active international recruitment. Subsequently in 2004, the Department of Health prepared a list of developing countries that should not be targeted for international recruitment. However the code does not cover the private sector and also cannot stop nurses from developing countries independently moving to the UK (Buchan, 2007a: 13, 2007b: 1332).

The concern for ethical recruitment of health care workers is of course important. However the migration of health professionals is not the sole or proximate cause of health system degradation in these countries (Dacuycuy, 2008: 24). The WHO estimated that in 2000, all African-born doctors and nurses working in the OECD represented no more than 12% of the total shortage for the region. For Southeast Asia the corresponding figure was only 9 % (OECD, 2010). Also ethical recruitment guidelines may be gender blind, given the feminization of nursing profession (Becklake, 2008). Besides, the European Region includes high-income countries that received migrants, for many years, and continue to attract them passively and actively, and particularly from low- and middle-income countries. Colonial history, common languages and membership in certain communities of nations all appear to contribute to these flows. Health workers are no exception to this general pattern (Dussault et al, 2009: 13). In this context, reduction of international migration would not be enough to address the worldwide health human resources crisis. Ethical recruitment concerns need to be balanced with openness to migration and to the aspirations of workers to seek better futures. Given the right of workers to emigrate, as provided by Article 13 of the Universal Declaration of Human Rights, policy makers should rather try to "manage" migratory flows if they are significant enough to affect the health services system (Buchan, 2008:14). Such management could include measures taken by countries to improve retention, encourage staff exchanges, entry into bilateral agreements, fast-tracked immigration

[26] The Philippines has agreements with Ireland, Japan and the U.K.

procedures for certain categories of workers, and compensation for source countries, regulation of recruitment agencies and codes of recruitment.

5. Indian Nurses in Europe

The stock of Indian nurses in European countries is negligible with the exception of the UK and Ireland.[27] In 2000, there were 105 Indian nurses in Portugal, 91 in France, 65 in Sweden, 30 in Austria and less than 25 each in Spain, Poland, Denmark and Hungary (DIOC-E data base in Bhattacharya 2012: 17). The flow of nurses in recent years could suggest emerging trends as the EU countries face up to the evident shortages in their nursing workforces. The share of foreign nurses among all newly registered nurses in 2008 was highest in Italy (28%, 9168), followed by the United Kingdom (14.7%, 3742) (Maier et al, 2011: 32). Over a 1000 Indian nurses registered in the UK in 2008 (Young, 2011).

Table 3: Immigrant Nurses (foreign trained or foreigners) registered in EU Countries

	2000/1		2005		2007/8	
Foreign trained nurses	Number	%	Number	%	Number	%
Ireland	6 204	14.3	8758*	14.4		47.1
United Kingdom	50 564	8.0				
Austria	8 217	14.5				
Denmark	4618	6.0	5109	6.2		
Finland	122	0.2	274	0.3	530	0.5
The Netherlands			3479	1.4		
Sweden	2517	2.5	2878	2.7	2585	2.6
Foreigner nurses						
Belgium	1009	0.7	1448	1.0	2 271	1.5
France			7058	1.6		
Germany	27427	4.2	25462	3.8	24 892	3.4
Italy			6730	2.0	33 364	9.4
Portugal	5 077	13.9			2 037	3.6

Source: Dumont and Zurn, 2007: 169, OECD, 2010, OECD, 2011

India replaced the Philippines as the leading source of international nurses to the UK and to Ireland in 2005. Between 1999 and 2008, about 17,000 Indian nurses registered with the

[27] Ireland has the highest dependence on foreign trained nurses among the OECD countries – 47 % of its nurses were foreign trained in 2008 (OECD, 2010: 3). In continental Europe, only Austria had a high reliance on foreign nurses - about 14 %. Nevertheless, some of the EU countries employ significantly large numbers of foreign nurses. Germany and Italy have between 25,000 and 35,000 foreign nurses, whereas France and Denmark have over 5000.

Nursing and Midwifery Council (NMC) in UK, significantly higher than the numbers of EU nurses that registered during the same period.[28] Data on the issue of work permits to Indian nurses corroborates this – 33,845 nurses from India were issued work permits between 2003 and 2008 compared to 32,010 nurses from the Philippines (Young, 2011: 304). In Ireland, 5,466 nurses on the active register in March 2008 were Indian educated compared to 4,091 nurses from the Philippines. Reflecting this trend, almost three-quarters of employers canvassed under a survey ranked India as the primary source country for registered nurses followed by Philippines, the second strongest supplier of nurses, ranked by a fifth of respondents as the primary source nation (Bobek et al., 2011: 66-7). Non-EU migrant nurses accounted for 35% of new entrants to the Irish Nursing Register between 2000 and 2010 (Humphries et al, 2012: 45).[29] Their share grew from 9 % of annual registrants in Ireland in 1995 to 60.2 % in 2005 (Yeates, 2009: 155).

It has been reported that employers in Ireland avoided recruiting from the EU because they the English language skills of EU nurses to be inadequate (Bobek et. al. 2011: 105). India has signed an agreement with the Department of Health in the UK to enable migration of nurses, with the caveat that nurses would not be recruited from four Indian states that receive development aid from the UK – Andhra Pradesh, Madhya Pradesh, Orissa and West Bengal. Ireland too follows this policy (Quinn, 2006: 17). The increase in the movement of Indian nurses to the UK has been attributed to the activity of recruitment agencies and the greater proficiency of Indian nurses in the English language. The boom in recruitment by the UK in the first half of 2000 was followed by a slump in annual registrations, particularly from the Philippines. However, Indian nurses are likely to find it increasingly difficult to enter the UK in the future. New immigration rules in the UK, new English language tests and other revised requirements for international applicants introduced by the NMC from September 2005 raised the barriers to entry of foreign nurses (Buchan, 2006). Since 2008, non-EEA nurses may enter the UK as a sponsored skilled worker only if they have a job offer from a licensed NHS sponsor (Young, 2011). In 2012, further changes were spelt out in immigration rules for non EU nurses – that from 2016, skilled temporary workers or tier 2 migrants must earn at least £35,000 to be eligible for permanent residency and that temporary stay will be capped at six years (Ford, 2012).

[28] For the break up of nurses joining between 2003 and 2008, see Young, 2011.
[29] Registration only indicates intent to work as a nurse in Ireland. In the majority of cases the registration process is initiated prior to arrival (Bobek et al, 2011: 101).

Table 4: Countries of origin of nurses registering annually with the NMC in the UK

Country	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
India	30	96	289	994	1830	3073	3690	3551	2436	1020
Philippines	52	1052	3396	7235	5593	4338	2521	1541	673	249
Australia	1335	1209	1046	1342	920	1326	981	751	299	262
Nigeria	179	208	347	432	509	511	466	381	258	154
South Africa	599	1460	1086	2114	1386	1689	933	378	39	39

Source: Statistical analysis of the register (2005-06, 2006-07, 2007-08), Nursing and Midwifery Council, UK, http://www. nmc-uk .org/

The increase in Indian educated nurses in Ireland was the direct result of active international recruiting projects by public agencies and substantial recruitment by private agencies for private health care institutions in Ireland.[30] Of the two major public recruitment projects - the Dublin Academic Teaching Hospitals (DATH) Recruitment Project and the HSE Nursing/Midwifery Recruitment and Retention National Project, in 2005 the HSE recruitment project targeted recruitment drives at nurses from Philippines and India and in 2006 at only Indian nurses. Indian nurses also benefited from recruitment drives in Bahrain, Saudi Arabia and Singapore (Quinn, 2006: 17, Yeates, 2009:160; Walsh and O'Shea, 2009: 49; Bobek et al, 2011: 105).[31] The introduction of a 'fast track' working visa scheme in 2000 (up until 2006) greatly facilitated the flow of nurses to Ireland. Between 2000 and 2006, 9441 visas were issued to nurses under the Working Visa and Work Authorization Scheme (WA/WW), 40 % of who were from India and 50 % from the Philippines. During the same period nurses were employed on other types of work permits as well (Humphries et al, 2008: 9; Bobek, 2011: 72-73).

After 2007, however there was a sharp decline in the number of nurses registering in Ireland, affecting Indian nurses drastically. With the recession setting in, some public hospitals in Dublin decided to stop international recruitment in 2008. In March 2009, the Health Services Executive

[30] Interview panels, consisting of private and public sector employers and nurse recruitment agencies travelled to India and the Philippines among other countries to recruit nurses. While most of nurses that went to work in Ireland were recruited from their home countries, a sizeable number of them were recruited by a private agency while working in the Middle East (Yeates, 2009: 160).

[31] The selection of countries depends on the type of personnel needed in Ireland. For example Indian nurses have experience in, and may prefer to work in, acute hospitals while Filipino nurses are skilled in care of the elderly. The DATHs project has recruited approximately 1000 nurses since it was set up in 2001. Of that number 507 were recruited in the last year to fill the gaps resulting from the lack of domestic graduates caused by the change from a three-year to a four-year course (Quinn, 2006: 16-17).

introduced a recruitment moratorium i.e. a directive that there is to be no more recruitment of staff or promotions in the public service (Bobek et al., 2011: 110).[32] Bobek et al. (2011: 113) note that the nurses in private nursing homes have not been affected by the economic downturn – they even report receiving higher salaries. Nevertheless, there are signals that non EU nurses are looking for opportunities elsewhere. Between 2008 and 2010, verification requests were processed on behalf of approximately 4202 non-EU migrant nurses, which would amount to 29% of those recruited since 2000 (Humphries et. al, 2012: 48).[33] A decline in total verification requests made on behalf of nurses in Ireland in 2009 and 2010 to 2714 and 1356 respectively (Humphries et al, 2012: 49), may suggest that the peak in 2008 was on account of the initial fears brought on by the recession. Notably, some of the stakeholders interviewed by Humphries et al (2012: 49) disagreed over the import of the verification data for non EU nurses pointing out that there were yet to see evidence of emigration at the hospital level.

Table 5: Country of training of annual non EU Registrants in Ireland, 2005-08

Country	2005	2006	2007	2008	2009
India	1634	2037	1868	295	71
Philippines	366	439	195	94	17
Australia	44	37	49	68	17
New Zealand	13	22	27	22	9
Nigeria	39	36	46	18	8

Source: Annual Reports, An Bord Altranais.

Table 6: Newly registered qualification at the Irish Nursing Board

	2004	2005	2006	2007	2008
Ireland	1,851	570	1,631	1,805	1,918
EU	707	851	912	996	950
Others	1,075	2,154	2,631	1,347	550
Total	3,633	3,575	5,174	4,148	3,418

Source: An Bord Altranais, Annual Reports.

[32] The moratorium on recruitment in the health service has been subject to criticism in the Irish media and by stakeholders in the health system. Criticism includes that the ban will lead to newly qualified Irish nurses leaving for foreign shores thereby exacerbating future shortages as about 20 per cent of the nursing workforce is in the 50-59 age bracket and due to retire (Bobek et al., 2011: 110).

[33] Verification requests received by the Irish Nursing Board are considered an indication of intent to migrate but does not guarantee that a person will actually emigrate. They are submitted by the Nursing Board of the country that nurses have sought registration in.

Table 7: Requests for Verification of Qualification received by the Irish Nursing Board

Countries	2003	2004	2005	2006	2007	2008
United Kingdom	1,516	856	440	279	163	272
Other EU	24	18	25	21	15	16
Australia	1,012	572	718	1,024	1,641	4,896
USA	306	297	151	195	117	88
Canada	1	36	30	42	158	282
Other	16	39	79	53	74	69
Total requests	2,875	1,818	1,443	1,614	2,168	5,623
Total nurses	2,002	1,443	973	877	1,139	3,108

Source: An Bord Altranais, Annual Reports and Irish Nursing Board, 2009 cited in Bobek et al 2012: 142

Continental Europe has cut down systematically on recruitment of nurses from non EU sources through immigration policies. In this context, Malayalee nurses may be losing the foothold they gained in Austria in the 1970s.[34] Hospital associations and single hospitals in Austria that had recruited large numbers of nurses from the Philippines and India in the 1970s and 1990s stopped doing so because of quotas for immigration and family reunification introduced in 1993 and with other restrictions that emphasized the role of neighboring countries – Germany, Slovakia and the Czech Republic (Offermanns et al., 2011: 110). An upward trend in the annual inflows of nurses to Austria from 428 to 773 between 2003 and 2008 comprised mostly nurses from neighboring countries. Table 8 shows the increasing share of the EU - 10 countries, Romania and Bulgaria in the applications by foreign nurses for work permits in Austria. In 2003, more than half these applications were from the non EU countries as compared to only 13 % in 2008 indicating a lull in the aspirations of 'third country' nurses.

Table 8: Foreign national nurses applying for work permits in Austria, 2003-08

Blocks	2003	2004	2005	2006	2007	2008
EU 10	381 (44)	782 (69)	985 (78)	1142 (82)	1031 (80)	630 (80)
Romania/Bulgaria	31 (4)	26 (2)	21 (2)	23 (2)	67 (5.2)	68 (8)
Non EU	461 (53)	330 (29)	249 (20)	232 (17)	190 (15)	111 (13)

Source: Offermanns et al., 2011: 98

[34] The Vienna Malayalee Association was founded in 1974 when there were 80 Malayalees in Vienna, notes that the number of Malayalees had increased to 6784 in 1999. Recently however about 3000 Malayalees left Vienna and went away to Switzerland or London (http://viennamalayalee.com/page-About-Us.html, accessed on January 29, 2013).

The number of foreign educated nurses in Germany is large but it registered a small decline between 2000 and 2005.[35] Asian nurses and midwives registered the sharpest decline (30 %) as compared to EU nurses (3%), according to data on foreign national nurses and midwives subject to social insurance contributions in Germany between 2003 and 2008 (Ognyanova and Busse, 2011: 221). In the absence of a country-wise breakup of the Asian nurses and midwives in Germany, it is difficult to say how many are Indian. However, in view of the migration of Malayalee nurses to Germany in the 1960s and 1970s and recent work that mentions a sizeable presence of Malayalees within the Indian community and especially in nursing (Gottschlich, 2012) it may not be incorrect to assume that they comprise a sizeable section of Asian nurses.[36] Anecdotal evidence suggests that Malayalee nurses continued to migrate to Germany in small numbers in the last decade.

Table 9: Foreign-national nurses and midwives subject to social insurance contributions in Germany, 2003–2008

	2003	2004	2005	2006	2007	2008
Asia	2999	2693	2539	2359	2192	2103
EU	10259	9967	9939	10041	9992	9971
Total	26364	25452	25115	24977	24489	24387

Source: Ognyanova and Busse, 2011: 221

The number of foreign nurses in Italy registered a steep rise from 6730 (2%) in 2005 to 34,043 (9.4%) in 2008. Foreign nurses on the register were a mere 2612 in 2002 (Bertinato et al., 2011: 246).[37] Just over half of the 34,043 strong foreign workforce in 2008 was from the EU but 5.3 % was from Peru and 3.5 % (or between 1100 and 1300 nurses) were from India. It is not clear how many Indian workers entered between 2005 and 2008. In 2005, 127 Indian nurses received

[35] No registry data are available as nurses and midwives are organized through voluntary membership of a variety of professional organizations and are not required to register with a particular organization or chambers. The data on nurses and midwives subject to social insurance is from the Federal Employment Agency. At present, there is no monitoring system for the number of nurses and their professional qualifications (Oganyanova, 2011: 220).

[36] According to data from the World Bank, the total migrant stock from India in Germany was 67,779 persons in 2010. Gottschlich (2012: 6) writes that because of the comparatively small size of the Indian population in Germany, the amount of remittance per emigrant is relatively high at US-Dollar 8,144 a year and almost doubles the average yearly sum of US-Dollar 4,841. Given the comparatively high percentage of Malayalee immigrants, it seems plausible to conclude that much of the money is directed towards the state of Kerala.

[37] The European Monitoring Network put it at 11 % but OECD used a larger denominator and therefore came up with 9.4 % (P 246). Most of the approximately 7 000 foreign nurses, working in Italy at the end of 2005 (2% of the work force), were employed in the private sector, because private employers could offer a contract necessary for acquiring the visa much easier (Chaloff, 2008). It is almost impossible for foreign nurses to get a job in public – state owned hospitals while they are still in their native country (Ivlovic, 2011).

recognition for their nursing qualifications and in 2004 during a quota exemption ten Indian nurses received authorization (Chaloff, 2008). According to data from the Italian Federation of Nurses there were a total of 1, 511 Indian nurses (1, 329 women and 182 men) registered in Italy and with naturalized Indians, the number rises to 1740 nurses (Lum, 2012: 14).

A large number of Christians from Kerala who come to work as nurses and other healthcare workers are employed especially in hospices or *case di riposo* in Italy (Lum, 2012).[38] Malayalees are concentrated in the Lazio region in central Italy, where a survey showed that 62% of Malayalee women worked as domestics, 25% in the hospital sector (versus 13% for men), 12% were looking for work, and the remaining 1% worked as secretaries or in the restaurant sector (Gallo, 2008: 55 in Lum, 2012: 14). In general foreign nurses are concentrated in the north of Italy.[39] This is one indication of the influence of social networks in channeling Malayalee nurses to Italy despite restrictions on 'third country' workers.

Thus, despite restrictive immigration policies, strong social networks in some countries of continental Europe have facilitated at least a trickle of nurses in recent years. The flow of nurses has also corresponded to the recent perceptions of shortages, Italy being a case in point. However, the use of social networks is exclusionary as it allows persons of social groups that have had prior access to consolidate or entrench their position and excludes those who do not have such access irrespective of their qualifications or aspirations. Non Christian nurses have voiced this concern (Walton-Roberts, 2010).

6. Challenges to the Mobility of Nurses to the EU

6.1. Case Study of the Netherlands

Only 1.4 % of nurses in the Netherlands were foreign trained in 2005 but they numbered over 3000. Belgian and German migrants account for 23 % of nurse inflows into the Netherlands; the

[38] According to estimates provided by the Indian Consul General in Milan, Malayalees comprise less than 20 % of Indians in Italy. Malayalees in Italy are mostly Roman Catholic but are divided sharply into two social groups – the Syrian Christians and Latin Catholics, who were converted by European missionaries. In Rome, the main Malayalee place of settlement, two Masses are celebrated in the Syro-Malabar rite, and one in the Latin rite (Lum, 2012).

[39] In 2008, 56% of foreign nurses were in the north, 25% in central Italy and only 11% in the south. The proportion of new foreign nurses registering in the northern Turin Province rose from 14.5% in 2000 to 41% in 2007 and 37% of them were from non-EU countries (Bertinato et al., 2011).

Philippines, Indonesia, Suriname and the Dutch Antilles are other major contributors.[40] An attempt by the Netherlands in the early 2000s, to recruit Polish nurses met with little success. The difference in 'health and care culture' and in training meant that the Polish nurses required more training or would have to work at a lower level of qualification. Language too was a barrier (Tjadens, 2011: 7). According to information provided by the Ministry of Social Affairs and Employment, out of 120 highly skilled migrants to the Netherlands from India in 2011, 40 were in the health sector. Separate information about nurses was not available.

6.1.2. Supply of Health Professionals

Health professionals, who wish to practice using their professional title, must be on the national legal register for Professionals Individual Health care. As of 1 November 2011, 73,358 physicians, 4,456 midwives, 12,849 dentists, 6,237 pharmacists and 267,622 nurses were registered (MoH Prof Netherlands Summary: 3). The increase of the number of practicing nurses and licensed practice nurses is consistently higher than the growth of the population. However, growth, especially of the number of licensed practice nurses, seems to follow that of the population aged 65 or over, increasing by 14% in a decade.

The qualifications necessary to practice as a nurse in the Netherlands may be obtained through two principal routes. Nurses may acquire an intermediate vocational education leading to a 'level 4' qualification either through a full-time course including internships or through an agreement with an employer and a practice-based study. Both require four years. The second option is of higher vocational education (university of applied science) leading to a 'level 5' qualification. Nurses at 'level 4' may obtain 'level 5' qualification through three more years of study (MoH Prof Summary 2011: 4). Recent data about qualifications reached suggest that 'non-native' background plays an increasing role, but the concept should be treated with care as most will have Dutch nationality and will be second, or even third generation migrants. Of those acquiring the lowest level vocational qualifications, some 40% were from a non-native background, of which the majorities were of a non-Western European background. The higher the qualification gained, however, the lower their share, especially because of shrinking shares of qualifications acquired by people from a non-Western European background (CBS, 2011).

[40] In 2007, Suriname, which was a colony till 1976, provided 199 nurses and the Netherlands Antilles provided 108 nurses (Bhattacharya, 2012: 15, 21).

6.1.3. Institutional Framework

The Netherlands imposed greater control on entry into the labour market in the early 2000s.[41] The same conditions apply to non-EU nationals seeking entry into different sectors of the labour market but institutional focal points and regulatory authorities differ. An applicant may seek to enter in the category of 'self-employed' or as an 'employee'. Since 2004, they could enter the health sector also through the High-Skilled Knowledge Migrant Scheme. Unlike Dutch and EU/EEA nationals[42] 'third country' nationals (or aspirants from outside the EU) must fulfill certain conditions importantly that there is a lack of labour supply from the former regions.[43]In the Netherlands, labour migration is under the jurisdiction of the Central government and is governed by the Aliens Act 2000 (Vw 2000) Vreemdelingenwet 2000) and related legislations and regulations.

The Aliens Employment Act (Wav) regulates the admission of foreign nationals in to the Dutch labour market. For admission to work on a self-employed basis, the main condition is the existence of a material Dutch interest, in the case of medical professionals a material Dutch public health interest. In the case of a foreign worker seeking entry as an 'employee,' the employer must apply and procure a work permit for that worker. The grant of a work permit is subject to several conditions: that the competent authority determines that priority labour does not exist for the position; the employer reports the vacancy to the Centre for Work and Income (CWI) at least five weeks prior to submitting the application for a work permit; [44] the employer shows that the foreign national will be earning the statutory minimum monthly wage and that the foreign national has a residence permit that allows him to work, or has applied for a residence permit.

[41] Previously, the immigration policy allowed entry on humanitarian grounds.
[42] This does not include Bulgaria and Romania which will receive full access to the EU labour market only on 1st January 2014.
[43] As defined in Article 1, under g of the Aliens Employment Act (Wav) (Wet arbeidvreemdelingen).
[44] The application may be rejected if the employer is unable to demonstrate that he has made sufficient efforts to fill the vacancy with priority labour available in the labour market or if he obstructed the fulfillment of the vacancy with priority labour; it may be anticipated that such priority labour will become available in the near future; the current employment terms and/or the employment terms that are common to the sector are not complied with; the foreign national does not have suitable accommodation; the foreign national is under 18 or over 45 years of age; the foreign national did not comply with restrictions of a previous permit; the foreign national was previously admitted to the Netherlands and was granted a non-renewable temporary work permit and did not move his principal residence outside the Netherlands for a period of at least one year after expiry of this permit; and the recruitment did not take place in a manner that was prescribed by a covenant for the sector in question (EMN: 16-17).

Nurses may be recruited through private recruiting agencies or through health care organization but they must go through the process of getting the sanction of government through verification and assessment from several agencies and/ or departments.

6.1.4 Highly Skilled Knowledge Migrant Scheme (HSKM)

The highly skilled migrants' arrangement in the Netherlands is of special interest in terms of managing migration, as it aims explicitly to promote the Dutch knowledge economy.[45] The main condition for entry is a minimum level of income. The HSKM reflects the Dutch interest in becoming self-sufficient in its domestic health workforce. This desire for self-sufficiency reached its peak in early 2000 when sudden shortages were experienced in nursing and care sector personnel leading to recruitment at the initiative of private hospitals and recruitment agencies.

Politicians and Dutch society criticized the private recruitment drive for foreign medical personnel, *albeit* limited, for failing to use existing Dutch labour and because it meant additional training costs for employers owing to poor language skills and professional skill gaps. Unions opposed the foreign recruitment over concerns of 'unfair competition' and questions were also raised over 'brain drain' implications of such foreign recruitment. In view of the criticism there was political discussion of the issue; questions were asked in the Parliament. The Central government also held consultations with interest groups representing employers and employees in the health sector (EMN: 9). In this context, the employers sought to demonstrate their desire to properly regulate labour migration into the health sector (Roosblad, 2005).

The Aliens Employment Act Implementation Decree stipulates that highly skilled migrants do not need a work permit. The Decree also defines a highly skilled migrant according to the salary level of the migrant and his/her age. It appears that the qualifying salary has increased steadily since the inception of the scheme. In 2012, the minimum annual gross salary for knowledge migrants of 30 years of age or older was €51.239 and €37.575 for those below 30 years of age (Weisbrock & Hercog, 2011). This condition is assessed when the application for a residence

[45] As a result of the resolutions made during the Barcelona and Lisbon European Councils to make the European Union the most dynamic knowledge economy in the world by 2010 (the Lisbon Agenda), the highly skilled migrants arrangement came into effect on 1 October 2004. The objective of this arrangement is to simplify the admission of highly skilled migrants from outside the EU/EEA, thus reinforce the position of the Netherlands as a knowledge economy.

permit is processed. The foreign national must also meet several general admission conditions, such as being in possession of a valid border crossing document.

Nevertheless, there are significant advantages to the HSKM for both employers and workers. Entry under the HSKM is a lot less tedious compared to entry as 'an employee' because the latter requires a work permit. Furthermore, it is a fast-track procedure with the Immigration and Naturalization Services (IND) which strives to make a decision regarding a residence permit within two weeks of receiving a request for advice or an application (Paragraph B15/4 of the VC 2000). Decisions regarding entry may be taken even within a day. An additional advantage under the HSKM is that there are no language and integration exam requirements (Tjadens, 2011: 6) and the initial period of stay in the Netherlands is five years rather than the maximum of three years allowed for a migrant who has an employment contract for an indefinite period. However, to enter, a highly skilled knowledge migrant must have the following in place. The employer must sign a standard statement before applying for knowledge migrant's residence permit. Companies and institutions have to submit completed applications, report relevant changes and make financial provision for the employee. To qualify under the HSKM, an employer must prove previous compliance with social security benefits and taxes and sufficient turnover to pay the salary of the migrant.

Most highly-skilled migrants to the Netherlands are from India (2,020) followed by the US (780) and Japan (360).[46] A large proportion of them appear to have applied as foreign students.[47] Between 2005 and 2008, the number of migrants under the scheme increased from 1600 to 6600. About 5,900 people came to the Netherlands to work under the HSKM in 2011, slightly more than in 2010 (Annual Report, IND, 2012).[48]

[46] Dutch New.nl, "More Highly Skilled Migrants came to Holland last year", 20 March 2012, available at http://www.dutchnews.nl/news/archives/2012/03/more_highlyskilled_migrants_ca.php

[47] Foreign students have one full year to look for positions as highly-skilled migrants after the completion of their studies in the Netherlands. Moreover, a different salary criterion applies to former students who find work at their education level immediately after the completion of studies. For 2012, the minimum starting salary for students, using a one-year job-search period, is stipulated at €26,931. The lowered salary criterion corresponds better to the actual salary levels of beginners on the labour market. (See Weisbrock and Hercog 2011: 13).

[48] http://www.rijksoverheid.nl/documenten-en-publicaties/jaarverslagen/2012/03/20/de-ind-belicht-jaarverslag-2011-van-de-ind.html

Table 10: Top 3 Nationalities with number of VVR applications received in the first instance

Sl. no.	Nationality	Number	Percentage
1	Indian	2,000	34
2	American	800	13
3	Japanese	350	6
	Remaining	2,750	47
	Total	5,900	100

Source: Annual Report, IND 2011: 13

6.1.5. Experience with Operation Theatre Assistants from India

Around 2009, university hospitals began to recruit operation theatre assistants (OTA) from India under the HSKM (Tjadens, 2011: 7-8) and not as nurses *per se*, which is defined as a legally registered profession in the Netherlands. In August 2009, the Groningen University Medical Centre (GUMC) hired 14 theatre assistants from India through a recruiting agency from the UK.[49] In November the same year the Amsterdam Medical Centre and the Free University Medical Centre were reported to have hired 56 nurses from India to work as operation theatre assistants.[50] A 2011 survey conducted by the union of theatre assistants (LVO) claims that 88 Indian theatre assistants are working in 14 Dutch hospitals.

The hiring of operation theatre assistants from India came under fire from a foundation that promotes health care in the developing countries which charged Dutch employers with resorting to the cheaper option 'rather than employing and training up its own personnel'. Following this Socialist MPs raised parliamentary questions about the issue and the Ministry of Health and the Ministry of Foreign Affairs issued statements that Dutch hospitals should avoid recruiting health workers from countries with shortage. Officials of the Ministry of Social Affairs and Employment (MSAE) and of the Immigration and Naturalization Services (Dutch: IND), Ministry of Interior (MOI) in the Netherlands told us that it was no longer possible for individual hospitals to recruit 'third country' nurses because they would be denied approval by the

[49] According to newspaper reports in August 2009, the hospital justified this move owing to the difficulties faced in recruiting in the EU market. "Home grown" workers quit to work with through private job agencies that allows them better wages and working hours. The additional costs of hiring through these agencies is expected to be borne by hospitals. See (UMCG, 2009)

[50] Available atwemos.nl/Eng/994_two_other_dutch_hospitals_are_activelyrecruiting_staff_from_india.htm, accessed December 21, 2012.

immigration department. According to them, currently the government strategy was to combat shortages by encouraging more intensive use of the existing nurse workforce, to train nurses within the country and if necessary to use nurses from other EU countries.[51]

The hiring of Indian operation theatre assistants turned controversial at least partly on account of the prevailing political climate. According to an IND official, the experiences of the hospitals that hired Indian OT assistants "were not very good. They were less experienced and had less skills than the Dutch hospitals thought they should have. Also some cultural differences made it difficult to work together with Dutch nurses. At the end the hospitals were satisfied with the skills. They became good, but the hospitals had costs, lots of adjustments to get the Indian assistants to come to the level they wanted. Because they were under the Highly Skilled Migrant programme they had very high salary in respect of Dutch workers, who had to give assistance to them. This created friction". [52] A Dutch Health Ministry (MoH) official however clarified that the problems in foreign recruitment in health care sector were felt in the past also with South African, Polish and Filipino nurses. "There is always a lot of language problems - one of the big problems and I think [there is the problem of] the cultural adaptation to the Dutch working situation".[53] The survey by LVO reported that language and cultural differences present major problems in the day-to-day work, and that Indian theatre assistants required extra supervision, which ends up being a burden to other colleagues rather than alleviating the workload, and that potential threats to patient safety were present (Tjadens, 2011: 8).

Subsequently, however, employers came under pressure from multiple sources.[54] The IND official said that in 2010, some political parties asked the Dutch Government, "Why do we recruit nurses from India when at the same time Dutch unemployment is rising very rapidly?" He quipped that it is almost impossible to recruit people from outside the EU with unemployment in the Netherlands at about 11%.[55] "We may recruit German nurses. We have a free labour market

[51]Interview with Dutch officials on 5th October 2012.
[52]Interview with Dutch official from the IND, 5th October 2012.
[53]Interview with Dutch official from the Ministry of Health, Welfare and Sports, 5th October 2012.
[54] Despite efforts, we failed to get interviews with the three hospitals. .
[55] Contrary to estimates and expectations raised by media and stakeholder groups, the 2004 and 2007 EU enlargements led neither to a "swamping" of the EU- 15 countries nor to a massive brain drain of health professionals from the then accession states (EU-12). EU enlargement did not produce the predicted dramatic effect on the mobility of health professionals owing to a number of factors. Apart from the labour market restrictions that applied in several EU-15 Member States in the transition periods, overestimated predictions based on intention to leave data were also to blame. Workforce policies on salaries and working conditions in some eastern European

within EU. But outside the EU, you have to have a very good story to recruit nurses…while our own labour unemployment is growing so fastly (sic) in the Netherlands."

The official from the MSAE threw light on the recruitment process, saying that the problems arose because "the people from outside the EU were not prepared about what they could expect".[56] The MoH official said that the hospitals went to India and recruited around 100 OT assistants. He said 20 percent of these were sent back "because they were not good enough and with the other 80 percent the hospitals must do a lot of investments to train…".

This official pointed out that in recent months the highly skilled migration policy had become more restrictive. "[I]n the past there have been cases of abuse or misuse of the scheme in the migration of fairly low-skilled workers like pancake makers, staff in restaurants, with very high salaries when it was not within the terms of the scheme to admit such low-skilled workers". To avoid similar legal loopholes in the system, for instance if a nurse from outside the EU has been offered a much higher salary than Dutch nurses, the immigration service would refuse the application for a residence permit.[57] The basis on which the salary levels would be determined is a bit unclear given the fact that we learnt that in the Netherlands, nurses work through different routes .i.e. either directly with the hospitals or through "temp" agencies as temporary workers, drawing different levels of salaries.

The temporary workers in the Netherlands get paid more than those recruited directly by hospitals, with greater flexibility in work hours, a factor that has led many Dutch nurses to quit their regular jobs and work in self-employed capacity. A representative of the V &VN Dutch Nurses Organization, based in Utrecht revealed that the opposition to the recruitment of Indian OT assistants in 2009 was overemphasized in the media by "anti-foreigner parties" and played up on the "jealousy" felt by regular Dutch nurses who get paid less compared to other Dutch nurses (leave alone foreign workers) holding jobs through recruitment agencies.[58] So while the language and cultural barriers to the use of foreign healthcare workers was a factor, it was just a sign of a "bigger problem" in the Netherlands. She however asserted that the recruitment of

countries may have helped to retain health professionals by reducing incentives to migrate as seems to have been the case in Estonia, Lithuania and Poland. EU enlargements received much public and media attention, which also possibly contributed to excessively high expectations (or fears) related to intra-EU mobility (Mathias et al., 2011: 45).

[56]Interview with Dutch official, Ministry of Social Affairs and Employment, 5th October 2012.

[57]Interview with Dutch official, Ministry of Health, Welfare and Sports, 5th October 2012.

[58] Interview on 8th October, Utrecht, the Netherlands.

Indian nurses for the Dutch Nurses Organization was "like a shift to an easy opt-out instead of working on the issue structurally, focusing on education and training" of nurses in the Netherlands.[59]

6.1.6. Language and Cultural Barriers

Language and cultural differences are major barriers to the migration of healthcare workers. Foreign languages and accents tend to be challenging in destination countries (Hazarika et al, 2011: 98). A number of EU countries require language skills in health care, though the levels keep varying over time. The failure to gain competence in the local language has proved to be real barrier for foreign health care workers in Italy (Challof, 2008). [60] For non-EU citizens a certain degree of integration is required before even entering the Netherlands. This involves a Dutch language course and a basic course on Netherland's culture and history (Tjadens, 2011: 6). As was pointed out earlier, entry under the HSKM does not require any prior Dutch language skills. This may have perhaps facilitated the quick recruitment of Indian OT assistants by Dutch employers. We learnt from the V & VN Dutch Nurses Organization representative that the real concern is "if the patients can't talk to the caregivers or nurses anymore but also that the nurses can't understand each other anymore". An important cultural barrier pointed by the V & VN representative was the failure to question doctor's authority so as to ensure best possible patient care. Some of the other concerns expressed were about the ability of the foreign workers to integrate and be accepted by Dutch nurses. In this context, she pointed out:

> We've talked about Indian and South African nurses….we have people coming from Poland and Bulgaria coming to work in nursing homes. But there is a rule in EU that you can freely travel and work in the EU if it is the same diploma. But you still face the problem of communication and culture. But the problem is that it is legally allowed so you can't just say no...

[59] Most nurses in the Netherlands work in the hospital sector. Nurses level 5 are seen more in mental health care while more nurses level 4 work in nursing and elderly homes.

[60] Nurses from non-EU countries need to pass a language test in Italy. Prior to registration with the National Federation of Professional Nurses, Health Assistants and Childcare Workers (IPASVI) -- the umbrella body for the professional organization of nurses-- every foreign nurse will be offered a free test to verify her knowledge of the Italian language, entailing 100 questions in one hour. The language test is evaluated by a certified institute of languages and compared to the European reference standard. If the test result states that the level of Italian is not in line with the European standard, the applicant is offered additional language courses in order to improve knowledge skills.

6.1.7. Future Shortages, Strategies for Growth and the Role of Migration

The Dutch healthcare sector will face a shortage of 4,50,000 employees in 2025 (Wemos, 2010: 16). Currently in the Netherlands 18,000 students follow the level 4 nurses education; some 11,500 students enter nursing level 5 with an overall qualified output rate of 70%. Nurses are known to stay in the sector for around 14 to 21.5 years. Nearly half the nurses (46%) are said to quit their job under work-pressures, lack of quality care and for lack of professional development opportunities. Almost one in four nurses leaving a Dutch hospital-job leaves the industry (Tjadens, 2011:14).

The Dutch MoH has acknowledged that the sharp increase in the number of older people is among the challenges it will face in the near future and this will affect the demand for care. The number of people with chronic illness is also rising in the Netherlands. Labour shortages are increasing, making it necessary to deploy scarce human resources as efficiently as possible. The Dutch MoH recently consulted the Nursing Staff Panel (NIVEL) to uncover some of the moral dilemmas being faced by nursing and care staff. [61] It was found that at least once a week, one third of nurses and carers asked themselves: 'Should I make overtime to prevent understaffing?'. Four in ten indicated that this dilemma is becoming more and more common. Therefore shortage of (qualified) staff and the attendant lack of control over patient care is a persistent problem in Dutch nursing homes (Westert et al, 2010).

Current vacancy rates do not reflect shortages, even though regional differences exist. However, for the near future, the smaller, specialist professions, suffer high vacancy rates. This was the context in which three hospitals, using intermediary, recruited theatre assistants from India. There may be similar overseas recruitments for other 'niche' professions. For the more distant future, some expect shortages of 40% in nursing and care, but recently options were developed to have enough human resources in care and welfare in place in 2025 without substantial foreign recruitment.

The IND official pointed out that with respect to projections of future demand:

[61] The Nursing Staff Panel (NIVEL) is used to measure satisfaction with quality of care every two years. The scale score is calculated on the basis of three questions related to: the extent to which there is sufficient time to properly care for clients, the level to which clients can be given personalised care, and the degree to which clients can be given psychosocial support.

> The experiences in the past with long term labour market prognosis are very bad…in the sense that they often do not come true. Of course there are research institutions also working for the government who are making those kinds of prognosis. But the day to day policy often has a time perspective at the best of 4 or 5 months. Because prognosis of the labour market on a larger scale –say of 10 years or more ahead–tend to be very insecure. So we are not basing our policies on these kinds of projections.

In view of the impending shortages in the healthcare sector, the Dutch MoH with the overall responsibility for the continuity and quality of care in the Netherlands, took the initiative to draw up an action plan to work with employers and worker's organizations and other interested parties to innovate healthcare processes, invest in staff retention and increase the flow of new personnel (Berenschot 2009: 7). As a result of these initiatives the ZIP Committee on Labour and Immigration of Health Personnel was constituted, with a mandate until June 2009 to give its opinion on "how increasing care needs with targeted development of manpower can be solved". We spoke to a Managing Consultant at Berenschot, the firm that received a commission from the ZIP to examine the scope for immigration of health care personnel as a solution to future long term health care labour shortages in the Netherlands.[62] It was estimated (Berenschot 2009: 8) that of the 252,087 registered nurses under the BIG,[63] only 2887 persons (1.15%) have been trained abroad.[64] Berenschot came to the conclusion that immigration would not be a viable solution to the future shortages in healthcare because the political climate is not conducive to it. It acknowledged that the biggest shortages would be felt in the elderly care sector and shortages faced by individual hospitals would be less by comparison. Thus, for instance in the case of shortage of theatre assistants even a small number of people from abroad (50-100) would help a lot.[65]

As the representative of the Dutch V&VN pointed out, global migration is not a problem as long as it is facilitated well, with good training and cultural acclimatization. However, she was quick to add that while it was true that there is a development dimension to the desire to migrate, concerns remained over the perception that nurses from India were brought into Europe by

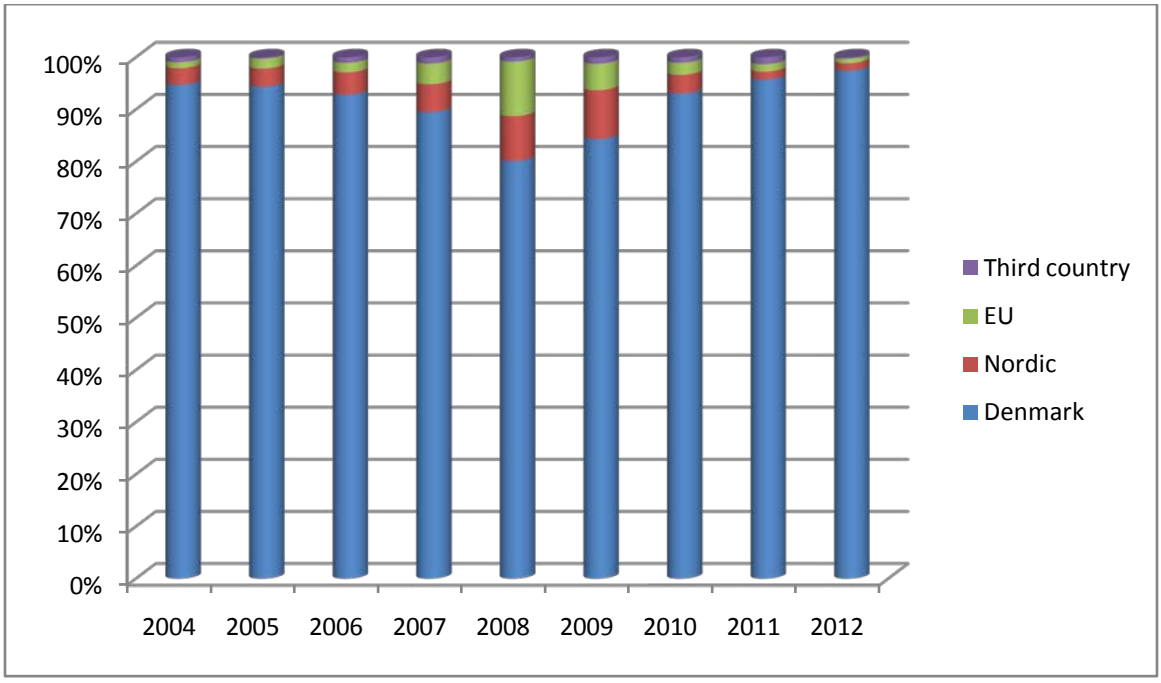
[62] Interview with a Managing Consultant, Berenschot on 8th October 2012.
[63] BIG is the Dutch acronym for the Individual Health Care Professions Act in the Netherlands.
[64] BIG data is based on origin of qualification and not on nationality.
[65] Interview with Managing Consultant at Berenschot, the Netherlands on 8th October 2012.

"dodgy" recruiters. In conclusion she said: "My biggest fear is that there will always be care for the rich but not for the poor…may be we need to be less afraid of the unknown".

6.2. Case study of Denmark

Foreign trained nurses comprised 6.2 % of Denmark's foreign trained workforce in 2005, an increase of 0.2 % over 2000. The stock of foreign nurses in Denmark was over 5000 in 2005. Most of these nurses are from the Nordic countries, Germany, the Netherlands and Eastern Europe. In 2008, Denmark received 511 foreign nurses, double the number that had arrived in 2007 (236). However, between 1996 and 2006, only 62 nurses from non-EU countries obtained authorization to practice in Denmark (The Danish Nurse's Organization: www.dsr.dk).

Number of Nurses Licensed in Denmark during the period 2004-2012 (grouped on the basis of country of training/origin)



Source: Author's representation of data obtained from Danish National Board of Health, Sundhedsstyrelsen on 01-10-2012

Denmark has one of the most restrictive immigration policies in Europe. However, in recent years the Danish Government has taken up new policy initiatives regarding international recruitment. On 28th February 2008, the Danish Government and the Danish People's Party, the Danish Social Liberal Party and the Liberal Alliance agreed upon a Job Plan that aims at increasing the labour supply in Denmark, both currently and in the longer run. The agreement

contains seven main initiatives including the Positive List and the Green Card scheme[66] The Positive List applies to persons who have been offered jobs in a profession that is experiencing a shortage of qualified persons, and professionals on the list have particularly easy access to the Danish labour market. The expanded "Green Card" System gives foreigners the opportunity to take on employment in Denmark for a period three years. To obtain a residence permit under the Green Card System, the applicant must have a minimum of 100 points on the basis of educational level, language skills, work experience, adaptability and age. The applicant also needs to show adequate financial resources to stay in Denmark in the first year upon entry. The Green Card Scheme is also related to the Positive List in so far as assessment of work experience is concerned. Based on experience within the last five years, assessment is made in a field where Denmark is currently experiencing a shortage of qualified professionals.[67] Thus, it can be reasonably concluded that an Indian nurse with a Bachelor's degree, even with a 3-5 years' experience, will not qualify directly under the Green Card Scheme, given the language requirements and need to be on the Positive List. The Pay Limit scheme, gives persons who have been offered a job contract with an annual pay above a certain limit, a particularly easy access to the Danish labour market. In order to qualify one must have a gross annual pay of no less than DKK 375,000, together with a job contract specifying the same requirements as under the Positive List and an authorization to practice (www.nyidanmark.dk.)

Since the 2008 Job Plan, there is greater flexibility with respect to changing jobs during a residence period in Denmark. Foreigners who have entered the country for employment purposes can start a new job before receiving a new residence and work permit. Foreigners who have been granted a residence permit for employment under the Positive List, or under the Pay Limit Scheme which requires a minimum pay of 375,000 Kroner, may remain in Denmark for 6 months to seek work after the expiry of a contract or in the case of involuntary unemployment.[68]

[66] http://www.oecd.org/els/mig/41705800.pdf

[67] A maximum of 15 points can be attained under this category. Where the applicant has 1-2 years work experience within the past five years as a researcher/in field listed on the Positive List 10 points can be obtained; 15 points for 3-5 years for those eligible under the Positive List and 5 points for those having 3-5 years' experience but not eligible under the Positive List. Information available at http://www.nyidanmark.dk/en-us/coming_to_dk/work/greencard-scheme/greencard-scheme.htm (accessed February 21, 2013).

[68] http://www.oecd.org/els/mig/41705800.pdf

6.2.1. Conditions for Entry of Foreign Nurses

Currently, any foreign trained nurse wishing to practice the profession in Denmark must obtain authorization from the National Board of Health.[69] Rules governing the recognition of qualifications depend on the applicant's nationality and the country of education (National Board of Health: www.sst.dk). While European institutions have established rules to facilitate the mutual recognition of professional qualifications between the Member States, according to the Directive 2005/36/EC, the case of 'third country' nationals is determined on a case-by case basis. Experience is to be taken into account while considering professional competence but "experience is a difficult matter to assess" because of the differences in hospital settings, facilities, disease profile etc.[70]

The National Board of Health determines on an individual basis whether non-EU applicants need to undergo supplementary courses at a Danish School of Nursing, or if they are eligible for a temporary registration and trial employment. Trial employment and temporary registration are expected to make it easier for qualified foreign nurses to get employment within the Danish health care system. For trial employment, foreign nurses must obtain a temporary registration, assigned on the basis of qualifications equivalent to Danish nursing education. Temporary registration for 6 months may be extended to 18 months during which time the foreign nurse must secure employment in a hospital ward, where she is tested for her practical and theoretical competencies (The Danish Nurses' Organization, www.dsr.dk).

The five Regions in Denmark are responsible for the working and administration of hospitals. The vast majority of the Danish health care service is public and only about 1% of all nursing care and treatment is practiced in private hospitals (The Danish Nurses' Organization, 2009: 4).[71] Language is an essential precondition for working as a nurse in Denmark, however it is up to the individual employer to decide on the level of language skills required for a specific position (The Danish Nurses' Organization, 2009: 8). A foreign nurse is required to undergo adaptation of over 6 months (National Board of Health website) by working for a Danish hospital. The hospitals

[69] In March 2012, a merger between the Danish Health and Medicines Authority and the National Board of Health became effective.
[70] Interview with Nursing Adviser, National Board of Health, Copenhagen, 2nd October 2012.
[71] In Denmark, almost all vacancies are posted on the internet. If a foreign health professional is interested in a job in the Danish health services, Work in Denmark's job and CV bank is a good place to start the search. The job bank contains most job postings for which foreign employees are required (www.workindenmark.dk). Furthermore, links on workindenmark.dk direct to job advertisements from other Danish websites – e.g. the hospitals' websites.

offer language tuition to all their foreign employees. Often, the language tuition begins in the home country and includes the entire family prior to departure. Additionally, the municipalities offer Danish language tuition, which focuses on the labour market and which is free of charge for the first three years (www.workindenmark.dk).

6.2.2. Recruitment Strategies

The recruitment strategies in Denmark, following the EU model, are 'demand-driven' with specific initiatives such as the EURES engaged in job-matching. The preference continues to be to recruit from within the EU. Shortages are discerned through statistics and working closely with employers, though there are no broad marketing schemes to reach out to employers.[72] Every six months, the Danish authorities do a survey of the Danish labour market asking for a representative sample of Danish companies whether they have tried in vain to recruit and in this way which kind of jobs are in demand. Apart from statistics, in the case of certain categories like specialized physicians, where the need is few in numbers (and hence not statistically significant) yet of vital interest to hospitals, the Danish Agency works closely with employers to find solutions to their needs. Danish recruiting agencies have stayed away from recruiting Indian nurses citing the shortage of nurses in India.[73] While nursing shortages in Denmark have gone through its ups and downs, shortages in elderly care are expected in a large way in the years to come.[74]

[72] Interview with the Danish official, EURES, on 1st October 2012. Explaining the benefits of the EURES system, the official claimed that the vast "organised network" of over 800 public employment service advisers across the EU allows for access to information on potential supply of labour in the event of shortages.

[73] One of the biggest recruitment agencies in Denmark, Scandinavian Medhelp has deliberately chosen not to recruit nurses from India due to ethical considerations, a decision taken after a field visit to India to explore opportunities for the recruitment of Indian health professional (www.dsr.dk).

[74] Elderly care in Denmark comes within the purview of municipalities and the Regions and is subject to the priorities set by the local politics. While the demographic decline and the attendant problems of aging are true for Denmark, Copenhagen for now is an exception to the trend. Certain category of health care workers engage in elderly care with a large percentage of them qualified as "social helpers." These require fewer years of training compared to nurses and nursing assistants. Assessment procedures with regard to language skills are not clear. Nonetheless, a great emphasis is placed on the need for requisite Dutch language skills given that very few elderly persons feel comfortable communicating in English. Much of the elderly care is public-funded with some extra services provided on payment to private agencies. In the next 10-15 years shortages are possible in the elderly care sector. *Currently this sector is not particularly attractive for Danish youth. It is mostly second generation immigrant youth who are involved in this sector. In the wake of the economic crisis, nurses who have been forced to leave hospitals have turned to the geriatric care sector. Shortages in the years to come are a distinct possibility given that many of the second generation immigrant youth are aspiring and enjoying greater social mobility.* Interview with Danish official, Elderly Care Management for Health and Care, Copenhagen, 1st October 2012.

6.2.3. Danish Recruitment of Indian Nurses

Through 2004-2012, over 80 per cent of the licensed nurses in Denmark have either obtained their training in Denmark or are of Danish origin except in the year 2008, where there appears to have been a rise in nurses from the Nordic and EU region. Compared to 2005, when only five 'third country' nurses were reported by the Danish National Board of Health, a six fold increase took place in their numbers in the years 2009 and 2011. Out of the total of 100 nurses trained abroad who obtained authorization in 2011, Indians headed the list for 'third country' nurses, followed by the Philippines, Nepal and Thailand.

In 2011, ten Indian nurses received temporary registration, which was larger than from the Philippines (7) or from any single source in the EU (NBH Register), only the Nordic countries had larger numbers registering. However, the large number of applications received in 2009 needs to be seen in the context of the setting up of a 'Work in Denmark' Centre at the Danish Embassy in New Delhi in October 2008. Set up on an experimental basis to encourage applications from qualified Indian professionals to seek employment in Denmark, it was the first of its kind outside Denmark. India was chosen apparently for the programme because of its skilled workforce, the level of English language proficiency in the country and because of the adaptability of Indians.[75] Of the 6000 plus applications received in 2009, 5000 included the documentation that was essential for the acceptance of applications. However, the Board decided to consider only those applications that had a potential job offer and ended up sending all the applications back to India (Nordisk Arbetsmarknad for Sjukvårdspersonal, 2009: 10). The scale of the response from Indian nurses to the 'Work in Denmark' programme shows that there is no dearth of aspiration among Indian nurses to work in less familiar countries like Denmark.

Table 11: Applications received from Indian nurses for registration in Denmark and Registrations

Year	2007	2008	2009	2010	2011
No. of electronic applications	9	90	6787	35	34
Permanent Registration	1	0	14	3	0
Temporary Registration		1	2	7	10

Source: National Board of Health, Denmark

[75] Interviews with Danish Officials, October 2 and 3, 2012; see also Financial Express, October 17, 2008.

The response was entirely unanticipated by the Danish authorities and in some quarters clearly unwelcome. A senior nursing advisor at the National Board of Health (NBH) described the experience as being "hit by the Indian tsunami". She said that the NBH simply did not have the capacity to deal with such a large number of applications but also indicated that there was something dubious about the way the applications had been mobilized. The timing of the applications (applications received in 2009 though the programme was announced in 2008) indicated that the information had filtered down slowly through unscrupulous recruiting agents in India. Further, she believed that nurses looking to migrate from India were basically interested in "making gains", which did not bode well for the quality of care, they were likely to provide (Interview, Oct 2, 2012). Reports that circulated on the web citing Danish diplomats in Delhi and Danish recruiting agents too stressed the role of agents in India who 'do not provide their clients with all the necessary information' in mobilizing these applications.[76]

6.2.4. Experience of a Danish Hospital with Indian Nurses

In contrast to the government initiative, the efforts of hospitals to recruit Indian nurses have met with greater success. In recent years, a small number of nurses were able to secure jobs in Danish hospitals that faced shortages. One hospital recruited nine nurses from India between 2007 and 2009, all from Kerala. In October 2012 there were Indian nurses in this and two other hospitals not far from Copenhagen and several in a hospital in Jutland, a total of 27 Indian nurses. Faced with a shortage and difficulties in finding local nurses, the hospital decided to pursue an application from an Indian nurse. The head nurse said that her colleagues had been skeptical at first. Daisy had applied to 50 Danish hospitals but heard only from this hospital.[77] At the time, she was in Portugal, where her husband was employed and she was unemployed for nearly four years. After a successful interview, she gained temporary registration in Denmark and started working in August 2007. Daisy did not speak Danish at the time. During the adaptation period of six months, the department first assigned a 'social assistant' to her for three months to help her interact with patients and then a nurse for the following three months to orient her towards her duties as a nurse. She also attended Danish language classes after duty hours

[76] The Director of a Danish company that reportedly trained nurses in India was quoted as saying that a few companies in south India had seized the opportunity to make money by advertising in local papers. 'These nurses have a good reputation but they probably won't get jobs because they need someone in Denmark to represent them. So there are a couple of companies that make a lot of money and a lot of disappointed nurses.' (Corrupt recruiters behind Indian nurse boom, http://www.diwala.com/90/corrupt-recruiters-behind-indian-nurse-boom/).

[77] Names of respondents have been changed to maintain confidentiality.

which are provided free of cost by the Danish Government. According to the head nurse, in six months she was able to work like a "normal Danish nurse". The authorization process in Denmark takes six months. Daisy gained permanent authorization on the basis of the recommendation by the hospital and got a full time job there.

Danish health and immigration officials had underlined the importance of language and culture for patient care in the context of hiring foreign nurses. If foreign nurses failed to cope adequately with these requirements, it could imperil patient care, especially in the case of older patients who were less likely to understand English.[78] More generally too, the Danish administrative view underlined the costs of taking on foreign labour even in the face of shortages.[79] At the hospital, however, the experience with Indian nurses demonstrated that with prudent management, immigrant nurses had little difficulty in rising to the required standards within the adaptation period. "They were all good nurses, well-educated and they fitted into the system very well. In six months they had learnt "enough to communicate with patients and to understand the Danish humor. Yes, it [Danish humor] is so important…that shows that they understand Denmark".[80] A profile of the Indian nurses at the hospital touches upon Danish apprehensions about employing nurses by suggesting that their success owed to 'a western frame of mind due to their upbringing in a Christian state' (Bjerg, 2009: 13). In Denmark, language requirements for foreign professionals have been raised or lowered depending on the nature of shortages. While language skills are essential, it was up to the employer to decide on the level of skill required for a specific position (The Danish Nurses' Organization, 2009: 8). However, the nursing advisor at the NBH pointed out that from 2013, knowledge of Danish would be made a pre requisite for taking up a nursing job in Denmark.

Daisy's entry into the hospital opened doors for more nurses from Kerala. In an intervention that demonstrates the importance of individual initiative and social networks, Daisy's husband, John, was instrumental in mobilizing applications from nurses in Kerala. On learning from his wife

[78] Interviews with officials at NBH and Danish Agency for Labour Retention and International Recruitment, Management of Health and Care, City of Copenhagen.
[79] The Chairman of the Association of Danish Regions' Health Committee, Ulla Astman, is quoted as saying in response to the large number of applications that the Work in Denmark programme elicited from Indian nurses, 'We are always happy to take on well-educated labour if the authorization is approved. But of course we can't take 4,500 at once even if they are qualified, because it's a huge task for hospitals to integrate foreign employees' (Corrupt recruiters behind Indian nurse boom, http://www.diwala.com /90/corrupt-recruiters-behind-Indian-nurse-boom/).
[80] Interview with former Head, Nurse at the Hospital, Copenhagen on 2nd October 2012.

that there were vacancies for nurses in the hospital he met the head nurse and offered to get her applications from Indian nurses. The head nurse took up the proposal with her colleagues, who were skeptical once again but the Director of the hospital approved. John had used his personal network of relatives and friends to mobilize the applications. Of the two nurses we met in Copenhagen, Sneha was his cousin and Rubina was his friend's sister. They said he had encouraged them to go to Denmark for the initial interview though there was no guarantee that they would get the job. He had facilitated their travel to Denmark and their accommodation during the initial visit. Daisy and he had also provided guidance on how to approach the interview. Sneha had gone for her interview to the hospital less than a year after Daisy had joined the hospital, hence Daisy could not sponsor her and John had arranged for an older nurse to do so. Daisy had sponsored the nurses who came after Sneha. In 2012, Sneha and Rubina had been in Denmark for three to four years and in turn they had received many inquiries from nurses in India of the possibility of finding jobs. They had not been able to help because the recession had set in by 2009, almost as soon as they had been able to find their feet in their new context.

6.2.5. Collaborative Private Recruitment Efforts in Denmark

Previous efforts to recruit doctors from India for Denmark provide insights into the potential for mobility of healthcare workers from India in the context of critical shortages in the EU. In the early 2000s there were widespread reports about shortages of doctors in Danish hospitals[81]. The government was even forced on occasion to send patients abroad for treatment at high costs. In this context, hospitals started recruiting from Poland and some Asian countries. However, there were language issues, issues related to authenticity of documents etc. In the backdrop of these facts, a consultant we spoke to met with officials from hospitals and engaged a team to research the exact needs of each hospital with respect to types of doctors who were needed. The consultant together with a delegation from Danish hospitals then visited India to ascertain the competence level of doctors and their suitability for the Danish hospital environment. When this was found to be satisfactory, the consultant at the behest of these hospitals advertised for doctors in a number of Indian newspapers. At the time of advertisement, there was a need for around 40-

[81] Interview with a consultant who had previously worked with an agency involved in recruitment of highly qualified persons for the Danish labour market. He is a businessman of many years of experience in Denmark who is of Indian origin, presently settled with his family in Copenhagen. He has been involved in advisory capacity with the Work in Denmark Centre, at New Delhi, India.

50 doctors in Denmark. They received so many applications and "didn't know how to cope with them".

Following stringent and disciplined language training of the selected candidates, around 50-60 doctors were placed in hospitals in Denmark (for details of the recruitment process see Appendix B). The biggest challenge for the Indian doctors was however the extreme cold and the "social climate" in Denmark.[82] We were told that most of these doctors who went to Denmark around 2003-04 were still around, with even some of their spouses working in Denmark.

7. Perspectives of Internationally Recruited Nurses from Kerala / India

The migration of nurses from Kerala has been demand driven to the extent that nurses have responded to opportunities where they were available and altered their movement in response to incentives arising from policies in destination countries. As noted above, access to networks and information has been crucial to this process. Unlike IT professionals, nurses receive little recognition as contributing to India's social profile as a source of skilled labour or to remittances. Nurses have received little official support for migration until recently but also importantly the Indian state did not erect barriers to their movement. In this context, Indian nurses have relied extensively on social networks and commercial agencies as mechanisms that channel information and provide support for migration. Networks and agencies have shaped the aspirations of nurses towards potential destinations and defined the perspectives of aspirants with respect to the migration process. In this section, we draw upon the literature and upon interviews with two immigrant nurses in Denmark and a return migrant nurse from Denmark to understand international nurses' perspectives on the migration process and on working and living overseas.

7.1 Choosing to Migrate

Nurses from developing countries emphasize the economic motive as the principal reason for migration because the compensation packages in their home countries is far from attractive. 'Here we slog for more than eight hours a day and are paid a pittance. In the U.S. we are

[82] The consultant commented that Danish people like to go back to their homes and live a closed life, not mingling much with others; a sentiment which was echoed by other interviewees at the Danish Agency for International Recruitment and Labour Retention. Our personal experience while interacting with Danish people however showed them to be affable, warm and ready to help when the need arose.

promised more than $45,000 per annum [in 2003].'[83] However, onward migration of nurses from countries that provide high salaries to others is only one indication of more diverse motivations. Migration is a life strategy for Indian nurses (Percot, 2006). Increasingly, Indian nurses are using the Gulf countries, where salaries are attractive, as a stop on their journey to the OECD countries.[84] There is also significant movement of Indian nurses within the OECD countries. Prominently Indian nurses' in the UK and Ireland have indicated their intent to shift to the US, Canada and Australia.[85] [86] Indian nurses are known for their preference for permanent residence in an OECD country compared for instance to Filipino nurses, the other large sending country of nurses (Alonso-Garbayo and Maben: 2009).[87] This preference is likely to make them look for destinations that are relatively more secure. Destination countries subject to chronic or cyclical shortages may need to factor this into their policies.[88]

The nurses we spoke to said better salaries were the main draw of overseas employment. Sneha and Rubina, staff nurses at a hospital in Copenhagen, received a basic salary of 21000 Danish Kroner.[89] Roughly three years ago, as junior staff nurses in hospitals in Delhi, they drew between Rs 6000 and Rs 7000.[90] In Denmark, the taxes deducted are high, but there is scope for

[83] A nurse from Kerala set to migrate to the US in 2003 cited in Pazhanilath (2003).
[84] Many Malayalee nurses in the US had worked previously in the Gulf and African countries (George, 2000: 153).
[85] According to a survey in 2005, about 25 % of Indian nurses in the UK said they intended to move to another country (Buchan, 2007a: 17). There is further evidence that international nurses in the UK regard their stay in the UK as a stop on the way to the US - in 2005, more than 85% of the nurses who took the CGFNS exam in London were not educated in the UK; of them the majority were from the Philippines and India (Buchan, 2007: 20). Of 265 candidates who took the test in London in 2005, 90 were educated in the Philippines and 79 in India.
[86] Verification requests made to the nursing councils in the UK and Ireland, which reached high levels in the 2000s, indicated the intent of nurses to shift to Australia, the US, New Zealand and Canada. In 2009, 1321 Indian educated nurses were among the 2714 nurses registered in Ireland on whose behalf verification requests were made and the vast majority of these were issued to various States/Territories in Australia with some issuing to the USA and Canada (Annual Report, An Bord Altranais, 2009: 30). NMC verifications in the UK rose from less than 3500 in 1997-98 to over 8000 in 2002-03 and have remained at about 8000 up to 2005-06 (Buchan, 2007: 19). These nurses have been seeking opportunities in Australia, New Zealand, Canada, the US and Ireland (Kumar and Simi, 2007: 31).
[87] Filipino nurses move independently as temporary workers with the intention of going back home after some years (Alonso-Garbayo and Maben: 2009). Over 75 % of Indian nurses enter New Zealand with family members as compared to about 60 % of Filipino nurses and only about 20 % of Chinese nurses (Badkar, 2008).
[88] The Royal College of Nursing has expressed concern over the new immigration rules that could force thousands of overseas nurses to leave and prove detrimental to attracting overseas nurses to the UK (Ford, 2012).
[89] An Indian Rupee is 9.44 Danish Kroner (as of March 25, 2013).
[90] A study by the Centre for Women's Development Studies in New Delhi found that the entry-level salaries of three year diploma nurses in private hospitals ranged from Rs 2500 to Rs 6000 prior to the implementation of the Sixth Central Pay Commission recommendations (Nair S, 2010: 23). In 2012, the average take-home salary for a junior staff nurse in leading private hospitals in Banglore was between Rs. 4,300 and Rs. 7,000. In tier-II hospitals and smaller nursing homes, three and one year diploma nurses were paid between Rs. 2,500 and Rs. 4,000 (Kurup, 2012). According to the President of the Kerala Trained Nurses Association, in 2011, the salary for three year

additional allowances for working on holidays (65 to 70 Kroner per hour) and night shifts (50 Kroner per hour extra compared to day shifts). Their major expense was on rent, which could go up to 5000 Kroner. Effectively they were able to save between Rs 80,000 and Rs 1 lakh every month. Yet, higher salary was not the sole motive of migration. All of them had nurtured the aspiration to go overseas. Daisy said she grew up in a place where many nurses were going overseas. Her aspirations grew seeing them. Rubina said, "there is this feeling in us. We want to go out". They attributed it to a complex set of factors, salary most importantly but also working conditions, the experience of life and work overseas and the desire to travel. Daisy said she and her husband had no intention to settle down overseas but 'wanted to spend a few years, travel, see places and then return'.

7.2 Choice of Destinations

In the early 2000s the UK and Ireland became favored destinations for Indian nurses.[91] Though salaries were higher in the US and in Australia, migration to these countries took longer (up to two years) compared to the UK or to Ireland (six months to a year) (Matsuno, 2006: 62, Pazhanilath, 2003). The tightening of immigration on account of the recession has brought to the fore the uncertainties of migration to Europe. The economic downturn has led to less favourable conditions of work in Ireland - wage reductions and tax increases – and non EU nurses are feeling insecure despite having permanent contracts (Humphries et al, 2012: 48).[92] The non payment of overtime, part of the austerity, has substantially reduced the incentive for foreign staff to seek employment in Ireland and caused some of the Irish health professionals to consider job opportunities abroad (Bobek et al., 2011: 108). Notably, aspiring nurse migrants have pointed out that restrictive immigration policies and language barriers were curbing their movement to the other EU countries (Hazarika et al., 2011: 76). In this context, social networks have served to promote destinations and also to dissuade nurses from going to particular

diploma nurse (GNM) was between Rs 1500 and 2000 rupees and graduate nurse was Rs 3000 rupees (George, 2011).

[91] Few respondents mentioned European countries, specifically UK, Ireland and Netherlands, as their preferred destination in a survey of 36 nurses distributed across several states (Hazarika et.a., 2011: 87). In a survey of 40 nurses in Delhi, the UK was second only to the US and few nurses mentioned Germany and Switzerland (Khadria, 2004: 29). Less than five percent of nursing student surveyed in Kerala in 2008 preferred the UK, significantly below the Gulf countries, the US, Australia and Ireland. About two
percent had a preference for Switzerland (Walton Roberts, 2010: 9).

[92] Offer to nurses to work in the US have included the Green Card for the candidates and her family, standard industry benefits, airfare, temporary housing, free placement, transit accommodation, guidance on spouse employment, and excellent all-round grooming (Pazhanilath 2003).

destinations. In recent years, aspiring migrants were encouraged by their friends and 'seniors' to go to Australia and New Zealand but also dissuaded from going to the UK and Ireland (Hazarika et al., 2011: 88).

Sneha and Rubina, had received information from their relatives / family friends, Daisy, who was working as a nurse in Denmark and her husband John. Sneha and Rubina said that they gained greater clarity about overseas work opportunities from their seniors who were doing training courses for examinations to particular destinations or preparing to leave. The most talked about destinations in their social circles as students were the Gulf countries, the US and the UK. They had completed short term training courses in English and were planning to take the IELTS when they had learnt about the opportunity in Denmark. They were only 22 years old and had worked in Delhi for less than a year when John suggested that they apply to Denmark. Both of them had completed their training and internship in Kerala. Denmark had not been on their mental horizon. Daisy had migrated after her marriage when she was comparatively older. Hence, she had also attempted to get jobs in other countries than the one's she worked in. She worked for two years in Kottayam and for nearly a year in Bangalore before she moved to Portugal with her husband, who had a job there. She said she went to Bangalore because she had always been in Kerala and wanted to learn other languages. Daisy had applied for jobs in Denmark when she was unemployed in Portugal because the conditions for entry were relatively simpler – she mentioned that there was no entry test. She had also applied to Norway but was discouraged because she would have to undergo additional training. During her days as a student (1996-99), the popular destination was the Gulf countries and later the UK. Daisy had applied to the UK and had got temporary registration.

7.3 Migration Channels

There has been a marked expansion of organized international recruitment of nurses through private agencies (Brush et al, 2004; Khadria, 2007; Kumar and Simi, 2007). When the opportunities in the West registered a spurt in the early 2000s, it was reported that many recruiting agencies set up shop in Kochi. 'The competition among these institutions have turned so keen that they lure them [nurses] with offers of free exam fee, free training for CGFNS, TOEFL and TSE. Today, Kochi has more than 25 such centres' (Pazhanilath, 2003). The first survey of internationally educated nurses in Ireland showed that the majority of survey

respondents, 83% (278) reported that a recruitment agency facilitated their migration to Ireland (Humphries et al, 2012: 47). During the boom years for international nurses in Ireland, a single agency operating in Dublin, recruited as many as 3000 nurses and allied health professionals, 95 per cent of whom were for the public sector. In general, though nurses tend to be wary of commercial networks, they also find it difficult to forgo their services altogether. In this context, they rely on overseas friends and relatives for advice on the choice of commercial agencies (Hazarika et. al., 2011: 92). Recruiting agencies derive their salience from being able to provide 'services' that social networks, even where they exist, may not be able to provide. The services provided by agencies have been expanding over the years. From 'general' immigration related services - making placements for nurses, putting together documents and attestations, accessing and 'decoding' specialized information about licensing and visa procedures – to more specialized services - training aspirants for qualifying examinations and orienting them towards conditions in the destination. The US – India nurse migration corridor for instance is marked by tie ups between hospitals and recruiting agencies at both ends. Indian recruiting agencies in Delhi partnering with US agencies to supply nurses to US hospitals are said to invest $ 4700 – $ 7000 in training a single nurse and to earn as much as $ 47000 when a nurse is placed abroad (Khadria, 2007).[93] Given the high costs and even higher returns, international recruiting agencies screen nurses carefully, provide training to the ones that qualify, pass the required examinations fees and enable a relatively smooth transition by providing information and counseling. Only one in ten nurses who attended the screening process was said to qualify for admission to the programme of one leading recruiting agency (Kumar and Simi, 2007: 67).[94]

Sneha and Rubina were aware of the risks associated with using commercial agencies as a few of their friends had been shortchanged with offers of jobs as staff nurses which turned out to be appointments in nursing homes. However, they had not approached any commercial agencies. The countries of continental Europe may be disadvantaged in the longer term because of the lack

[93] According to Brush et al (2004: 83) on an average, hospitals pay recruiting agencies $5000 to $10,000 per nurse in return for a contract from a nurse to work for two to three years. But this was prior to 2004. The CEO of Nurses Anytime, which trained nurses for the American market, said in 2003 that American recruiters spend $ 10,000 per nurse exclusive of the commission he receives (Rai, 2003).

[94] State government agencies too have turned their attention to recruiting nurses for the international market. Kerala has been a pioneer in this regard (Kodoth and Varghese, 2012). Uttar Pradesh, Andhra Pradesh, Punjab, Tamil Nadu, Karnataka, Himachal Pradesh, Haryana and Delhi too have established recruiting agencies, some of which have begun to facilitate the movement of nurses explicitly to safeguard them against exploitation from the private recruitment agents (Hazarika et al., 2011: 73).

of credible network of commercial agencies. Indeed, nurses are likely to have much less access to information about these destinations compared to the Gulf or the US. Mobility to continental Europe is restricted as much by the scarcity of commercial networks catering to these countries as the fact that only a small section of nurses, mostly Christians from Kerala has social networks in the region.

7.4 Migration Strategies

Aspirants are seeking more secure modes of entry into the OECD countries. Enrollment in nursing education in Canada, the UK, Australia and New Zealand is seen as a promising route to permanent migration to these destinations.[95] The number of international nursing students in New Zealand has grown from a mere 50 in 1995 (when there were about 7000 domestic students) to 760 in 2006 as compared to 9600 domestic students. During this period, students from Asia rose from a third of international students to two thirds (Badkar et al., 2008: 6). International students in New Zealand, when they finish their course, have the advantage of being able to offer employers New Zealand qualifications. However, the transition from studies to finding a job is not always smooth. Take for instance, the case of the 400 international nursing students, mostly from India, who were the subject of controversy in Australia in 2010 when after finishing their nursing course they were faced with the prospect of having to leave for lack of proficiency in English. This occurred because the Australian nursing authorities announced an increase in the minimum scores in English language testing on July 1, without prior notice, leaving students whose visas were due to expire soon without adequate time to repeat the exam (Times of India, Aug 9, 2010a). Certain EU countries have shown their openness to the students entering for training, as a more "strategic" route rather than recruit doctors and nurses from India, since they are needed here.[96] Indian students are quite prominent in some of the countries in continental Europe but nursing students do not seem to be among them. The low prospects of immigration combined with the high expenses of education and the socioeconomic backgrounds of nursing students may explain this.

[95] Walton Roberts (2012) identifies this as an established trend among Indian aspirants in Canada. Recruiting agents' are noted to advice Indian students to follow this route (Hazarika et al., 2011: 93).

[96] Comments made by Mr. Ulrich Meinecke, Counsellor on Social and Labour Affairs, German Embassy, at the ILO Roundtable on "Migration, Scientific Diasporas and Development: Impact of Skilled Return Migration on Development of India", on 4th February 2013, at Jawaharlal Nehru University, New Delhi.

7.5 Language

Indian nurses consider the need to learn a new language a disincentive to the movement to countries in continental Europe in comparison to countries that require proficiency in English (Hazarika et al., 2011: 87). This is one reason for the preference for the US, the Gulf countries, the UK and Ireland. However, when the opportunity arises, nurses prepare themselves for the challenge of less familiar languages. When she learnt that there was a good chance that she would get a job in Denmark, Sneha enrolled in a Danish language course in Delhi for three months paying Rs 6000. She said that the instructor made her listen to compact discs in Danish and then translated them. She found this tedious and boring compared to learning the language in Denmark. Sneha and Rubina attended language classes in Denmark after duty hours. The classes were very useful because they were introduced to Danish culture as well and it was a great back up for the practical learning they were engaged in at work. Rubina said they were given the impression that Asians would find it particularly difficult to learn Danish because there was little in common with their local languages. She felt that it had not been so difficult and pointed out that there was much in common with English. In six months they were able to speak adequately i.e., they were able to make themselves understood but learning the ability to write took a little longer. Both appreciated the firmness with which the head nurse, who was instrumental in appointing them, approached them. "The biggest problem was that there are a hundred phones in the wards. We have to pick them up. When they ring initially we would feel like running from it. It's not like speaking directly when we can speak slowly, they know us… We must answer. Kathinka made us take it. If at the time we had been inhibited we would not have reached this stage now". Daisy said it was tough juggling a new job with language classes in a new place but 'you have to do it and knowing that gives you the strength'. According to her, the classes were much easier to follow because she was working in a Danish language context.

7.6 Working Conditions

Working conditions are crucial in sustaining migrants. These include the quality of physical and social infrastructure but also crucially the attitudes of employers, colleagues and patients. All three nurses appreciated the combination of a high degree of professionalism with informality in personal interactions with colleagues in Denmark. The lack of hierarchy in the workplace was particularly commended. Daisy emphasized that 'there is nobody to control us there… They did

not know us at all [at first] but gave us responsibility with confidence. This was a real motivation.' The three nurses underscored the respect they received as nurses. Sneha said, "we call people by their name. Here respect for people is not on the basis of their job. Everyone is so polite. It is said that they do not have the authority to shout at us." They pointed out that doctors and nurses wear the same uniform such that you cannot tell them apart. Rubina explained that the welfare system in Denmark provided the conditions for a less stressful work environment. "The work is very different. Here the government takes responsibility for everything. The patient comes, gets admitted. We pay tax and services are provided by the state". This is unlike India where nurses come under stress frequently, for instance, if they break something it causes difficulties because the patients pay for everything from their own pockets. Her words found echo in recent narratives of trainee nurses in Kerala. 'Humanitarian concern is hardly shown to us' (a trainee nurses cited in George, 2011). 'Any breakage of equipment, theft, misplacement and negligence are a cause of great fear and trauma for trainee nurses, who are always at the mercy of the management' (George, 2011).

7.7 Training and Skills

All three nurses were trained in private Catholic institutions in Kerala. They were of the view that the training they had received in Kerala had provided a very strong foundation for working overseas. Whereas they had to learn the language and to work within a different system, as far as nursing practice was concerned they had drawn upon their training at home. Rubina had said, "Someone trained in Kerala can work anywhere. In other places like Karnataka, clinical facilities are not good". The reputation of nurses trained in Kerala for their 'nursing and technical skills' are reflected also in the perceptions of recruiting agencies and even embassy staff of some of the receiving countries in India.[97] Through their interactions with students, Rubina and Sneha had learnt that there was more emphasis on theory in the training in Denmark whereas the training in Kerala emphasized practical training.

7.8 Living Overseas

The nurses' pointed out that they had difficulty in the initial days in finding accommodation which was very expensive. Unlike in destinations with relatively large Malayalee communities,

[97] See comments by representatives of placement agencies and by the Second Secretary of Immigration, British Deputy High Commission Office, Chennai in Pazhnilath (2003).

the prospects for social life were limited in Denmark. Daisy said it had been particularly tough in the first few months before her husband and children joined her. The nurses' social life was limited to their friends from Kerala. They looked forward to a monthly meeting in the Church when there was a service in Malayalam and people from Kerala, irrespective of religious affiliation, came together and followed up the service with a meal. There were roughly 30 people who got together at this monthly meeting. A senior resident from Kerala who had lived in Denmark for over 30 years had made it a practice to invite all of them to her home on the major festival days observed in Kerala. Sneha and Rubina were unmarried when they came to Denmark and had shared an apartment until recently. Both of them agreed that the downside of working in Denmark was a sense of isolation and a feeling of boredom especially on holidays. They sought relaxation through Malayalam channels on television, cinema and internet.

7.9 Return

Malayalee nurses have shown strong aspiration to stay on and work in the European countries. In the late 1970s, when Germany refused to extend their residence permits because of unemployment among 'white' nurses, they sought judicial remedy.[98] In this context, nurses in the more liberal states and those married to German citizens stayed, others migrated to Canada, the Middle East or elsewhere and some returned to India.[99] Twenty years later, faced with shortages once again, some nurses who were sent away in the 1970s were re-recruited under more stringent conditions – their families were not allowed to join them (Goel, 2008: 5). Nurses who return to Kerala do not usually continue working in the profession because of its low status (Percot, 2006: 162). The nurses we spoke to in Denmark were recruited in the past decade. Daisy had returned to Kerala after five years of work in Denmark whereas Sneha planned to return in a year's time and Rubina planned to return eventually. Daisy said they (she and John) planned to return eventually but their decision was prompted by their failure to get admission for their children into an international school that was located at a convenient distance from their home. They did not want to send their children to a Danish language school and believed that relocating later would mean a more difficult transition for the children. She is now a full time housewife. She said she did not want to work in a local hospital as it would be much too

[98] Caritas, an NGO associated with the Catholic Church helped the nurses to file petitions and the issue received considerable media attention but these efforts did not succeed.
[99] This is a reason for a concentration of "Malayalee" nurses in North Rhine-Westphalia.

stressful and the salary too small. The shift system and lack of adequate staff in local hospitals meant that nurses were required to take up heavy responsibilities. Sneha was married recently to a civil servant whose training period would end in 2013. She too planned to stop working, "because I attach more importance to family. Work comes only second". Once her children grew up she may like to return to work but not as a nurse. "There is no respect for nurses in our country". She was doing an MBA so as to qualify for a different job in the future. Rubina planned to return eventually. She was soon to get married to a Malayalee nursing instructor who was interested in doing a Ph. D. in Denmark so she planned to stay maybe for another ten years. She said that she would work as a nurse on her return only if the conditions of work and respect for nurses in India improved substantially.

8. Conclusion and Recommendations

The recent experience of recruitment of Indian nursing staff to hospitals in Denmark and the Netherlands offer useful insights into the contexts and factors that influence success in international recruitment and migration. With increasing global demand for nursing staff, countries in North America and Australasia provide incentives for international migration of nurses through higher salaries or work visas for spouses. In this context, countries with restrictive policy environments could suffer in the event of sudden short term needs as well as longer term requirements. The emerging pattern of international migration of nurses suggests that effective management of the migration process could benefit the destination and the source. This requires co-ordination among States, employers and recruiting and placement agencies.

The 'Work in Denmark' programme failed in recruiting nurses from India, despite the significant interest shown by Indian nurses. This was largely because of poor management of the process that resulted in ad hoc attempts at recruitment and / or profiteering by 'unscrupulous' agencies. In the absence of credible management, the entire process was viewed with suspicion by government agencies and the media in Denmark and considerable effort in preparing and processing applications was put to waste. In contrast, direct recruitment of small numbers of nurses by hospitals was successful and the nurses were well integrated. However, the latter mode of recruitment depends almost entirely on personal and social networks which exclude aspiring skilled nurses who lack them.

Recruitment of OT assistants by hospitals in the Netherlands revealed incongruence between policy perspectives and the demands of employers. In this context, employers recruited nurses through legal gaps at higher than normal pay which in turn led to discord among nurses and fuelled a political controversy. However, there seems to have been co-ordination between recruiting agencies and employers in the recruitment of nurses; recruiting agencies facilitated the process and employers travelled to India, to conduct interviews. Analysis of the views of government officials, the representative of the nurses association and the management consultant in the Netherlands suggest that an initial inadequacy of language and cultural skills and other transitional problems of newly recruited nurses may have received greater media attention than they deserved. The higher pay received by the OT assistants brought them under the spotlight. The Dutch nurses' association representative pointed out that Dutch nurses feel recruitment of nurses from abroad puts them in an unequal and unfair situation. These foreign nurses with their problems in language and cultural skills therefore become easy targets for criticism by Dutch nurses who are already unhappy with "a lot of other things" related to their employment situation.

The EU suffers from shortages in nursing staff. The visibility of the shortage depends on the economic and political environment which may require cuts in employment on account of a contraction of the economy or restrictions on 'third country' workers under political pressures. In such a context, it may be difficult to factor international recruitment into longer term workforce planning. For instance, the 'Positive List' in Denmark included nurses up to July 2012. At the time of our visit, officials at the Danish Agency for Labour Retention and International Recruitment categorically denied the possibility of 'importing' nurses from 'third countries' in the near future because of unemployment and the prioritization of other strategies, including greater use of Nordic and EU nurses. However, in a rapid shift in January 2013, general nurses, surgical nurses and anesthetic nurses were on the Positive List.[100] Hospitals and patients bear the brunt of policy shortsightedness and are left to recruit from among international nurses who seek them out through personal or social networks. Even when political environment is a constraint from time to time to the recruitment of 'third country' nurses, it is possible to have

[100] (http://www.nyidanmark.dk/en-us/coming_to_dk/work/positivelist/positive_list_overview.htm, accessed on Feb 10, 2013).

greater clarity on longer term policy goals through time bound planning. At present, Denmark and the Netherlands lack this and thereby may signal uncertainty and dissuade aspiring migrants.

For now, however, even as EU countries prepare to deal with the effects of the demographic shift in their population and health care workforce, coupled with other related concerns over protecting jobs for "their own", there is a pool of aspiring nurse migrants in India. We have seen that Indian nurses have risen to the challenge of learning a new language when the opportunity for employment has arisen and that they have felt accepted in hospital settings in Denmark. Systematic 'export' of nurses such as by the Philippines could prove to be inimical to the interests of Indian health system but restrictions would also deny the right of citizens to pursue employment through migration. The extent of EU's openness to international recruitment of nurses may require review. There is evidence that the policy preference for recruitment of nurses within the EU is not successful as it belies problems of integration, language and skills compatibility. Significant shortages, especially in elderly care in Europe will also emerge and the time is therefore opportune for relevant stakeholders to put their heads together to develop means that are beneficial to host, destination countries and migrants and their families.

Importantly, India must face up to the serious concerns that are emerging with respect to the quality of training in the country in the context of the vastly expanded scale of nursing education. This is of particular import if India aspires to enable its nurses to benefit from overseas opportunities. India also has a reputation at stake built by several generations of nurses mostly from Kerala. The conditions of work in India are such as to dissuade even those nurses who choose to return from tenures overseas from working as nursing staff in Indian hospitals. Thus in order to benefit fully from the international migration of nurses, India must improve the conditions of work of nurses to encourage skilled nurses with international experience to return to work in the country.

Recommendations:

1) There is pressing need for an organized and well-coordinated approach to the international recruitment of nurses by the destination countries. It would help if there were medium term policies (like those valid for say 3 years), made by considering political economy constraints. These policies can be well advertised in possible source countries.

2) To enable transparency in recruitment, an information campaign on these policies and recruitment procedures in destination countries is necessary. The Ministry of Overseas Indian Affairs (MOIA), Government of India (GoI), currently undertakes awareness campaigns to facilitate safe and legal migration at national and state-level. The focus has been in recent years on vulnerable groups such as women domestic servants and low-skilled workers. It may therefore consider including information for aspiring nurse migrants about the agencies/ resources such as web sites that may be consulted in order to get information about rules and procedures of migration and also about the risks they run by involving recruiting agencies that are not properly licensed.

3) Information to better match labour supply and demand is a good practice in temporary labour migration arrangements. Efforts and resources may therefore be directed towards the development of an online integrated labour market information system that would not only give information on legal opportunities available for nursing and allied services abroad but also provide a labour database and job matching system. The Ministry of Labour and Employment (MoLE), GoI, may therefore consider creating a national registry of qualified and certified skilled nurses complemented by a database on local and foreign employment opportunities.

4) The online system should be buttressed by short, regular evidence-based research on health care sector opportunities in priority countries where shortages are impending.

5) Rating methods or participation in international accreditation and assessment programmes may be used for nursing education in India as a way of improving the quality and to communicate widely the quality of the nurses coming out of Indian colleges.

6) The Ministry of Human Resources and Development, GoI, must initiate efforts towards setting and implementation of standards in nursing education that are on par with global standards. This is important in view of the expansion of nursing education particularly in

the private sector and evidence of cost-cutting practices such as poor clinical facilities in private educational institutions. Given that nursing education is both in the public and private sector in India, consultations may be held with stakeholders to gauge interest.

7) To move towards implementation of globally acceptable standards in nursing education, it is important to conduct studies that will reveal the nature of existing gaps within nursing education in India and suggest ways of overcoming these.

8) Firm steps by the GoI on implementing quality standards could provide the basis for initiation of discussions on mutual recognition of qualifications.

9) Coordinated public sector recruitment can be attempted to address the need for a reliable source of skilled health workers, despite some efficiency costs. Adequate capacity building among state run recruitment agencies will be required to equip them with an understanding of the needs and expectations of employers abroad and various regulatory requirements.

10) Initiate greater interaction between recruitment and placement agencies and nursing education institutions so that students are well informed about their prospects.

11) Engage with private recruitment firms to encourage ethical recruitment practices such as sharing credible and adequate information prior to recruitment on matters related to contract, salary, working conditions etc. in the destination countries to alleviate the fears of "dodgy" recruiters.

12) Develop a framework for formal collaboration in nursing education with EU countries to align training requirements.

13) Apprenticeship/student exchange programmes for nurses and allied health care workers in India and the EU could be considered to facilitate mutual learning. Such efforts would be easier to reconcile with EU concerns related to "brain drain" in India. Such measures

have been taken by the U.K. which has signed a Memorandum of Understanding (MoU) with the Philippines and an agreement with South Africa for mutual education exchange of health workers.

14) Exchange programmes for nursing staff working in the public and private sectors with countries of the EU could serve to share knowledge and provide exposure. Review/study of relevant existing or past exchange programmes between countries would help identify and detail the contours of such a proposal.

15) Integrate language training within skills development initiatives in preparing prospective migrants in the health care and allied services. In this regard, the Government may consider entering into agreements with interested hospitals/institutions in priority countries to explore the prospects of sharing of costs for such training and recruitment.

16) It is imperative to improve salaries and working conditions of all nurses in India if nurses are to have the incentive to return and work in the India.

17) Fear of losing tenure and social security benefits tend to constrain temporary return of professionals to home country. MOIA may consider appropriate bilateral arrangements to provide for portability of social security benefits.

18) Schemes and incentives for return and re-employment to India, translating work experience abroad into promotions or salary increments or faculty positions may be further explored by GoI to avert the loss of health care professionals following return from abroad.

19) Geriatric/elderly care is likely to present opportunities for less educated women to work at comparatively high salaries in the EU. This avenue is already being utilized by women from the West Coast states in Italy and Israel through social networks and recruiting agencies. GoI could enable a wider section of Indian women to access these opportunities by providing a framework for training and recruiting geriatric care workers

to the EU. A pilot project with selected EU countries like Spain, Italy could be considered by GoI to recruit personnel for nursing homes. Spain and the Philippines have agreed to such a pilot project.

20) GoI may consider organizing state-level stakeholder consultation workshops to understand perspectives and concerns related to the mobility of nurses and allied healthcare workers as an initial step towards conceptualizing a pilot scheme. These consultations may include relevant Central Government representatives from the Ministry of Labour and Employment (MoLE), Ministry of Human Resources and Development (MHRD), Ministry of Overseas Indian Affairs (MOIA) etc. Other relevant stakeholders for such consultations include representatives from the Indian Nursing Council (INC), State Nursing Councils, NRI Departments, emigration authorities, private recruitment agents, CII Health Sector Council, public and private educational institutions imparting nursing education (including those who have experience in receiving international students and international placements), private hospitals engaged in nursing training, recruitment and placement abroad, nursing students, faculty and academics. These could be complemented with international workshops to facilitate policy dialogues.

21) An important facet to a safe, informed and beneficial mobility of healthcare workers is the need to map and connect relevant stakeholders in priority destination countries with their counterparts in India. MOIA may therefore consider organizing an Employers' Conference focused entirely on health and allied services.

REFERENCES

Abraham, B. 2004. 'Women nurses and the notion of Empowerment', Discussion paper no 88, KRPLLD, Centre for Development Studies. Trivandrum.

Alonso-Garbayo, Álvaro and Maben. J. 2009. 'Internationally recruited nurses from India and the Philippines in the United Kingdom: the Decision to Emigrate'. *Human Resources for Health* 7:37.

AP-MagNet, (Asia-Pacific Migration Network). 2012. 'Circular Migration of Health Workers'. Discussion Paper, ILO Regional Office for Asia and the Pacific.

Aravamudan. 1978. 'Nurses and Nuns of Kerala', in Devaki Jain ed., *Indian Women*, New Delhi: Publications Division, Ministry of Information and Broadcasting, Government of India

Arbejdsmarkedsstyrelsen (The National Labour Market Authority). 2011. *Report omrekrutteringafhøjtkvalificeretarbejdskraftfratredjelande.* Available online: http://www.sfr.dk/da/Nyheder/Forsidenyheder/Arkiv/2012/04/Rapport-om-rekruttering-af-hoejt-kvalificeret-arbejdskraft.aspx

Badkar, Juthika et al. 2008. 'The Origin, Family Structure and Labour Supply of Overseas Born Nurses'. *Labour, Employment and Work in New Zealand*.

Bageshree S. 2012. The gritty women from the west coast, The Hindu, Bangalore edition, March 20, 2012

Becklake. S. 2008. 'A Gender Sensitive Analysis of the International Migration of Nurses and its Governance through 'ethical' Recruitment Codes'. Working Paper no.1/2008. New Research in Global Political Economy.

Berenschot, van Baalen. M. et al. 2009. *Immigratie Van Zorgpersonnel, Van sluitpost van arbeidsmarkt-beleid naar oplossingen voor een modern migratiebeleid voor de zorg. (Immigration Care Staff: Final item of Labour Policy Solutions for a modern Migration for Care)*. Ministry of Health, Welfare and Sports. Netherlands.

Bertinato. L et al. 2011. '*Oversupplying Doctors but seeking Carers: Italy's Demographic Challenges and Health Professional Mobility'*. From Health Professional Mobility and Health Systems. Evidence from 17 European Countries. The European Observatory on Health Systems and Policies. Available from www.euro.who.int

Bhattacharjee. A. 2012. 'Migration of Indian Health Professionals to selected European Nations: The Case of Denmark, Netherlands, Norway, Sweden', Working Paper 375, Indian Institute of Bangalore.

Bjerg. T. 2009. '*Ni indiske sygeplejersker på Gentofte i 2009'*. From the magazine Agenda, Personaleblad for Gentofte hospital. Available from www.gentoftehospital.dk

Bobek. A. et al. 2011. 'Ireland Mobility of Health Professionals'. Centre of Migration Research Warsaw, Poland.

Brush, B. and Sochalski. J. 2007. 'International Nurse Migration: Lessons from the Philippines'. *Policy, Politics, & Nursing Practice* 8 (1): 37–46.

Brush. B. L. et al. 2004 'Imported Care: Recruiting Foreign Nurses To U.S. Health Care Facilities' *Health Affairs*, 23(3):78-87.

Buchan. 2007a. 'The UK, Asia and Internationally Recruitment of Nurses, Asia Research Institute'. Working Paper no. 87, Queen Margaret University College, Edinburgh.

Buchan. J. 2007b. 'International Recruitment of Nurses: Policy and Practice in the United Kingdom'. *Health Services Research*, 42: 3, Part II.

-----. 2002. 'Nurse Recruitment: Going Places'. *Health Services Journal* 112(5816): 22-24.

Buchan, J. et al. 2006. 'Internationally Recruited Nurses in London: A Survey of Career Paths and Plans' *Human Resources for Health* 4: 14.

CBS. 2011. *Zorgopleidingenpopulairderdanooit.*Webmagazine, 9 May 2011.

Chakravarthy, R. and A. Nair, 2010. 'From Kerala to Philadelphia: The Experience of Malayalee Hindu Nurses in Philadelphia', in Ayumi Takenaka and Mary Johnson Osirim eds. *Global Philadelphia: Immigrant Communities, Old and New,* Philadelphia: Temple University Press

Chaloff. J. 2008. '*Mismatches in the Formal Sector, Expansion of the Informal Sector: Immigration of Health Professionals to Italy'* OECD Health Working Papers. Available at www.who.int

Dacuycuy, Lawrence B. 2008. 'The Migration of Health Professionals'. Working Paper No. 7, ILO Asian Regional Programme on Governance of Labour Migration.

Danish Nurses' Organization (Dansk Sygeplejeråd). 2009. *Nurse in Denmark? a Guide on Salary, Pension and Employment.* Accessible from www.dsr.dk

Dussault.G, et al. 2009. *Migration of Health Personnel in the WHO European Region*, WHO Europe.

EMN, (European Migration Network). Small Scale Study II: Managed Migration and the Labour Market-the Health Sector The Netherlands.

Ford, S. 2012. 'Immigration Cap would 'halve' UK's Migrant Nurse workforce'. *Nursingtimes.net*, March 31, 2012.

Gallo, E. 2005. 'Unorthodox Sisters: Gender Relations and Generational Change among Malayali Migrants in Italy'. *Indian Journal of Gender Studies* 12: 217.

George, Sheba. 2005. *When women came first: Gender and Class in Transnational Migration*, Berkley: University of California Press.

-----. 2000. "Dirty Nurses" and "Men who play": Gender and Class in Transnational Migration, in Michael Burawoy et al eds., *Global Ethnographies: Forces, Connections and Imaginations in a Post modern World*, California: California University Press

George, Shwetha. 2012. 'India: Livelihood or Motherhood? The Kerala Nurse Dilemma', Women's Feature Service.

-----. 2011. 'The Trap that Trainee Nurses Face in India', Women's Feature Service, December 2.

Goel, Urmila. 2008. 'The 70th anniversary of John Matthew: On "Indian" Christians in Germany Knut' A. Jacobsen and Selva J. Raj (eds) 2008. *South Asian Christian Diaspora: Invisible Diaspora in Europe and North America*. Farnham: Ashgate, pp. 57-74.

Gottschlich, P. 2012. 'German Case Study'. CARIM-India Research Report 2012/03. Developing a Knowledge base for Policymaking on India-EU Migration.

Hazarika, I. et al. 2011. *India Mobility of Health Professionals*. Available from Mobility of Health Professionals: http://www.mohprof.eu/LIVE/

Hintermann, C. and U. Reegar. 2005, 'On Nurses and Newsvendors: Asian Immigrants on the Vienna Labour Market', E Spaan et al eds., *Patterns and Processes of Immigrant Labour Market Insertion in Europe*, Oxon: Routledge.

Humphries et al., 2008. 'Overseas Nurse Recruitment: Ireland as an Illustration of the Dynamic Nature of Nurse Migration. Epidemiology and Public Health Medicine Articles, Department of Epidemiology and Public Health Medicine, Royal College of Surgeons in Ireland, e-publications@RCSI

Humphries, N. et al. 2012. 'Nurse Migration and Health Workforce Planning: Ireland as Illustrative of International Challenges. *Health Policy* 107: 44– 53.

IND (De IND belicht Jaarresultaten). 2009. *Annual Report* Immigratie-en Natarulisatidienst Ministerie van Binnenlandse Zaken en Koninkrijksrelaties. Netherlands.

Ivković. Marija. 2012. International Nurse Migration: Global Trends, Journal of the Geographical Institute "Jovan Cvijić" SASA 61(2) (53-67)

Jeffrey, 1992. *Politics, Women and Well Being: How Kerala became 'a Model'*, Basingstoke: Macmillan

Khadria, B. 2004. 'Migration of Highly Skilled Indians: Case Studies of IT and the Health Professionals'. Working Paper 2004/6. OECD, Science, Technology and Industry.

-----. 2007. 'International Nurse Recruitment in India'. *Health Services Research* 42:3, Part II.

Kodoth P. and V. J. Varghese, 2012. 'Protecting Women or Endangering the Migration Process, Gender, State Policy and Emigrant Domestic Workers from Kerala', *Economic and Political Weekly*, October 27, Vol xlvii no 43.

Krishna D Rao et al. 2012. 'So many, yet few: Human resources for Health in India'. *Human Resources for Health* 10:19.

Kumar, P. and T B. Simi. 2007. *Barriers to Movement of Healthcare Professionals: A Case Study of India, Report*. CUTS International.

Kurup, D. 2012. Angels of mercy themselves need a lot of it, *The Hindu*, Bangalore edition, March 20.

Lum, Kathryn. 2012. 'Indian Diversities in Italy: Italian Case Study'. CARIM-India Research Report 2012/02, Developing a Knowledge Base for Policy Making on India-EU Migration.

Maier, Claudia B., Irene A Glinos, Matthias Wismar, Jeni Bremner,Gilles Dussault, Josep Figueras, 2011. In Wismar et al eds. Cross-country analysis of health professional mobility in Europe: the results Health Professional Mobility and Health Systems, Evidence from 17 European countries, European Observatory on Health Systems and Policies, Study series 23

Matsuno, A. 2006. 'Nurse Migration: The Asian Perspective'. Technical Note. ILO/EU Asian Programme on the Governance of Labour Migration

Maya, C. 2012. Excess supply bane of nursing sector; job market saturated, *The Hindu*, Thiruvananthapuram, Feburary 9. Mejia, A. 1978. 'Migration of Physicians and Nurses: A World wide Picture'. *International Journal of Epidemiology* 7 (3): 207-15.

Moh Prof Netherlands Summary. 2011. 'National Profile of Migration of Health Professionals-the Netherlands'. Health and Social Care Associates (HASCA), Alphen Aan Den Rijn, The Netherlands.

Nair, N. 2011. 'The Nurse from Kerala'. *The Indian Express*, December 25, 2011.

Nair, S. 2010. Nurses' Strike in Delhi: A Status Questions, *Economic and Political Weekly*, Vol XLV (14), pp 23 – 25.

National Council of State Boards of Nursing. 2012. Fact Sheet, www.ncsbn.org

Nordisk Ministerråds arbeidsgruppe Långa Namnet. 2009. *Nordisk Arbetsmarknad for Sjukvårdspersonal: Årsrapport.* Available at: www.norden.org.

Nordisk Ministerråds arbeidsgruppe Långa Namnet. 2009. *Nordisk Arbetsmarknad for Sjukvårdspersonal: Årsrapport.* Available at: www.norden.org.

Nursing Council of New Zealand, 2012. '1000 Indian nurses registered in NZ in the past three years', Press Release, 23 May.

OECD. 2008. *The Looming Crisis in the Health Workforce: How can OECD Countries Respond?*. OECD Health Policy Studies.

OECD. 2010. 'International Migration of Health Workers: Improving International Cooperation to Address the Global Health Workforce Crisis'. Policy Brief, February 2010.

OECD, 2011. www.oecd.org/health/workforce

Offermanns, G et al. 2011. 'Mobility, Language and Neighbours: Austria as Source and Destination Country from Health Professional Mobility and Health Systems'. Evidence from 17 European Countries. The European Observatory on Health Systems and Policies. Available from www.euro.who.int

Ognyanova. D and Busse. R. .2011. 'A destination and a source: Germany manages regional health work disparities with foreign medical doctors'. *In* Health Professional Mobility and Health Systems. Evidence from 17 European Countries. The European Observatory on Health Systems and Policies. Available from www.euro.who.int

Pazhanilath, J. 2003. 'NURSE-ing NRI dreams they flock to Kochi', *The Hindu*, September 29.

Percot, M. 2006. Indian Nurses in the Gulf: Two Generations of Female Migration, *South Asia Research,* 26 (1): 41-62.

Quinn, E. 2006. 'Managed Migration and the Labour Market – The Health Sector in Ireland'. European Migration Network, European Commission Directorate-General Justice, Freedom and Security and Department of Justice, Equality and Law Reform. Ireland.

Rai, S. 2003. Indian Nurses Sought To Staff U.S. Hospitals, *New York Times,* February 10.

Rao, M. et al. 2011. 'India: Towards Universal Health Coverage 5 Human Resources for Health in India'. *The Lancet*. Online Publication. 11 January 2011.

Rao M.M. 2012. 'Their road to heartache starts at college itself', *The Hindu*, Bangalore Special Issue, March 20, 2012.

Rao. Krishna D. 2012. 'Situational Analysis of Health Workforce in India'. Human Resources Background Paper I, Public Health Foundation of India.

Roosblad, J. 2005. *Vissen in een vreemde vijver: het werven van nurses en verzorgenden in het buitenland. Ervaringen met en toekomstverwachtingen over arbeidsmigratie in de zorgsector. (Fishing in a foreign pond: recruiting nurses and auxiliaries abroad. Experiences with and Future Expectations for Labour Migration in the Health sector*). Amsterdam.

Rosen, R. 2006. Outlookindia.com

UCA News. 2013. Drop in recruitment worldwide could have serious knock out effects', January 11. ucanews.com reporter

Silva A. & Fernandes R. 2008. *Foreign Nurses in Portugal*, Ordem dos Enfermeiros, International Affairs Office.

Sinha, K. 2007. 'Nurse Exodus leaves India Short'. *Times of India*. September 12.

Sharma, N. 2005. 'Nursing Big Dreams', *The Sunday Tribune*, July 24.

Times of India. 2010a. 'Indian nursing students in Australia fear deportation', August 9.

Times of India. 2010b. 'India will need 2.4m nurses by '12: WHO', Times News Service, May 12

Thomas. P. 2006. 'The International Migration of Indian Nurses'. *International Nursing Review*, Vol 53 (4).

Tjadens. 2011. 'The Netherlands: Mobility of Health Professionals'. Health and Social Care Associates (HASCA), The Netherlands.

UMCG. 2009. 'haaltpersoneeluit India. Dagblad van het Noorden'. (University Medical Centre, Groningen Pull staff from India), 6 August 2009

US Human Resources and Service Administration 2004. The Registered Nurse Population: Findings from the March 2004 National Sample Survey of Registered Nurses, Department of Health and Human Services.

US Human Resources and Service Administration 2010. The Registered Nurse Population: Findings from the 2008 National Sample Survey of Registered Nurses, Department of Health and Human Services.

Varghese, V. J. 2007. 'The alluring Music of Labour: Modernity, Migrations and Recreation of the Syrian Christian Community'. *Tapasam*. January to April.

Walsh., K and O'Shea. E. 2009. *The Role of Migrant Care Workers in Ageing Societies: Context and Experiences in Ireland*, The Irish Centre for Social Gerontology. Available from Centre on Migration, Policy and Society (COMPASS) www.compas.ox.ac.uk

Walton Roberts, M. 2012. 'Contextualizing the Global Nursing Care Chain: International Migration and the Status of Nursing in Kerala, India, *Global Networks*, 12 (2).

-----. 2010. 'Student Nurses and their Migration Plans: a Kerala Case Study'. *In* S. Irudaya Rajan (ed.) *Governance and Labour Migration: India Migration Report 2010*, pp. 196-216.

Walton-Roberts, M. and Hennebry, J. 2012. 'Indirect Pathways into Practice: a Comparative examination of Indian and Philippine internationally Educated Nurses and their entry into Ontario's Nursing Profession'.CERIS Working Paper No. 92, The Ontario Metropolis Centre.

Williams, R. B. 1996. *Christian Pluralism in the United States: The Indian Immigrant Experience*, Cambridge: Cambridge University Press.

Weisbrock, Anja and Hercog, Metka. 2012. 'Making Europe more Attractive to Indian Highly Skilled Migrants?: the Blue Card Directive and National Law in Germany and the Netherlands'. *CARIM-India Research Report* 2012/09, available at http://www.india-eu-migration.eu/media/CARIM-India%202012%20-%2009.pdf

Wemos. 2010. 'Chances for Change: Dutch Measures to Improve the Global Distribution of Health Personnel'. Available at http://www.wemos.nl/files/Documenten%20Informatief/Bestanden%20voor%20HRH/Chances_for_Change_web.pdf

Westert, G.P. et al (2010), *Dutch Health Care Performance Report 2010*, National Institute for Public Health and Environment, Bilthoven: the Netherlands, available at http://www.gezondheidszorgbalans.nl/object_binary/o10298_dhCPR2010.pdf

Wismar, Matthias et al. 2011. Health Professional Mobility and Health systems in Europe: an Introduction, *In Health Professional Mobility and Health Systems. Evidence from 17 European Countries*. The European Observatory on Health Systems and Policies. Available from www.euro.who.int

Yeates, N. 2009. *Globalising Care Economies and Migrant Workers: Explorations in Global Care Chains*, Basingstoke: Palgrave Macmillan.

Young. R. 2011. 'A major Destination Country: the United Kingdom and its Changing Recruitment Policies.' In Wismar et al, eds., *Health Professional Mobility and Health Systems. Evidence from 17 European Countries*. The European Observatory on Health Systems and Policies. Available from www.euro.who.int

Zachariah, K. C. 2006. *The Syrian Christians of Kerala: Demographic and Socio-economic Transition in the Twentieth century*, Hyderabad: Orient Longman.

Zurn, Pascal and Dumont, Jean-Christophe. 2008. 'Health Workforce and International Migration: Can New Zealand Compete?'. OECD Health Working Paper no 33.

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Appendix A

Mobility of Indian nurses to non EU Destinations

The share of Indian nurses who passed the NCLEX exam increased from only 3.5 % of the total in 1995 to 13 % in 2004 (OECD, 2007: 187) and over 15 % in 2007. The movement of Indian nurses to the US received a boost with the opening of exam centers in India by the US Commission on Graduates of Foreign Nursing Schools.[101] The CGFNS, which gauges nurses' ability to work in the USA, now has four offices in India, the most in any country. Previously, Indian candidates spent over a lakh of rupees to travel to Thailand, Bangkok or Sri Lanka to write the exam (MOH, India case 82). Since January 2006, NCLEX-RN exam is being conducted at five major cities of India (Kumar and Simi, 38). However, the number of Indian candidates who appear for the NCLEX exam has decreased sharply since the peak in 2007 and 2008.

In 2007/8, about 22.1 % of nurses in New Zealand were foreign trained compared to 16.4 % in Australia (OECD, 2010: 3). Permanent migration of foreign registered nurses to Australia increased six-fold since 2000 (OECD, 2010: 3).

Table 1: Share of foreign trained nurses in North America

	2000		2004/5		2007/8	
US	99456		100791	3.5	165539	5.4
Canada	14910	6.4	19230	7.6	20 319	7.9

Source: US Human Resources and Services Administration, 2010: 8-1, 2006: 58; National Sample Survey of Registered Nurses; OECD, 2007, 2010

Table 2: Top countries where IENs in the US received education by employment status, 2008

Country	2004		2008	
	Number *	%	Number*	%
Philippines	50605	50.2	82988	50.1
India	1271	1.3	15827	10
South Korea			4359	2.7
Canada	20345	20.2	19619	12
UK	8444	8.4	15410	4.9
Nigeria	2363	2.3	3409	2.1

*Estimated numbers

Source: Human Resources and Services Administration, 2010, 2006; National Sample Survey of Registered Nurses

[101] The Philippines government has been proactive in supporting the migration of nurses. It is also the case that the predominantly bachelor's education programs for nurses in the Philippines allows Filipino nurses to meet the requirement from the U.S. Citizenship and Immigrations Services whereas most of the education programmes in India are at the diploma (General Nursing and Midwifery) level.

Table 3: Top five countries of IENs who appear for the NCLEX exam

Country	2012*	2011	2009	2008	2007
The Philippines	2662	6361	3582	21495	19964
India	707	910	336	3773	5430
South Korea	324	714	291	1772	2063
Canada	446	613	161	726	899
Puerto Rico	307	300			
Cuba			435	824	681

* The number of candidates who appeared for the exam up to September 2012, not for the fiscal year 2011-12.

Source: Annual Reports, NCLEX; the 2012 figures are from NCLEX Fact Sheet, https://www.ncsbn.org/533.htm

Table 4: Share of foreign trained or foreign nurses in Australia and New Zealand

Country	2000		2005		2007/8	
	Number	%	Number	%	Number	%
Australia			31472	12.1	34886	16.4
New Zealand	6317	19.3	9334	24.3	9895	22.1

Source: OECD, 2007, 2010

Appendix B

Details of the Danish Private Collaborative Recruitment of Doctors from India

The consultant was personally involved in the interview process together with two other doctors. This helped explore the potential of the candidates keeping in mind the needs and practices of both sides. They ensured that all the documents of the candidates were properly checked. The candidates were shortlisted to around 100 doctors who were then interviewed by a delegation from Denmark. Upon selection by the Danish delegation, the candidates were offered employment at specific Danish hospitals, conditional upon them learning the Danish language within four months. "We know how important it was for doctors to know the language, especially for the elderly patients".

For the purpose of language training, 4-5 Danish language teachers were recruited from Denmark and the classes were held in a resort at the outskirts of Delhi. The selected candidates were expected to learn the language in residence, with their meals and expenses related to the stay covered by the recruiters. During this period, the selected 50-60 candidates were also paid a salary/stipend. The language course was intensive for four months, during which time the candidates were expected to take various exams to test their language skills. Once these exams were cleared they were considered eligible for work in Denmark. Only two doctors could not learn the language, possibly owing to their age.[102]

The consultant helped with the visa papers, ensuring that tax issues were sorted out and helped in the settling down process in Denmark by helping with tax papers, procuring the CPR number, finding a place to stay etc.

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[102] Most doctors were in the 40-45 years category.