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Investigating the working conditions of Filipino and Indian-born nurses in the UK

Davide Calenda
Return Migration and Development Platform (RDP)
Robert Schuman Centre for Advanced Studies (RSCAS)
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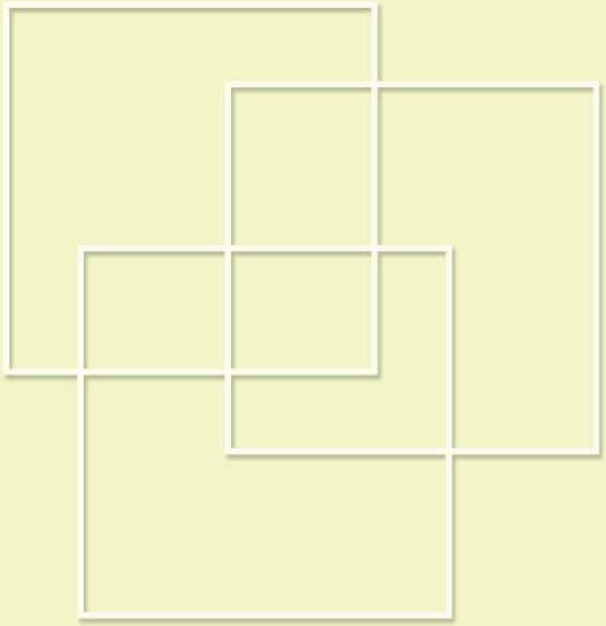

Promoting Decent Work Across Borders:
A Project for Migrant Health Professionals and Skilled Workers

Country Office for the Philippines

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Foreword

The increasing global shortage and inequitable distribution of health professionals in many developed countries has intensified the need for health workers globally. Developed countries often rely on foreign health professionals to address gaps in the supply and demand of their health workforce.

The Philippines and India are the biggest sources of foreign health workers for the Organisation for Economic Co-operation and Development (OECD) countries, including European nations. According to an OECD report in 2010 , Filipino-born nurses and Indian-born doctors each represented about 15 per cent of all immigrant nurses and doctors in the OECD.

Despite the valuable contribution they make to their host societies, migrant workers often find themselves over-qualified for the job they hold and often encounter vulnerable employment situations. They experience considerable job insecurity, and the sectors and occupations they are employed in are characterised by less advantageous working conditions. Overall, women and young migrants are particularly vulnerable. Little information is, however, available on the specific situation regarding skilled workers, and in particular health professionals, after migrating to Europe.

In the context where a significant proportion of the European health workforce is assured by migrant workers, it is crucial to explore the working conditions offered to those migrant workers in order to ensure that decent work and fair treatment is offered to all.

The ILO, through its European Union-funded Decent Work Across Borders: a Pilot Project for Migrant Health Professionals and Skilled Workers, is grateful to Mr Davide Calenda for this contribution to the debate on the working conditions of health professional migrants in the United Kingdom.

The current working paper clearly brings out the perspectives of Filipino and Indian nurses on their working conditions, and relates these to their immigration status. The issues discussed are very relevant and deserve to be brought to the attention of the wider public -- especially policy makers to whom the ILO wishes this paper to be of service to.

Lawrence Jeff Johnson
Director
ILO Country Office for the Philippines

[1] Policy Brief on “International Migration of Health Workers: Improving International Cooperation to Address the Global Health Workforce Crisis”. OECD. 2010. http://www.oecd.org/health/healthpoliciesanddata/44783473.pdf.

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Key informants interviewed
UNISON London: Ms Susan Cueva, Ms Gail Adams, Ms Argie MacLean, Mr Rommel C. Abellar, Mr Kuya Allen A. Reilly.

Royal College of Nursing: Ms Susan Williams and Ms Rachael McIlroy.

NHS Employers: Ms Rachel Dean.

Migrants' Rights Network in London: Mr Don Flynn.

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Executive Summary

Situated within the framework of the ILO's *Decent Work Across Borders Project*, this study is primarily intended to investigate the recruitment experiences and the working conditions of migrant workers in the health sector. In particular, this study explores the experiences of Filipino-born and Indian-born nurses in the United Kingdom (UK). The objective is to understand the intersections between the institutional framework, which has evolved across time in response to changes in the political and economic priorities, and the work experience of the Internationally Recruited Nurses (IRNs).

The review of policy documentation and literature in the field is combined with interviews with 13 key informants who were identified among trade unions, professional unions, employers association, immigrant associations and governmental bodies. An on-line survey was also developed to hear from IRNs working in the UK; a total of 433 valid questionnaires were collected from March to June 2013.

Information and data collected during the fieldwork indicate a positive relation between satisfaction about recruitment experiences, motivations and working conditions of nurses. Respondents hired directly by the NHS tend to report more positive assessments than other respondents and especially compared with the ones recruited by private agencies to work in care and nursing homes.

The recruitment process is only one factor influencing IRNs' working conditions, however. Changes in the situation of IRNs must be interpreted within the wider leverage of working conditions of healthcare workforce stemming from the economic crisis and consequential cuts in NHS funding starting in 2008 as recent surveys in the UK and in Europe demonstrate. Concerns about losing the job are common among nurses in the UK. IRNs interviewed in our survey also reported concerns; only 1 in 10 of them considers that job security has increased over the years. Many also feel operating in increasing unsafe working conditions. Most of the respondents arrived in the UK before 2006 as the result of NHS expansion and have therefore been witnessing cuts in NHS funding and structural reforms of the whole public health sector started after that period.

Overall, empirical evidence suggest that the easiest way for employers to deal with funding cuts in the public health sector has been reducing the personnel and intensifying work shifts and workloads. IRNs seem to be in a vulnerable position to such pressure. Changes in immigration rules, cuts in NHS funding and the progressive privatization of the health care system in the UK combine and shape employers' utilization of migrant health workers in ways that may increase risks of unequal treatment in the workplace. A substantial proportion of IRNs who participated in our survey reported lacking professional and career prospects, their professional identity not adequately recognized and valued by the manager and lacking cooperation and solidarity from colleagues in the team. These feelings correlate with what IRNs reported about equality issues in the workplace – i.e. unequal treatment and discrimination in the workplace driven by ethnic considerations.

The consequences of such a situation are not limited to the working conditions of the IRNs but also extend to the quality of care as demonstrated by the correlation between disappointment reported by respondents about their working conditions and the quality of care they are able to provide to patients. Results of the fieldwork indicate a significant relation between the worsening of working conditions, experiences of ethnic discrimination and unequal treatment in the workplace. Empirical evidence also suggest that differences between IRNs in terms of working conditions significantly cut across issues of access to opportunities, equality and diversity management in the workplace. Finally, differences in working conditions reflect different IRNs' orientations towards the UK labour market. Namely, disappointment about working conditions combined with a general feeling of uncertainty about

the future in the UK turned out to be an important factor in influencing the decision of many IRNs interviewed of leaving the UK.

About the author

Davide Calenda obtained his Ph.D. in Political Sciences from the University of Florence (2003). He is currently carrying out research at the *Return migration and Development Platform* of the Robert Schuman Centre for Advanced Studies (RSCAS) at the European University Institute of Florence. Previously, he was research fellow at the Political Science and Sociology Department, the University of Florence. He has over ten years of experience as scientific consultant and project manager of several national and international research projects and studies in the field of industrial relations, development and migration. For the ILO, he is currently coordinating a documentation of promising practices of ethical recruitment of health professionals in the UK, India and the Philippines.

This publication has been produced with the assistance of the European Union. The contents of this publication are the sole responsibility of Mr Davide Calenda, consultant to the International Labour Organization, and can in no way be taken to reflect the views of the European Union.

Abbreviations

AIIMS	All India Institute of Medical Sciences
ALOS	Average Length of Stay
ARPOB	Average Revenue per Occupied Bed
AYUSH	Ayurveda, Unani, Siddha and Homeopathy
BAMS	Bachelor of Ayurvedic Medicine and Surgery
BAPIO	British Association of Physicians of Indian Origin
BHMS	Bachelor of Homeopathic Medicine and Surgery
BUMS	Bachelor of Unani Medicine and Surgery
DHKI	District Health Knowledge Institute
DWAB	Decent Work Across Borders
ENCs	Exceptional Need Certificates
FICCI	Federation of Indian Chambers of Commerce and Industry
GDP	Gross Domestic Product
GSCs	Good Standing Certificates
HRH	Human Resources in Health
HSMP	Highly Skilled Migrant Programme
ILO	International Labour Organization
JCI	Joint Commission International
MBBS	Bachelor of Medicine, Bachelor of Surgery
MCI	Medical Council of India
MDGs	Millennium Development Goals
MOHFW	The Ministry of Health and Family Welfare, Government of India
MOIA	The Ministry of Overseas Indian Affairs
MOU	Memorandum of Understanding
NABH	National Accreditation Board for Hospitals and Healthcare
NCHRH	National Commission for Human Resources for Health
NGO	Non-Governmental Organization
NORI	No Obligation to Return to India
NRHM	National Rural Health Mission
PPPs	Public-Private Partnerships
SON	Statement of Need
TOR	Terms of Reference
WHO	World Health Organization

1. Introduction

Situated within the framework of the ILO's *Decent Work Across Borders Project*, this study is primarily intended to investigate the recruitment experiences and the working conditions of migrant workers in the health sector. In particular, this study explores the experiences of Filipino and Indian-born nurses in the United Kingdom (UK).

The international recruitment of nurses and health professionals in general has gathered momentum in the last twenty years due to the increasing global shortage of the health workforce. Developed countries increasingly rely on foreign health professionals to address gaps, and the Philippines and India have become the greatest sources of foreign nurses for the Organisation for Economic Co-operation and Development (OECD) countries.

Massive recruitment of health professionals from developing countries has raised broader issues of ethics and impact for the migrant worker and for the health-care systems in both the sending and receiving countries. Active recruitment in countries that are experiencing shortages or inequitable distribution of health-care professionals is nowadays considered as unethical. National and international organizations are increasingly warned of abuses in recruitment practices and "aggressive" approaches of recruitment. The International Labour Organization (ILO) has been particularly active in addressing these issues, drawing on a long-standing policy for the protection of migrant workers' rights[1]. In 2010 the World Health Organization (WHO) adopted a Global Code of Practice on the International Recruitment of Health Personnel and similar policy initiatives at national and international levels. However, there is still little information available on the actual recruitment practices of health professionals, while abuses are still reported in countries with well-developed labour regulation and industrial relations. For instance, the United States (US) State Department's 2012 Trafficking in Persons Report (TIP) mentions that even "engineers and nurses are subjected to conditions of forced labour abroad" (US State Department, 2012: 284). In 2013, the Philippine embassy in Norway likewise issued warnings to potential nurse migrants that some recruitment consultancy firms had been spreading false information regarding language lessons and other requirements to work in Norway[2].

Previous studies in the field suggest that bad experiences with recruitment are likely to impact negatively on motivations, working conditions and employment orientations of the migrant health worker in the destination countries, and on the quality of care as well. However, there is still much work to do in order to disentangle the complex intersection between recruitment mechanisms and working conditions. This study aims to provide new empirical-based knowledge to fill this gap through looking at the actual experiences of internationally recruited nurses (IRNs) in the UK.

[1] ILO Conventions and following Recommendations No. 97, (1949) and No. 143 (1975); Private Employment Agencies Convention No. 181 (1997). See also the ILO reports "Decent Work" (1999); "Towards a fair deal for migrant workers in the global economy" (2004); and the ILO Multilateral Framework on Labour Migration: Non-binding principles and guidelines for a rights-based approach to labour migration (2006).

[2] Available at http://www.philembassy.no/news-item/advisory-filipino-nurses-healthcare-workers-should-be-wary-of-advertisements-consultancy

The UK context is interesting for several reasons. It has a particularly high proportion of IRNs. International staffing for nursing is rooted in the UK's history as a colonial power. It began with the creation of the Colonial Nursing Service in 1940, applying initially only to Commonwealth countries (Solano and Rafferty, 2006: 1056).

It was then extended beyond commonwealth countries, with the Philippines and India in particular becoming important origin countries. Up to 2006, nurses coming from the Philippines, India and China accounted for around 60 per cent of all non-European nurse registrants in the UK (Buchan and Seccombe, 2006). However, there has been a progressive change in numbers and patterns of IRNs, especially from 2008 onwards. New registrations from within the European Economic Area (EEA) have been growing in the UK, whereas new registrations from non-EEAs have fallen.

These changes are mainly explained by changes in the political agenda. State policy has been particularly effective in influencing employers' utilization of IRNs (Bach, 2010). Successive governments have influenced the number of international recruitment of health professionals and their possibilities to stay over the period now granted for work by changing health policy and/or migration policy. Three policy phases can be identified. Young (2011) has termed the period following the election of Tony Blair's Labour government in 1997 as "openness to mobility". This period extends until changes in 2006, and is then followed by two periods (2006-08 and November 2008 onwards) that were characterized by progressive restrictions on migration of skilled health staff.

The economic crisis and the widespread perception that the UK "model" of multiculturalism -- the "British Dream" as Goodhart (2013) termed it -- was failing, abetted the major changes in UK immigration policy in that period. The current Conservative-led coalition has prioritized in its agenda the reduction of net migration "from hundreds of thousands to tens of thousands" (Salt and Dobson, 2013) and of the number of permanent immigrants in the UK.

Many migrant workers with permanent residence are in the health sector. General nurses were removed from the shortage occupation list from 2007 (Cangiano et al., 2009: 183), and tougher requirements to register as a nurse in the UK at the Nursing and Midwifery Council (NMC) were implemented. Such a development is also driven by economic considerations -- the 2009 economic crisis and the progressive cuts in the National Health Service (NHS) funding have led to a curbing in overseas recruitment.

By implementing tougher registration rules for health-care workers, the UK government has re-asserted its power to define the "categories of people able to enter the labour market, the parameters under which they can work (temporary and permanent), and the extent to which they are allowed to circulate freely between employers" (Bach, 2010: 252-253). The recent shift to temporary migration marks a relevant change in immigration policy not only in the UK. The current approach on migration management in the UK reflects as well as shapes the dominant schemas of migration management fabricated at the international level since the Berne Initiative Process in 2001. In the agenda of migration management, the temporary and selective acceptance of legal foreign labour is among its pillar priorities (Cassarino, 2013).

These changes in the immigration policy and access to profession should not be overlooked when investigating the working conditions of IRNs. Several scholars have observed that tougher immigration and registration rules for migrant health workers have contributed to generate a climate of uncertainty that is likely to impact on the working conditions of IRNs, their motivations, and their decision on whether to stay or leave (e.g. Meardi et al., 2011; Buchan, 2007; Bach, 2010).

This occurs within a generalized growth of uncertainty among the nursing workforces in the UK and Europe, due to the economic crisis (RCN, 2013; Aiken et al. 2013). IRNs seem to be particularly affected by this situation. As is argued in the next sections, many IRNs interviewed for this study reported having moved to the UK because they were attracted by job and career opportunities. They successfully registered as nurses in the UK in a period of NHS workforce expansion and lax immigration policy. Most respondents succeeded in securing their employment situation and their legal status in the UK. However, at the time of the survey, many respondents reported that they were planning to leave the UK in the near future. Disappointment about working conditions and job prospects is the most important factor driving their decision to re-emigrate.

Results presented in this research report are based on the review of literature and policy documentation, as well as fieldwork carried out in the UK from March to June 2013. This included interviews with 13 key informants from unions, employers' associations, immigrant associations, governmental bodies, and a survey of Indian and Filipino-born nurses.

Results of the fieldwork show a mixed picture in terms of recruitment experiences and working conditions of IRNs. On one hand, many IRNs interviewed seem to be satisfied with their experiences of recruitment and their working conditions in the UK. They consider their professional identity valued by the employer and are likely to develop further their employment trajectories in the UK. Conversely, a substantial proportion of respondents reported problems in the recruitment process, disappointment about working conditions, and having experienced practices of unequal treatment in the workplace. These IRNs show a high propensity to move to other countries to work as nurses. Differences among IRNs are explained by a combination of different factors, among which the recruitment experience turned out to be an important one. That is, results from our fieldwork suggest that "ethical recruitment" may trigger better working conditions in the destination country.

There are other factors, however, that shape the working conditions of IRNs, such as the political and economic conditions in the destination country, and the way these conditions have evolved over time. The extent to which employers commit in tackling issues of equality and diversity in the workplace is also an important factor to consider when investigating the working conditions, as well as when explaining why some IRNs have better conditions than others.

Supplementary research needs to provide robust evidence of causal relations between these factors and their impact on working conditions. In particular, how do political, ethical and economic aspects of international recruitment, equality and cultural diversity actually intersect within health-care organizations?

The report is divided into five chapters. The first chapter comprises the analysis of the institutional context in the UK and the second chapter reports the key findings from the literature review on the working conditions of IRNs in the UK. The third chapter presents the methodology and the fourth and fifth chapters report and discusses the results of the fieldwork research. The main observations are reported in the conclusion.

Chapter 1.
The institutional context and patterns of transformation

In the UK, international staffing of the health-care sector is rooted in the British imperial age and has been progressively institutionalized since the establishment of the Colonial Nursing Service in 1940, which created the "policy foundations" for international nurse recruitment from and to Britain (Solano and Rafferty, 2006: 1056).

Firstly applied to the Commonwealth area mainly for warfare purposes, international staffing was then extended to other regions and has since progressively become part and parcel of the health-care industry in the UK (Buchan, 2002; Kingma, 2006; OECD, 2007; Bach, 2010; Cangiano et al., 2009).

The UK has continued to attract IRNs in order to fill shortages. In the last 20 years, the share of IRNs has increased, accounting for approximately 18 per cent of the total nurse workforce in the UK, although this growth began to decrease starting from the mid 2000s.

In 1998, under a favourable domestic economic situation, the Blair Labour Government initiated a policy of massive NHS workforce expansion across all health professions, which fostered a period of active international recruitment. Memorandums of understanding (MoU) with targeted countries such as India and the Philippines were signed in order to facilitate international recruitment. A mix of factors such as attractive wages, promising working conditions and career prospects, lax immigration laws, and historical linkages succeeded in matching both the desire as well as the desperate need of thousands of nurses from less developed countries to emigrate to the UK in search of a better life (Young, 2011: 314-17; see also Cangiano et al., 2009).

International staffing of nurses has been important to meet such a demand in the UK, but this policy has been put into question by the current government through the implementation of tougher immigration policies and requirements to register as nurses in the UK. Policy changes affecting international recruitment actually started a few years before the Coalition won the election in 2010. Beginning 2005, the policy priorities have progressively changed and the policy of active international recruitment was upturned.

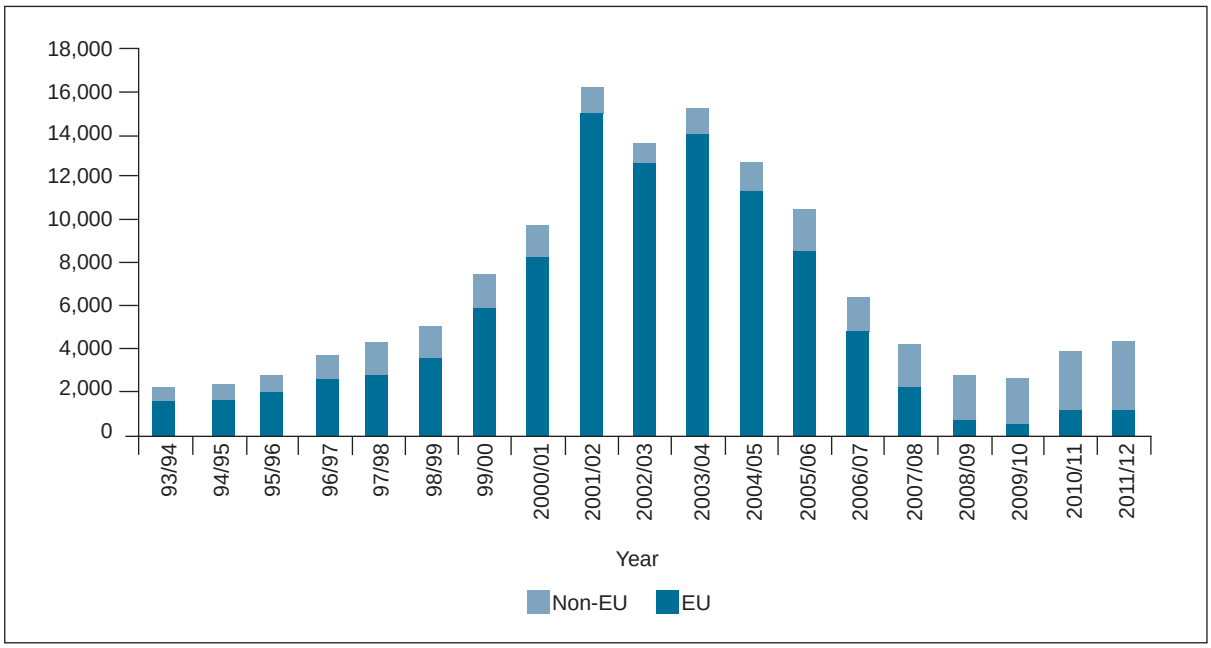
On one hand, there has been a welcomed attempt by national governments to reduce international staffing through encouraging the growth of a domestically trained nursing workforce as a way to respond to the national demand for healthcare. A policy of "self-sufficiency" based on domestic training was started by the UK government in 2003 and accelerated in 2007 when general nurses were omitted from the shortage occupation list (Cangiano et al., 2009: 183). This was considered the best solution to address shortages in the health sector (see also principles 5.4 and 5.5 of the WHO Global Code 2010[3]).

On the other hand, immigration rules in the UK have become more restrictive and changes in licensing requirements have made it more difficult for overseas nurses to gain registration. Additionally, Buchan has highlighted how the period of adaptation in the UK that non-EU nurses applying for registration are

[3] WHO Global Code of Practice on the International Recruitment. Recruitment of Health Personnel. Retrievable at; http://www.who.int/hrh/migration/code/WHO_global_code_of_practice_EN.pdf

required to undertake "represents a significant additional requirement for international nurses" (Buchan, 2007: 10). The change to the education requirements that required all overseas nurses to undertake 20 days of NHS protected learning, and, if required, a period of supervised practice, "not only increased the cost of registration, but there were also shortfalls in the number of places available" (Bach, 2010 : 257). A more selective English language test was also introduced in this period and was implemented in 2007. These developments help in explaining the progressive decline of IRNs annual admission into the UK during the last few years, as showed in Chart 1.

Chart 1: Admissions to the UK nursing registered from EU countries and other (non EU) countries 1993/4 to 2011/12



Source: NMC/ Buchan and Seccombe, 2012: 14

The Figure shows that there has been an exponential growth in the annual admission of overseas nurses into the UK since the early 1990s, reaching its peak in 2001. But the number of nurses in the UK coming from non-EU countries has declined from the beginning of 2004-05 in favour of a substantial growth in the number of nurses coming from European countries[4].

Asian-born nurses have made an important contribution to the UK nurse staffing growth, especially from the Philippines and India. The growth in nursing staff from the Philippines and India has been noted since the late 1990s (NMC Register Statistics, 2001-02). However, the number of NMC initial admissions declined in 2006 (NMC Register Statistics, 2007-08) and has continued to do so since (see also data reported in Lorenzo et al., 2011: 7). Up to 2006, nurses coming from the Philippines, India and China accounted for around 60 per cent of all non-EU nurse registrants in the UK (Buchan and Seccombe, 2006).

[4] This figure must be interpreted with caution owing to the lack of precise data on how many international nurses were recruited to, arrived in, and continued to work in the UK (e.g. Buchan and Seccombe, 2012: 13). There is also evidence of practices in the labour market undertaken both by foreign-born nurses and employers, which may make difficult to gather a reliable figure of the number of IRNs in the UK (e.g. *The Telegraph*: "Freeze on foreign nurses over fake documents fears", 10 Mar. 2013. Available online: http://www.telegraph.co.uk/health/healthnews/9920433/Freeze-on-foreign-nurses-over-fake-documents-fears.html

The Philippines leads the group of Asian countries in supplying nurses worldwide. In 2006, the Philippines supplied 25 per cent of all overseas nurses worldwide and 83 per cent of foreign nurses in the US (Matsuno, 2007: 3). As far as Indian-born nurses are concerned, the registration figures provided by NMC in the UK demonstrate increasing migration of nurses from India to the UK -- only 30 Indian nurses were registered in 1998-99; but this figure had grown to 1,830 by 2003-04 and to 3,551 by 2005-06. By 2005-06, India was one of the most significant source countries, accounting for 41 per cent of all non-European Union (EU) entrants on the UK nursing register.

A broad transformation of international recruitment patterns seems to have emerged in the UK in the last few years. The share of IRNs from the EEA, especially from Eastern Europe, has more than doubled in the last few years and has outweighed the number of annually admitted nurses since 2008-09. This has resulted in a growing activity of recruitment firms in Eastern European countries (Bludau, 2010). It is noteworthy to remark, however, that old colonial ties and the importance of English as a common language -- e.g. in India and the Philippines – continues to influence migration patterns and employers' preferences as well[5].

The reduction in overseas annual admissions may intersect issues of working conditions of IRNs in a complex manner. Some scholars have argued that such reductions may actually hide downgrading patterns in the health-care labour market. Nichols and Campbell (2010) have suggested, for instance, that "reliance on valuable overseas recruits will continue as migrant nurses meet staffing requirements in the UK by working as health-care assistants" (Nichols and Campbell, 2010: 30). Scholars note that such a pattern of downgrading seems to increase demotivation among IRNs, as well as exacerbate already existing problematic relations between nurses and health-care assistants (e.g. Smith et al., 2006; Aboderin, 2007).

There is evidence that moving nursing staff to lower pay bands has been used as a way to cut costs (Snow 2009; see also RCN 2013)[6]. This practice may especially address IRNs who have not yet secured their legal status in the UK. A key informant interviewed for this research reported the case of a Filipino nurse who arrived in the UK in the 1970s who is now retired, but still works as a nurse:

> "She told us that nurses in her trust have been demoted from Band 6 to Band 5. She said she doesn't mind for herself, but younger migrants who now risk not being able to match the requirements for applying for permanent residence."[7]

A key informant of British trade union UNISON reported that IRNs, especially those who had arrived most recently, are powerless against their employers when demanded to accept poor working conditions and downgrading "because they need to keep their job and earning in order to secure their legal status in the UK" (UNISON 2013; see also Cangiano et al., 2009: 184).

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[5] It has been noticed that there is a certain amount of caution from the side of employers about considering non-EU nurses as a temporary component of the labour market, and about the idea that shortages will be progressively filled through internal workforce and health-care workers coming from Europe (Bach, 2910: 262).

[6] A recent opinion of the RCN can be found in the comments of Nursing Standard's editorial, available at: http://nursingstandard.rcnpublishing.co.uk/news-and-opinion/editorial/the-degrading-effect-of-downgrading-staff.

[7] Band refers to pay bands or rates. A list of pay bands can be found on the NHS website at: http://www.nhscareers.nhs.uk/working-in-the-nhs/pay-and-benefits/agenda-for-change-pay-rates/

Another pattern of transformation in international recruitment in the UK that has been noted is the growing number of nurses that leave the country. This outcome may be explained by both the shift to a more accentuated policy orientation in favour of temporary labour migration, and the increased uncertainty among IRNs about job prospects in the UK. There are countries such as Australia and Canada that may be perceived as more attractive in terms of immigration policy, wages and career perspectives. Humphries et al. (2009) conducted in-depth interviews with 21 migrant nurses in Ireland and found that more than half of the respondents were considering leaving for other countries, for the most part because the destination country had failed to provide them with sufficient stability, particularly in terms of citizenship and family reunification. Because helping their families in the home country is often a key motivation for IRNs to emigrate, and because many IRNs wish to re-unite with their children and spouses, issues related to cost of living as well as family reunification should not be overlooked (Nichols and Campbell, 2010: 34). Buchanan et al. (2005) also found that although the majority of the nurses they have interviewed hoped to stay in the UK for a long-term stay (five years or more), many nurses were also considering the possibility of moving to another country.

It has been argued that changes in inflow and outflow trends of IRNs may stem from immediate economic considerations, exacerbated by the progressive deregulation and marketization of the health sector, rather than driven by long-term policy planning (Young et al., 2010; Meardi et al., 2011), with the consequence that the capacity or the willingness of host countries to predict future needs of health professionals may be seriously undermined (Meardi et al., 2011: 5; see also Buchan and Seccombe, 2011). This aspect has several policy implications. Nursing and healthcare in general is a special type of job demanding endless training, high motivation and dedication, and that health service providers are "the personification of a system's core values -- they heal and care for people, ease pain and suffering, prevent disease and mitigate risk -- the human link that connects knowledge to health action" (WHO, 2006).

Chapter 2.
The working conditions of IRNs in the UK: Evidence from the literature

The international mobility of health workers has been widely studied in recent years (Connell, 2010). However, overall the literature has mostly focused on issues of ethics and impact stemming from active recruitment in developing countries -- i.e. impoverishment of healthcare -- whereas lesser knowledge is available on the actual recruitment experiences of migrant workers and their working conditions in the destination countries.

Research in the UK has been more prolific than in other countries, which can be explained by the importance of IRNs' phenomenon in this country. Qualitative and quantitative empirical studies have been carried out from the early 2000s, many of which were commissioned by trade unions and professional associations. Overall, however, research appears somewhat fragmented and mainly explorative due to unviability or difficult access to data. It can be also noted that research was developed mainly within departments of nursing, which explains why the focus is mainly on cultural and managerial aspects. Few studies in the field of industrial relations have attempted to examine the situation of IRNs within the wider frameworks of labour regulation and the political economy in the UK.

The following literature review does not pretend to be exhaustive, but is mainly aimed at disentangling the institutional and economic aspects that influence the of work experiences of IRNs in the UK.

2.1 The regulatory framework

Changes in immigration regulation in the UK -- i.e. recent amendments of employment-related settlement (see Box in the Appendix) -- have not only contributed to the reduction in the number of new non-EU IRNs registered in the UK, but have also mainstreamed the idea that non-EEA migrant health workers are a transitory component of the workforce (Bach, 2010: 262). Additionally, researchers of the Migration Policy Index (MIPEX) have argued that by introducing "earned citizenship" -- stemming from the introduction of the points-based system as the main device of immigration regulation[8]-- integration policies may be discouraged in the UK. In particular:

> On the eve of the May 2010 elections, MIPEX found the recent turn in policies made conditions slightly less favourable for integration. The UK fell ten points -- the most of any country -- and out of the top-10 … If implemented, the long and confusing path to "earned citizenship" may delay and discourage potential citizens and local communities from investing in integration as they had before.[9]

Whether such developments have actually increased uncertainty among IRNs and negatively impacted on their working conditions has yet to be determined by empirical evidence, but previous studies have provided some evidence of this.

Drawing on the notion of uncertainty as defined by Colin Crouch (Crouch, 2009)[10] , Meardi et al. (2011) have conducted a comparative study in the UK and Spain on the employment trajectories of foreign,-trained doctors and nurses. The authors point out that because "for non-EU employees the right itself to stay in the country may be uncertain" and "given the shortage of information, the limited recognition of experience and the need for immediate employment due to visa requirements" migrant health workers "may be prone to accept any job, and then find it difficult to change, without clear career perspectives" (Meardi et al., 2011: 4).

In a similar vein, results of a survey by Cangiano with 557 migrant care workers in the UK indicate a correlation between the uncertainty of immigration status suffered by the skilled health-care workers and inequalities in the working conditions. The authors argue that the "willingness" of migrant workers in the health sector "to accept unattractive working conditions can reflect the constraints related to their immigration status rather than genuine choice" (Cangiano et al., 2009: 184).

[8] Information on the points-based system are available at: https://www.points.homeoffice.gov.uk/gui-migrant-jsf/SelfAssessment/SelfAssessment.faces

[9] UK country profile available at: http://www.mipex.eu/uk

[10] Crouch sees uncertainty as the product of economic globalization and "associated sectoral changes in employment, as well as rising costs of social policy" that "challenged former approaches to reconciling work and welfare based on guaranteeing security to the working population" (Crouch, 2009: 5-6). See working paper -- "The governance of uncertainty and sustainability: tensions and opportunities". Available at: http://www.gusto-project.eu/index.php?option=com_content&view=article&id=68:gusto-paper-21&catid=35:academic-papers&Itemid=57

The costs to access the profession have been gradually increased since the introduction of tougher regulations. Buchan provided a detailed example of how the period of adaptation in the UK that non-EU nurses applying for registration are required to undertake -- according to the Overseas Nurses Programme (ONP) introduced in 2005 -- "represents a significant additional requirement for international nurses" (Buchan, 2007: 10). He noted that "many applicants, even when successful in the initial phase of application, are stuck in the recruitment pipeline -- awaiting a place on an ONP course, or an adaptation place". There is reportedly a significant backlog of international nurses awaiting full assessment before they can register to practice in the UK. In July 2005, the NMC reportedly estimated that there were "37,000 overseas nurses already in the UK who are unable to start work because they cannot find supervised practice placements" (Buchan, 2007: 10-11).

Similar constrains were found in Canada by Walton-Roberts and Hennebry (2012), who investigated the experiences of internationally educated nurses from the Philippines and India who intended to enter Ontario's nursing profession indirectly via temporary migration streams (Walton-Roberts and Hennebry, 2012). Additionally, the authors argue that the complexity and diversity of migration pathways for IRNs open the door "to greater propensity for exploitation and abuse from employers, recruiters, and others who might profit from these migrants while they attempt to navigate the system or complete eligibility requirements" (Walton-Roberts and Hennebry, 2012: 21).

2.2 Recruitment practices

The literature has provided evidence that IRNs are often subject to fees for recruitment that in extreme circumstances can amount to creating an indentured employment relationship. Many more are given inadequate information about their placements and face unexpected challenges upon arrival within the destination countries. These problems have been reported even in countries with advanced legislations on labour protection (e.g. see Connell, 2010: 118-119).

Non-statutory regulation mechanisms have been implemented in the last few years to tackle these problems. Codes of practices for recruitment, bilateral and multilateral agreements are cases in point. A number of recruiting countries, including the UK, have adopted codes of ethical recruitment to tackle abuses in international recruitment. Some sending countries also have developed codes of conducts to protect their workers. Viet Nam Association of Manpower Supply (VAMAS) introduced a Code of Conduct (COC-VN) for recruitment agencies in 2010 with the support of the ILO. The Philippines has developed its own system to increase the protection of migrant workers from abuses. The success of codes and agreements seems to be still limited, however, because they are voluntary and because recruitment agencies tend to move the "geographical focus of their operations rather than modifying practices" (Connell, 2010: 119).

Concerns about unfair pratices of recruitment and their impact on reputation are widespread among firms in the sector. Manpower associations are taking initatives to a) improve self-regulation and monitoring mechanisms; and b) foster business case for ethical recruitment. The International Confederation of Private Employment Agencies (CIETT) is a case in point. It shows strong commitment with the regulatory framework stemming from ILO conventions and imperatively requires associate agencies to adopt strict non-fees policy for recruitment.

International recruitment practices in the health sector are difficult to assess, especially since private recruitment agencies have become gatekeepers in the recruitment process (Bludau, 2010). The lack of access to data and the increased complexity of the recruitment system, which encompasses international firms, local recruitment agencies, individual brokers and an array of regulatory frameworks, pose challenges to research in this field.

Probably the only research that has provided robust empirical evidence is the one Pittman carried out in the US in 2012. She used a web-based survey to investigate the recruitment experiences of 502 foreign-educated nurses (FENs) who had received a VisaScreen[11] between 2003 and 2007 to work as nurses in the US. The sample includes both nurses recruited by agencies (active recruitment) and nurses who found jobs in the US on their own (self-directed). Problems in recruitment were assessed with references to the Voluntary Code of Ethical Conduct for the Recruitment of Foreign-Educated Health Professionals to the United States. Pittman found that 50 per cent of actively recruited nurses experienced recruitment practices that explicitly contravene with the code (Pitman et al., 2012).

Similarly to the findings provided by Pittman in the US, Allan and Larsen (2003) observed that nurses recruited directly by UK employers were in a better situation than nurses recruited from private agencies (Allan and Larsen, 2003: 38). Drawing on the results of 380 interviews with internationally recruited nurses in London, Buchan found that two-thirds of respondents had used the services of a recruitment agency and a majority had to pay for services provided by the agency (Buchan et al., 2005: 9). Nurses interviewed in that study also reported that the recruitment agencies they had used provided them misleading information about their pay and working conditions in the UK (ibid: 18).

Buchan also found that many IRNs had initially worked in the UK for private-sector employers before moving to the NHS. Buchan argued that "back-door recruitment" is often hidden in this pattern of recruitment (Buchan et al., 2005: 8). According to the author, the NHS became the end-beneficiary of recruitment practices of the private sector employees, including employing IRNs from countries where the NHS is otherwise prohibited from actively recruiting. This does not contravene the Department of Health Code adopted in 2004, but it does help to explain why in the years 2004-05, the share of nurses entering the UK from developing countries on the NHS "banned" list accounted for about one in four entrants from all non-EU countries (ibid: 19)[12].

Alonso-Garbayo and Maben (2009) have also found that IRNs interviewed in their study reported having been provided with insufficient, inaccurate and sometimes misleading information during the recruitment process. Authors argued that this can generate "unmet expectations, causing a negative impact on their psychological contract with the employer, their motivation and potentially on their intention to stay or to leave" (Alonso-Garbayo and Maben, 2009: 8).

[11] Visa Credentials Assessment Service is "a programme that requires specific health-care professionals to complete a screening programme before they can receive either a permanent or temporary occupational visa" in the US (http://www.cgfns.org/services/visascreen/)

[12] Dumont and Zurn (2007) provide another explanation for why, in some cases, codes of conduct have limited impact. The authors suggest that factors such as "the quality of training, network effects, and the size of the pool of health workers" in some countries such as the Philippines and India keep high the share of international mobility of the health workers coming from these countries (Dumont and Zurn, 2007: 187).

The UK Department of Health implemented a non-binding code of practice on international recruitment of health workers in 2004 (DH 2004)[13] and a guidance on international nursing recruitment in 2005. The UK's code prohibits active recruitment of health-care professionals from countries on the banned list and requires that all international recruitment by health-care employers have to demonstrate a sound ethical approach. The code explicitly states that international health-care professionals will not be charged fees in relation to gaining employment in the UK: "Any recruitment agency registered within the UK charging fees to applicants will be in contravention of statutory employment agency legislation[14]… Employers should also satisfy themselves that UK recruitment agencies with whom they contract are not in any partnership agreement with agencies in other countries who allow fee charges to individuals solely for the purpose of placement within the UK" (Department of Health 2004: 14).

When it was initially implemented the code was binding on the public sector, however with the advent of NHS trusts it became voluntary. NHS Employers, the sectors employers' organization, strongly encourages their members to abide by the code when they recruit both directly and through employment agencies. In fact there is the risk that other intermediaries -- recruitment agencies or individual brokers -- intervene especially at the source of the recruitment process. Abuses in recruitment at this stage are not easy to prevent unless the recruitment chain is accurately scrutinized by local authorities, manpower headquarters and employers.

The lack of access to data limits the possibility to verify the extent to which employers actually comply with the code. Furthermore, as Buchan has remarked, the "Department of Health Code covers some, but not all private sector employers, and does not prevent health professionals taking the initiative to apply for employment in the UK" (Buchan, 2007: 13).

2.3 IRNs' work experiences and working conditions

Trade unions and professional organizations were among the first in the UK to foster investigation into the working conditions of IRNs (e.g. Pike et al., 2005; UNISON, 2009). A common set of problems -- i.e. job segregation, barriers to professional development and insidious discrimination -- can be drawn from these findings and other evidence from the literature.

Diversity in professional and ethnic backgrounds may be the origin of conflicting interpretations of the roles, tasks and expectations unless diversity is properly appreciated and managed by the employer. Difficulties can stem from insufficient language proficiency, prejudice of the patients, different job routines and interpretations of work tasks. Evidence of these difficulties was first provided by ground-breaking studies commissioned by the Royal College of Nursing (RCN) in the early 2000s. For example, Allan and Larsen carried out 11 focus groups across three UK cities involving 67 IRNs from 18 different countries with long experience of working in the UK (Allan and Larsen, 2003). Participants of the focus groups reported having experienced both vertical and horizontal discrimination often stemming from poor diversity managment.

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[13] Web pages and file repositories on the Department of Health in the UK have changed over time. The Code of practice (April 2014) can now be retrieved online at: http://webarchive.nationalarchives.gov.uk/20130107105354/http://dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4097734.pdf. More details about the code, guiding principle and good practices can be retrieved on the NHS Employer website at: http://www.nhsemployers.org/RecruitmentAndRetention/InternationalRecruitment/Code-of-Practice/Pages/Code-practice-international-recruitment.aspx

[14] Background legal provisions can be found in the Employment Agencies Act 1973 and the Conduct of Employment Agencies and Employment Businesses Regulations 1976 and 2003.

> "IRNs gave reports of being excluded from the solidarity of their UK colleagues. Many experienced a radical drop in status, coming from a senior nursing position in their home countries to working under the supervision of untrained care assistants in the independent sector." (Allan and Larsen, 2003: iv).

Authors discovered that IRNs in the NHS tend to be in a better situation than IRNs working in the private health facilities, however.

In a similar vein, IRNs interviewed by Smith et al., (2006) widely reported that motivations, skills and experiences were not sufficiently recognized in the workplace. Scant attention, as authors argued, may stem from changes in the organizational settings of health-care facilities such as the increasing segmentation and hierarchy in the field of nursing specialist expertise (see also Daniel et al., 2001 and Buchan et al., 2005b).

As argued in the previous section, working conditions seem to be partially shaped by changes in immigration regulation. Increasing uncertainty of legal status may expose IRNs to more pressure from employers, as well as increases their propensity to accept tougher working conditions. IRNs in the process of obtaining permanent residence and citizenship may be a case in point. Given the centrality of financial eligibility for obtaining permanent residence and citizenship, IRNs need to secure employment and earnings and therefore have a higher propensity to accept pressure in the workplace. This issue was frequently addressed by key informants of unions interviewed during the fieldwork.

Meardi and his colleagues noted that patterns of segregation and vulnerability among IRNs in the UK and Spain tend to translate into worse shifts, professional hurdles and deskilling. They also noted a tendency to allocate nurses to basic care tasks only. Deskilling and qualifications issues, "path dependency" in nurses' professional trajectories, and segregation between sectors -- "in the private sector rather than in the more 'secure' public sector" -- emerge as the major constraints that shape the working conditions and career prospects of IRNs both in Spain and in the UK (Meardi et al., 2011: 12-15; see also Buchan 2007: 9-10).

A recent study conducted by the RCN among nurses in the UK shows that IRNs seem to be significantly exposed to the worsening of working conditions stemming from cuts in funding in the NHS and sectorial reforms (RCN, 2013). This study and other investigations show, however, that nurses in general are facing a hard time in coping with changes in the health-care sector in many European countries. A recent survey (Aiken et al., 2013) undertaken in 488 general acute care hospitals in 12 European countries, including England, shows that a "sizeable fraction of nurses in every country perceive that care has deteriorated over the preceding years" (Aiken et al., 2013: 152). This survey shows that "nurses in hospitals across Europe are rationing care because of high workloads, and have concerns about eroding quality of care and insufficient priority by management on patient safety" (Aiken et al., 2013: 144).

As far as England is concerned, the survey sampled almost 3000 nurses -- in 46 hospitals, among whom 16 per cent are foreign-educated nurses. According to authors, England is among the countries with the highest proportions of nurses disappointed with their job and career opportunities. England also reports one of the highest proportions of nurses who intend to leave their current job within one year and who consider their work environment as "poor/fair" (Aiken et al., 2013: 147-148).

Chapter 3.
Methodology

Drawing on the common framework of problems discussed in the previous sections, fieldwork research was designed and carried out in the UK. The fieldwork consisted of interviews with key informants and a survey among IRNs.

3.1 Interviews with key informants

In-depth interviews with key informants were aimed at collecting information on a) past, current and future trends in international stuffing of nurses in the UK; b) recruitment practices; c) regulatory framework; and d) policy issues. Given the explorative nature of the fieldwork, interviews were open and adapted to the role and the type of organization of the interviewees.

The key informants were identified from among the organizations in the UK most relevant to dealing with IRNs. A snowball procedure was used to select potential key informants. Inputs collected from desk-research, literature review and personal networks generated a comprehensive list of potential key informants who were contacted from January to March 2013.

After a long process of email exchanges, phone conversations and coordination with other colleagues who were arranging interviews in the UK during the same period for similar purposes[15], we succeed in interviews with representatives of five organisations were sucessfully carried out. Namely, a total of nine individual interviews and one group interview with four key informants were carried out in London during April 2013. Some key informants were re-contacted during the implementation of the fieldwork in order to get more inputs and triangulate information as well. Repeated interviews through email exchanges and phone calls enabled us to clarify and deepen some aspects of the research. Personal interviews involved persons from the following organizations and departments:

1. Royal College of Nursing, Research Unit -- face-to-face interviews (repeated interviews);
2. Migrants' Rights Network -- face-to-face interview (repeated interviews);
3. UNISON, National Strategic Organizing Unit -- face-to-face interview (repeated interviews);
4. UNISON, Head of Nursing -- face-to-face interview (repeated interviews);
5. UNISON, Filipino Activist Network; Coordinator in Scotland -- phone interview;
6. UNISON, Representative of the Filipino Community -- face-to-face interview;
7. UNISON, South West London Community;

[15] Piyasiri Wickramasekara and Agnieszka Makulec were also commissioned by the ILO to conduct studies within the framework of the Decent Work Across Borders Project during the period. In some cases we shared information collected from key informants that would have benefitted respective research.

8. NHS Employers, Programme Lead for healthcare science & international recruitment -- phone interview (repeated interviews); and

9. Kanlungan UK -- phone interview.

The group interview was made with the Philippines Embassy in London and included persons of the following offices:

1. The Office of the Labour Attaché;

2. Consular General;

3. First Secretary and Consul; and

4. Welfare Officer.

The higher number of persons interviewed within UNISON is explained by the availability of several key informants in this organisation who had direct experience dealing with IRNs. UNISON is indeed the UK's largest public service union with local branches and health facilities across the country. It also has a well-developed Filipino activist network working with IRNs.

Several potential key informants of the Indian community in the UK were also contacted, but the outreach strategy did not translate as well as it did for the representatives of the Filipino community. Conversely, referees of the Indian community in the UK proved to be more helpful in channeling the online survey, as explained in the next section.

3.2 The survey

There is little official information on the employment trajectories and working conditions of IRNs in the UK. The UK Labour Force Survey includes nurses and health-care assistants and allows a distinction between foreign-born and native workers to be made. However, the low number of cases does not actually allow the analysis of working conditions to be investigated.

The only organization who makes considerable empirical work on this category of workers in the UK is the RCN, which carries out a regular employment survey among nurses in the UK and takes into consideration the national backgrounds of nurses and several aspects of working conditions[16]. The RCN's survey was thus used as the main reference in this study in order to compare the results of our fieldwork. Several questions in our questionnaires were actually borrowed from the RCN survey and discussed with research persons at the RCN.

Several qualitative studies previously carried out in the UK on IRNs were also used to interpret our results in a comparative perspective. In particular, this approach helped to cushion the risks stemming from the self-selected nature of our sample. It was in fact not possible to create a random sample due to

[16] The RCN Employment Survey has been ongoing since the 1980s; 24 surveys have been implemented up to 2013.

the impossibility of accessing existing official databases and obtaining disaggregated data and personal contacts of potential respondents. Given this constraint, a web-based questionnaire was considered as an optimal strategy to collect information from IRNs.

There are several biases that could have originated from a self-selection sample. Bias in resulting data can stem from the fact that respondents' propensity for participating in a study is likely to be correlated with the substantive topic the researchers are trying to study. As far as this study is concerned, this bias might have resulted in a higher participation rate of IRNs concerned with issues of working conditions. This hypothesis cannot be fully checked. What the data collected show, however, is that we gathered respondents with an array of experiences, attitudes and opinions regarding their situation in the UK.

The channels of the survey may also generate bias. One organization -- i.e. an online portal very popular among the Indian community in the UK -- was, as it is argued next, particularly effective in channelling our survey through their website. It is a comprehensive news portal mainly dedicated to people from the Indian state of Kerala living in the UK with more than three million monthly page views[17]. To the best of our knowledge, such characteristics do not raise major concerns about specific bias that may generate from responses gathered by visitors of this website -- i.e. political orientations -- except for the obvious fact that many questionnaires were filled from Kerala-born nurses.

Another type of bias may originate from digital divide. As the survey was delivered online, this aspect might have constituted a major challenge. A number of actions were taken in order to mitigate this risk. The outreach survey strategy targeted an array of organizations and informal groups to spread the survey throughout their digital channels (websites, social networks, newsletters etc), but also through traditional channels such as radio and posters. Approximately 100 printed questionnaires were also delivered to referees of the Indian and Filipino communities in London. This action was meant to facilitate the access to the questionnaire to nurses who might not have easy access to the Internet. However, nobody actually returned a printed questionnaire, and referees explained that nurses they had contacted said they would have rather preferred to fill in the online form. Therefore, digital divide did not seem to constitute a major constraint for the outreach strategy.

The questionnaire was designed and administered online with LimeSurvey[18]. It was in English as we assumed that IRNs have a good knowledge of this language, since this is a strict requirement to register and work in the UK. A draft version of the questionnaire was delivered in February 2013 and reviewed by the ILO Office in Manila.

A second draft was delivered in March drawing on new inputs received by the research unit of the RCN in the UK and by the ILO. In the meantime, the functionalities of the online questionnaire were tested by persons belonging to different organizations (RCN, ILO, European University Institute) and by some nurses in the UK contacted through personal networks. The final version was tested and finally published online during the third week of March. Login data collected by LimeSurvey estimated the time needed for respondents to fill out the questionnaire to be between 25 and 30 minutes. The online system allowed respondents to save, complete and return the questionnaire at their leisure.

[17] Statistics can be retrieved at: http://urlm.co.uk/www.britishmalayali.co.uk
[18] http://www.limesurvey.org/

The access to the online questionnaire did not require previous registration. This might have resulted in false respondents or repeated responses. These risks were reduced through several technical features, such as setting cookies in order to limit the access to the questionnaire from the same machine after the questionnaire was completed and returned, and monitoring the Internet Protocol (IP) of respondents to check from where the questionnaire was filled. The rule was to exclude questionnaires returned from outside the UK and to keep only the first questionnaire in case more than one was returned from same IP. Consequently, only a few questionnaires were excluded for these reasons.

A list of inclusion criteria was elaborated and monitored across the survey in order to re-adjust the outreach strategy.

3.3 Inclusion criteria

a) Target: the survey included only Indian and Filipino-born nurses in the UK who had either immigrated to the UK direct from their country of origin, or from another country.

b) Employer: NHS, independent and private health facilities.

c) Gender: official statistics indicate that women predominate among IRNs. We therefore expected more women answering the questionnaire than men.

d) Year of arrival in the UK: drawing on official data, we expected that most of the respondents arrived in the UK between the 1990s and early 2000s, but recent migrants were particularly welcome.

e) Recruitment process: both nurses directly recruited by the employer in the UK and nurses recruited through the intermediation of recruitment agencies in the UK and in their countries of origin.

f) Geographical distribution: potentially all UK regions, although we expected many respondents working and living in the London area.

Most of the criteria listed above were matched, and 433 questionnaires were collected between March and June 2013 from IRNs working throughout the UK in both NHS and private health facilities. Almost eight in ten respondents are women, with the majority aged between 31 and 40.

Table 1: Respondents by sex and age
(N = 433)

	Women	Men	Total	Total
	N	N	N	%
25-30	19	11	30	6.9
31-40	201	55	256	59.1
41-50	97	23	120	27.7
51-65	22	5	27	6.2
Total (N)	339	94	433	100.0
Total (%)	78.3	21.7		

Approximately nine in ten respondents are married and have children living with them in the UK. We gathered IRNs who were recruited both through direct mechanisms and through the intermediation of private recruitment agencies. Almost all areas in the UK are covered by the survey (see next section for details).

The country-of-origin's criterion was not fully satisfied. The online questionnaire was filled in mainly by Indian-born IRNs. Thirty-six valid questionnaires were collected from Filipino-born nurses and 397 form Indian-born nurses, out of which 384 respondents come from Kerala. Such a high number of respondents being IRNs from Kerala stems from two reasons: 1) the high number of nurses from Kerala in the UK; and the survey was advertised on one of the most popular online portals of the Kerala community in the UK. This strategy turned out to be particularly successful.

According to Walton-Roberts and Rajan (2013), Kerala owns a leading position among Indian states in training nurses. It is distinct from many other states in India "because it has a long tradition of female education, nurse training and migration rooted in the state's history of Christianity … Historically since the 1970s mostly Christian women from Kerala have trained as nurses in order to emigrate to the Gulf Cooperation Council (GCC) and OECD nations" (Walton-Roberts and Rajan, 2013: 1-2).

The survey was advertised on the website British Malayali[19]. According to the editor of the web portal, Mr Shajan Scaria, the portal has over 25,000 UK-based Indian nurse readers (private communication). As a result, a large number of nurses who completed the survey were transferred to the questionnaire through the link posted on British Malayali.

This can be seen as an achievement, not only due to the high number of respondents, but also due to the fact that the working experience of Kerala-born nurses in the UK is almost unknown. This is despite the fact that India supersedes other Asian countries -- e.g. the Philippines -- as the most significant source country of recruitment of international nurses. The registration figures provided by the Nursing and Midwifery Council in the UK demonstrate increasing migration of nurses from India to the UK. Only 30 Indian nurses were registered in 1998-99, but this figure had grown to 1,830 by 2003-04, and to 3,551 in 2005-06. By 2005-06, IRNs from India accounted for 41 per cent of all non-European Union entrants on the UK nursing register.

[19] http://www.britishmalayali.co.uk/

Referees and channels of Filipino community in the UK were the target of the survey outreach strategy, but it didn't translate as well as it did for the Indian community. As soon as this figure emerged from the monitoring of the online survey, interviews with key informants were partially rearranged in order to deepen the knowledge of the situation of Filipino-born IRNs in the UK. However, we are aware that the low number of Filipino-born respondents does not allow for comparisons to be made.

The questionnaire comprised seven sections for a total of 90 questions :

1. socio-demographic information;
2. current employment;
3. education and training;
4. working conditions;
5. recruitment;
6. migration trajectory; and
7. living in the UK: social and institutional aspects.

Several questions were aimed at collecting respondents' self-assessments of different aspects of their recruitment experience and working conditions. Some questions borrow or adapt from other sources such as the European Working Conditions Surveys (EWCS) -- Eurofound[20]; the RCN Employment Survey[21], the National NHS Staff Survey[22]; Cangiano et al., 2009; Buchan et al., 2005; Pittman et al., 2012; and the Return Migration and Development Platform[23].

Chapter 4.
Arrival and life in the UK

4.1 Reasons for emigrating and choosing the UK

Respondents did not emigrate because they did not have a job. Nine in ten respondents worked in the health sector before emigrating (see Table 5). Table 1.1 shows that improving working conditions was by far the main reason motivating respondents to emigrate, followed by a "better wage" and professional aspirations such as "to gain career progression" and "to gain experience working abroad".

[20] Available at http://www.eurofound.europa.eu/ewco/surveys/index.htm
[21] http://www.rcn.org.uk/support/the_working_environment/employment_relations_publications
[22] The 2013 version of the NHS Staff Survey can be obtained here: http://www.nhsstaffsurveys.com/Page/1035/Survey-Documents/Survey-Documents/
[23] Available at http://rsc.eui.eu/RDP/

Similarly, Kodoth and Jacob (2013), who conducted interviews with Indian nurses from Kerala in Denmark and the Netherlands, found that interviewees emigrated mostly for increasing earnings. But working conditions, the experience of life and working overseas, and the desire to travel were also mentioned as important motivations (Kodoth and Jacob, 2013: 45-46; similar evidence in Buchan et al., 2005).

Table 1.1: Respondents' three main reasons for leaving their country of origin or their former country of immigration, in percentage (N = 433)

	First reason	Second reason	Third reason
Lack of job prospects	7.4	2.5	1.8
Looking for better working conditions	38.8	12.2	12.2
I had a job offer abroad	4.2	3.7	2.3
Looking for better wages	21.0	26.6	14.1
To gain experience from working abroad	6.0	13.9	10.9
To gain career progression	8.1	14.8	15.9
To help my family	4.8	12.9	17.8
My family pressed me to leave	0.0	0.5	0.7
Adventure	0.0	0.2	0.5
To join my family abroad	1.8	1.2	3.2
To change lifestyle and live in a different culture	1.6	5.1	7.2
Other personal reasons	0.5	1.2	6.2
No specific reasons	5.8	0.7	1.6
Total (%)	100.0	95.4	94.5
Missing (%)	0.0	4.6	5.5
Total (%)	100.0	100.0	100.0

Overall, the selection of the UK as the destination country by the respondents appears to be based on access to opportunities and individual aspirations. Most respondents reported that having a job offer was the main reason for choosing the UK over other countries. Again, most of the respondents chose the UK wishing to find “better working conditions”, a “better wage” and “more career opportunities”. The knowledge of the language, the desire to live in the UK and other personal and family reasons also turned out to be important factors for choosing the UK.

Table 2: Respondents' main reasons for choosing the UK, in percentage (N = 433)

	First reason	Second reason	Third reason
It was easier to get a visa	5.3	4.0	1.6
I had a job offer	28.4	6.2	4.6
Better working conditions	20.6	15.3	9.7
Better wages	11.3	22.0	15.9
More career opportunities	7.2	18.0	14.3
It wasn't really my own choice	2.1	2.5	1.2
To join my family/friends	5.3	4.0	5.8
I knew the language	3.7	11.4	8.5
I just liked the idea of living in the UK	5.3	8.6	8.5
Presence of a big community from my home country	0.0	1.0	2.3
Other personal reasons	3.5	4.0	11.3
No specific reasons	7.4	3.2	4.8
Total (%)	100.0	100.0	88.7
Missing (%)	0.0	0.0	11.3
Total (%)	100.0	0.0	100.0

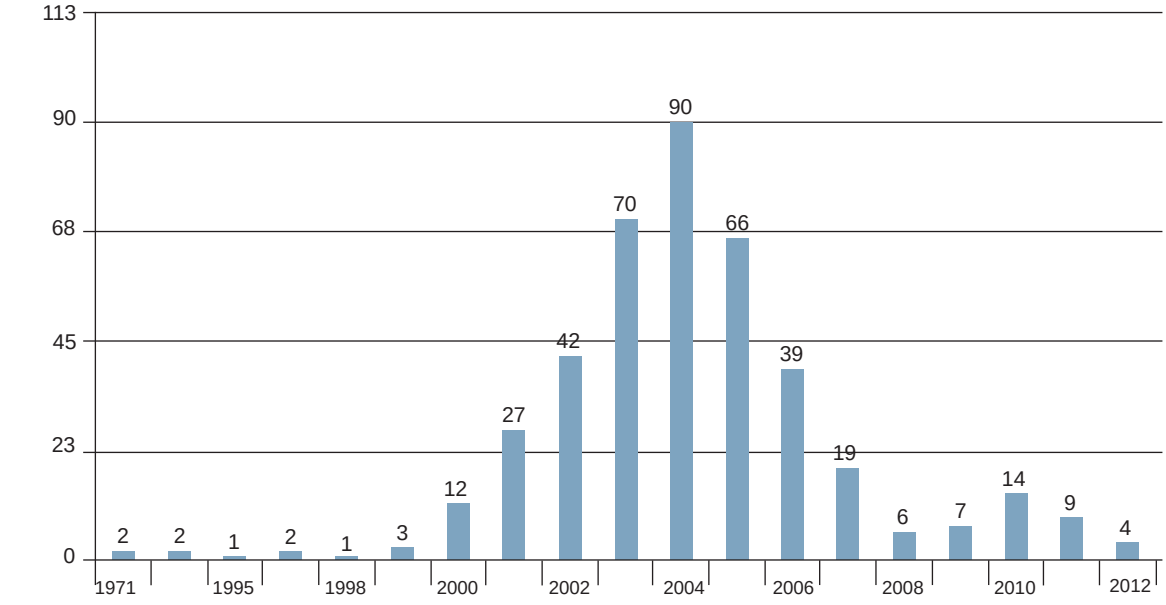
Preferences of respondents for the UK may also have been shaped by opportunities given by the UK in the early 2000s to foreign-born nurses for working in the UK, and more specifically by the active recruiting in India and the Philippines.

Data analysis shows that among respondents for whom the UK was the second-step in their migration experience (henceforth "2nd step-IRNs"), they seemed to be more concerned about working conditions. There is a higher proportion of respondents among those who selected the UK wishing to improve their working conditions than among respondents who moved to the UK directly from their country of origin (30 per cent and 18 per cent respectively). Most of 2nd step-IRNs, as argued in the next paragraph, were probably in the Middle East region before moving to the UK. Unfortunately, data does not allow this finding to be investigated deeper, but previous studies suggest that an increasing number of Indian IRNs move to Europe and the US as a second, or eventually the final step, of their migration cycle (Issac and Syam, 2009). Nair and Percot (2005) note that "becoming a nurse in India today is in effect preparing to leave one's homeland, if not forever, at least for long periods of time", and that many Indian nurses move in a "step-by-step phased manner: first within Indian states, mainly to metropolises, then to countries in the Persian Gulf, and further towards the West" (Nair and Percot, 2005: 2).

4.2 Entry in the UK

The evolution of respondents' year of arrival in the UK is consistent with the overall picture provided by official statistics presented in chapter 1. As Chart 2 shows, the majority of respondents arrived in the UK between 2002 and 2006. This period is characterized by lax immigration laws and a massive NHS workforce expansion across all health professions that encouraged international recruitment.

Chart 2: Respondents' year of arrival in the UK, in numbers
(N = 416)



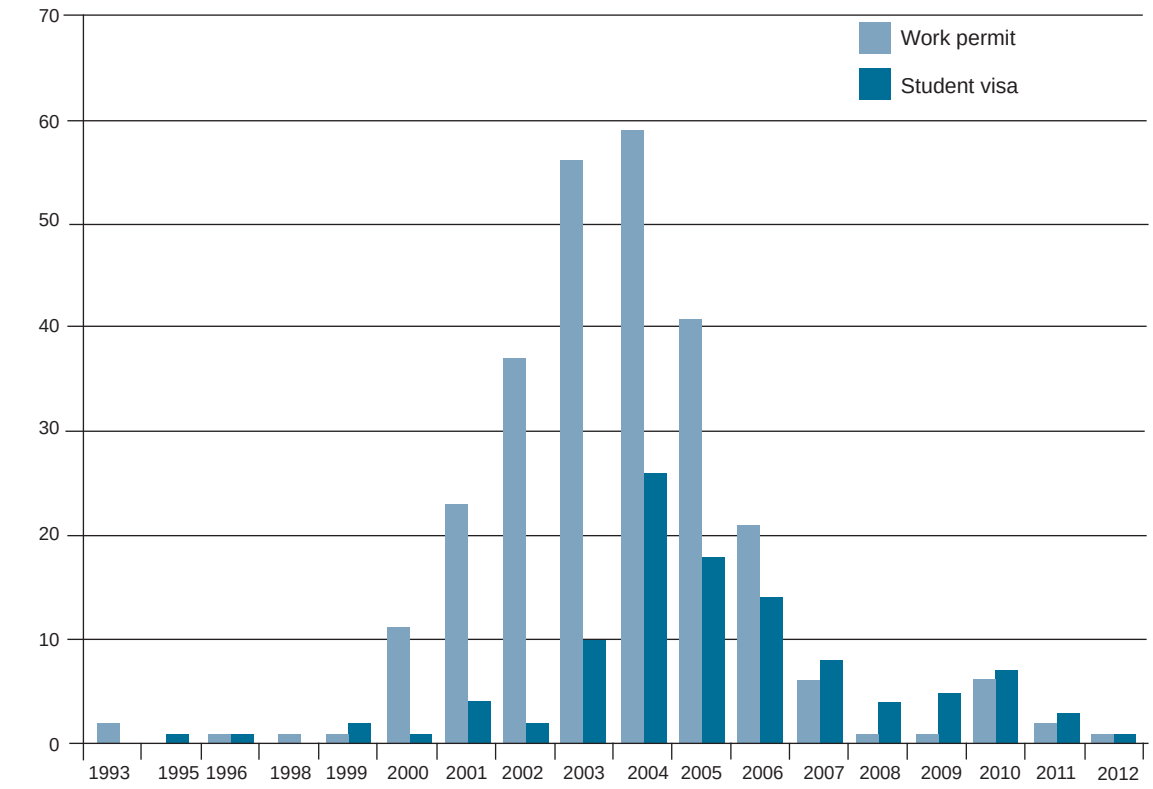
Missing cases = 17

Seven in ten respondents came into the UK directly from their home country, whereas three in ten lived in another non-European country before arriving. Although the survey did not include a question regarding the country where respondents were prior to the UK, their former country of immigration was probably in the Middle East region. India, or more precisely Kerala, has been a source of nurses for the Middle East since the 1960s, a movement that gained momentum in the 1970s with the oil boom in the Middle East (see for e.g. Nair and Percot 2005). The duration of the migration experience of 2nd step-IRNs respondents is longer than the one for respondents who moved to the UK directly from India or the Philippines; they have lived abroad, on average, 7.6 years and 5.8 years respectively.[24]

The majority entered the UK with a work permit (overall 64 per cent), but a student visa was also common (overall 25 per cent).

[24] Four in ten of 2nd step-IRNs have lived abroad between 11 and 16 years, and four out of ten for more than 16 years. Overall, the duration of the migration experience is more than ten years for approximately half of the sample.

Chart 3: Number of respondents entered in the UK with a work permit and student visa by year (N =377)



Note: Respondents entered with other types of visa = 33. Missing cases = 23.

Data reported in the chart shows a progressive increase in the number of respondents who entered the UK with a student visa from 2004; student visas became the predominant mode of entry from 2007 onwards. This result may stem from changes in the regulation framework. As explained in the first chapter, in 2006 the UK government removed general nurses from the government's shortage occupation list, but nurses from the Philippines and India continued to arrive in the UK as students. Several key informants interviewed during the fieldwork reported that many nurses arrived in the UK as students, but with the idea of working as nurses after a period.

> "Students, together with senior care workers, represent the last generation of nurses. In fact, only a few Filipinos have succeeded in coming into the UK in recent years as registered nurses. But many others, we don't exactly know how many, came into the UK via student visas. Senior care workers were hoping to become nurses, but this has not happened, due to legal constraints and a lack of job opportunities". (Interview with Filipino Embassy in London, April 2013).

Similarly, key informants of UNISON interviewed during the fieldwork estimated that a high number of students have fallen into the "immigration trap":

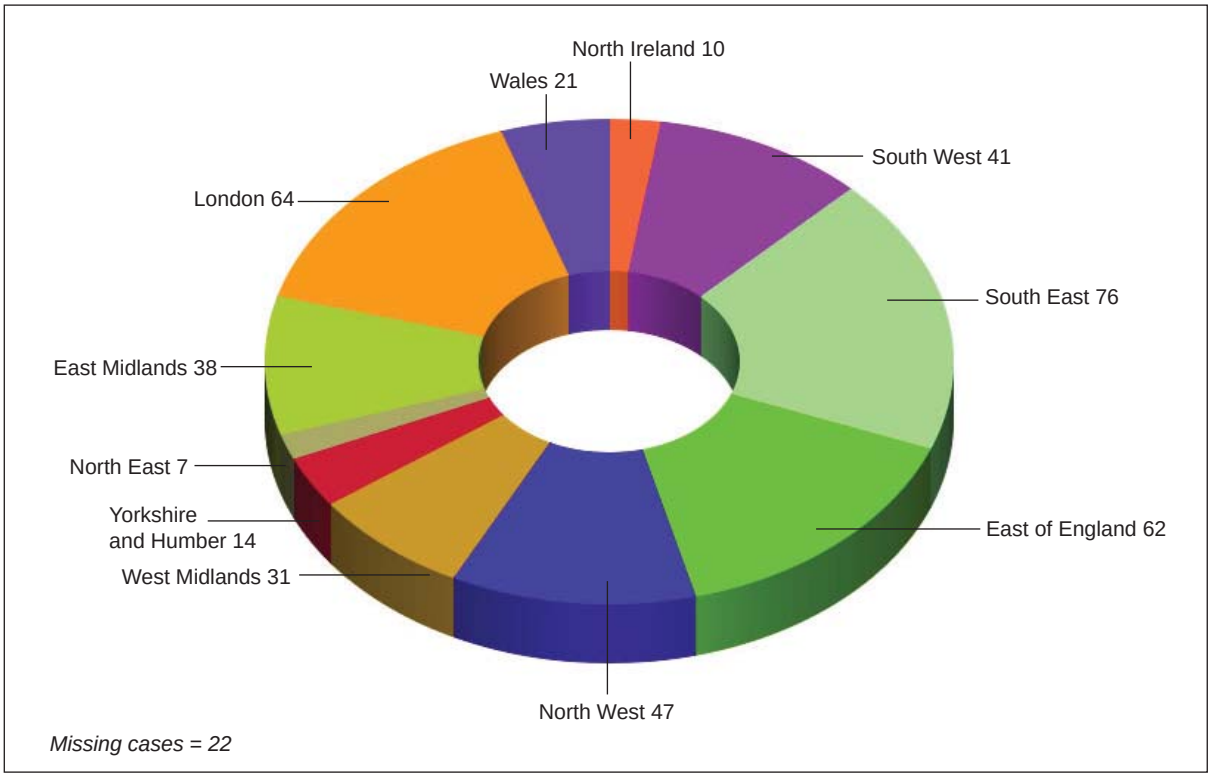
> "They came as students but actually they were nurses in the Philippines and are now working part-time as carers. When in 2008-09 the government stopped recruiting care workers and general nurses, recruitment agencies in the Philippines told them to come as students. Despite the fact they were already trained and even working as nurses, many hoped to find a sponsor for the adaptation and an employer who would have sponsored and hired them. Many came, they found rubbish courses, and no one told them that they couldn't work. In the meantime, the work permit mechanism was replaced by the points-based system. Many of them became undocumented. The exact number is not known but we know that they were many: an assisted voluntary return programme, mostly targeted to refugees, was carried out by a charity in collaboration with the IOM (International Organization for Migration). The Home Office told the charity that Filipinos in such a situation could have also been assisted. In the end they were in the top ten countries list assisted by the programmes". (Interview with UNISON, London, April 2013).

Given the low number of respondents arriving in the UK from 2008 onwards -- a period characterized by the introduction of a tougher immigration regulation -- we cannot actually assess if and to what extent changes in immigration regulation correlate with working conditions of these respondents. Data from our survey show that most of the respondents who entered with a student visa found their way to change their legal status in the UK, and to work in health-care facilities. Half of them became UK citizens, while others became permanent residents or succeeded in extending the duration of their visa.

4.3 Life in the UK

The Chart 4 survey covers all of the regions in England -- most of the respondents have settled in the south and in the east of England, and many in the London area. The survey also received a few respondents from Wales, Scotland and Northern Ireland.

Chart 4: Regions where the respondent lives in the UK, in numbers (N = 411)



The majority of the respondents live in large urban areas (60.3 per cent) -- e.g. London, Manchester, Essex, Cardiff, Glasgow -- followed by medium urban areas (25.3 per cent) -- e.g. Aberdeen, Brighton, Derby, Southampton -- and small cities (14.2 per cent) -- e.g. Chester, Dundee, Exeter, Norwich). Only a few respondents reported living in rural areas[25].

Overall, almost nine in ten respondents reported a change in their legal status while in the UK. Among those who have changed status, 67 per cent became UK citizens, 26 per cent obtained permanent residence, and 7 per cent extended their permit. Only one respondent reported that their permit had expired.

As mentioned in the previous section, almost all respondents live in the UK with their spouse and children. On an average, their household comprises four to five members. For almost seven in ten respondents, their families joined them after settling in the UK. However, many respondents (40 per cent) had some family members already living in the UK when they arrived and overall, seven in ten respondents had social connections in the UK, such as family members, friends or colleagues. Several respondents also shared their emigration journey with friends or colleagues (28 per cent and 18 per cent respectively).

[25] The distinction between urban and rural areas and between large, medium and small urban areas draws on the UK 2011 Rural Urban Classification, retrievable online at: https://www.gov.uk/government/publications/2011-rural-urban-classification

Very few respondents reported benefiting from an external support -- i.e. from public authorities, employee associations, social organizations or trade and professional unions -- during the move to the UK and after their arrival. Since many respondents had family members and friends already settled in the UK, one may presume that these contacts were mobilized by respondents to settle in the UK. Other studies have showed the importance of the diaspora as a supportive resource for migrants in the UK (e.g. Della Giusta and Kambhampati, 2006). After their arrival, only few respondents, 29 to be exact, reported having contacted trade and professional unions, mainly for legal matters related to work and family, as well as to get information about employment-related matters. A representative of UNISON interviewed for this study pointed out the following:

> "IRNs often come to us only when other channels have not worked out. Filipino nurses, for instance, often find solutions to their problems through the mobilization of social contacts within the Filipino community." (Interview with UNISON, London, April 2013).

As Table 3 shows, social contacts outside the workplace and the family environment develop mainly with people with the same origins. Only one third of the sample reported having regular contacts with people with UK origins. Less than one quarter of the sample have regular contacts with persons with foreign origins (not the UK). As Table 4 shows, respondents' involvement in social organizations in the UK seems to be also channeled by the Filipino and Indian organizations, mainly through religious ones.

Table 3: People outside the workplace and the family with whom respondents have social contacts, in percentage (N = 433)

	Very Often	Often	Sometimes	Rarely	Never	Missing	Total
Persons from my country of origin	39.5	28.4	17.6	6.2	0.5	7.9	100.0
Persons from the UK	12.5	18.7	25.6	24.0	8.1	11.1	100.0
Persons from other countries	5.5	13.9	35.1	24.0	9.5	12.0	100.0

Involvement in professional and trade unions is common among respondents. Overall, 73 per cent of respondents are members of a trade union or a professional union/association; 17 per cent are members of both.

Table 4: IRNs' participation in organizations in the UK, in percentage
(N = 433)

	I consider myself an active member	I am a member but I rarely participate in the activities	I am not a member	Total
Professional union/association	18.5	41.0	40.5	100.0
Trade union	8.8	21.7	69.5	100.0
Religious organization	29.4	18.5	52.1	100.0
Charity/Not-for-profit organizations	9.3	13.0	77.8	100.0
Political organization	0.7	1.6	97.7	100.0
Migrant association	2.8	5.1	92.1	100.0

Nevertheless, only a minority participate actively in the life of associations. Key informants of UNISON and migrants' associations reported their concerns about the low participation. UNISON is tackling this problem through developing a network of Filipino-born IRN activists within the organization across the UK. This action also has the objective of valuing as well as fostering a better coordination among the Filipino community, familiarizing Filipino activists with UNISON branches, and encouraging them to take more responsibility within the organization. According to the key informant interviewed, if this experiment succeeds, it may be extended to other IRNs.

The participation in other types of organizations is low, except for religious ones. Those participating in religious organizations go to church and support activities organized by church members -- a widespread form of engagement among respondents. Overall, eight in ten respondents go to church regularly (58.2 per cent do it very often and 24.6 per cent often), and only 3.8 per cent never go to church.

Conversely, only few respondents engage in political participation: the proportion of respondents who have never participated in any political activities in the UK (e.g. demonstration, strike, signing petitions, and political campaign) is 74.6 per cent. Only 4.7 per cent did it often or very often. Respondents are not totally disconnected to what's going in the UK and in connection to the local community, however. In fact most of the respondents keep regularly informed on what's going on in the UK and in the city where they live (50 per cent and 43 per cent do it often or very often); while 62 per cent of respondents also keep regularly informed on the situation in the country of origin. The majority of respondents who have children living with them in the UK attend teacher-parent association meetings in school on a regular basis (51.2 per cent).

Chapter 5.
The working conditions of IRNs

5.1 Previous and current employment situation

Table 5 summarizes the main employment characteristics of respondents before moving to the UK. The majority of respondents had acquired skills in the health sector before immigrating to the UK, mostly as nurses in the private health facilities, although a substantial proportion of respondents worked in the public sector as well. Only a few respondents were trained as nurses in the UK, who entered with a student visa.

Table 5: Overview of respondents' employment situation before immigrating to the UK, in percentage (N. 433)

Type of employer and job	Total
Respondents who worked in the health sector before emigrating to the UK	91.2
Respondents who worked as nurses before emigrating to the UK	87.3
Type of employer before emigrating to the UK	
Public/government-owned health facility	35.6
Private health facility	50.8
Respondents whose job in the health sector was the main paid job	88.9
Training and formal qualifications	
Respondents who were trained as nurses before emigrating to the UK	93.5
Respondents who obtained a university degree in nursing before emigrating to the UK	21.5
Respondents who obtained a diploma in nursing before emigrating to the UK	70.9
Overall level of fluency in the English language	
Proficient	30.0
Advanced	41.1
Intermediate	23.8

Respondents' employment trajectories in the UK and their current situation are summarized in Table 6. The general picture that can be drawn from data reported in the table is somewhat similar to the picture provided by previous studies. The majority of respondents followed labour migration pathways of many IRNs who entered the UK during the massive recruitment period in the early 2000s. After registration with the UK Nursing and Midwifery Council as general nurses and a period of adaptation, most respondents started to work in the private sector and then progressively turned to the NHS. Almost three-quarter of the sample were employment full-time and on a permanent basis at the time of the survey.

Table 6: Overview of respondents' employment situation in the UK, in percentage (N. 433)

Occupational Group	Total
Registered nurses or midwife	79.0
Nursing auxiliary/nursing assistant/healthcare assistant	18.5
Branch of nursing	
Adult/general	70.2
Registration and induction	
Respondents who registered as a nurse at the UK Nursing and Midwifery Council	84.5
Respondents who completed the supervised practice/adaptation to practice in the UK	82.2
Respondents who did the adaptation period in the NHS (National Health Service)	36.0
Respondents who did the adaptation period in a nursing home	62.5

Almost eight in ten respondents work as registered nurses or midwives. Two in ten work as nursing auxiliaries or assistants and did not register as a nurse at the UK Nursing and Midwifery Council. Only four respondents did so and work as auxiliaries or assistants. The majority of respondents work as general nurses and completed the induction period in a nursing home. As data reported in the table below show, the majority of respondents started to work in a residential care or a nursing home and then moved to the NHS. Many IRNs have succeeded to make this move after some years after their arrival in the UK. Almost 70 per cent of respondents followed this pathway[26]. The sample evenly distributes two groups in terms of length of time worked with current employer (i.e. up to five years and six years or more), and a slight majority of respondents have changed employer (public or private) since their arrival to the UK.

First employer in the UK	
NHS (National Health Service)	10.3
Care and nursing home	87.1
Current employer in the UK	
NHS (National Health Service)	69.7
Care and nursing home	27.0
Years worked for the current employer	
Five years or less	48.9
Six years or more	51.1
Respondents who did change employer since the arrival in the UK	54.5

[26] The RCN Employment Survey 2013 show that 72.5 per cent of 9,754 nurses who participated in the survey, among which 6 per cent identifying as black or another ethnic minority background, reported that they work for the NHS (RCN, 2013: 20).

Full-time employment on a permanent basis clearly predominates among respondents, as data reported below show[27]. Most of respondents (70.9 per cent) have a normal working week of between 30 and 37.5 hours a week[28]. The majority of respondents reported their salaries contributing substantially to the total income of their household[29].

Current employment contract	
% of respondents employed on a permanent basis	85.2
Hours worked per week (up to 29)	5.3
Hours worked per week (30-37.5)	70.9
Hours worked per week (more than 37.5 hours)	13.8

A set of questions addressed the composition of the team in which respondents currently work. Only seven respondents work alone, with the majority of respondents working in large team (more than ten persons). In most cases the proportion of women predominates in the gender composition of the working teams. This outcome is consistent with evidence by official statistics indicating that nursing tends to be a gendered profession (e.g. NMC, 2008; RCN, 2013).

Working in a team/department	
In a team of 2-5 persons	26.1
In a team of 6-10 persons	15.0
In a team of more than ten persons	55.2
Comprised mainly of women	66.3
Comprised mainly of persons originally from the UK	40.9
Comprised mainly of persons with mixed national origins	43.4

In a nutshell, the set of qualifications, skills and work experiences developed by respondents in the country of origin or in another country before coming to the UK made them successful candidates to work as nurses in the UK. As argued in the previous chapter, most respondents were also able to secure the corresponding work permit and most of them could also obtain UK citizenship or permanent residence. Most of the respondents, in fact, belong to a generation of IRNs in the UK who could benefit from a relatively relaxed immigration policy.

[27] This proportion is higher than the one reported by RCN Employment Survey 2013 (67 per cent).
[28] The RCN Employment Survey 2013 found similar results: 69 per cent of respondents reported that they work between 30 and 37.5 hours a week (RCN, 2013: 69).
[29] Namely, 11.8 per cent of respondents reported that their earnings represent all household income and 33.9 per cent of respondents reported that their earnings represent over half of all household income. RCN Employment Survey 2013 reports similar figures (RCN, 2013: 45-46).

5.2 The recruitment experience

Section 2.2 argued that previous studies have identified a common set of problems experienced by IRNs. The most frequent problems reported in the literature are a) insufficient, inaccurate and sometimes misleading information received during the recruitment process about the type of employer, the terms of employment and working tasks; and b) disproportionate fees charged to migrants by recruitment agencies. Previous studies have also showed that nurses internationally recruited by employers in the public sector tend to report better experiences than nurses recruited by private health facilities. This section reports the results of questions about the recruitment experience of IRNs.

The majority of respondents (60 per cent) found information about a job offer in the UK before emigrating, mostly through advertisements in newspapers, social networks and friends, and to a lesser extent through advertisement on the Internet and staffing agencies (27.7 per cent, 22.2 per cent, 10.9 per cent and 9.2 per cent respectively).

As far as the recruitment mechanisms are concerned (Table 7), over 60 per cent of respondents reported that they were recruited in their country of origin or in another country before moving to the UK.

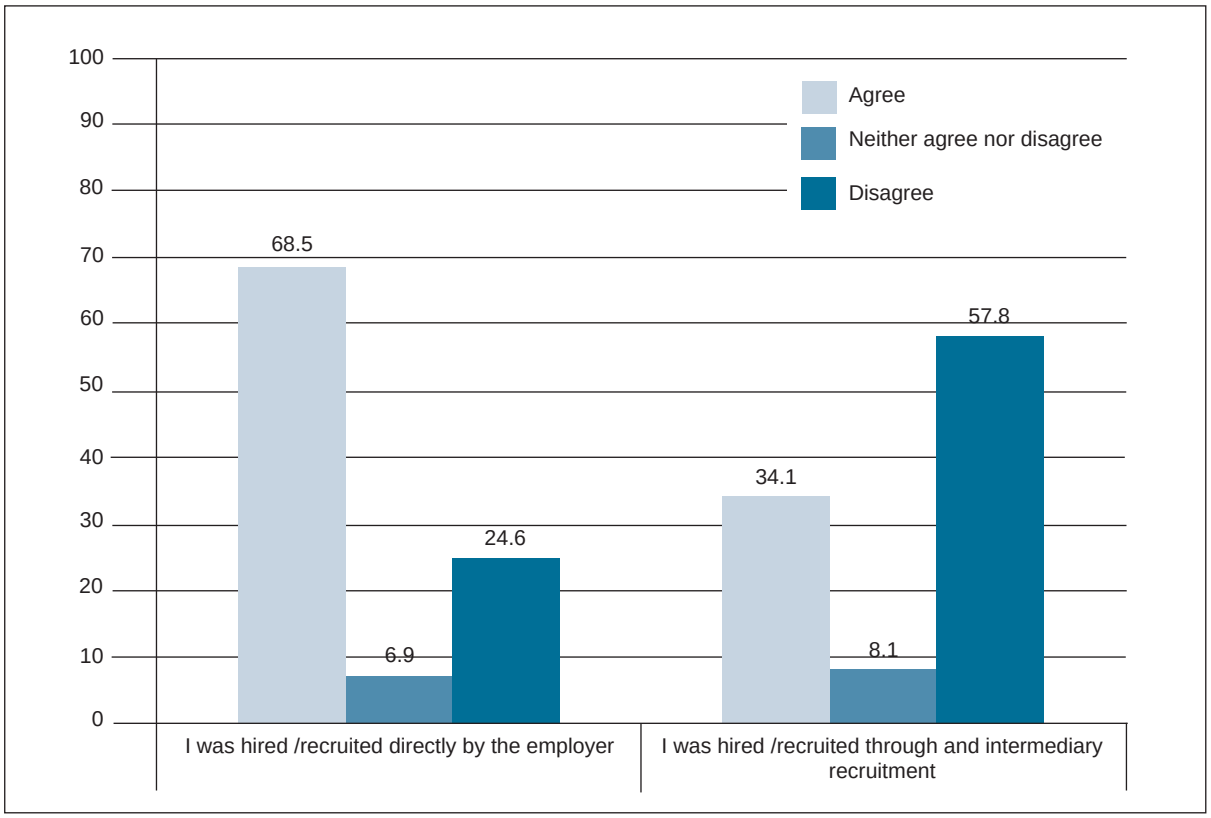
Table 7: Type of recruitment mechanism used by respondents to get their first job as a nurse in the UK (N. 433)

How did you get the first job as a nurse in the UK?	N	%
I was hired/recruited directly by the employer, after my arrival in the UK	102	23.6
I was hired/recruited directly by the employer, before coming in the UK	135	31.2
I was hired/recruited through an intermediary/recruitment agency	140	32.3
Total	377	87.1
Missing	56	12.9
Total	433	100.0

In order to assess the international recruitment experience of respondents, the questionnaire included a sub-set of conditional questions for respondents, who reported that they were recruited before moving to the UK. In particular, these questions aim to understand whether and to what extend respondents consider the information they have received from the recruitment agency about the employment contract and job tasks as adequate, and the fees charged for recruitment as appropriate to the service they received.

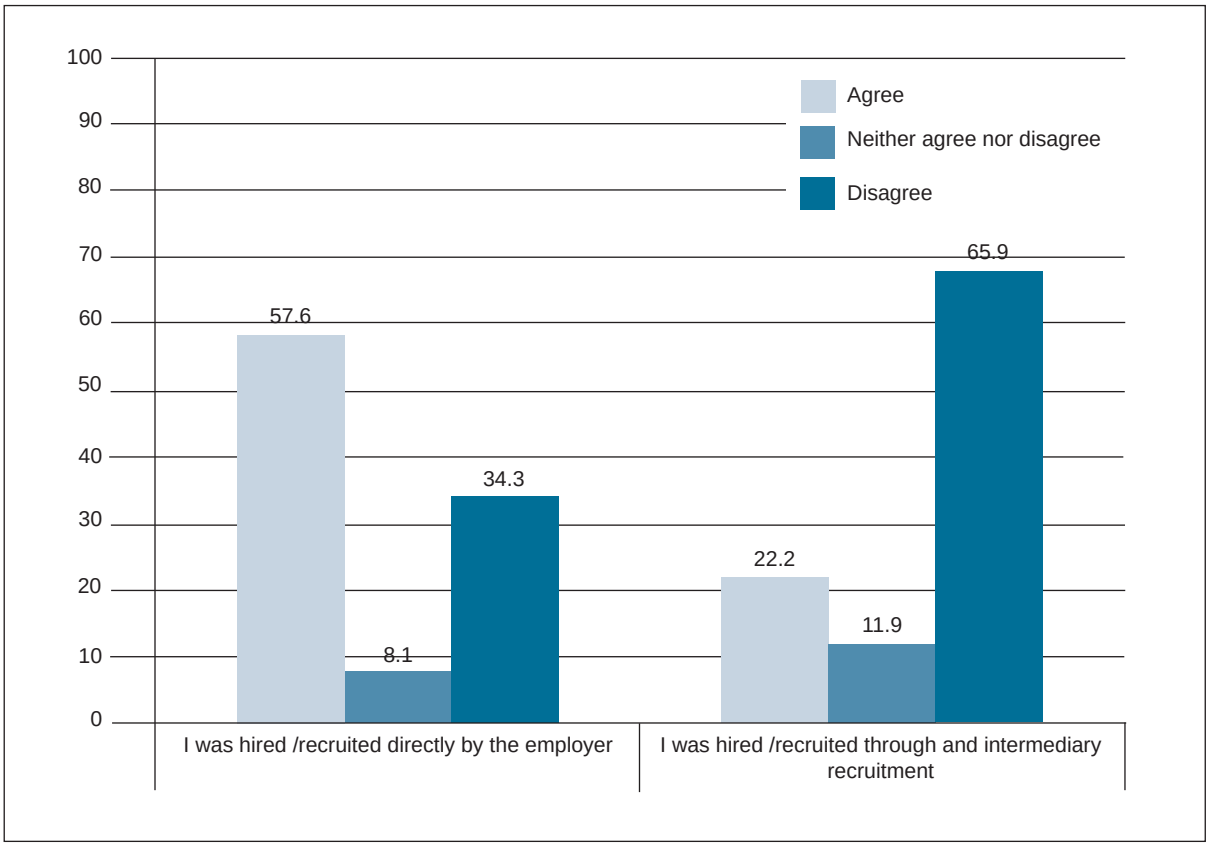
The results of our survey reported in the following charts indicate that the proportion of respondents reported having received inappropriate information and considering the fees charged as disproportionate is higher among respondents recruited by recruitment agencies than among the ones recruited directly by the employer.

Chart 5: Respondents' self-assessment of the information received about the employment contract and working conditions ("I received appropriate information) (N = 265).



Note: Data reported in the chart refer to respondents recruited before moving to the UK. The question used is the following: "To what extent do you agree/disagree with the following statement: Before coming to the UK, I received appropriate information about the employment contract and working conditions of the job I applied for (e.g. role and the tasks, type of contract, salary, health and insurance, weekly work hours, etc.)". Missing values: 10.

Chart 6: Respondents' self-assessment of fees
("I consider the fees charged as appropriate to the service I have received) (N = 225).



Note: Data reported in the chart refer to respondents recruited before moving to the UK. The question used is the following: To what extent do you agree/disagree with the following statement: "I consider that the fees charged by the agency were right and appropriate for their services". Missing values: 50.[30]

This outcome is confirmed by the results of another question that collected respondents' assessments of the wider recruitment experience: 67 per cent of respondents directly recruited by the employer are satisfied and would recommend the agency they used. But this proportion drops to 29 per cent among respondents who were recruited through a recruitment agency.

Data collected showed that direct recruitment was mainly used by the NHS, whereas indirect recruitment -- through a recruitment agency -- predominates (80 per cent) among respondents whose first employer in the UK was an independent/private health organization (care or nursing home)[31]. After controlling the recruitment experiences for their first employer in the UK, it became clear that the proportion of respondents who reported disappointment about the recruitment process is higher among nurses recruited through a recruitment agency to work in a care or nursing home as their first employer in the UK.

[30] The high number of missing values -- i.e. 50 cases -- may stem from the fact that not all respondents were charged with fees; 39 out of 50 cases that did not answer to this question reported having been recruited directly by the employer.

[31] Direct recruitment does not necessarily mean, however, that local recruiters in the country of origin were not involved in the recruitment process. Local recruiters are in fact usually involved and they operate within a framework of agreements -- i.e. procurement contracts.

It is worth noting, however, that a substantial proportion of respondents who reported having been recruited directly by an NHS employer answered in the affirmative to the question about fees charged for recruitment, which may indicate that an intermediary was used by the employer during the recruitment process, or that the employer operated with its own recruitment department and charged recruitment fees. Data collected do not allow this aspect to be clarified. Charging migrant workers with fees for working in the UK is prohibited. Recruitment by the NHS or any other employer, for that matter, whether direct or indirect, should not involve fees charged to the IRNs to gain employment. But collecting fees for recruitment is legal in India and in the Philippines, as long as the fees don't exceed one month's salary.

The NHS' Code of Practice for international recruitment of health-care professionals states that:

> Any recruitment agency registered within the UK charging fees to applicants will be in contravention of statutory employment agency legislation and will be reported to relevant authorities for further investigation. Employers should also satisfy themselves that UK recruitment agencies with whom they contract are not in any partnership agreement with agencies in other countries who allow fee charges to individuals solely for the purpose of placement within the UK (Department of Health 2004: 14).

However, the recruitment chain can be complex and not easy to monitor, especially in countries in which informal and illegal mechanisms of recruitment are widely diffused -- i.e. bribery, corruption and unscrupulous agents and brokers (e.g. Khadria, 2007).

Codes of practices for the international recruitment of health-care professionals -- including the UK NHS Code adopted in 2004 -- are voluntary and there is no statutory mechanism for ensuring compliance. Scholars (e.g. Buchan, 2007; Dumont and Zurn, 2007) have argued that these codes are an important development, but are in fact very difficult to implement. Similarly, a key informant of UNISON interviewed for this research explained the following:

> "The problem is that these codes are ineffective, especially because IRNs often have no options other than accepting what the agencies offer them. An improvement of recruitment can hardly come from this side of individual nurses and this represents a limit. This is true especially in those countries where the 'production' and the 'export' of nurses is a policy priority. We have spoken with Filipinos working as nurses in the UK who have loaned their houses and incurred debts in order to pay these agencies and come to the UK." (Interview with UNISON, London, April 2013).

Unfair practices of recruitment are not limited to overseas nurses. The key informant of Kanlungan, based in London, reported in an interview carried out during the fieldwork that "unethical recruitment is now affecting senior care workers, either recruited by private agencies or by UK business people, who went to the Philippines to recruit them"[32].

[32] Briefings and reports can be found online at: http://www.kanlungan.org.uk/research-new/

> "We organized briefings with senior care workers aimed at understanding how they were recruited. We discovered that they have been charged with high fees … agencies play with the desperation of people. We found that they had to pay at least £6,000 to come (to the UK) and be employed here. Agencies went into the rural areas where they know that people have lands and properties to loan in order to the pay for their recruitment." (Interview with Kanlungan, London, April 2013).

A key informant of NHS Employer, interviewed for this research, argued that the situation has improved since the creation of a list of commercial recruitment agencies that adhere to the UK Code of Practice, and the provision of a dedicated support service to NHS organizations aimed at helping them in following the guiding principles of the code in all their recruitment activities. However, the key informant argued that:

> "It is not easy to implement strict monitoring, we are not involved in operational aspects … basically, we have an application process and we ask key questions and we then control. We make spot checks on the agencies' website ... if we find or hear about a breach of the code we undertake an investigation process and eventually remove the agency from the list." (Interview with NHS Employer, London, April 2013).

The main monitoring tool seems to be the informal network through which information and reputation can circulate and be checked: "We have a network with employers that we use to communicate. We also have personal networks from which we can get feedback on international recruitment" (Interview with NHS Employer, London, April 2013).

According to the key informant, the situation has now changed, however, in a way that seems to enable a positive selection among recruitment agencies: "International recruitment is reducing across the sectors in the UK. This is clear in the health-care sector, where prices and reputation have become key factors in the self-selection process of recruitment agencies." (Interview with NHS Employer, London, April 2013)[33].

This may suggest that the recruitment industry within the health-care sector is maturing and consolidating. A recent change in the recruitment agency sector is the move away from agencies that have individual relationships with NHS trusts, towards framework agreements managed by procurement consortia that may foster compliance with the codes of practices.

Do recruitment experiences impact on working conditions? The explorative nature of this study does not allow this question to be fully answered. Data collected indicate that respondents less satisfied with their recruitment experience tend to be overall less satisfied also with several aspects of their working conditions, compared with respondents satisfied with their recruitment experiences.

[33] Detailed information of the procedure used by NHS Employers is available on their website: http://www.nhsemployers.org/RecruitmentAndRetention/InternationalRecruitment/Code-of-Practice/Pages/Agencyapplicationandappealsprocedures.aspx

This difference is not statistically significant to allow conclusive remarks to be made. Data collected also suggest that there are some aspects of working conditions that seem to correlate more with the recruitment experiences of IRNs than others. The degree of professional recognition and equality in the workplace seem to be important ones. For instance, respondents less satisfied with their recruitment experience are more likely to consider -- when compared with other respondents -- that their role, work duties and responsibilities are not appropriate to their grade and qualifications, and their work and efforts are not adequately recognized by the manager. What is clearer still is that the proportion of respondents who report having experienced harassment, bullying and abuse from the manager and/or colleagues in the workplace is significantly higher among the ones who reported less satisfaction with their recruitment experience. This outcome will be discussed further in the conclusions.

5.3 The evolution of working conditions across time

A mixed picture emerges from the fieldwork research in terms of working conditions. Almost half of respondents reported their working conditions having worsened since they arrived in the UK, and a substantial proportion reported having experienced unequal treatment and discrimination at work. Half of the sample reported being satisfied with their working conditions in the UK.

Table 8 reports data on respondents' self-assessment of how their employment situation has evolved across the years after their arrival in the UK. Some aspects refer to specific terms of employment, whereas others refer to more general aspects.

Job security -- the probability that an individual will keep his or her job -- is by far the most important issue that most of the respondents are concerned about. The perception of job insecurity has increased over time for five in ten respondents, despite the fact that most of them were employed on a permanent basis at the time of the survey. Only one in ten respondents reports that his/her position in the UK labour market has become more secure over the years.

Job security concerns may be explained by economic uncertainty stemming from economic recession. Such a concern affects the British workforce on a large scale, as demonstrated by the key results of the Skills and Employment Survey funded by the Economic and Social Research Council and the UK Commission for Employment and Skills: "British workers are feeling less secure and more pressured at work than at any time in the past 20 years, with pay cuts and diminished control over their jobs among the biggest concerns" (Osborne, 2013).

Similarly, the 2013 RCN survey among nurses in the UK shows that preoccupations about job cuts and the threat of redundancy have increased in the last year for almost half of the respondents (RCN, 2013: 46). Data collected by RCN also show that job security concerns reported by nurses combine with nurses' feelings that their "pay band does not reflect their level of responsibility and that there is little prospect of promotion" (RCN, 2013: 37):

> "The main reason given is that the level of pay or grade/band is not felt to match the level of responsibility, autonomy and intensity of the job … Other explanations show how many nursing staff feel they are working to a level unrecognized by their pay band or grade due to increased workload or an expanded role, while others feel stuck in their pay band with no room for progression" (RCN 2013: 39).

Results of our survey also show that many respondents feel stuck in their current employment position with low expectations of improvements (Table 8). The proportion of respondents who consider the security in their workplace having worsened over the years is also particularly high.

Table 8: Respondents' self-evaluation of their employment situation since their arrival in the UK, in percentage (N. 433)

Considering the following aspects of your employment contract(s), have you noticed any changes since you started to work as a nurse in the UK?					
	Increased	Unchanged	Decreased	Missing	Total
Job security (e.g. keeping your job)	10.2	27.9	50.8	11.1	100.0
Career progression	18.2	37.9	29.1	14.8	100.0
Wage	37.9	39.3	11.5	11.3	100.0
Qualifications and skills	46.7	35.8	8.5	9.0	100.0
Health insurance coverage	10.9	38.6	14.5	36.0	100.0
Security at workplace	7.9	37.6	38.8	15.7	100.0

Data on respondents' self-assessment of several aspects of their workplace settings confirm that the lack of professional recognition and the feeling of working to a level that does not correspond to their qualifications are the main sources of disaffection among respondents.

Table 9: Respondents' attitude towards quality of the work, workplace relationships and professional identity, in percentage (N. 433)

	To what extent do you agree/disagree with the following statements					
	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree	Missing
My role, work duties and responsibilities are appropriate to my grade and qualifications	14.1	21.9	10.6	36.7	9.5	7.2
I consider the achievements of my company/organization as personal achievements	6.7	14.1	22.9	33.3	10.4	12.7
I can talk and share reflections with my colleagues on how the team works together	7.6	15.7	20.3	35.8	11.1	9.5
My manager recognizes my work and efforts	14.3	16.9	20.3	28.9	11.8	7.9
I have enough autonomy in choosing how to best organize my work	9.7	21.0	18.9	31.6	8.8	9.9
I work so hard that I have very little time to dedicate to my family and friends I am satisfied with the quality of care	2.5	15.5	16.4	37.2	19.6	8.8

	To what extent do you agree/disagree with the following statements					
	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree	Missing
I am trusted to do my job	2.3	3.2	3.0	35.3	44.3	11.8
I am often forced to work unpaid extra hours	23.6	36.5	11.8	11.3	6.9	9.9

Data reported in Table 9 are consistent with the ones showed in Table 8. For instance, 75 per cent of respondents who reported that their career has progressed since they started to work in the UK feel their work and efforts recognized by the manager. This proportion drops to 27.6 per cent among respondents who reported that their career has not progressed over the years.

5.4 Bullying and harassment in the workplace and unequal treatment at work

Experiences of different forms of discrimination in the workplace -- such as bullying, harassment and abuse -- that are driven by cultural and ethnic considerations have often been reported by IRNs interviewed in previous empirical research in the UK (Pike et al., 2005; Unison, 2009; Allan and Larsen, 2003). Discrimination often stems from stereotypes and prejudices. Inadequate language skills may also expose foreign nurses to discrimination, especially from patients, as previous studies have demonstrated. Many IRNs have reported discrimination in the workplace from team members/managers as well.

The 2013 RCN survey shows that overall experiences of bullying and harassment in the workplace were reported by a third of nurses, and that nurses with black or another ethnic minority background were more likely to experience discrimination -- especially from team members or managers. According to the RCN survey, the incidence of bullying or harassment is markedly higher among respondents working for the independent sector care homes (RCN, 2013: 112): “Just under one third (30 per cent) of white respondents had experienced bullying or harassment from a colleague or manager, compared to 46 per cent of Black/African/Caribbean respondents, 43 per cent of Asian respondents, and 38 per cent of respondents with mixed or multiple ethnic backgrounds” (RCN, 2013: 115).

The RCN survey discovered that Asian respondents are more likely to state that bullying and harassment is a general problem in the workplace than their white colleagues, and felt less confident that they or their colleagues would be treated fairly if they reported bullying or harassment by a fellow member of staff (RCN, 2013: 118). Many respondents in our survey also reported having personally experienced harassment, bullying or abuse in the workplace in the previous 12 months. Similarly to the 2013 RCN survey, the most frequent sources of harassment, bullying or abuse were reported to be patients/service users or their family, or other members of the public, followed by colleagues and the manager/team leader.

Table 10. Respondents' experiences of harassment, bullying or abuse in the workplace over the previous 12 months. N = 418

	Have you personally experienced harassment, bullying or abuse in the workplace over previous 12 months?			
Source of discrimination	NHS	No	Missing	Total
Patients/service users or their family or other member of the public	43.5	44.3	12.2	100
Colleagues	40.9	44.7	14.4	100
Manager/team leader	28.7	54.5	16.7	100

Note: Data include only respondents who work in a team.

When responses to the three questions regarding the sources of unfair treatment in the workplace were aggregated, it turned out that nearly six in ten respondents reported having personally experienced at least one form of harassment, bullying or abuse in the previous 12 months. Unfair treatment from multiple-sources -- i.e. more than one -- was experienced by approximately a third of respondents.

When looking at the reasons for harassment, bullying or abuse, 75 per cent of respondents reported that these practices were driven by ethnic considerations. Nearly 20 per cent did not answer this question, and only a few respondents reported that unfair treatment was driven by other factors such as gender, age, religion or sexual orientations.

Differently from what was found by the 2013 RCN survey, our survey does not provide evidence of a clear correlation between discrimination and the type of employer. Descriptive data show that the proportion of respondents who reported having experienced discrimination in the workplace is somewhat higher among those who work for the NHS, as the following table shows. This difference is higher when considering discrimination coming from colleagues. This outcome may be explained by the fact that the proportion of respondents who reported to work in teams in which persons with British origins predominate, is slightly higher among the ones working in the NHS than among the ones working in the independent/private health facilities.

Table 11. Respondents' experiences of harassment, bullying or abuse in the workplace in the previous 12 months, by type of employer. N = 418

	Respondents who reported having experienced harassment, bullying or abuse in the workplace over the previous 12 months by type of employer		
Source of discrimination	Yes	Independent/private	Total
Source of discrimination	%	%	N.
Patients/service users or their family or other member of the public	74.2	70.3	180
Colleagues	73.3	57.1	119
Manager/team leader	52.9	46.7	119

Note: Data include only respondents who reported working in a team and having experienced harassment, bullying or abuse in the workplace in the previous 12 months.

The survey also invited respondents to self-assess equality issues in the workplace with reference to several aspects of working conditions. Namely, respondents were invited to consider their working conditions as compared with the ones of other nurses working in their team or department. Results are reported in the following table:

Table 12. Respondents' self-assessment of their working conditions as compared to their colleagues. N = 418

Would you say that the following aspects of your working conditions are better, similar or worst compared with the ones of your colleagues working as nurses in your team or department?						
	Better	Similar	Worse	Do not know	Missing	Total
	%	%	%	%	%	%
Work shifts	16.2	50.7	18.8	8.5	5.8	100
Wage	10.6	49.5	22.2	11.1	6.5	100
Work duties	13.8	41.1	34.5	3.9	6.8	100
Career progression	18.6	35.0	33.3	6.3	6.8	100
Training opportunities	22.5	43.2	22.2	5.1	7.0	100

Note: Data include only respondents who reported working in a team.

Data reported in the table show that the majority of respondents feel that they have experienced similar treatment at work compared with their colleagues. However, a substantial proportion of respondents feel they are treated unequally, especially with regard to work duties and opportunities of career progressions. After controlling for the type of employer and the structure of the team, it turned out that feelings of unequal treatment are somewhat higher among IRNs working in smaller teams (less than ten persons) in the NHS, and working in teams in which nurses of British origins predominate.

5.5 Correlation between working conditions, equality and discrimination in the workplace

Empirical data suggest that respondents who reported having experienced practices of harassment, bullying or abuse tend to be more disappointment about their working conditions and levels of equality in the workplace environment than other respondents.

First, answers on harassment are consistent with the ones given by respondents on questions about equality in the workplace. That is, IRNs who reported having experienced harassment, bullying or abuse in the workplace are twice as likely to report unequal treatment regarding work duties, career progression and training opportunities compared with the ones who did not report personal experiences of harassment, bullying or abuse.

Second, IRNs who reported having experienced harassment also reported higher degrees of disaffection about the evolution of their working conditions. In a nutshell, these respondents feel more demotivated,

consider the job prospects more uncertain, show a lower degree of identification with their employer, and are doubtful about the quality of care they are able to provide to patients.

Finally, respondents who reported unfair and unequal treatments in the workplace seem to be more disappointed about the levels of professional recognition, collaboration and solidarity in the workplace.

These findings are summarized in Table 13, which reports the overall correlations between three indicators that were elaborated through aggregating all questions on discrimination, equality and working conditions:

"Ethnic discrimination in the workplace" is the indicator that aggregates answers to the questions about harassment, bullying or abuse in the workplace experienced by respondents from the manager/team leader, colleagues, and patients driven by ethnic considerations. The indicator varies from 0 to 3 -- 0 means the respondent had not reported experiences of discrimination, and 3 means the respondent had reported discrimination from all the three above mentioned sources.

"Equality in the workplace" aggregates answers to questions about equality of treatment in the workplace. Values vary from 0 to 5 -- 0 means the respondent feels treated equally compared to their colleagues, while 5 means that the respondent feels treated unequally across all items.

"Working conditions" is the indicator that aggregates answers to questions about the evolution of the six dimensions of working conditions as presented in section 5.3. Originally, each question had three values: they were codified to obtain dummy variables -- worsened/non worsened -- which were then aggregated. The indicator therefore varies from 0 to 6 -- 0 means that the working conditions have not worsened over time, and 6 means that the respondent reported a worsening of the situation across all dimensions.

Table 13: Correlation between equality in the workplace, working conditions and ethnic discrimination

		Equality in the workplace (unequal treatment	Working conditions (worsen over time)	Ethnic discrimination in the workplace
Equality in the workplace (unequal treatment)	Coefficient Number of observations	1 418	0.276** 399	0.306** 384
Working conditions (worsens over time)	Coefficient Number of observations	0.276** 399	1 409	0.270** 375
Ethnic discrimination in the workplace	Coefficient Number of observations	0.306 384	0.207 375	1 393

*Note: ** means the correlation is significant at the 0.01 level. Kendall's Tau b correlation coefficient has been used for the analysis.*

5.6 Employment orientations and migration prospects

What are the IRNs' employment orientations and migration prospects? Do their current employment situation and working conditions shape their orientations towards the UK labour market?

Previous studies have indicated that many IRNs do not stay in the UK forever (e.g. Buchanan et al., 2005). Many respondents envisage leaving for other countries or a return back to home. A most recent investigation, conducted by Young (2011) provided similar evidence but, as the author admits, it was not possible to know "how much of this overall movement is due to emigrating UK nationals, or to foreign-qualified professionals returning home or moving on to a third country for which the UK is simply a stepping stone" (Young 2011: 304).

Our survey enables us to shed some light on the migration trajectories of the respondents and their reasons for re-emigrating, and allows us to understand whether issues of working conditions influence the propensity of IRNs to re-emigrate.

Overall, four in ten respondents (42.5 per cent) reported considering moving to another country to work as nurses. The proportion of respondents who reported planning to emigrate is slightly higher among the ones who came to the UK directly from their home country than among respondents who come to the UK after having been IRNs in another country (45 per cent and 37 per cent respectively). This outcome may stem from the fact that "more experienced" nurses – those having more migration experiences -- have better information in order to compare the situation in the UK with the situation in other countries, and may consider staying in the UK as the best option.

As far as the country of destination is concerned, Australia is, by far, the most popular destination (63 per cent), followed by the US (24.5 per cent) and Canada (15.8 per cent). The possibility of returning to their home country was reported as being considered by 31 per cent respondents. Only a few respondents are planning to move to another European country (3.8 per cent) or to the Middle East (2 per cent). Respondents' attitudes about their next steps are framed in a medium-term perspective. Only 16.4 per cent of them plan to leave within one year. The majority is planning to leave in one to two years (46.7 per cent), or in three years or more (36.8 per cent).

Table 14 shows the three mains reasons by respondents for re-emigrating in order of importance. Overall, respondents want to leave mainly because they are disappointed with their current working conditions and their career prospects in the UK.

Table 14. Respondents' reasons for leaving the UK.
N = 184

	First reason	Second reason	Third reason
Working conditions in the UK			
I am disappointed with the working conditions here	21,2	12,9	11,4
I don't see opportunities for a career progression here	15,2	10,6	6,0
My employment situation here is too uncertain	6,0	11,2	11,4
I feel discriminated at the workplace	6,0	13,5	1,3
Subtotal	**48,4**	**48,2**	**30,1**
Living in the UK			
Uncertainty about my future here in the UK	14,1	14,7	1,3
It's too expensive to live here	11,4	3,5	22,1
Too many problems to adapt in the UK	2,7	8,2	14,1
Subtotal	**28,2**	**26,4**	**37,5**
Immigration rules in the UK			
My UK visa is going to expire and I cannot renew	2,7	0,6	2,7
My family living abroad is not allowed to settle here with me	0,5	2,4	1,3
Subtotal	**3,2**	**3,0**	**4,0**
Other reasons			
I have a better job offer	9,2	1,8	10,1
I feel I have achieved what I expected to gain in the UK	0,5	0,6	1,3
No specific reasons	6,5	16,5	1,3
To continue with my adventure	2,7	2,4	6,0
Homesickness	1,1	1,2	9,4
Subtotal	**20,0**	**22,5**	**28,1**
Total (%)	**100**	**100**	**100**
Missing	**0**	**14**	**35**
Total (N)	**184**	**184**	**184**

As data reported in Table 14 show, the cost of life in the UK and a general feeling of uncertainty about the future in this country are also important aspects for IRNs when considering to stay or to leave. Unsurprisingly, issues related to the immigration status are not so important, since most of the respondents have secured their status in the UK and their families have joined them. Adaptation to UK society is mentioned as the second and third most frequent reasons for leaving the UK (overall two in ten respondents have mentioned this factor).

Homesickness is not an important factor that shapes the decision to leave the UK, even among respondents who are planning to leave the UK to return home. A better job offer abroad and "non-specific reasons" are also indicated by several respondents, striking evidence given that practically nobody is planning to leave, because they feel that they have realized what they had expected to gain from the UK.

Overall, data on reasons to leave the UK indicate that concerns about working conditions drive the propensity to re-emigrate. The proportion of respondents who are planning to leave the UK is much higher among the ones who reported having experienced a worsening of their working conditions, as well as among the ones who reported having experienced discrimination in the workplace.

Table 15. Relation between discrimination in the workplace, working conditions and plans of leaving the UK

Discrimination/working conditions	Planning to leave the UK		
	Yes (%)	No (%)	Total (N)
Ethnic discrimination in the workplace	52.1	47.9	234
Not ethnic discrimination in the workplace	30.2	69.8	159
Working conditions worsened	51.4	48.6	247
Working conditions not worsened	31.0	69.0	171

Conclusive remarks

This study investigated the actual recruitment experiences and working conditions of Asian-born nurses in the UK. The existing literature and interviews with key informants enabled to examine these aspects within the wider political and economic context in the UK. The attempt was to understand the intersections between the institutional framework, which has evolved across time in response to changes in the political and economic priorities, and the work experience of IRNs. At the micro level, the personal experiences of IRNs was analysed through a survey. The fieldwork evidence allows several conclusive observations and suggestions to be drawn, and to be brought into the broader debate on international recruitment of health workers.

International recruitment

In 1998, under a favourable domestic economic situation, the UK Labour Government initiated a policy of massive NHS workforce expansion across all health professions, which fostered a period of active international recruitment. Young (2011) identified this period as one of "openness to mobility", which extended until 2006. It is during this period that issues of ethics and impact emerged.

Problems can be divided into two main areas. First, there are ethical concerns about causing skill shortages in origin countries, famously highlighted by Nelson Mandela in 1999 when he criticized the British government for causing a shortage of health workers in South Africa. Second are the concerns for the workers themselves. It was in this period that cases of abuses in the recruitment process were reported by the media and workers' associations. There was evidence that some IRNs were subjected to fees for recruitment that in extreme circumstances could provoke indentured employment relationship. Many more were given inadequate information about their placements, and faced unexpected challenges upon arrival in the destination countries.

Results of the survey conducted among IRNs show that inappropriate information provided during the recruitment process, and disproportionate fees charged for recruitment, are widely reported problems by respondents across health-care facilities throughout the UK. Nevertheless, results also indicate that there are differences in the recruitment experiences that cut across types of employers and recruitment mechanisms. On the one hand, nurses recruited through the intermediation of recruitment agencies, and especially the ones recruited to work in care or nursing homes or in a private facility as first employer in the UK, tend to report problems in their recruitment experiences. Conversely, respondents recruited by the NHS turned out to be, overall, more satisfied with their recruitment experiences. This outcome is coherent with what was discovered by other studies (i.e. Pittman et al., 2012).

Data analysis also shows a positive relation between degrees of satisfaction about recruitment experiences, motivations, and working conditions of nurses. Respondents hired directly by the NHS tend to report more positive assessments than other respondents, especially compared with the ones recruited by private agencies to work in care and nursing homes. That is, the recruitment experience seems to impact the working conditions of respondents. This correlation deserves further investigation, however. A relevant question is whether and to what extent ethical recruitment triggers -- and reflects -- better equality and better appreciation of diversity in the workplace.

As far as policy implications are concerned, information collected through the fieldwork suggest that the sharp decrease observed in the number of new non-EU nurses in the UK in recent years, as well as the increased concerns of ethics and impact of international recruitment, are contributing to the consolidation and maturing of the recruitment industry in the UK. That is, there are less recruitment agencies operating in this sector today, or at least less agencies recruiting for the NHS, and compliance with high standards of ethical recruitment has become the key requirement in procurement contracts. However, quantitative and qualitative evidence suggest that health-care facilities in the UK will resume the recruitment of international nurses sooner or later, in view of the growing demand for health services, fuelled by the aging population (e.g. Buchan and Seccombe, 2011). Policy makers and employer associations should therefore not lower their guard on the operations of the recruitment industry. Evidence suggests that the independent health-care organizations -- i.e. residential and nursing homes -- deserve specific monitoring, since it is within this sector that problems with recruitment practices seem to be more likely to occur.

The NHS Code of practices for the international recruitment of health-care professionals (NHS 2004) was initially binding on the public sector, but became voluntary with the advent of NHS trusts. A new operational model has been developed and the NHS Employers has become accountable for the implementation of the code. NHS Employers strongly encourages their members to abide by the code when they recruit both directly and through employment agencies. There is still little documentation, however, on how monitoring and sanctioning mechanisms actually operate. Similarly, there is still much investigation to be done in order to understand how recruitment practices actually work. Improving transparency and research in this field, as well as fostering policy initiatives aimed at exchanging good practices, would help to assess and disseminate business cases for ethical recruitment.

Working conditions

It would be naive to consider IRNs' working conditions in the destination country are only determined by the recruitment process. Working conditions can be directly or indirectly influenced by manifold factors, as previous studies and this ones have highlighted. Changes in the situation of IRNs must be interpreted within the wider leverage of working conditions of the health-care workforce, which stem from the economic crisis and consequential cuts in NHS funding that started in 2008, as recent surveys in the UK and Europe have demonstrated (RCN 2013; Aiken et al. 2013).

A comparison between the results of our survey and the ones of the RCN Employment Survey 2013 indicates that there are no major differences between IRNs and non-IRNS across several aspects of working conditions and orientations towards the labour market in the UK. Concerns about losing their job are common among nurses in the UK. IRNs interviewed in our survey also reported concerns; only one in ten consider that job security has increased over the years. Many also feel they operating in increasing unsafe working conditions. Most of the respondents arrived in the UK before 2006 as the result of NHS expansion, and have therefore been witness to the cuts in NHS funding and structural reforms of the whole public health sector, which started after that period.

In a nutshell, evidence suggests that the easiest way for an employer to deal with the cuts in funding in the public health sector has been to reduce the personnel, and intensify work shifts and workloads. IRNs seem to be in a more vulnerable position to such pressure however. Changes in immigration rules, cuts in NHS funding and the progressive privatization of the health-care system in the UK may combine and shape employers' utilization of migrant health workers in ways that may increase risks of

unequal treatment in the workplace. This is the argument that has been putted forward by scholars and professional organizations that have drawn on empirical and policy evidence (Meardi et al., 2011; Bach, 2010; RCN 2013).

A substantial proportion of IRNs that participated in our survey reported lacking professional and career prospects, their professional identity is not adequately recognized and valued by their manager, and lacking cooperation and solidarity from colleagues in the team. These feelings correlate with what has been reported by IRNs about equality issues in the workplace -- i.e. unequal treatment and discrimination in the workplace driven by ethnic considerations.

The consequences of such a situation are not limited to the working conditions of the IRNs, but also extend to the quality of care, as demonstrated by the correlation between disappointment reported by respondents about their working conditions and the quality of care that they are able to provide to patients.

Collected data indicate differences in the working conditions of respondents. That is, a mixed picture emerges from the survey. Despite the fact that almost all respondents have the same ethnic background, share similar migration experiences and, at the time of the survey, had succeeded in securing their immigration status and their employment situation, some respondents report that they are in a better situation than others.

Cross-tabulations and correlations have been used to shed some light on these differences. Results indicate that worsening of working conditions, experiences of ethnic discrimination and unequal treatment in the workplace are correlated. Data also indicate that unfair recruitment practices may strengthen this correlation. Empirical evidence suggests that differences between IRNs in terms of working conditions significantly cut across issues of access to opportunities, equality and diversity in the workplace.

Qualitative studies carried out among IRNs in the UK have observed that feelings, and experiences of unequal treatment are often caused by a poor understanding by employers on issues of cultural diversity and professional backgrounds (Allan and Larsen 2003).

The UK has one of the most advanced anti-discrimination and equality legislation in world. This provides solid basis for the implementation of policies and practices aimed at fostering better appreciation and valorization of diversity in health-care settings, which are characterized by a growing variety of cultural and professional backgrounds among the workforce.

Finally, differences in working conditions reflect different IRNs' orientations towards the UK labour market. Namely, disappointment about working conditions combined with a general feeling of uncertainty about the future in the UK turned out to be an important factor in influencing the decision of leaving the UK. Four in ten respondents are planning to do so, but only few are thinking to return back home. Most of them are planning to go to Australia, Canada and the US. Such a figure raises policy challenges. First, it poses issues of impact on the UK health-care system -- i.e. the loss of workers with relevant professional and social skills acquired through their experience in the UK. Second, it points to the question of the portability of social security entitlements and rights (see the ILO Multilateral Framework on Labour Migration, 2006). That is, will IRNs planning to leave the UK be able to transfer their social rights (e.g. pension contributions) to their new immigration country or to their home country after returning?

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ILO Country Office for the Philippines
19th Floor, Yuchengco Tower,
RCBC Plaza, 6819, Ayala Avenue
Makati City, Philippines
Telephone: +63-2-580-9900
Website: www.ilo.org/manila
Email: MANILA@ilo.org

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