Executive Summary

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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Nurses from Kerala have been working in 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. Currently the major destinations of Indian nurses are the Gulf countries and the OECD. An estimated 60,000 Indian nurses are in the Gulf countries, often seen as a stepping stone to migration to the OECD countries. It is also apparent that Malayalee nurses are showing increasing interest in the OECD countries. The stock of Indian nurses in European countries is however negligible with the exception of the U.K and Ireland. Overseas employment for these women has generated increased wealth, better conditions of work and prospects for professional improvement together with the promise of greater freedom, travel and adventure.

Despite this positive impact of the migratory experience on Indian nurses and their families documented in various studies, concerns remain on the “supply side” and the availability of an adequate nursing workforce in India. Recently, health experts have pointed out that India faces a 40 to 50 % shortage of nurses and some scholars claim that India loses 20% of its nursing students to work opportunities abroad. However, the push factors for such a choice are significant given the poor salary structures, long working hours and bond system prevalent among private institutions in India owing to the high demand for nursing education. The rapid mushrooming of nursing institutions in recent years without adequate clinical facilities, faculty and quality of training has made nursing students even more vulnerable.

Countries such as the U.K. which were known to have actively recruited nurses from India have expressed concerns over “brain drain” and the need for ethical recruitment. These concerns have translated into restrictive immigration policies that curtail entry based on sponsorship requirements, income levels, enhanced language tests, recruitment from within the EU etc. However there is evidence that the policy preference for recruitment of nurses within the EU is not as successful as it belies problems of integration, language and skills compatibility. The study also reveals a discernible mismatch between immigration policy sometimes and the demands of the labour market, with employers in the Netherlands having used loopholes in the Highly Skilled Migrants Scheme to recruit operation theatre assistants. Survey in Denmark and the Netherlands showed that nursing shortages have been experienced in both these countries in the recent past; these tend to be cyclical and hard to foresee significantly in advance. While both Denmark and the Netherlands have experience in the recruitment of Indian nurses, the impact of the global recession, anti-immigrant sentiments and political pressures have influenced the perceived success of these new recruits. Private initiatives in Denmark to recruit nurses and doctors were fairly successful, with the Indian health workers perceived as professional and hard workers. Efforts at public recruitment through Work in Denmark Centres proved to be an absolute failure, with the Danish authorities left totally unprepared for the “tsunami” of Indian applications. The need for language proficiency was stressed by a number of respondents, yet it was found in the case of the few nurses we interviewed that with encouragement and hard work these nurses were able to learn the Danish language in a matter of few months, resulting in successful completion of their “adaptation period”.

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A brief assessment of working conditions for Indian trained nurses in Denmark revealed that while there was some skepticism over the portability of skills in a European context amongst national health administration officials, experience with Malayalee nurses recruited by a private hospital in Denmark showed them well-endowed in practical skills once the language barrier was broken. The nurses received salaries significantly higher than what they drew in their brief stint in New Delhi, allowing almost Rs. 1 lakh in savings every month despite heavy rents and taxes in Denmark. The working conditions were found to extremely favourable, with the nurses expressing happiness over the non-hierarchical working style, encouragement to think critically of treatment practices and the respect of colleagues. Over-time payments were also significant and attractive. The flexibility of working hours and the possibility of working lesser hours through the week was also found useful by the nurses, especially once they had saved money and felt more secure at their workplace. Though the persistent cold weather conditions were initially hard for the nurses to surmount, the nurses managed to settle into the community, closely networked with the small number of other Indian nurses in Denmark. Religious celebrations and festivals formed reasons for engaging with one another and marked a time for enjoying Indian dishes.

The plans for return to India were varied among the nurses although all of them knew that work and stay in Denmark would be limited. The non-availability of good schools in Denmark, concerns about cultural integration of children etc. were important factors affecting return plans. Importantly, none of the nurses saw themselves returning to work in India sensing the lack of respect for their work and skills, substantial reduction in salary and poor working conditions.

The paper concludes with recommendations for a well-coordinated and organized approach to international recruitment by both India and the EU. The need to improve access to information to better match labour market needs in destination countries and a registry of skilled and qualified nurses in India is among some of the recommendations. Efforts by relevant Ministries to improve quality of nursing education in India, framework for recognition of qualifications by the EU and formal collaboration in nursing education to align training requirements are some of the other suggestions. The perception amongst both nurses and foreign employers of “dodgy” recruiters should also be addressed by encouraging private recruitment firms to use ethical recruitment practices such as sharing credible and adequate information prior to recruitment on matters related to contract, salary, working conditions etc. 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. 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. 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 the Government of India to avert the loss of health care professionals following return from abroad.

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