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Indian-EU Healthcare workforce migration in data: 2010-2020

Gunjan Sondhi

Introduction

This chapter provides country level data on internationally mobile health workforce between India and the EU for the period 2000-2019 to support evidence-informed policy making to ensure safe migration and decent work for migrant health workforce. The predominantly descriptive analysis draws on the unique OECD Health Workforce database (HWD) that harmonises data from OECD countries on migrant and non-migrant health workforce. Through this analysis of international migration of health workforce, the discussion aims to a) encourage further research on India-EU migration corridor, and b) highlight the strengths and limitations of the HWD to support evidence-informed policy making.

The global demand for health professionals was expected to increase even before the COVID-19 pandemic. The pandemic has made visible a potential crisis in the health force labour force and the dependency on internationally trained doctors and nurses. Migrant doctors and nurses constitute increasing proportions of health professionals in OECD countries. In 2010/2011, foreign born doctors and nurses accounted for 22% and 14% of all doctors and nurses currently working within OECD countries (OECD 2019). Foreign-trained doctors and nurses make up 17% and 6% respectively of total doctors and nurses in OECD countries in 2012-2014¹. Nursing in particular is a profession highly entangled within infrastructures of international mobility (Walton-Roberts 2021). According to the State of the world's nursing report 2020, one nurse out of every eight practices in a country other than their country of training or birth (World Health Organisation 2020).

The US and the UK are the top two receiving countries while India and the Philippines are the largest sending countries for doctors and nurses within OECD countries. In many of the receiving countries foreign trained doctors usually face greater challenges as they need to apply for work permits or undertake exercises for equivalence qualifications due to a lack of portability of skills. The limited portability of skills of migrant doctors and nurses leads to loss of skills further exacerbating the challenges posed by shortages in the health workforce. While majority of the movement has been of trained medical professionals for work, there is also an emerging mobility streams for initial and further training as international students from India to places such as Canada, Ireland, Poland and Romania(OECD 2019) . This is because a 'western' experience and training is ascribed greater value than non-wester and non-anglophone. Moreover, there is a sending country premium that impacts the ascribed value of the received training. Students from Norway, Sweden and France who obtain their medical degrees from countries such Poland and Romania do not face a devaluation of their training and certificates unlike other international graduates (OECD 2019). Thus further making complex the issues around portability of skills, as it isn't only the country of the training, but also nationality, and race.

Additionally, this crisis has specific gendered implications as women make up majority of the health workforce and hence are disproportionately on the front lines (ILO, 2020). As research on nursing migration has long shown, women are also disproportionately responsible for unpaid care work (Percot and Rajan 2007; Yeates 2004; Kofman and Raghuram 2015). Overall, health worker migration, particularly of nurses, is highly feminised – with women making up 72% of the skilled

¹ https://www.who.int/hrh/com-heeg/International_migration_online.pdf

health workers (ILO 2020, PSI 2020). However, there is limited global gendered data to inform policies and programs that are aimed at migrant health workforce.

Taken together – portability of skills and gendered implications – this geography of skills (Raghuram 2021) produces a national, gender, class and racial hierarchy within the global health workforce. This is of course made more complex through other intersecting social locations such as religion, colonial linkages, and other regional/cultural affiliations. This hierarchy of the migrant health workforce is well documented especially within Nursing (Nair 2020; Nair and Percot 2007; Oda, Tsujita, and Rajan 2018; Smith and Mackintosh 2007; Kofman and Raghuram 2015). Based on the geographies of skills (Raghuram 2021) – such as the place of training, qualification, and years of experience, many of the nurses potentially end up undertaking non-nursing work, but work which is still considered work in the healthcare sector as care aides, live-in caregivers, or other named categories which vary depending on the country of destination. Within this geography of skills is also the regional specification of both receiving and sending countries. Such as the movement of nurses from India are likely to originate from the state of Kerala in the south of India, or Punjab a state in the north of India. Little is known about regional specifications of international mobile doctors from India.

All of this combined impact the flows of migrants both from the sending and receiving country perspective. And simultaneously, these flows shape the policies and programs of the countries within bilateral corridors. With the increasing recognition of the global shortage of health professionals and need for cooperation and long-term investments training a health workforce (World Bank 2020a; 2020b; IOM 2020; Ratha 2021), there is increasing need for reliable and global data that can be used to develop evidence-informed policies and programs that ensure that migration is safe and secure and migrants are afforded the opportunities for decent work – key components of the Sustainable development goals. This global demand is shaping the flows from India despite the shortages in the national health workforce sector (Walton-Roberts and Rajan 2020).

Migration of healthcare professionals from India – as trained doctors and nurses is entangled in a colonial history of bilateral movements between India and Britain for training, and work; which in mid-20th century extended to include other anglophones countries such as the US. South Asian-trained doctors have been credited for their significant impact in shaping Geriatric medicine as a discipline within the UK NHS (Bornat, Henry, and Raghuram 2011). The migration of doctors from India has long been a discussion within academic and policy spheres (Khadria 2004; 1999; Khadria and Perveen Kumar 2012) including several pieces that have been published in this series such as by Bhattacharjee(2018) examining the India-EU corridor. Migration of nurses from India and its impact on both sending and receiving societies has been well documented especially across India-Canada(Walton-Roberts 2012; Walton-Roberts et al. 2017) and India-GCC corridors (Percot 2006; Percot and Rajan 2007; Ray 2019). The Kerala Migration survey has been a key instrument in capturing and understanding the dynamics of this migration of migrant workforce from sending country perspective (Rajan 2021), and it remains one of the few resources to undertake longitudinal quantitative analysis of the migration workforce flows which is crucial for evidence-informed policy to ensure safe and secure migration, and decent work.

Amongst these health migration flows, European countries make up a smaller group of receiving countries of Indian-trained doctors and nurses and thus far have received limited attention (Percot 2012; Gallo 2005; Kodoth and Jacob 2013; Stievano et al. 2017) . The healthcare labour market sector in the EU has always experienced labour shortages. Reports published by the EU commission have pointed to the labour markets experience shortages. In light of the increasing global demand, the EU countries are certainly not an exception. The EU has sought out India as a strategic partner

(Jain and Sachdeva 2019; Stefan 2017) which includes looking to Indian workforce to fill EU's labour market shortages. In light of the evolving demands for trained health workforce, and shifting relations between India and the EU, it is important that policies and programs developed within this relationship are evidence-informed to ensure safe and secure migration and decent work. For this purpose, reliable national and sub-national level data is imperative, especially on health workforce. This data is also crucial to start to develop a macro-level understanding on the migration flows along the India-EU corridor from the receiving country perspective.

To fully understand the complex and entangled landscape of international health workforce mobility along the India-EU corridor, this chapter maps the current trends and patterns. The next section discusses the data sources and definitions used and the strengths and the limitations of the data sources. Section three provides a gendered overview of the India-EU migration flows over the last decade. Section four describes the stocks and flows of Indian-trained doctors and nurses across the EU by focusing on country-case studies of Germany, Italy, and Ireland. Section five closes this chapter offering avenues for future research on India-EU migration, the strengths of the data presented for evidence-informed policy making, and lastly it recognises the chapter's analytical limitations to descriptive data.

Data sources and definitions

OECD

There is limited data available on migrant healthcare workers. In response to this gap, the OECD started a database that consolidates and harmonises data of health workforce, - Health Workforce Database (HWD), of which migration is component. The key data presented in this discussion has been extracted from the OECD Health workforce migration databased. This captures both migrant and non-migrant labour force. As the EU member states comprise a large part of the OECD countries, and consolidates its own data definitions

From a receiving country perspective, Immigrant doctors and nurses are an increasingly share of health professional working in OECD countries. There are two groups of immigrant health professionals: foreign-born and foreign-trained. Foreign-born health professionals are those who are born in a country different from the one they are practicing in. This does not reflect their country of training. This means that someone who moved into country during their younger years, would still be counted within foreign-born. Foreign-trained refers to those health professionals who are working in country different from the one in which they received their received their training.

A key difference is that foreign-born health professionals may not need to apply for work permits, or undertake exercises for equivalence qualifications. Foreign-born health professionals' qualifications may have been acquired in the country in which they are practising. In 2010/2011, Foreign born doctors accounted for 22% of all doctors, and foreign-born nurses made up 14% of all nurses actively working within OECD countries(OECD 2019).

Data and definitions on Doctors (OECD health statistics 2020, definitions, sources and methods)²

The stock data described below includes the number of doctors who have obtained their first medical qualification (degree) in another country, and are entitled to practice in the receiving country. The annual flow data on foreign-trained doctors includes the number of doctors who have

² <http://www.oecd.org/health/health-data.htm>

obtained their first medical qualification (degree) in another country and are receiving a new authorisation in a given year to practice in the receiving country.

	Stocks	Flows
Include	<ul style="list-style-type: none"> foreign-trained doctors who have obtained any type of registration to practice in the receiving country medical interns and residents who have obtained a medical degree in another country but have not yet obtained a (full) registration to practice in the receiving country. 	<ul style="list-style-type: none"> foreign-trained doctors coming in the country under all types of registration status (full, temporary, limited, provisional or conditional registration). <i>Source:</i> professional registers foreign-trained doctors coming in the country under a permanent or temporary working permit. <i>Source:</i> working permits delivered to immigrants medical interns and residents who have obtained a medical degree in another country but have not yet obtained a (full) registration to practice in the receiving country.
Exclude	<ul style="list-style-type: none"> foreign-trained doctors who are registered to practice in the receiving country but are practising in another country (temporarily or permanently) 	

Data and definitions on Nurses

The stock data described below includes the number of nurses who have obtained a recognised qualification in nursing in another country and are working as a nurse in the receiving country. The annual flow data on nurses counts the number of nurses who have obtained a recognised qualification in nursing in another country and are receiving a new authorisation in a given year to practice in the receiving country.

	Stocks	Flows
Include	<ul style="list-style-type: none"> foreign-trained nurses who have obtained any type of registration to practice in the receiving country. Nurses who have obtained a recognised qualification in nursing in another country but have not yet obtained a (full) registration to practice in the receiving country. 	<ul style="list-style-type: none"> Foreign-trained nurses in the country under all types of registration status (full, temporary, limited, provisional or conditional registration). <i>Source:</i> professional registers Foreign-trained nurses coming in the country under a permanent or temporary working permit. <i>Source:</i> working permits delivered to immigrants
Exclude	<ul style="list-style-type: none"> Foreign trained nurses who are registered to practice in the receiving 	

	country but are practising in another country (temporarily or permanently)	
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As this data collection is recent, there are known issues of data comparability among countries, especially across EU member states.³ Thus far data for only a select EU member states is available to help identify Indian-trained doctors and nurses. Hence, the data presented in this chapter does not represent the key receiving countries. Rather, these are the only countries for which substantial data was available – Belgium, Germany, Ireland, Italy and Norway.

While helpful, the dataset can offer more detail to support deeper analysis. It is also not possible to undertake OECD wide gender analysis on this dataset. While individual countries may offer gendered data, this has not been made available through the OECD web portal. As this data collection and consequently the database matures, deeper analysis of this migrant workforce ought to be possible.

EUROSTAT

In addition to the key OECD database, discussion in section 3 on India-EU migration is based on data compiled and presented in EUROSTAT.

The EUROSTAT database is the most complete, including statistics on the number of female migrants from India to each of the EU-27 countries. It identifies 4 categories of migration reasons for first permits: work, education, family reunification, and “other reasons” and this report is organised around these categories. When Indian migrant health workers – as coming from third country (outside of the EU member states) – enter the EU they are usually required to obtain a visa/permit to enter an EU member state. These first permits – granted for a minimum of three months – show the annual flow of migrants entering the EU countries for work, education, family and other reasons. Other reasons include international protection, residence without the right to work (for example, pensioners), or people in the intermediate stages of a regularisation process. While this is an important category and is included in the figures below, the chapter does not include a discussion of this category.

There is limited gendered data analysis. Comparable data on Indian female migration to the EU-27 is not easy to obtain. Each country has its own data collection, analysis, and reporting system that are then merged into international databases. There is also a great deal of variety between individual country statistics with respect to quality, completeness, gender disaggregation and base year for which data is reported (Raghuram and Sondhi, 2019). The gendered data analysis of stocks and flows of Indians into the EU is derived from two key tables. The *migr_pop3ctb* provides gendered stock data; the *migr_Resfas* tables provides gendered data on flows – first permits. Lastly, a third table *migr_resfirst* is used. The tables are identified alongside the figures.

The discussion in the following sections starts by presenting a gendered breakdown of the population of India-born in EU countries using the Eurostat datasets. The next set of discussion on the migrant health workforce is drawn exclusively from the OECD health workforce database.

³ For details on comparability issues, please see data definitions document https://ec.europa.eu/eurostat/cache/metadata/Annexes/hlth_res_esms_an13.pdf

India-EU migration – a gendered overview

Migration flows and stock are both crucial for the measurement of migration but cannot be directly compared. Flow data shows migrant entrants, i.e., residence permits granted in each year, while stocks show the number of migrants in a country.

Over the past decade the total Indian population (stock) in EU-27 has increased from 275,000 in 2011 to 478,349 in 2020, accounting for approximately 1% of total foreign-born population in the EU.

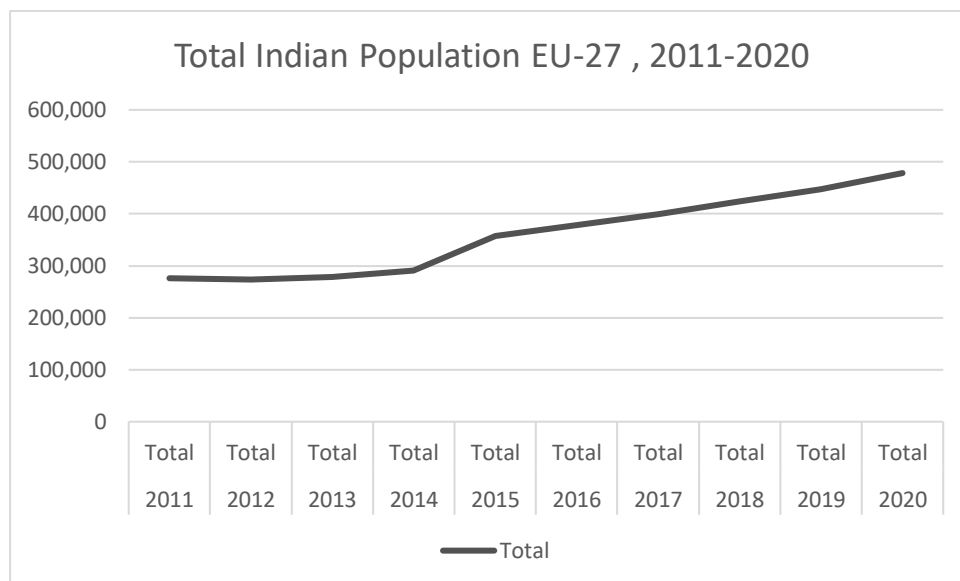


Figure 1: Total Indian-born population in EU-27, 201-2020; Source: Eurostat (online data code: migr_pop3ctb)

Women made up approximately 43% of the total Indian-born population. The percentage varies across EU member states. In 2020, the Member States with near gender parity in their Indian-born population were Iceland (52%), Denmark (49%), Switzerland (49%), Belgium (48%) and France (48%). The top 5 countries with largest population of Indian-born are Italy, France, Netherlands, Spain and Sweden. These member states also have high female proportion (see figure 2).

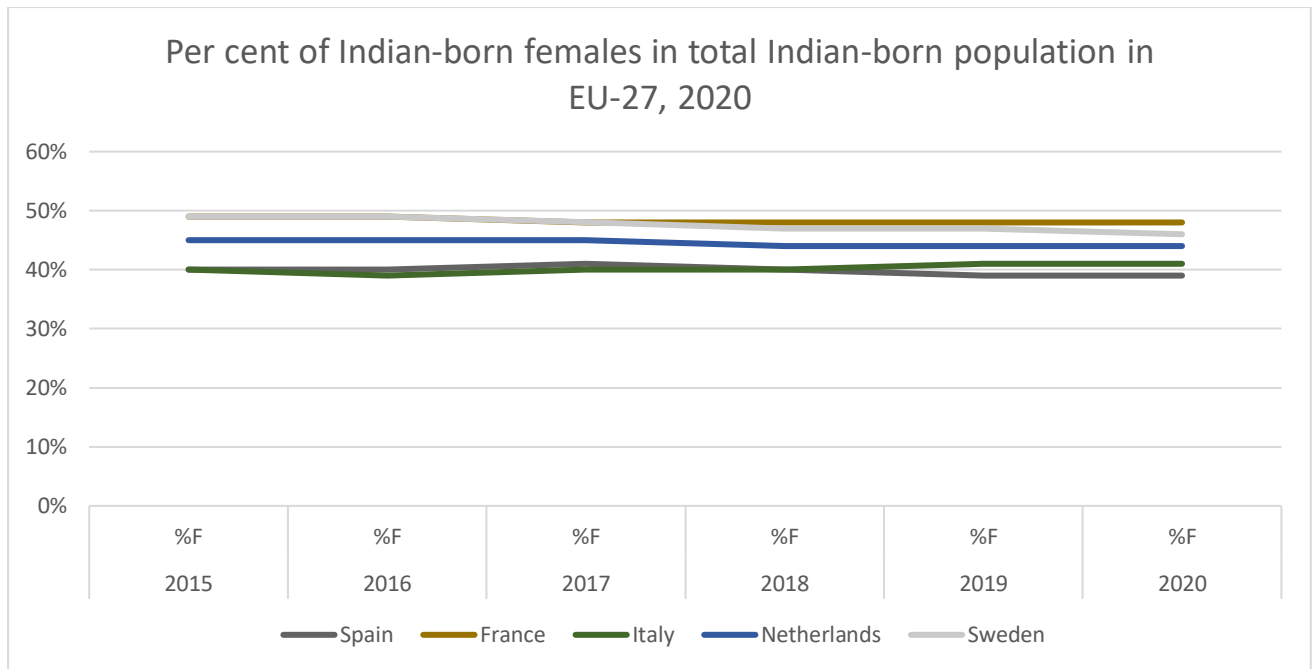


Figure 2: Percentage females as total Indian-born population in EU-27 by sex, 2020; Source: Eurostat (online data code: migr_pop3ctb)

Over the past decade the population of Indian-born in the EU member states has increased and the streams through with migrants enter the EU countries has also evolved during this time across all categories except employment. The proportion of Indian migrants entering the EU for *employment* held steady at 38% of the total flows between 2015 and 2019. By contrast the proportion of Indians entering as *family* migrants fell from 38% of total Indian migrants in 2015 to 32% in 2019, and migration for *education* increased from 15% of total annual flows in 2015 to 25% in 2019.

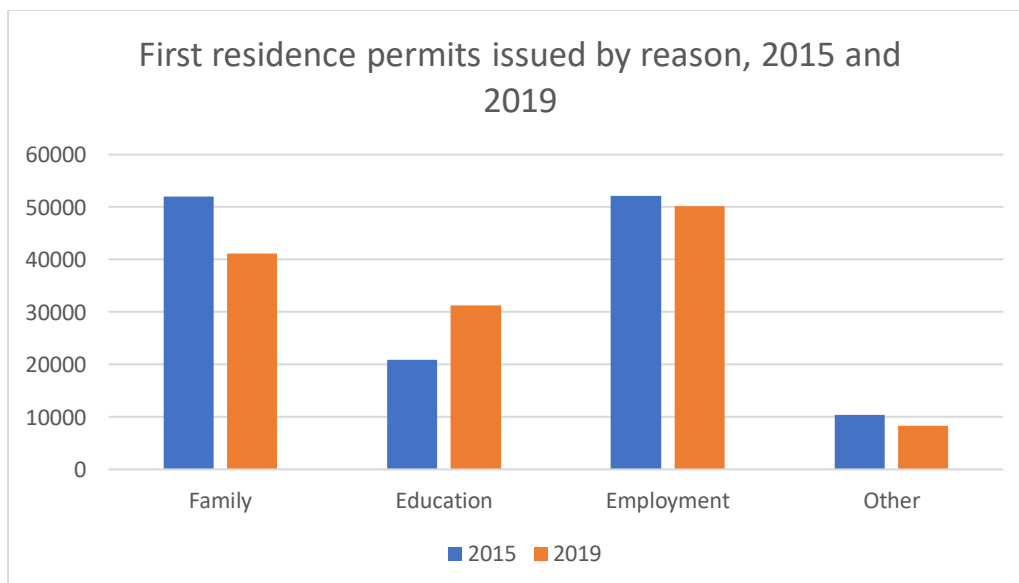


Figure 3: Residence permits issued to Indians by reason, 2015 and 2019; Source: Eurostat (online data code: migr_resfirst)

Women over all account for approximately 40% of the total annual flows⁴. They make up the largest proportion of migrants entering under the family category (75%), as shown in the figure below on first permits issued in 2019. By contrast, flows for education (70%) and employment (82%) are skewed toward men.

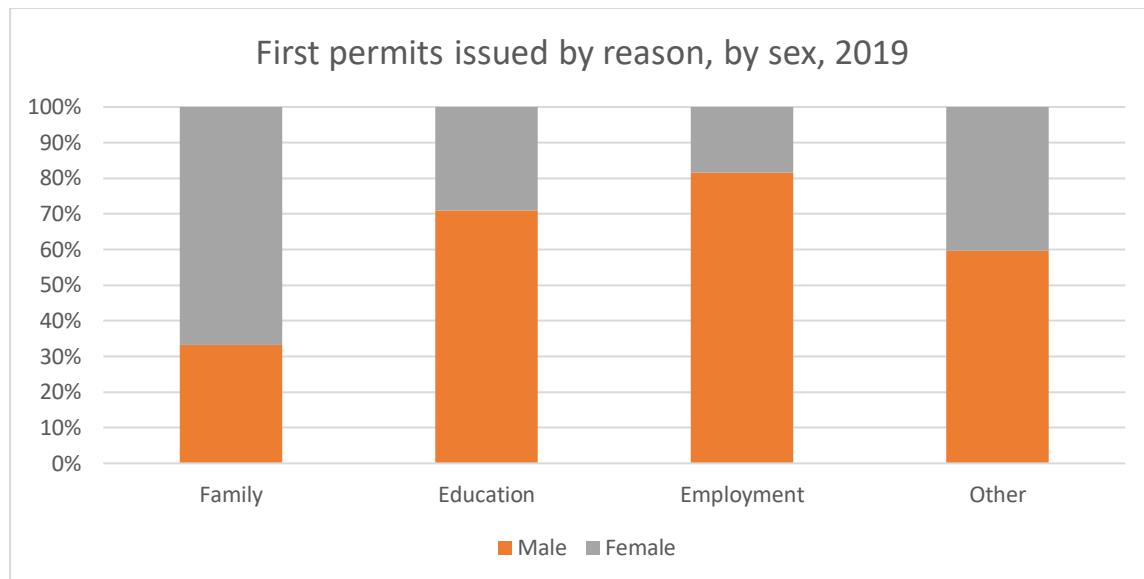


Figure 4: First permits issued to Indians, by reason and sex, 2019; Source: Eurostat (online data code: Migr_Resfas)

The highest proportion of men are in the new countries of migration such as Latvia (85%) and Lithuania (85%). Countries such as Italy, which already have significant numbers of employed female migrants due to a longer history of migration (ref), have comparatively more gender balanced profiles with regards to Indian migrant flows (see figure 3). This is especially the case where there are also significant flows of women moving as family migrants.

⁴ Author's calculations based on data available in Eurostat table: Migr_Resfas, available here: https://ec.europa.eu/eurostat/databrowser/view/migr_resfas/default/table?lang=en

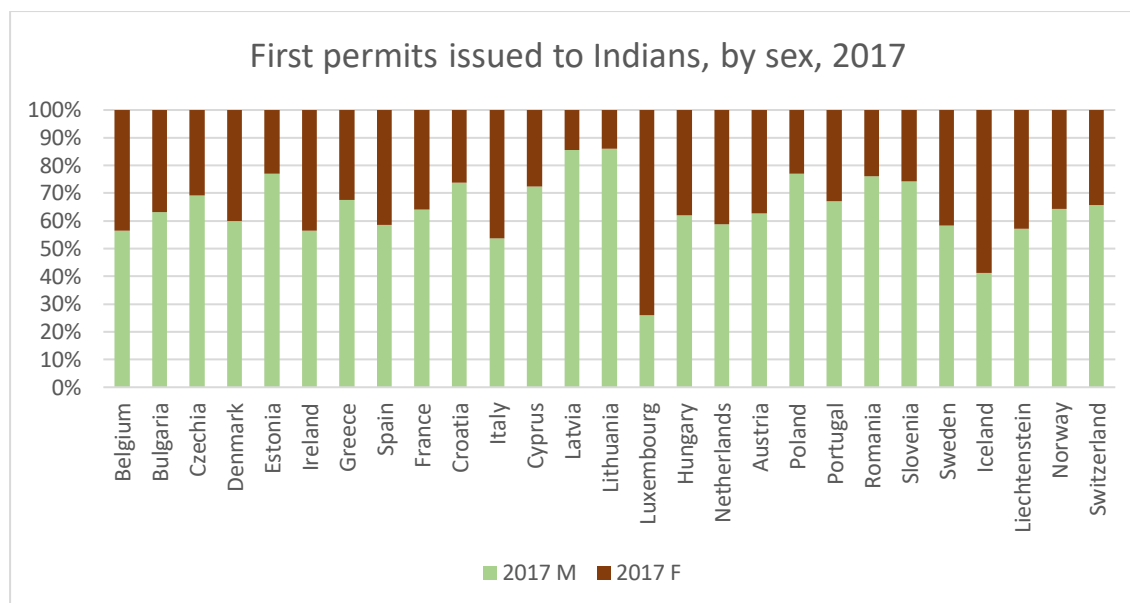


Figure 5: First permits issued to Indians, by sex, 2017; Source: Eurostat (online data code: Migr_resfas)

The above description is to give an idea of what the stocks and flows of Indian born population in the EU looks like. Unlike the US, and the UK, the EU is not a common or popular destination for Indians.

Indian healthcare professional migrants in EU-27

The mobility from India to the EU has been varied – spread across the categories of work, study, family and other. The following discussion focuses on a subsection of the mobility for work of doctors and nurses. It may appear that the increasing movement along the EU-India corridor is a ‘relatively’ recent phenomenon by comparison to the longer linkages to move to the US, the UK and GCC for nurses for instance. However, further examination shows that while the increase in the number of people moving is relatively recent, the corridor has long existed. The current movements are a continuation of a longer history of movement, especially those of health professionals such as doctors and nurses.

This contemporary increase in flows, particularly in the health sector has been a result of increasing recognition amongst EU member states of their significant labour shortages within the healthcare workforce. Across EU member states Healthcare is the sector with the largest labour market shortage (Gupta 2013). This demand has increased during the pandemic. However, as mentioned at the beginning of the chapter, there is a geography of skills (Raghuram 2021) – meaning a migrant’s nationality, ethnicity, gender, place of training/qualification all combine to shape whether their skills and knowledge are recognised, and then if they are able to deploy them fully. For instance, in Norway, all health personnel are required to seek an authorisation or license from the sectoral professional body - Norwegian Registration Authority for Health Personnel (Bhattacharjee 2013; Brenne and Jensen 2013). However, before the migrant can enter the country, they also need to meet the criteria as setup within the national migration policies/programs. It’s the entanglements of these professional, sectoral and national structures of the receiving countries that shape who enters, under which category, and for how long. Depending on the where the migrant sits within the hierarchy of healthcare work – Doctors, nurses, carers, care aides, and general healthcare workers, reflects the differentiated national labour market demands, the migration requirements and the requirements of the regulatory body. The hierarchy also determines whether the migrant is classed

as highly skilled or low skilled migrant. These are determined by demands and structures of the local labour markets of the receiving country rather than migrant qualifications. These inequalities are important considerations as we explore in detail below the stock and flows of Indian-trained doctors and nurses over time, and delve into the three country case studies: Germany, Italy and Ireland.

Stock of Indian-trained Doctors and Nurses in EU-27

Over the past decade, within the EU-27 group of countries Germany, Ireland and Norway are noted receiving countries for Indian-trained doctors. The figure below shows the number of Indian-trained doctors between 2011-2018.

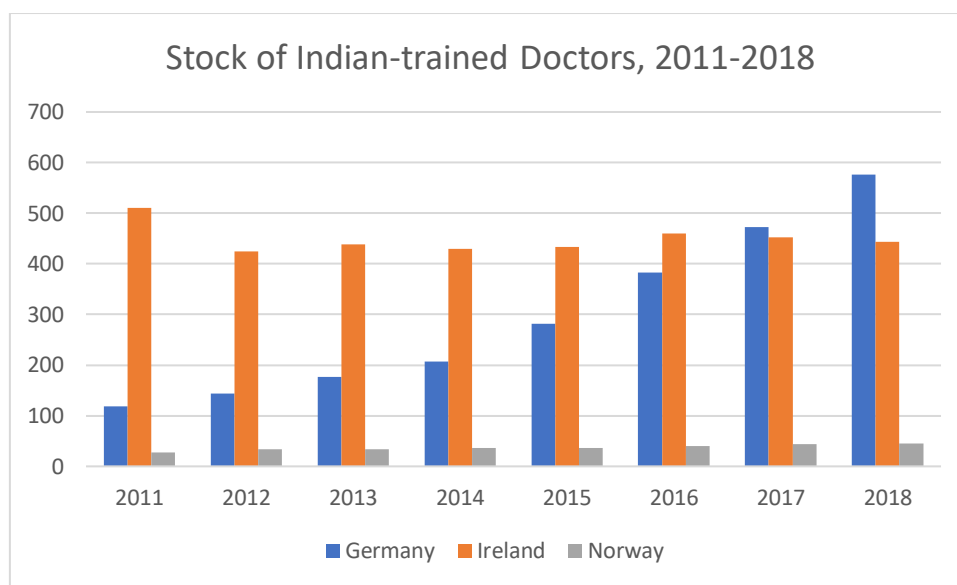


Figure 6: Stock of Indian-trained doctors 2011-2018; Source: OECD health workforce migration database

Germany is notable here as there has been continual increase of Indian-trained doctors in Germany over the past 20 years (Figure 8 below), while Norway, with its much smaller stock of Indian-trained doctors is a relatively new receiving country. The three countries amongst the EU-27 countries have been identified in the figure above. These three countries – Germany, Ireland and Norway – do not necessarily represent the countries with the largest number of Indian-trained doctors. Rather, they represent the availability of the data in the OECD health workforce database (HWD). Due to the newness of the database, it currently has significant gaps in the available data. Hence, this chapter explores three countries for which sufficient data is available.

This also limits cross-country comparisons as well as those between nurses and doctors for same sets of countries. Consequently, there isn't comparable data for stocks of nurses for Germany, Ireland and Norway. Instead, by looking at available data for Italy, Norway and Belgium, we see that, unsurprisingly, the stocks of foreign-trained nurses are larger than those of foreign trained doctors.

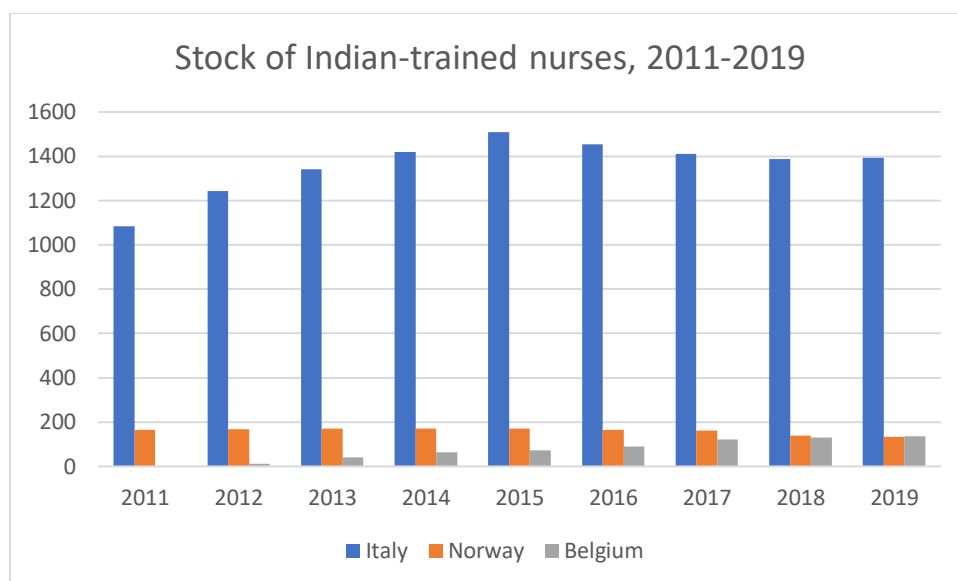


Figure 7: Stock of Indian-trained nurses 2011-2019; Source: OECD health workforce migration database

As Figure 7 shows, the stock in Italy are notably larger than those in Norway and Belgium. This is in part because Italy has a longer history of hosting Indian-trained nurses (Figure 9 below). This is discussed more in the sections below. There is no discussion of the annual flows of doctors and nurses across EU-27 countries. This is due to the limited and poor quality of the flow data currently available in the database.

A third limitation of this database is the absence of sex-disaggregated data. While we do not have the HWD does not have this data, it would not be incorrect to say that the stocks and flows of nurses are likely to be dominated by women since women make up majority of the nursing workforce. Similarly, men make up the majority of the physicians in the health workforce (Boniol et al. 2019). This gendering of the health workforce also impacts the migrant categories. For instance, while women labour migrants within global care chain (Yeates 2004) are likely to be embedded within the lower end such as domestic workers, or care aids (the hierarchy of nursing), men are likely to be embedded within the highly skilled as doctors.

Nursing is not necessarily considered as highly skilled across all countries. For instance, in Germany, nursing and midwifery are not considered as skilled professions due to their local apprenticeship structures. This leads to devaluing of skills of migrant women who are tertiary level educated trained and experienced nurses (Raghuram and Sondhi 2019, Raghuram 2021). By contrast, in Norway the definition of skilled worker or specialist includes vocational training at upper secondary level including health workers with appropriate training, completed education/degree from university such as nursing. Hence someone who may be considered as a skilled worker in Norway, might not be considered as one in Germany due to different labour market and qualification structures.

However, other factors also impact the entry of doctors and nurses into specific countries. The case study of Italy below also offers us an example on how religious affinity may also play a role in shaping the movement of nurses from India to the EU.

Germany

There is long history of migration of health workforce migration from India to Germany. During the 1960s-70s nurse migration from Kerala to Germany was a key flow of the corridor (Faist, Aksakal,

and Schmidt 2017). Though, this route was closed in 1970s as West Germany decided to close its border to immigration. This meant that many Indian nurses were unable to extend their visas during that time, and neither could they benefit from family reunification programs at that time. In 2000, Germany started to reopen its labour market to highly skilled migrants – particularly IT professionals from India. Alongside the IT stream, there has been slow increase of number of Indian-trained doctors working within the Germany health workforce (figure 8) as evidenced by the increasing stock of Indian trained doctors. It is important to note that these are not annual flows. A limitation of OECD database does not allow for further examination of these stocks, and neither is data for nurse migration into Germany is available.

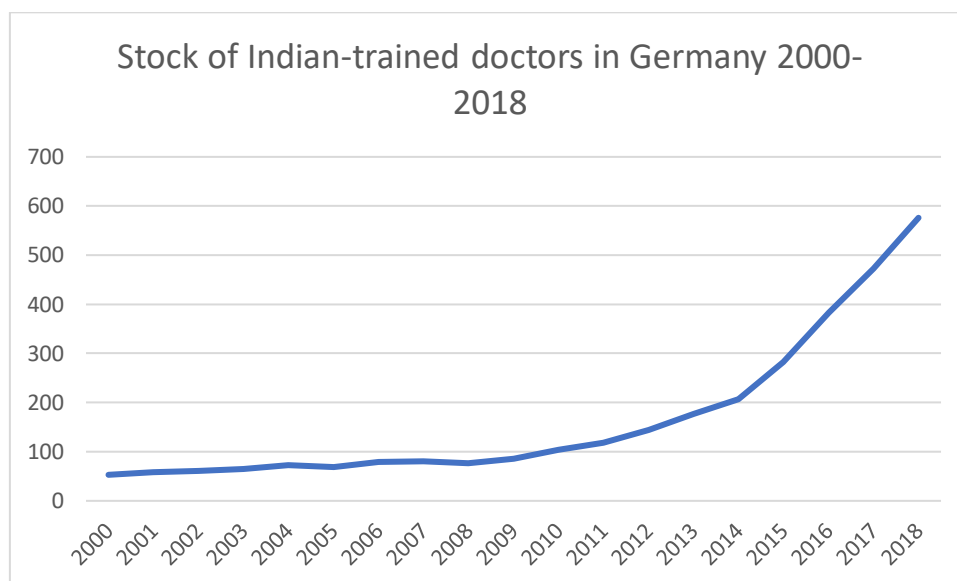


Figure 8: Stock of Indian-trained doctors in Germany 2000-2018; Source: OECD health workforce migration database

Despite the increasing numbers of the India-trained doctors visible in figure 8, research has highlighted that there is limited migration of Indian healthcare professionals into Germany, particularly nurses. This is due to the mandate from World Health Organisation which has listed India as being on the list of human resources crisis within the health sector. Hence Germany has not proposed or signed any agreements with India for recruitment of health workforce (Gereke 2013). In principle, Germany differs from the other two country cases in this chapter – Italy and Ireland – two countries which have greater dependence on migrant health workforce comprised of non-EU third-country nationals.

Italy

Like Germany, migration of Indian nurses into Italy is part of the long history of movement along the India-Italy corridor. Indian migrant nurses in Italy primarily come from Kerala, a state in South India (Gallo 2005) or from Punjab, a state in north India in , which has a long history of out-migration of nurses, including to the Gulf countries, US and the UK . It is salient that a number of the nurses are Catholic, making it easier for Italians to accept nurses (and carers) from this region of India.

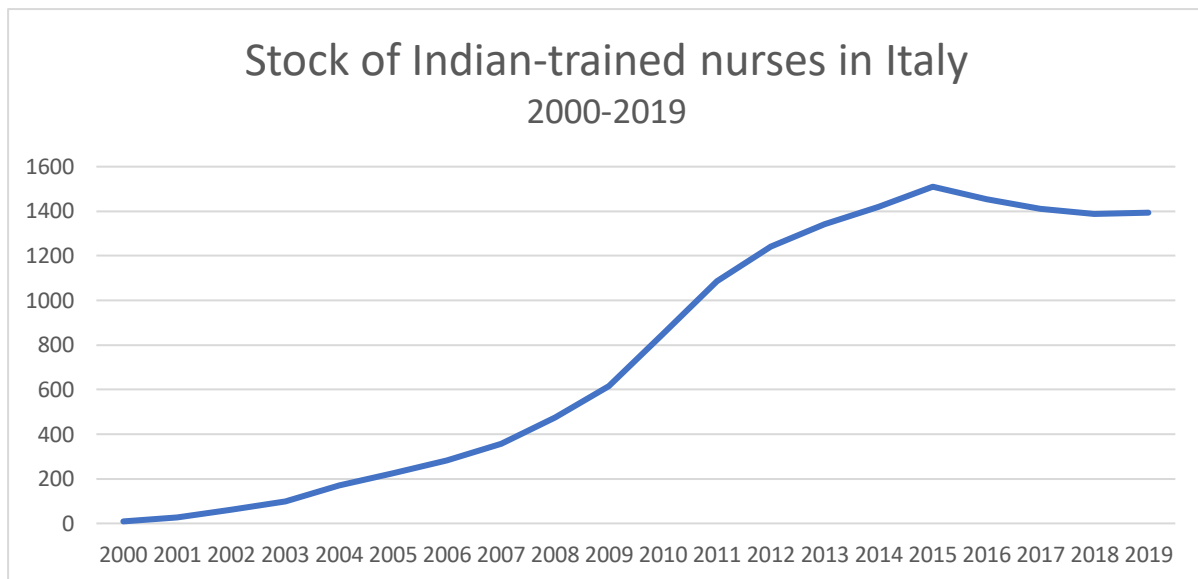


Figure 9: Stock of Indian-trained nurses in Italy 2000-2019; Source: OECD health workforce migration database

However, this trend is changing. Between 2000-2010 there was an upward trend in the annual flows of Indian nurses into Italy as evidenced in the increasing stocks and annual flows (figure 10). However, since 2011, there has been a steep decline in the annual flows.

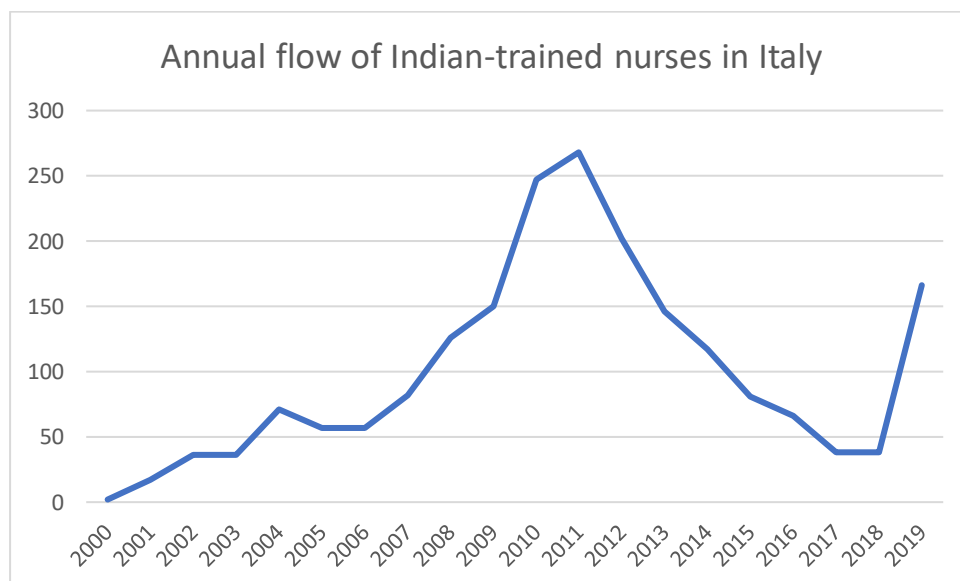


Figure 10: Annual flow of Indian-trained nurses in Italy 2000-2019; Source: OECD health workforce migration database

This sudden decline in the flows has started to influence the stocks as well since 2016 as seen in the figure 11 below.

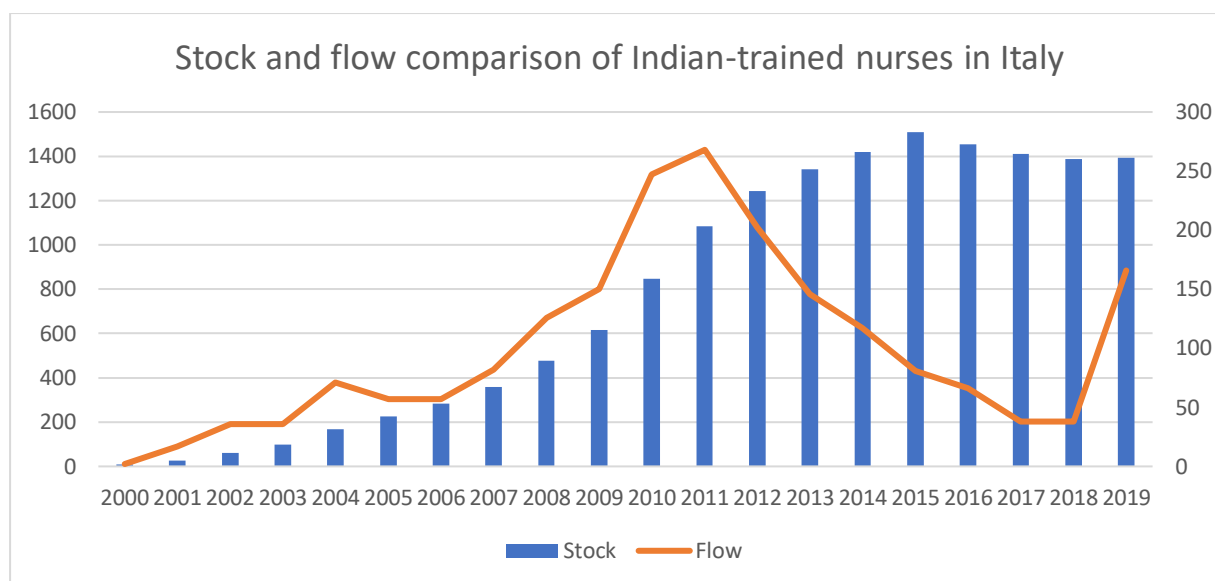


Figure 11: Comparison of stocks and flow of Indian-trained nurses in Italy 2000-2019; Source: OECD health workforce migration database

There appeared to be a change in the trend in 2018, however the impact of COVID is likely to shape the future trend of this flow, and consequently the stocks of Indian nurses in Italy.

Ireland

Thus far we have seen stock data for doctors in Germany, and stock and flow data for nurses in Italy. In this section we compare the limited annual flow data on Indian doctors and nurses in Ireland.

Over the years Ireland has undertaken several special initiatives to attract qualified workers in the health sector to cover the projected shortages of doctors and nurses (Talbot 2013). As part of one of the initiatives in 2011, it recruited over 200 doctors non-EU foreign-trained doctors, of which nearly 25% were Indian-trained (see figure 12). Ireland's foreign-trained doctors are largely third country nationals from India, Pakistan, South African and Sudan. Between 2000-2010, foreign-trained doctors as a percentage of the health workforce increased from 13% to 33%, making the second most dependant OECD country on foreign-trained health workforce (Brugha, McAleese, and Humphries 2015). In 2014, nearly 35% of the health workforce of Ireland was composed of international medical graduates (Brugha, McAleese, and Humphries 2015).

	Doctors	nurses
2010	38	5
2011	41	45
2012	31	77
2013	26	71
2014	6	126
2015	30	266
2016	35	612
2017	34	786
2018	36	816

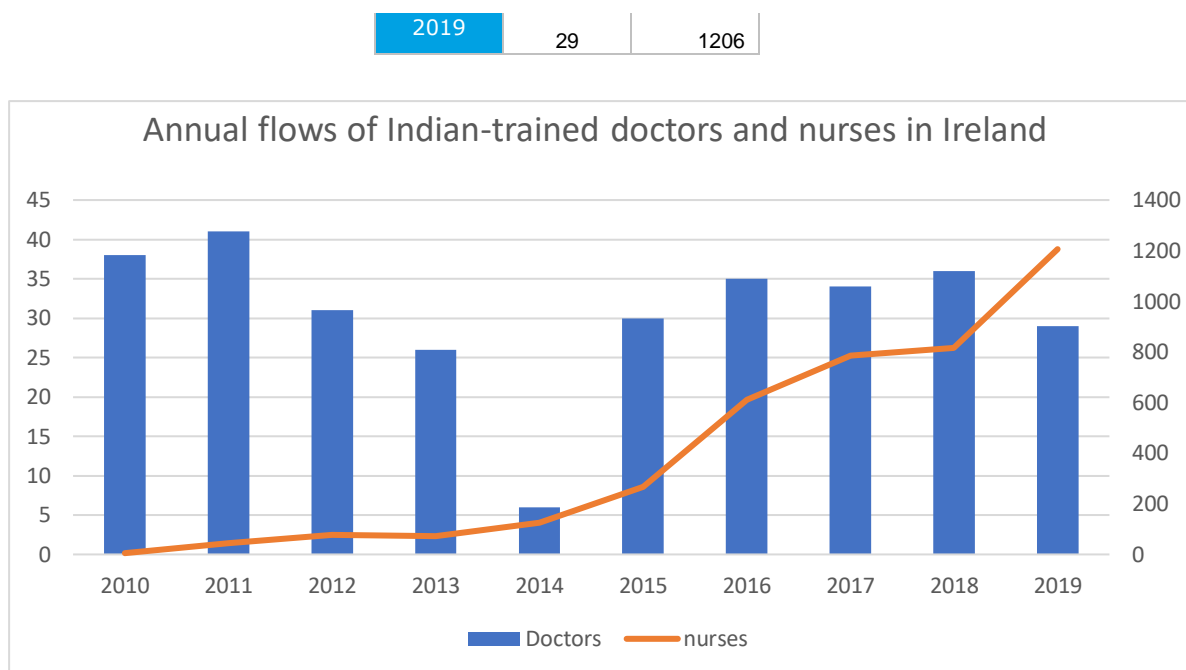


Figure 12: Annual flow of Indian-trained doctors and nurses in Ireland 2010-2019; Source: OECD health workforce migration database

Figure 12, and table 1 show that the numbers of doctors entering Ireland annually have remained more or less the same over a period of 10 years (other than a sharp drop in 2014), but nurse migration has increased steadily through the period 2010-2019. During 2000-2009, Ireland undertook large-scale recruitment of nurses recruiting nearly 12,000 nurses from India and the Philippines (Brugha, McAleese, and Humphries 2015). Figure 12 shows that over the past decade, the flows of nurses from India has been on a steady increase. The data prior to 2010 is unavailable in the OECD database – hence there is discrepancy between data from other studies and the OECD database, and thus another limitation of the HWD.

While recruitment of doctors and nurses has been more or less steady, research has shown that Ireland has faced retention challenges due to limitations on the scope of practice, as well as barriers to securing long term residency in Ireland. Hence, Ireland is likely to be a stop on a multinational migration (Paul and Yeoh 2021) career pathway of health professionals rather than the destination.

Conclusion

This chapter has presented descriptive statistics from the OECD health workforce migration database. The aim of the discussion has been to point to the need to a) open up further research on India-EU corridor and b) examine the strengths and limitation of the OECD health workforce database to support evidence-informed policy development for safe and secure migration and decent work. This chapter starts to map out the trends of this India-EU mobility to open up avenues for future research.

The contemporary crisis has forced international, regional and national stakeholders to think more of the migrant health workforce beyond the development deficit-models of brain or care drain to consider more carefully and responsibly the safety and security of migrants and migration processes, as well as issues around decent work along the mobility corridors and in the receiving countries.

Through the case of health workforce migration the chapter has shown that the movement between the India-EU corridor is not a new. Its trends and patterns (even with limited data) reflects both existing corridors such as Italy and Germany, but also emerging such as Ireland, and Norway.

While the data in this database is limited, it does provide a window into existing and emerging trends and patterns of migration between India and the EU. The chapter has shown three types of comparisons that can be undertaken with the current data set. For the case of Germany, the stocks of doctors over a 20 year period was examined. The case of Italy focused on nurses rather than doctors, compared both stocks and flows of nurses over 20 year period. Lastly, the Irish case provided a unique opportunity to compare the trend of annual flows of doctors and nurses. Hence, the database offers various possibilities of undertaking occupational, spatial and temporal comparative work to identify national level patterns of migrant health workforce, particularly along the India-EU corridor.

However, due to the relative newness of this database, there are several limitations for migration analysis, particularly one that focuses on movement from India to EU member states. The three limitations identified in this chapter are: missing data, inconsistent data (between individual country sources and data available in the HWD, and lastly the absence of sex-disaggregated data. The latter missing data therefore limits deeper gendered analysis of health workforce migration both in this specific content of India-EU mobility, but also globally. This absence sex-disaggregated data is of particular relevance due to the dominance of women within the health workforce globally both migrant and non-migrant.

Despite its limitations, the database opens up several avenues for future research employed diverse methodologies. Firstly, an improved database will lead to improved quantitative analysis of the migration of health workforce especially, gendered analysis. The existing body of research on Indian nurse migration – which has remained mostly micro-level, can now extend the analysis by looking at receiving country data. The data on migration of doctors can also benefit from gendered analysis to complement the gendered analysis of mobility within the nursing profession. Lastly, the database could offer an opportunity to examine multinational migration trajectories that nurses and doctors may undertake.

Second, for every country case presented in this chapter, several questions have been raised regarding the specificities and commonalities across EU member states. While some context of each receiving member states is provided, in depth analysis of the structures within which the migrations occur have not been examined. Thus undertaking analysis for instance of the national labour markets and professional bodies that impact entrance and retention of migrant health workforce would highlight the barriers and enablers both at the level of member states and the EU.

As a final point it is important to say that not all health workforce is captured under the movement of doctors and nurses. For instance, migrant women are employed as care workers in a range of EU countries. Many of them are trained as nurses but are deskilled after migration as they navigate the intersecting hierarchy of health work and care work, and are then employed as live-in care workers, or care aides. Hence, it is important to recognise the limitations of quantitative-only analysis and reliance on one type of database. The OECD HWD is a useful starting point, especially as it enables cross-country comparison. However, this quantitative analysis needs to be complemented with qualitative methodologies to ensure that a deeper and productive analysis of this stream is usefully undertaken to improve our understanding and improve policies and programs that support migrant workforce.

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