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1 **Market making and the production of nurses for export. A case study of India-UK health worker**
2 **migration**

3

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8

9 **Abstract**

10 **Background:** High-income countries increasingly look to the international recruitment of health
11 workers to address their domestic shortages, especially from lower and middle-income countries. We
12 adapt conceptual frameworks from migration studies to examine the networked and heavily
13 commercialised nature of the Indian market for nurse migration to the UK.

14 **Methods:** We draw on primary data from 27 expert interviews conducted with migration
15 intermediaries, healthcare providers and policy makers in India and the UK.

16 **Findings:** India-UK nurse migration occurs within a complex and evolving market encompassing ways
17 to educate, train and recruit nursing candidates. For-profit actors shape the international orientation
18 of nursing curricula, broker on-the-job training and offer language, exam and specialised clinical
19 training. Rather than merely facilitate travel, these brokers produce both generic, emigratory nurses
20 and more customised nurses tailored to a specific national context ready to meet specific shortages
21 in countries such as the UK.

22 **Discussion:** The dialectic of producing emigratory and more customised nurses is similar to that seen
23 in the Post-Fordist manufacturing model characterised by flexible specialisation and a networked
24 structure, made possible by an evolving array of markets and services. As the commodity in this case
25 are people attempting to improve their position in life, these markets require attention from health
26 policy makers. Concerns include the existing inequalities amongst the Indian nurse force which may
27 be reinforced as nurses without specialised exposure are left behind. Further, the requirement of
28 hands-on clinical experience puts recently qualified nurses at risk of exploitation. Not least, migration
29 services largely escape state regulation; there has been a mushrooming of private nursing schools
30 and training centres in India which may fail to provide quality education and further weaken public
31 service provision.

32

33 **Keywords:** recruitment; intermediaries; brokers; workforce; human resources for health; NHS

34

35 **What is already known on this topic**

- 36 • High-income countries (HICs) increasingly look to the recruitment of healthcare workers
- 37 from low- and middle-income countries (LMICs) to fill domestic labour shortages
- 38 • Commercial brokers often mediate health worker migration in LMICs

39 **What this study adds**

- 40 • A complex and evolving industry is involved in the education, training and recruitment of
- 41 Indian nurses seeking to migrate with services driven by profit-orientation and often
- 42 fluctuating international labour market demands
- 43 • The education and training of health workers encompasses more than clinical skills but also
- 44 involves social and cultural competencies; we thus refer to a migrant production process
- 45 seeking to transform nurses into fully-fledged workers
- 46 • Actors in the field increasingly produce nurses for specific employer or labour market
- 47 requirements in high-income countries such as the UK, further reorienting nursing education
- 48 and training away from domestic health needs

49 **How this study might affect research, practice or policy**

- 50 • Market making in health worker migration is a concern for health policy making as the skills
- 51 taught to nurses seeking to migrate are governed by market opportunities rather than
- 52 domestic needs; the commercialisation of services may exacerbate inequalities in the Indian
- 53 nurse force and requirements for hands-on training contribute to the precarisation of nursing
- 54 labour

55

56 **Introduction**

57 The projected global shortfall of health workers is predicted to be 10 million by 2030 (1), the majority

58 in low- and middle income countries (LMICs). Migration plays a central part in this as high-income

59 countries (HICs) increasingly look to the international recruitment of health workers to address their

60 domestic shortages. Since November 2021, for example, the UK has signed agreements with India,

61 Kenya, Malaysia, Nepal, the Philippines and Sri Lanka to facilitate the recruitment of health workers

62 (2). Driven by poor working conditions and low pay, an increasing number of health workers in LMICs
63 migrate to wealthier countries in the hope of a better life (3–5). The World Health Organisation
64 estimates that around 15% of health and care workers are currently working outside their country of
65 birth or the country where they gained their first professional qualification (6).

66 India is an important case amongst the world’s suppliers of nurses; in 2017, around 56,000 worked in
67 the United States, United Kingdom, Canada, and Australia, corresponding to roughly 3 per cent of the
68 of the registered nurse force in India (7). In the last five years, the annual number of Indian nurses
69 and midwives joining the UK register has increased rapidly, to 10,841 as of March 2023, up from just
70 638 in March 2018 (2). A growing number of middle-income countries are aiming to replicate this as
71 a strategy for economic development; thus, events taking place in India’s nurse training and
72 migration sector carry global significance.

73 Some countries actively promote outward migration of domestically trained health workers as an
74 economic strategy. For example, the Philippines government has perpetuated a culture of out-
75 migration through the commercialisation of the nursing education sector and a laissez-faire attitude
76 towards increasing internal health workforce imbalances (8,9). The framing of these nurses as
77 potential sources of remittances, a driver of economic growth, has inspired a set of formalised
78 policies encouraging migration (10,11). The South Indian state of Kerala has similarly promoted the
79 migration of nurses. The latest incarnation of this policy is the government’s provision of free training
80 to tribal nursing professionals to increase their chances of finding overseas employment (12). This
81 stands in stark contrast with the cost of health worker migration for LMIC; Saluja et al. (13) for
82 instance, have estimated that LMICs lose US\$15.86 billion (or £12.92 billion) annually due to excess
83 mortality associated with physician migration with the greatest overall cost incurred by India,
84 Nigeria, Pakistan and South Africa.

85 Existing policy research in this area has aimed to understand key drivers for, and policy responses to,
86 outward migration of health workers (3–5), governance frameworks (14,15) and issues pertaining to
87 regulation and policy formation (15,16). Others have focused on the experiences of the migrant
88 workers themselves, including experiences of discrimination in their host countries (17–20). With the
89 increase in commercial activities geared towards health worker education for labour migration
90 (8,21–23), social science researchers have also begun to examine the processes and actors involved
91 in this market development. The latter often comprise an array of private and public providers (24)
92 including nursing schools (8).

93 Deshingkar (25) has argued that an understanding of contemporary migration is incomplete without
94 a robust understanding of brokers and their networks in recruiting, training and organising for
95 migration pathways. How do these brokers actively produce migrant workers such that they become

96 *ideal* migrant workers, ‘packaged’ or ‘positioned’ to match specific employer or labour market
97 requirements in HICs (25)? Existing research has flagged some of the facilitatory roles performed by
98 commercial brokers in mediating nurse migration (19,26). For the Indian context, Khadria (22, p.
99 1429) has found that such brokers are being used in both training and recruiting health workers,
100 following a ‘business processing outsourcing’ model to deliver services to clients in HICs. Walton-
101 Roberts, in her analysis of India-Canada nurse migration (26), refers to the requirements in Canada
102 for particular clinical knowledge and how these requirements create scope for involvement by
103 intermediaries and other actors as part of wider ‘regimes of skill’.

104 In this article we build on these and other scholars in migration studies (25,26) to present an in-depth
105 case study of the actors, practices and processes producing Indian nurses for both the international
106 labour market and for the specific requirements of the National Health Service (NHS) in the UK. By
107 examining primary data from expert interviews with a range of intermediaries, healthcare providers,
108 policy-makers and public health experts in both countries, the article sheds light on the increasingly
109 complex and commercialised nature of the nurse migration industry involved, and the proliferation
110 of different kinds of markets and agents seeking to position themselves in the field. Using the India-
111 UK pathway as a case study, the article argues that migration intermediaries do not simply ‘recruit’
112 but actively *produce* a nurse force that is both transnationally deployable *and* tailored to meet
113 specific labour market requirements in HICs. We suggest that it may be useful to conceptualise such
114 developments as similar to those that occurred in manufacturing’s transition from Fordism to Post-
115 Fordism. The article concludes by pointing to the implications for global health policymaking that its
116 empirical and conceptual insights warrant.

117

118 **Methods**

119 This article reports on a case study embedded in a research project [removed for peer review] that
120 investigated trade in health-related services with a focus on UK-India and UK-China engagements.
121 The wider study aimed to analyse the key drivers, actors, markets and supporting social and political
122 infrastructures of these trade relations. As part of this, we investigated transnational labour sourcing
123 as a key area of the increasingly commercialised transnational provisioning of healthcare between
124 India and the UK. The COREQ checklist was used to report the results of this study (see Appendix 2).

125

126 *Sampling and Recruitment*

127 Findings in this article are primarily drawn from 27 expert interviews conducted between 2021 and
128 2023 (see Table 1). Inclusion criteria for interview were: holding a managerial role within nursing

129 labour sourcing or providing healthcare organisations with specific India/UK responsibilities
130 (recruiters or brokers); a member of senior management of such an organisation with wide ranging
131 expertise and knowledge of the sector; working in consultative positions with in-depth knowledge of
132 the nursing labour sourcing sector, including for health policy-making; or working for a nursing
133 advocacy organisation or government with a focus on nursing labour sourcing.

134 Respondents were identified through a structured online search of key institutions and actors in the
135 field of international labour sourcing with a specific focus on India. This included a review of the NHS
136 list of ethical recruiters, which also featured India-based recruitment agencies and UK-based
137 agencies focusing on India. At the time, this list included 23 agencies sourcing nurses from India.
138 Where their contact information was available, we contacted the person responsible for the agency's
139 India operations (for UK-based agencies) or UK operations (for India-based agencies). Where we did
140 not have this information or a geographical division of responsibilities did not exist, we contacted the
141 institution's managing director. Eight of the agencies on the NHS list had relocated or ceased to exist,
142 had shifted their geographical focus or did not provide contact details. Of the remaining 14 eligible
143 agencies from the list, five did not respond to our invitations and two individuals initially agreed to
144 participate in an interview but did not attend; no reason for this were given. We eventually held
145 interviews with 7 representatives of these agencies. 3 additional recruiters were identified through
146 snowball sampling, all of whom took part in interviews. The majority of respondents in India were
147 based in two hubs for international nurse migration, Kochi and the Delhi NCR region, and we focused
148 our India fieldwork there.

149 Respondents in the UK focusing on labour migration, including from India, from a public sector
150 perspective were drawn from the comprehensive sample of respondents assembled for the larger
151 research project from which this paper stems. 8 respondents were recruited this way, and additional
152 respondents were recruited through snowball sampling. Primary materials were supplemented by
153 secondary data obtained through structured online searching to verify specific information such as
154 the current pricing of language exams.

155 'Experts' in qualitative research are those recognised as such in their social setting by virtue of their
156 specific knowledge, their community position, or their status (27). The experts we spoke with
157 spanned the public and private sectors in India and UK and included public health consultants and
158 civil servants, representatives from healthcare providers, industry associations, private agencies and
159 government departments. Individuals were contacted via email, phone or in person, informed about
160 the nature and objectives of the research, and invited to participate. Once they had agreed to
161 participate, respondents were interviewed at a date and time of their choosing. This was
162 predominantly in respondents' offices or online; two participants were met in public spaces.

Type of respondent	India	UK	TOTAL
Government representative		3	3
Healthcare consultant	2		2
Healthcare provider	4	4	8
Manager, nursing labour sourcing	9	1	10
Representative, nursing advocacy organisation	3	1	4
TOTAL	18	9	27

163 *Table 1: Sample description*

164

165 *Data Collection*

166 Interviews were conducted in English by two of the authors [removed for peer review] and followed
167 the tenets of expert interviewing (27). After a personal introduction and background information
168 about the interviewers (educational attainments, research expertise and interests, objectives for the
169 project) aimed at probing for information about practices and processes in the recruitment of nurses
170 from India. This included questions about key actors in the field; challenges people working in the
171 sector face; and any changes in the policy context that have facilitated or hindered international
172 nurse migration (see Appendix 1). The topic guide was developed based on findings from interviews
173 as part of the larger research project as well as a structured online search about key developments in
174 the field of India-UK health worker migration between 2019 (the year the 2019 NHS Long-term Plan
175 was launched, laying out the strategy for international health worker recruitment) and 2023 using
176 the search terms ‘nurse/nursing’, ‘health worker’, ‘UK’, ‘India’, ‘migration’, ‘recruitment’ and ‘NHS’
177 connected by Boolean operators. It was also guided by previous work by a research team member
178 examining brokers in healthcare (49, 50). Respondents were informed that all data would be
179 anonymised and that they could withdraw from the study any time before the end of the data
180 collection period. Interviews lasted between 40 and 65 minutes.

181

182 *Data Analysis*

183 Due to the commercially sensitive nature of the interview topics, the interviews were not audio-
184 recorded. Detailed notes were taken during and following the interview and subsequently typed up
185 in MS Word. Open questions and key points were discussed amongst the larger research team and,
186 when necessary, respondents were asked for clarification through follow-up interviews or via email.
187 Final interview notes were analysed thematically (28) by the first author with the help of the
188 qualitative data management software MAXQDA. After early familiarisation with the data, initial
189 descriptive codes were derived by [removed for peer review] through close and repeated reading of
190 the data and discussed with other members of the team. Coded data were subsequently reviewed

191 and grouped according to larger themes, processes and actors. There were three themes, each
192 comprising between one and three subthemes, reflected in the structure of the findings section. An
193 MS version of the coding tree has been added as an Appendix (Appendix 3). Rigour was maintained
194 through quality control procedures for interviews such as interviewer training, the joint development
195 of topic guides and co-interviewers; and the discussion of codes and findings amongst the research
196 team.

197

198 *Ethics*

199 Ethics approval for the research was provided by King's College London and is fully compliant with
200 the ethical principles enshrined in the Declaration of Helsinki.

201

202 *Patient and Public Involvement*

203 While patients were not involved in the design or management of this research, it has been
204 developed in cooperation with an advisory network including public and third sector organisations.

205

206 *Data availability statement*

207 Interview notes are available via the UK Data Service.

208

209 **Findings**

210 *A nurse migration industry*

211 In India, the evolving and heterogeneous nurse migration industry is comprised of an eclectic mix of
212 public and private actors. The majority of our respondents facilitating nurse migration worked for
213 commercial agencies but some worked for faith-based organisations, professional associations, trade
214 unions and government departments. All focused on the production of nurses for export. They offer
215 a range of services in the education, training and recruitment of nurses. Multi-speciality brokers offer
216 some combination of the brokering of professional placements, course enrolment (usually by agents
217 referred to as 'education consultants' who place Indian students in universities abroad), visa services,
218 exam and interview training, and language training for different national requirements. One agency,
219 for instance, worked closely with an English NHS provider and centre for Objective Structured Clinical
220 Examinations (OSCE - a clinical competency test that is part of the UK Nursing and Midwifery
221 Council's (NMC) registration process for nurses and midwives trained abroad) to set up their model.
222 It has also bought real estate to house nursing candidates and establish a residential "boot camp

223 style programme” (TNP267); this agency offers a comprehensive package from recruitment to
224 cultural induction and the initiation of social ties, claiming this has led to a 100% retention rate.

225 While the major share of the cost associated with international migration is borne by UK employers,
226 fees for any additional training or non-essential services, for example supporting the visa application,
227 are borne by the nurses themselves. Most agents we spoke with had somewhat opaque pricing
228 schemes; one suggested (TNP262) that just the additional support for a visa application costs
229 between INR 7,000 and 10,000, or £70-100, roughly a third of an average nurse’s monthly salary. Not
230 least, nurses usually have to pay back at least a share of their relocation cost if they break their
231 stipulated employment contracts within the first two to three years; while practices vary between
232 Trusts, this can be between 75% of the relocation costs during the first year and 25% during the third
233 year of their contract (TNP262). From a Trust perspective, this may well be justified given the large
234 investment needed to recruit internationally (respondents estimate the average cost of recruiting an
235 international nurse at between £10,000 - £12,000, e.g. TNP049); however, for nurses it means that
236 training for migration and migrating itself carries significant financial risk. The Indian Ministry of Skill
237 Development and Entrepreneurship has been an active player in the export of nurses too, pledging to
238 supply 300,000 healthcare workers, including nurses, to countries such as the UK, Germany and
239 Australia by 2022 (29). In addition, many respondents reported that Indian state governments were
240 seeking to boost outward nurse migration, not only for the economic benefit of increasing
241 remittances but also to counter growing youth unemployment or address gender inequalities
242 (TNP062; TNP262). Some state governments have set up their own recruitment wings to exert a
243 degree of control over outward migration. For example, the Kerala government oversees two
244 agencies, the Overseas Development and Employment Promotion Consultants (ODEPC), established
245 in 1977 under the Ministry of Labour, and the Department of Non-Resident Keralite's Affairs (NORKA)
246 Roots, established in 1996 to address the grievances of Keralites living abroad (48). Others, however,
247 seek the support of experienced market-based recruiters with the networks and capital to promote
248 migration in specific areas of employment. For instance, one agency had been approached by the
249 state government of Uttar Pradesh, said to be keen on developing a nurse migration programme as
250 part of the State government’s *Nari Shakti* programme to empower young girls and women through
251 education (TNP262).

252 *The large-scale production of nurses for export*

253 The production of Indian nurses for export involves mechanisms to educate, train and recruit nursing
254 candidates; to facilitate their sponsorship and visa applications; to organise their travel; as well as
255 providing pastoral care. The production of emigratory nurses for export specifically involves the

256 international orientation of curricula by nursing colleges, offering on-the-job training by
257 predominantly private providers, as well as language and exam training.

258 *Role of nursing colleges in shaping a workforce for export*

259 Nursing colleges play an active role in shaping a workforce for export. Interviews in our study
260 indicated three routes through which this occurs: the international orientation of nursing colleges;
261 collaborations between recruitment agencies and nursing colleges; and, consequently, recruitment
262 agencies' practice of approaching nursing candidates before they have passed professional licensing
263 exams.

264 Private nursing colleges have developed explicitly international curricula and orientations. One such
265 example is Charkos College of Nursing, a newly opened, private college for nursing and allied health
266 professions in Mysore, Karnataka, founded by recruitment agency Charkos Global. An agent working
267 with the college (TNP267) told us how it employs predominantly international faculty (50% of the
268 faculty are from the UK or US) and uses an "international curriculum" or "international pathway"
269 geared towards the US and UK labour markets but also including more general guidance on how to
270 secure employment abroad. Offers include instruction for the International English Language Test
271 System (IELTS) or the Occupational English Test (OET) as well as an NHS Orientation module and
272 training for the OSCE. While the college is not exclusively focused on educating nurses for export, the
273 majority of students choose this international pathway. Another UK-based agent (TNP062) suggested
274 the potential for developing nursing colleges in sending countries such as Kenya, dedicated to
275 meeting the training requirements for one specific country. Though these examples are from the UK-
276 context, the phenomenon itself is not restricted to India-UK migration routes: agents in our sample
277 have told us about their plans to extend international orientation to include, for instance, elements
278 of Australian and German clinical conventions and language skills (TNP257; TNP246; TNP269;
279 TNP267) or Japanese language skills (TNP269).

280 Nursing colleges also enter into collaborations with commercial agencies wherein the latter advertise
281 migratory services to nursing candidates, seeking to encourage aspirations for migration. Where we
282 encountered them, these collaborations were informal, but an India-based agent (TNP256) noted
283 that colleges collaborate willingly with agencies as it gives them a competitive edge, allowing them to
284 market themselves as providing international opportunities for nurses. Agents we spoke with held
285 seminars with nursing students in order to inform them about the opportunities awaiting them
286 abroad and to identify potential recruits (TNP256; TNP267). Collaborations between agencies and
287 nursing colleges are heavily commercialised and usually work on a commission-basis; if a nursing

288 student signs up to the recruiters' agency and secures a placement abroad, the nursing college from
289 which they graduated receives a share of the agency's commission (TNP265; TNP062).

290 Such is the penetration of agencies into the college system that many enlist nursing candidates for
291 future migration while they are still at college or studying for their language exam, creating what one
292 agent (TNP257) described as a "pipeline" of recruits. With the security of one lucrative job offer
293 abroad in hand, nurses rarely applied for other jobs abroad. English NHS Trusts are reported to have
294 followed this anticipatory recruitment model for some time, and have the advantage of colonial
295 language links (TNP257). However, respondents told us this was also increasingly popular for
296 destinations where English is not the main working language. For example, Germany has previously
297 struggled to find candidates due to their lack of German language skills. Recognising the opportunity
298 to move into this market, actors in the Indian migration industry are now lobbying for German
299 lessons to be integrated as electives into some Indian nursing curricula (TNP257). A downside is,
300 however, that many candidates end up not passing their language tests, reducing the effectivity of
301 this model (TNP062).

302

303 *Language schools and exam boards expand their market*

304 Another key player in shaping a nurse force for export are (English) language schools and exam
305 boards. A key requirement for Indian nurses seeking to move abroad is the acquisition of advanced
306 language skills, predominantly English. For example, nurses seeking to work in the UK need to
307 demonstrate a working level of English by a minimum overall level 7.0 on the International English
308 Language Test System (IELTS). Alternatively, they can choose to sit the Occupational English Test
309 (OET) where a minimum Level B in speaking, listening, and reading and Level C+ in writing is required
310 (47). Language schools offering coaching have been mushrooming across India. They are prominent
311 in urban hubs for nurse migration such as Kochi and New Delhi, as our fieldwork has shown, where a
312 steady supply of aspirants can be enrolled.

313 Recruitment agencies look to collaborate with these language schools, for example making use of a
314 centre's database of students to contact potential recruits (TNP062; TNP255). One agent explained
315 that some language schools make such data available to agents for a fee; others work on the basis of
316 results – the language school receives a 'referral' fee from the agent for each eventual recruit
317 (TNP062). There is also reputational benefit to be had by schools, which can cite to the high
318 proportion of their students who go on to work internationally which is "good for marketing"
319 (TNP062). One respondent (TNP255) described these language schools as "feeding centres" for
320 recruiters. While no exact figures are available, the same agent estimated that around 70-80% of the

321 nurses who initially joined their organisation for language training eventually also signed up to their
322 recruitment services.

323 Further opportunities for revenue generation have been created through the outsourcing of
324 language examination. While the IELTS used to be offered by a UK public body, the British Council, in
325 India it is currently offered by IELTS Australia Pty Ltd, a wholly owned subsidiary of private education
326 provider IDP Education Ltd with centres in 75 cities in India. At the time of writing the fee per test is
327 INR 16,250 (around £160). OET is offered in partnership with various educational institutions, usually
328 private, at multiple sites across India for approximately INR 30,000 (£300) (30,31). By way of
329 comparison, a Delhi-based recruiter told us that nurses in a government hospital earn around INR
330 40,000 to 45,000 (between £400 and £450) and only 22,000 INR (£220) in an average, 200-bed
331 private hospital. Large, internationally accredited hospitals such as Apollo were “somewhere in the
332 middle” and usually paid around INR 30,000 (£300) (TNP257). Fees for the OET thus surpass the
333 average monthly salary of a nurse working in the private sector.

334

335 *The role of private hospitals*

336 Since a minimum of one year of clinical work experience is required for nurses seeking employment
337 in the English NHS, Indian (private) hospitals play an important role in the export of nurses since,
338 after graduation, it is here that nurses can gain the clinical experience needed to obtain a job
339 internationally. This allows those hospitals to fill staffing gaps with newly qualified and therefore
340 relatively cheap nurse labour. A Kochi-based agent (TNP247) we spoke with was approached by a
341 private hospital chain to establish a scheme whereby nurses would work in their facility for around
342 one year and in turn obtain an “experience certificate” in order to be able to move abroad. In their
343 description, such placements resemble internships rather than full-time and remunerated positions.
344 Another respondent, a Delhi-based nurse activist and public health consultant (TNP213), noted that
345 while everyone had “their eyes on the big birds like Apollo”, it was usually the smaller private
346 hospitals that were collaborating with recruitment agencies. In their experience, recruiters and
347 hospitals also shared the recruitment fee paid by the overseas employer in the case of NHS Trusts
348 between £1,000 and £2,000 depending on the intermediaries involved (TNP213).

349 The downside of this situation for the private hospital employers is low staff retention. Recruitment
350 agents’ relationships with private hospitals in India can therefore be fraught: one agent (TNP 251)
351 jokingly said that hospital managers would “kill” any agent who tried to recruit amongst the
352 hospital’s staff. One respondent, a Delhi-based healthcare provider who had just lost a head nurse to
353 a post in Canada, noted that the “nurse drain” was a huge problem since “we have a crisis here”

354 (TNP268). Hospital managers have also reportedly refused to issue reference letters to nurses in an
355 attempt to prevent them leaving abroad (TNP251). This has created a form of dependency for junior
356 nurses working in the private sector and seeking to apply internationally. A reverse development,
357 however, is that some private hospitals have reportedly increased nurses' salaries in order to retain
358 them (TNP262).

359

360 *Niche production of customised nurses*

361 While the actors and processes described above claim to train and prepare nurses for a broadly
362 framed global career, in practice, training is often geared towards specific countries and the creation
363 of customised workers ready to meet specific shortages or working environments.

364 *Specialised simulation-based training*

365 Bespoke offers include educational and practical, also simulation-based, training. For instance, one
366 agency we spoke with had developed a special foundation programme for mental health to meet
367 demand from UK organisations for mental health nurses (TNP267). The creation of a dedicated
368 training programme was necessary because of the absence of specialised mental health nursing
369 training in the Indian curriculum, and the social stigma around mental health in the country. As the
370 agents struggled to identify certified mental health nurses for the UK labour market due to this
371 absence, they developed the idea for the programme in order to smooth the process and fulfil the
372 NHS requirements. At the time of the interview, they were about to place 120 mental health nurses
373 across different providers in the UK, and had created specific mental health training and practical
374 examination modules (ibid).

375 Training and simulation equipment is also procured on the basis that it adequately mimics equipment
376 used in the target country. One agent (TNP267) has developed a preceptorship programme for
377 clinical care nursing in collaboration with a London-based hospital Trust, with 50% of the programme
378 conducted in India in order to save on training costs. For this, the agent had purchased the same
379 model ventilators used in the Trust's ICU, enabling nurses to be trained specifically for this clinical
380 infrastructure. This way, the candidates develop highly specialised skills and expertise according to
381 the requirements of UK healthcare providers. Other large recruitment and training organisations
382 such as Chandigarh-based INSCOL have also been reported to be using simulation tactics for
383 specialised training.

384 *Soft skill training: country-specific clinical cultures*

385 The migration industry also offers a range of trainings about different clinical cultures in order to
386 shape nurses' practices and subjectivities according to specific national standards and expectations.

387 Respondents explained that such training is important because of key challenges related to differing
388 clinical cultures between countries; specific soft skills are crucial to caring for patients (TNP269). UK-
389 based respondents reported these to include differing perceptions for example around patient data
390 confidentiality and consent taking (TNP264). They described Indian nurses as often being rather
391 deferential or from a “culture of pleasing” (TNP062), making them very reluctant to raise concerns.
392 This, respondents argued, could provide a fertile ground for errors, ultimately compromising patient
393 safety. Many Indian health workers thus “run into trouble”, as one Indian recruiter (TNP264)
394 stressed, during their first six months in the UK. As a response to this, a range of programmes have
395 been developed that focus on cultural dimensions of living and working in the UK and specifically in
396 the NHS. Such programmes are not just aimed at helping nurses settling into their new communities,
397 but also at instilling the values and practices of the NHS in them, as another respondent in India
398 framed it.

399 These programmes range from month-long induction packages to the plans for a “finishing school”
400 for nurses and allied health professionals in order to learn “how to behave in a culturally appropriate
401 way” in the receiving country (TNP264). The focus here, then, is not on nurses’ clinical skills but on
402 the embodiment of the values of nursing in the target country, moulding nurses according to a
403 specific country’s or institution’s values and practices. Rather than focusing on verifiable skills or
404 competencies, such training targets subjective traits and personal characteristics such as being less
405 deferential. In brief, nurses need not only master clinical and language skills but also be well-versed
406 in their host country’s social and cultural competencies. One agent (TNP269) suggested that their
407 company charges around INR 20,000-30,000 (£200-300) for such soft skill and clinical training though
408 this cost is usually covered by the overseas employer.

409

410 **Discussion**

411 The recruitment of Indian nurses for the UK is made possible by an evolving array of markets and
412 services, each targeting either a specific or a variety of specialised services. Connected through a
413 networked structure of agents and other, predominantly private actors, these services are driven by
414 profit-orientation and often fluctuating international labour market demands. Recruitment thereby
415 involves more than merely the facilitation of migration but can be described as a migrant production
416 process, lasting from just a few weeks to several years, seeking to transform nurses, or nursing
417 candidates, into emigratory workers. While the mutual recognition of qualifications and degrees
418 provides the policy framework for this process (32), a transnationally competitive nurse not only
419 requires verifiable clinical and language skills, but must also embrace the cultural values and

420 practices of their host country and institution. In this sense, the process involves the production of
421 nursing subjectivities, i.e. particular positions of identity and agency according to dominant forms of
422 knowledge and practice (33,34). Here our work corroborates findings from earlier work in migration
423 studies in Indonesia and the Philippines that the shaping of the ideal migrant worker can include an
424 extensive set of attributes such as the gender of workers (35), and even extends to subjective
425 attributes such as being docile or hardworking (36).

426 The production of nurses thus involves both the large-scale production of emigratory nurses and the
427 niche production according to nationally-specific criteria and standards. Indeed, this seems to
428 resemble Post-Fordist production in manufacturing: a model characterised by flexible specialisation,
429 decentralised management and a networked structure for manufacturing accompanied by a global
430 orientation (37,38). Garment manufacturers such as Benetton, for example, derive their success from
431 adaptation to market trends and the networked production through a range of specialist
432 subcontractors concentrating on niche production (39). While clothes are still mass-produced,
433 smaller batches are tailored to specific market demands such that niche production sits amidst a
434 wider, mass-production environment (ibid.). There has been some discussion of post-Fordism in the
435 context of healthcare in HICs and changes in the nature of the welfare state, specifically the
436 introduction of market-oriented reforms in healthcare provisioning in Israel and the UK (e.g. 37,38).
437 Here we suggest its applicability to increasingly flexible and globalised healthcare labour processes,
438 as the demand for workers is no longer seen as only a mass market but a fragmented one that is best
439 served by specialised services and ultimately workers. The migration process resembles an assembly
440 line that produces both generic emigratory *and* customised workers in line with a Post-Fordist
441 production model. These types of workers are not always clearly distinguishable; there is significant
442 overlap in that nurses trained for the UK context may become more competitive for other contexts,
443 too, testament to the increasing step-migration of health workers (42).

444 The production of nurses is not a process of one-sided commodification, as it furnishes (some) nurses
445 with a new kind of agency, with benefits for those who migrate and who often have to pack back
446 educational loans, and their families. However, there are several potentially negative repercussions
447 for the nurses. First, the competencies taught to nurses are governed by international market
448 opportunities and the profits that can be made through these. This may suit nurses who leave India,
449 but the flexibilities intrinsic to post-Fordist production systems raise the spectre that trainee nurses
450 could find themselves trained to work in a market that no longer wants them. Further, these
451 flexibilities afford substantial leverage to buyers in HICs to make new demands at short notice, or
452 even shift production to other settings. This also leaves suppliers in LMICs in a state of dependency
453 and raises the spectre that they specialise in markets or services no longer needed.

454 Second, given the commercial nature of these markets, the various services we have described are
455 offered at a significant financial cost. The UK adheres to the WHO Global Code of Practice for
456 International Recruitment (6) such that the receiving healthcare institution is expected to cover the
457 largest share of the cost of training and travel. However, fees for additional training as well as
458 services related to the visa application process are borne by the nurses themselves. As noted in the
459 findings, costs to be borne by the nurses can include items like INR 16,250 for IELTS and INR 7,000-
460 10,000 for visa application fees. For context, nurses in an average private hospital in India earn in the
461 region of INR 12,000-15,000 to INR 22,000-30,000 (TNP257). Even those costs covered by future
462 employers such as flights may often have to be initially advanced by nurses, who therefore incur
463 large debts (on debt-financed migration of nurses see Walton Roberts and Rajan (43)), while some
464 employers in the UK include contractual clauses to repay a share of relocation costs in the event of
465 leaving employment within 2-3 years. This means that for nurses, international migration also poses
466 the risk of indebtedness. Moreover, international migration can increase the risk of exploitation
467 within India given the requirement of hands-on clinical experience incentivises recently qualified
468 nurses to work for very low or no remuneration in order to acquire this experience. This form of
469 exploitation has existed in the healthcare sector prior to the large-scale migration of nurses (44, p.
470 516) but may even increase with the surge of international labour market demands. In our case
471 study, healthcare providers contribute to the precarisation of nursing labour by creating forms of
472 employment that is more akin to internships or placements, unpaid but necessary to find
473 employment abroad. Overall, these developments may further entrench existing inequalities among
474 the Indian nurse force: those without language skills, cultural capital or the financial means to pay for
475 additional training or to recoup the cost of relocation are left behind with little opportunity for
476 specialised exposure. This may not only add to already existing inequalities according to class and
477 caste (see also 43), but also have negative repercussions for the source healthcare system as highly-
478 qualified nurses increasingly emigrate to work elsewhere and potential training resources are
479 redirected. Efforts exist at both the state and the federal level to counter the shortage of nurses in
480 India but regional disparities remain. For instance, a current central government scheme aims to
481 establish 157 nursing colleges providing full degrees as well as short-term training opportunities but
482 this scheme has not been utilised equally by all states (46). Concern has been raised over the poor
483 uptake of the scheme, especially by states with a chronic shortage of nurses such as Uttar Pradesh
484 (ibid). Several state-level initiatives aim to address gaps and the uneven rural-urban divide in the
485 number of nurses, and human resources for health more broadly; however, these have often failed
486 to be properly monitored and a long-term strategy to increase training opportunities has so far been
487 missing. How the trend to produce both emigratory and customised nurses shapes the development

488 of human resources for health planning and recruitment within India is an important area for future
489 research.

490

491 *Strengths and Limitations*

492

493 A key strength of this study is its qualitative approach which has allowed us to obtain data from a
494 relatively large number of representatives from a sector of agents usually difficult to reach given the
495 potential commercial sensitivity of the questions discussed. Similar studies, for example on
496 pharmaceutical procurement, manufacture and pricing (45) have worked with significantly smaller
497 sample sizes of less than ten participants. By using fieldnotes rather than recordings we gained
498 access to a group of companies that are typically difficult to research due to privacy concerns;
499 however, this has also meant we have relied on detailed fieldnotes rather than transcripts in our
500 analysis. For the same reason findings are not illustrated by direct quotations. Our study is also, to
501 our knowledge, the first to have specifically examined India-UK dynamics in international nurse
502 migration. Geographically, the study focused on specific hubs in India to enable local networking and
503 access, and to explore their relationship with the UK. Models and practices identified in this
504 geographical setting might be replicated elsewhere, but this relatively narrow geographical focus
505 may constitute a limitation. Finally, while highlighting their importation, this study has not been able
506 to systematically and quantitatively assess the costs of training, who bears these, and the knock-on
507 effects. a need for future research on this aspect.

508 **Conclusion**

509 We have used the case study of India-UK health worker migration to illuminate the making of new
510 markets in the education, training and recruitment of Indian nurses for international employment.
511 These commercialised processes not only facilitate migration but are more comprehensive in that
512 they aim to furnish nurses with a range of skills and competencies beyond their clinical expertise;
513 they thus actively produce specific nurses for export. The model is not dissimilar to that used in other
514 manufacturing industries. While some actors seek to produce generic emigratory workers, others
515 focus on the niche production of highly customised nurses for nationally specific labour market
516 demands. The skills and competencies taught to nurses are selected based on current international
517 market opportunities which may benefit nurses who seek to leave India, but the often ephemeral
518 and flexible production regimes mean that the skills and competencies are liable to change at short
519 notice. Given the commercial nature of these markets, the training nurses must adopt to secure
520 overseas employment are offered at a significant cost, possibly further entrenching existing social

521 inequalities in the Indian nurse force. This may ultimately also have negative repercussions for the
522 source healthcare system as highly-qualified, specialised nurses seek to work in better-resourced
523 healthcare systems abroad.

524

525 **Competing Interests**

526 None declared.

527

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