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International Nurse Migration from India and the Philippines: The Challenge of Meeting the Sustainable Development Goals in Training, Orderly Migration, and Healthcare Worker Retention

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Title: International nurse migration from India and the Philippines: the challenge of meeting the sustainable development goals in training, orderly migration, and healthcare worker retention.

Abstract: This paper examines nurse migration from India and the Philippines through the lens of the sustainable development goals (SDGs) 4.3 (access to training), 10.7 (orderly and responsible migration), and 3.c (retention of health workers). The international migration of health workers has increasingly featured on the agenda of global health agencies. Ameliorating the negative impact of international nurse emigration from low income nations has been addressed by several western governments with the adoption of ethical recruitment guidelines, one element of an orderly migration framework. One of the challenges in creating such guidelines is to understand how the emigration of trained nurses influences health education and clinical training systems within nurse exporting nations such as India and the Philippines, and how these relate to various SDGs. This paper maps the connections between India's and the Philippines' increasing role in the provision of nurses for international markets and the SDGs related to training and migration governance and the retention of health workers. The paper calls for greater attention to the *global* structuring of migrant mobility in order to assess *national* abilities to meet SDG goals in these areas.

1. Introduction

With the introduction of the Sustainable Development Goals (SDGs) as the global framework for development it is necessary to consider the ways in which nations might meet these new goals. While the SDGs are generally perceived as preferable to the previous millennium development goals (MDGs) for their more expansive and inclusive agenda, they also bring to the fore new development demands and expectations. In particular, this paper focuses on the challenges that India and the Philippines face in meeting the sustainable development goals 4.3 (access to training), 10.7 (orderly and responsible migration), and 3.c (retention of health workers) in the case of nursing. India and the Philippines are both leading countries in the supply of internationally trained nursing labor for global markets, and as 'developing countries' both nations are intended beneficiaries of the SDGs. In both places the increased number of nurses actually engaging in or desiring emigration has been shaped by changes in the delivery of and access to nurse training, raises important questions as to how migration can be responsibly managed, and affects the sending nations' ability and commitment to retain health workers domestically.

The international migration of nurses from low and middle income to higher income nations is significant in terms of the achievement of a number of the SDGs. We explore the connections between the migration of nurses from India and the Philippines and three SDGs in order to understand how various state policies in nursing education and migration governance structure the opportunities of nursing migrants. The three SDGs are; 4.3 “Ensure equal access for all women and men to affordable and quality technical, vocational and tertiary education, including university”; 10.7; “To facilitate orderly, safe, regular and responsible migration and mobility of people, including through the implementation of planned and well-managed migration policies”; and 3.c “Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States”.

The international migration of health workers has increasingly featured on the agenda of global health agencies and is increasingly informed and organized by international markets. A dominant pattern to this migration is the movement of healthcare workers from the global South to the global North (WHO 2014). The negative impact of international nurse emigration from low income nations is evident in terms of the transfer of resources invested in training and the loss incurred by the health sector when trained and experienced health professionals exit national health systems (Aluttis et.al. 2014). Derided as ‘brain drain’ and a perverse form of reverse aid, today healthcare worker migration has been subject to various attempts of international governance through agencies such as the World Health Organization (WHO), International Labour Organization (ILO), International Organization for Migration (IOM) and international medical and health professional councils (WHO 2014). The governance of healthcare worker migration has thus far been addressed by several western governments with the adoption of ethical recruitment guidelines, and by some sending nations including the Philippines in terms of migration management strategies (particularly in the case of recruitment agencies and fees), and strategies for the retention of healthcare workers (Connell and Buchan 2011, Kingma 2006). These approaches to manage the migration of healthcare professionals have

been assessed as having limited influence (Connell and Buchannan 2011). Programs and policies have also been advanced to promote the best use of internationally educated health professionals in their destinations, encouraging their equitable incorporation into receiving country systems, promoting opportunities for return and or circular migration, increasing skills transfers between source and receiving nations, and the increasing use of bilateral agreements that appropriately compensate sending nations for the health worker resources they deploy globally, again with limited effectiveness (Vartiainen et al 2016).

In this paper we demonstrate how the transnational and global nature of nurse emigration challenges national governments in their efforts to meet SDGs 4.3, 10.7 and 3.c. Using the case of the international migration of nurses from India and the Philippines, we argue that the potential of national governments to secure these sustainable development goals is limited by the very global nature of the migration context. We conclude that a more globally orientated approach to achieving the SDGs is needed. Our paper begins with an overview of training, migration and retention issues in nursing in India and the Philippines. We then move to consider the difficulties faced by both nations in improving access to training, the facilitation of orderly migration, and the implications large-scale migration has on healthcare worker retention. We argue that international migration of nurses from the Philippines and India creates distortions in education and health systems that undermine the ability of these nations to achieve these three SDGs; but more than that we argue that the case of nurse emigration illustrates the profound limitations of *national* policy systems being able to influence inherently *global* practices and processes.

2. The nursing sector in India and the Philippines: serving domestic and international demands

Nursing workforce density and distribution

Healthcare systems (including health worker density) in India and the Philippines are inadequate to serve the needs of their respective populations, especially in rural areas, and this is in spite of the fact that both nations have seen health worker training capacity (of variable quality) increase (Hazarika 2013, World Health Organization 2013). Notwithstanding rural health service limitations, it is important

to note that in India's largest cities, as well as in Metro Manila (the Philippines National Capital Region/ NCR) the urban healthcare delivery system can equal the best service in the west (Murray et al. 2016). This inverse relationship between population need and healthcare service delivery is admittedly a universal problem (Fiscella and Shin 2005), but the scale of this inverse relationship in India and the Philippines is immense. The Philippines' urbanised areas of the NCR and CALABARZON have around a fifth of the country's total hospitals and over a third of hospital beds (Romualdez Jr. et al., 2011). The maldistribution of healthcare provision is clear in that the most impoverished region, the Autonomous Region in Muslim Mindanao, has just 0.19 beds per 1000 population (Romualdez Jr. et al., 2011), while the NCR has 2.47 (DOH, 2012). Since 1991 health service delivery in the Philippines has been devolved and is now managed by Local Government Units (LGUs), although the centralised Department of Health continues as the governing agency (Romualdez Jr. et al., 2011). Widespread corruption throughout the Philippines means quality and provision of LGU provided healthcare differs drastically region to region. The urban population represents over 50% of the Philippines' total and while urban areas are well serviced by healthcare facilities at all levels, rural areas often depend on Barangay Health Centers for primary care, which are primarily staffed by non-professionals, professional volunteers and midwives; and where wages are significantly lower than in urban areas (Romualdez Jr. et al., 2011).

Medical services are likewise unbalanced in India, as the 6,281 rural government hospitals have 143,069 beds compared to 3,115 urban hospitals with 369,351 beds (Gupta and Bala 2011). India's rural health posts are staffed by Ancillary Nurse Midwives (ANM) who receive only a year and half of training. Medical posts in India's rural primary and community medical centres are seen as unappealing for medical graduates; they pay little salary, and require doctors to pay for and arrange administrative assistance. Medical officers who do fill these posts are rarely in attendance, and mainly use these postings as a channel for private referrals (Kumar 2013). Nevertheless, both the Philippines and India

have been developing policy solutions to expand healthcare services, mainly through developing forms of public/private universal health insurance to address the needs of the poorest sectors of their population (Drèze and Sen 2013, Bredenkamp and Buisman 2015). The urban-rural discrepancy in health service quality and access is partly due to the fact that healthcare systems in both countries are heavily privatized, which sharply limits access to services by socio-economic status. The state of healthcare delivery, which includes achieving the appropriate balance in health workforce provision, is a key dimension to securing a number of the SDGs. Preexisting imbalances in health delivery systems exacerbate and are exacerbated by the large scale emigration of nurses.

International migration of nurses

The feminized nature of nursing and of nursing migration gives women from India and the Philippines an unprecedented opportunity to train and migrate within the skilled professions rather than in low skilled, precarious work traditionally associated with women's migration (Gaetano and Yeoh, 2010). While acknowledging that precariousness and marginalization may still characterize some nurses' migrant experience (George 2006, Pratt 1999), the potential for greater earnings and improved quality of life through migration is possible. The Philippines has long been the world's primary source of migrant healthcare labor, providing domestic workers and healthcare professionals (predominantly nurses) to over 50 countries worldwide (Lorenzo et al., 2007; Romualdez Jr. et al., 2011; Thompson, 2016). Over 100,000 Filipino nurses were deployed on a temporary basis between 1997 and 2009, while a further 24,000 found permanent overseas positions in the same period (Romualdez Jr. et al., 2011). Significantly more nurses have also left on non-nursing employment contracts and are likely to be found as domestic workers, nannies, and students. While the Philippines has a reputation as the leading supplier of nurses to global markets (Choy 2003) India has also emerged as providing nurses for global demand, with recent media reports suggesting about 25,000 trained nurses are leaving India annually to

work overseas (Times Now 2016). Data from the destination end also suggest these two nations top the migrant nurse source rankings; with the US Commission on Graduates of Foreign Nursing School (CGFNS) (the US is the most significant destinations for internationally trained nurses) indicating that since 2003 India has ranked 2nd after the Philippines in terms of the number of nurses applying to take US nursing registration exams (NCSBN 2016).

Within the Philippines, large-scale migration has long sustained the countries' development goals, and migration can be understood as state-sponsored and state-managed (Guevarra, 2010). Due to its large emigration of domestic workers and nurses over the past four decades, the Philippines is often at the forefront of global commitments to ensure the mainstreaming of gender into migration policy (Tigno 2014). Some have hailed the Philippines as being a 'prototype of a labor exporting country' (Semyonov and Gorodzeisky 2005, 47) for the government's commitment to protecting and promoting migrant rights, yet others disagree. Calzado (2007) argues the protection of rights is prioritized so the government can decrease the risks associated with migration. Tigno (2014), conversely, believes the notion of protection is part of a wider discursive strategy to legitimize the Philippine government's strategy of labor export in the eyes of its populace and of the international community. While the actual extent to which the government offers protection to female migrants has been long disputed (Cai 2011; Tigno 2014), the implementation of Republic Acts such as the Migrant Workers Act, and the Magna Carta of Women are important in helping to ensure responsible migration and in offering equal access for women to training, resulting in the Philippines being ranked globally in the top 10 in terms of gender equity (World Economic Forum 2016). The relative success of nurse migrants in destination countries in comparison with domestic workers and healthcare assistants, their economic earning capacity, improved status, and increased mobility, freedom, and rights, has made nursing one of the most popular degrees in the Philippines; this is increasingly the case in India as well (Bhutani et al., 2013).

Combined with the Philippines' state-sponsored culture of migration, women, particularly nurses, perceive emigration as one of the only means to escape poverty and un- or under-employment, in order to achieve the social mobility they and their families' desire (Thompson 2016, Gill 2016). While the state organized nature of nurse emigration is less official in the Indian case, the Government of India appears to favor the increased privatization of the health educational sector, which is driven by commercial interests that play off the international demand for nurses (Timmons et. al. 2016). But, at the same time the Indian state has acted to restrict female domestic worker migration by age in the name of protecting their rights (Kodoth and Varghese 2012), and in the case of nursing, curtailing migration to certain countries (including Gulf Cooperation Countries) as permissible only in cases involving government recruitment agencies (GOI emigrate website). These restrictions were imposed in response to concerns voiced in media stories of the exploitation nurses faced in the notoriously unregulated intermediary industry in India.

These confounding discourses of promotion and restriction can also be revealed in how in the Philippines patriarchal national discourses positions women as 'suffering martyrs' who must sacrifice personal desires and needs to provide for the families, and accept suffering, servitude, and domesticity as a part of lived everyday experiences (Roces, 2009). Women are positioned as being natural caregivers, and therefore well suited for caring occupations such as nursing. When they cannot care for their families due to structural pressures in the Philippines, they are expected, by the state and by their family to migrate and seek opportunities elsewhere. Such gendered submissive norms are used by the Philippine state and recruitment agencies to actively market nurses and other migrants as being naturally caring, passive and subservient, hardworking, and inherently nice and friendly (Pratt, 1999; Terry, 2014; Tigno, 2014).

The potential international returns on the export of nurses makes it complicated (and perhaps even undesirable) for states such as India and the Philippines to focus excessively on domestic nurse retention strategies at the expense of skilled labor ‘export’. First of all, it is incredibly difficult to prevent people from seeking overseas opportunities if they so desire, additionally, as developing countries, it is difficult if not impossible for the states to implement policies or benefits which may encourage return migration (such as higher wages and better working conditions than those in destination regions), or to provide enough employment opportunities for nursing graduates in the first place. Moreover, nurse migration is one of the most economically lucrative forms of migration (particularly since women have repeatedly been found to remit more money than men (IOM n.d.)). The exportation of nurses is financially advantageous for national governments, and it is therefore undesirable and infeasible for sending states to reduce this revenue stream by heavily investing in the creation of new domestic opportunities. In light of these issues, the ambivalence both the Philippines and India exhibit toward reducing nurse emigration is understandable. Furthermore, the increasingly privatized training systems in place in both countries result in the respective governments having limited control over the very conditions of nurse production that service international, rather than national demands (Marcus et al 2014). The two countries have instead increased access to education in order to produce an excess of candidates so that both domestic and international needs can be served (Walton-Roberts 2015, Adeyemo and Schoole 2016).

3. Nursing education: Access, training quality and quantity

SDG 4.3 is to ‘ensure equal access for all women and men to affordable and quality technical, vocational and tertiary education, including university’. Nursing is an important professional occupation for women, and is partly framed by state investments in education, training and employment at the local, national and increasingly the international scale (Yeates 2009). Nurses comprise the largest sector of the

healthcare workforce and their incorporation in healthcare systems is a central factor in the quality and effectiveness of healthcare delivery systems (Connell and Walton-Roberts 2016).

The expansion of nursing educational facilities in both India and the Philippines offers more opportunities for women to enter professional training opportunities, but issues concerning quality, cost and subsequent retention trouble the sector. Part of the explanation for this concern with the quality and accessibility of nursing education emanates from the privatization and commercialization of nursing education in both countries. Nursing education in both India and the Philippines is largely provided through private institutions (Hazarika 2013, Sengupta and Nundy 2005, Walton-Roberts 2015). Educational institutions offering nursing degrees in both countries make explicit links between nursing qualifications and overseas employment (Masselink and Lee 2010, Walton-Roberts 2015). Nursing, in the Philippines and the Indian context, has been imagined and ‘considered an international passport’ (Hollup, 2012, p. 1296; Walton-Roberts 2015), and research suggests that nursing has become an occupation that young Indians are attracted to because it offers opportunities for overseas, not domestic, employment (Walton-Roberts et al 2017), and private training institutes are keen to service, as well as encourage this demand (Rao et al 2011).

India currently has 2,526 GNM, 1,627 BSc, and 529 MSc government and private training institutes recognized by the Indian Nursing Council in 2016-17; this contrasts to 1,667, 945, and 138 respectively in 2008-09 (INC 2016). In the 2000s the Indian Nursing Council, under pressure from both private and state level interests, relaxed various criteria for the establishment of nursing colleges, and in some states these institutions mushroomed (Walton-Roberts 2015). The country has subsequently experienced a substantial increase in nursing schools and registered nurses (Tiwari 2012). In terms of access, government college education is subsidized in India, but seats are limited, and caste based reservations feature in the allocation of seats. This leaves a large number of lower middle class students

having to complete a nursing degree in the more expensive, but more accessible, private colleges; which often necessitates they access loans in order to complete their studies (Walton-Roberts and Rajan 2013). Despite the recent growth in the number of nurses produced (in 2015 there were over 180,000 INC recognized diploma and BSc nurse training seats (India Nursing Council 2015)), training has been criticized by researchers and the state for not providing adequate practical experience and the nursing profession has not overcome its lower status within the medical hierarchy (Rao 2011, Nair 2012).

In the Philippines' nursing education is also largely privatized, and the sector has grown exponentially since the 1980s. There are currently at least 450 schools offering a Bachelor of Science in the Philippines, a tenfold growth since the 1970s, although most growth occurred from 2000 (Lorenzo et al., 2007). Many of these new institutions were created to offer courses in nursing, capitalizing on the increasingly profitable nursing education sector (Masselink and Lee, 2010), and the majority are found in the NCR or in other urbanized areas. In the Philippines, nursing degrees are often one of the most expensive courses available at institutions, prohibiting many working class and impoverished women from entering nursing (Zosa and Orbeta Jr., 2009). The rapid expansion of nursing colleges in the Philippines has also raised major concerns with issues of quality.

The privatization and expanse in nursing education in both the Philippines and India raises questions regarding the quality of nurse training, particularly in the newer institutions set up exclusively for nursing. In the Philippines, for example, only 12 nursing education providers are classified as 'outstanding' (Goode, 2009), and a significant proportion have pass rates of below 50% (Brush, 2008). Indeed, in 2008 although over 150,000 students sat the Nursing Licensure examination, only half passed the exam to become professionally registered nurses (Romualdez Jr. et al., 2011). It should also be noted, that since the global financial crisis, numbers of nurse enrollees have fallen as the opportunities for nurse emigration become less certain. Several new institutions have already closed, and others are

facing the possibility of closure due to consistently low standards and lower levels of enrolment (Pazzibugan, 2012). Such variable quality of nurse training in nurse exporting countries such as the Philippines and India means that international recruiters are unlikely to accept qualifications and evidence of training at face value. Instead, minimum levels of experience, generally in tertiary level large hospitals, are required, and nurses are almost always expected to take national nursing examinations of the country of destination. This makes nurse migration expensive, channels nurses into urban settings before migration, and results in many becoming deskilled after they migrate.

Despite the rise of increasingly privatized education sectors in India and the Philippines which are oriented to service international demand for nurses, the development of nursing as a profession in both countries has long had an external orientation, with instruction in both locations predominately (or in the case of the Philippines, solely) undertaken in English. This external orientation has been shaped through the colonial and neo-colonial influences of the US and UK (Choy, 2003; Reddy, 2015). Today both the Philippines and India have found a place as key providers of nursing labor for global markets, and in the case of the Philippines Tigno (2014, p. 28) goes so far as to argue that nursing education is undertaken ‘for the benefit of (and dictated by) the global market’. The Philippines has long had a close association with the US, and historically the US has been the preferred destination for Filipino nurses from the early 20th century onwards (Choy, 2003). The Philippines has had its own NCLEX test center since 2007, allowing nurses to take the US nursing examination for Registered and Practical Nurse status in Manila (Margallo, 2013). Today, as fewer opportunities remain in the US, it is increasingly common for nurses to enroll on language courses alongside their degrees in order to make themselves more flexible as future migrants. Japanese/Nihongo, Arabic, and German are now common courses in the Philippines reflecting bilateral agreements made between the Philippines and other nations (Masselink and Daniel Lee, 2013). In the case of India the main markets (OECD and GCC nations) are

mainly recruiting Indian trained nurses for their English language competency. India also hosts five NCLEX testing centers.

In both cases nurses become commodities in the large scale ‘exportation’ of care labor (Goode 2009, Choy 2006, Reddy 2015). Nurses are actively marketed to international recruiters based on supposed natural characteristics which are gendered, racialized, and ethicized (Terry 2014; Tigno 2014). Furthermore, the lucrative nature of nurse migration for sending nations results in government policies and initiatives which seek to ensure the growth and continuation of the ‘exportation’ of nurses. These factors suggest that the SDGs aimed to provide access to quality training, retain health workers while also managing migration may not be fully compatible. For example, while the Philippines has a multitude of policies that seek to offer protection to its migrants, there is a distinct lack of policies and initiatives that attempt to improve the condition of nurses domestically; indeed many proposed policies in this regard tend to be shelved (Dizon 2016). Poor working conditions including low wages, long shifts and low status, as well as a lack of opportunities for professional development, are often cited as a primary cause for Filipino nurses seeking employment overseas (Ronquillo et al., 2011). Additionally, the requirement for experience in large urban hospitals has led to the situation where health institutions are able to ask recent graduates to volunteer their time, or indeed in many cases pay a ‘training fee’ in order to gain the necessary experience for overseas employment. The same can be said for India in light of the hard fought battles over improved salaries and conditions of work for nurses domestically (Nair et al 2016). The poor domestic working conditions for nurses in both India and the Philippines are frequently noted as the cause for much nurse emigration; yet neither of these governments have significant motivation to vastly improve conditions in order to retain its nurses, depending instead on the significant oversupply of newly trained nurses that emerge from private colleges.

In the case of the SDG goal 4.3, we can see that the promise of international migration has distorted the nursing educational systems in both countries. While women and men can access training, as SDGs 4.3 demands, the affordable and high quality aspect of such training widely varies. The sustainability of an education sector oriented to serving the health needs of other high income national health systems will not necessarily advance the development needs of India and the Philippines.

4. Nurse migration, mobility and vulnerability

Since nursing is such a key international migration route for the both India and the Philippines, it is appropriate to explore how these systems might be considered through the lens of SDG 10.7 (orderly and responsible migration). First it should be noted that the state does harbor a responsibility for this practice. India has long been one of the main providers of doctors, and increasingly nurses, for overseas health systems, especially in the Post-Independence period when medical and health professionals were funneled into the NHS. The Philippines, due its post imperial ties with the US, has sent nurses to the US for more than a century (Choy, 2003). These migration histories, however suggest that sending, receiving and transit states and markets must all play a part in achieving SDG 10.7. In the case of nurse migration. Some of the key factors that need to be addressed through an orderly and responsible migration lens include the exploitation of nurses seeking experience before they can migrate, the role of recruiters, ethical recruitment, the vulnerabilities of geographical and visa category two-step migration, and international credential assessment problems.

Most international migration opportunities for nurses stipulate at least two years' experience of practicing as a nurse, and it is usually preferred that this experience is gained in a tertiary level or specialized hospital. This creates a high level of competition for urban employment opportunities where most tertiary and specialized hospitals are based. Private and public hospitals able to offer the experience required for international migration are therefore in a strong position to attract recent

graduates, and many have actively exploited the domestic oversupply of nursing labor. Until recently, graduates in the Philippines were taken on by hospitals as ‘volunteers’, and worked for free to gain the experience needed for international migration or domestic career progression (Ronquillo et al., 2011). High demand for these volunteering positions has led many hospitals to further capitalize on the dreams of nurse graduates, charging nurses for the very privilege of volunteering. Rates vary between \$20 and \$420 (increasing for prestigious positions in better hospitals) and volunteering opportunities tend to last between 1 and 6 months. Significant opposition to these practices from labor groups, nursing educators and nursing bodies has led the government to formally outlaw such practices. However, private hospitals have easily navigated the new restrictions, and now offer paid training opportunities to nurses. These training opportunities in practice are largely similar to volunteering, however payment is now required, and the ‘opportunities’ tend to be shorter in length lasting from a week to a few months, with nurses receiving certificates at the end to evidence the ‘training’ gained. Similarly some Indian nurses are ‘bonded’ to the colleges and hospitals where they trained to work for a set period (anything from 6 months to 2 years) after they graduate. Salaries are low and the practice has drawn the ire of the Indian Nursing Union. For many nurses however, the ability to travel overseas depends upon the first step of gaining prior work experience. This need is enhanced if the nature of their education resulted in very poor clinical training, which they then must develop in their first clinical position post-graduation.

When the time comes to seek overseas opportunities, recruiters play a key role in both countries. The Philippines has long had a state-sponsored emigration system which seeks to offer protection of workers through strict regulation of private recruitment intermediaries. Private recruitment agencies must be registered with the Philippines Overseas Employment Agency (POEA) and adhere to certain stipulations concerning fees and places of destination. Notably, since the 1990s as stories of abuse and exploitation became well-publicized, such policies and practices have a strong commitment to offer

additional protection to women migrants, recognizing their vulnerable positions as both women and migrant workers who frequently find employment in private homes such as domestic workers and nannies. But these practices often employ coercive and discriminatory practices. For example, the POEA has introduced mandatory ‘pre-departure seminars’, alongside training programs, a Handbook for Filipinos Overseas, and The OFW Code of Discipline. The seminars, training programs, and handbook arguably contribute to the exploitation and vulnerability of female migrants since such practices are employed to control the autonomy and bodily practices of women migrants when overseas, such as requesting no make-up is worn (O’Neil 2004, Guevarra, 2010, 2006). These seminars promote the ideal Filipino migrant as being the embodiment of the ‘suffering martyr’, a hardworking, caring, subservient woman who must suffer exploitation through silence (Roces, 2009; Tyner, 1994).

Nonetheless, these policies and practices are relatively effective in reducing numbers of unscrupulous recruiters, as all recruitment agencies, domestic and foreign, must be registered with the POEA, and can be blacklisted for illegal activities such as charging excessive recruitment fees (Scalabrini Migration Center, 2010). The POEA is also instrumental in facilitating bilateral agreements, and examples include the Triple Win policy with Germany as well as agreements with various Canadian provincial governments and Japan. In India public outcry over the exploitative practices of private recruiters involved in the movement of nurses to Gulf nations resulted in the Indian government constraining the mobility of nurses to the Gulf, while it promoted state recruiters, mostly in Kerala, and direct government recruitment (for example Saudi Arabia). India has also signed some health worker bilateral agreements, and educational agencies are still very active in sending recent nurse graduates overseas for post-graduate training. While these practices suggest some state involvement in and regulation of the migration process, the gendered discourses attached to ‘protective’ policy developments suggests that women migrants are not gaining equal access to the opportunities and

rewards international migration can offer. Women are at risk during the recruitment phase where illegal recruitment continues despite the government efforts, and the targets of such policies are women, whose mobility is constrained, rather than the agencies that exploit the nurses. Recruiters have been found to charge extortionate fees, produce fake employment contracts and incorrectly (or not at all) arrange visas and permits (Scalabrini Migration Center, 2010).

One of the main issues that disrupts orderly migration for skilled nursing professionals post-arrival arises from how equitably their educational credentials are recognized in other countries. With no clear global system to compare nursing education and professional competency, international credential recognition systems become a complex labyrinth of regionally distinct and often complex and opaque processes. This exposes migrants in this occupational sector to multiple vulnerabilities when they become internationally mobile (Kingma 2006; Walton-Roberts and Hennebry 2017). In most western receiving nations both Indian and Philippine nursing degrees are considered inferior to local and Anglo-American credentials, and nurses from India and the Philippines typically experience lower pass rates in professional registration exams. This often results in migrant nurses moving into less well paid occupations (practical not registered nurse) and sectors (community and elder care) (Choi and Lyons, 2012). The overall effect is an immense loss of value in terms of the educational investments made by migrants in their original education (often through private colleges), and in the numerous fees they pay for their migration and post-arrival credential and language assessments.

The geographical and visa category routes nurses take in order to engage in international migration exposes them to further vulnerability. Indian and Philippine healthcare professionals often seek to reach apex markets such as those in North America, Australia, and other European locations that offer the best pay, work, and living conditions. Entry points into these various systems are often via two step migration through less attractive markets such as the Middle East, currently the most common

destination for Filipino nurses (POEA 2013) and for nurses from southern India (Walton-Roberts 2010). Many Filipino nurses, for example, will seek employment in the Gulf States or in more developed Asian nations such as Singapore and Malaysia due to lower entry requirements. They then have the ability to work in large, high-tech hospitals, and can use this experience to reach preferred destination countries in the west (Matsuno 2009).

Indian nurses have also used the two step migration process to move from the Middle East to more preferable OECD nations (Percot 2006). However, nurses to the Middle East and Gulf generally engage in temporary migration, working for contracts of six months to two years and creating a snakes and ladder type mapping of migration routes. There is also another form of ‘two-step’ migration in terms of shifting from one visa category to another rather than from one geographical location to another. Research in Canada has explored this type of visa transfer for nurses from India and the Philippines who enter the country on international student or temporary foreign worker visas and subsequently move toward securing working visas that allow them to move into a nursing position (with highly variable results) (Walton-Roberts and Hennebry 2017).

The movement of nurses from the global South to North is fraught with issues concerning the ethical viability of recruiting nurses from nations already struggling to meet the healthcare demands of their own populations. Various national and international bodies, including the NHS, Commonwealth, and the International Council of Nurses have introduced ethical guidelines for nurse recruitment within the last 15 years (Connell and Walton-Roberts 2016; Kingma, 2006). Such guidelines state nurses may only be actively recruited from states with an oversupply of nurses. However, as Kingma (2006) has highlighted, there is a difference between the ‘demand’ for nurses and the ‘needs’ of healthcare providers, which these guidelines tend to obscure. Demand is the number of nursing positions that can be filled at any given time and is therefore dependent on the availability of capital to pay for labor. Need

is the number of nursing positions that should be filled in order to meet the healthcare goals of the population. When we hear of a surplus of nurses, more often than not, this equates to a large number of un- or under-employed nurses, and a shortage of economic capital to employ more nurses. It does not necessarily reflect a surplus of nursing care. This is the case in the Philippines where many thousands of nurses are unemployed or have left the profession for other opportunities, and in Kerala, India, where cyclical under and unemployment, low pay, especially in the private sector, and workplace safety and status concerns are evident. The employment of nurses is deeply embedded in the nature of state investment in healthcare, and state decisions about that investment structures the experiences of nurse migrants at both ends of the international migration spectrum. Some recognition of the structural nature of international health worker deployment means that states must see it as their responsibility to plan for shortages and the adequate staffing of their health systems.

In conclusion, nurses are vulnerable before migration, whether through ‘volunteering’ or paid training in the Philippines, or through bonded employment in India. They are also vulnerable in destination countries where they may be assigned unfavorable shift patterns working nights and weekends, and experience deskilling and racial discrimination from employers, colleagues, and patients (O’Brien, 2007). For example, migrant nurses in the west and the Middle East, particularly those who are visibly ‘othered’ from local populations due to racial and ethnic differences are generally positioned as practical or lower qualified nurses, and expected to occupy less well paid nursing and care roles regardless of previous experience and qualifications. This global devaluation process is the outcome of a complex intersection of source, transit and destination market and state systems, and not something that can be managed through sending country policy agendas alone.

5. Achieving the SDGs

In examining the context of nursing education and retention and the promotion of orderly, safe and responsible migration in India and the Philippines, it becomes apparent that the most common and glaring shortcoming of the SDGs is the reality that some of the key factors shaping the contours of these issues are inherently global rather than national. Health worker emigration is not just reflective of national government management of health human resources, but also a response to uneven capitalist development and its intensification under conditions of increased health marketization globally (Bradby 2014). In light of these realities it is jarring that the SDGs are constructed as targets to be addressed and achieved primarily within the *national* policy space. In the case of increasingly privatized training systems and expanding international, often exploitative migration, we must question whether the challenges associated with health worker migration in one country can be effectively addressed from within its borders, or if the solution requires system-wide change elsewhere? This is the argument that Sexsmith and McMichael (2015) pose in their critique of the SDGs, and it is one we see as highly pertinent to the case of nurse migration from the Philippines and India.

The example of volunteerism and paid training in the Philippines point to the difficulties faced by national governments in attempting to achieve the SDGs related to equality and accessibility of training when eventual employment opportunities are not even within their national space. This is not to say there is nothing nation states such as the Philippines could do to address these issues, but national policies will only partially address problems faced by their populations in a context of ever decreasing domestic opportunities versus the allure of expanding global migration avenues that the state itself promotes. Immigrant sending states such as India and the Philippines are placed in an untenable position when migrant remittances are so vital to the economy and under and unemployment so evident within their own domestic labor markets.

The migration mentality has also become domestically embedded in a manner that further exploits those seeking to move; for example the need for at least two years' experience in a hospital environment exposes nurses to one form of exploitation in situ as they prepare for another overseas. To overcome this problem of valorizing certain types of work experience, those hiring internationally trained nurses might benefit from recognizing how stringent and sometimes arbitrary experience requirements can be damaging to both individual nurses and healthcare systems in sending countries. We need to seriously question why migrant nurses—who are often absorbed into community, end of life, and care support roles in many destination countries—have to possess tertiary and specialty hospital experience prior to departure (Batnitzky and McDowell, 2011; Smith and Mackintosh, 2007). Some examples of the 'triple win' and bilateral educational partnerships evident in nursing mobility might offer models worth examining and improving upon in order to address issues of credential mismatch. For example Clemens (2015) explores an example of the triple win model in Germany, and Schwenken (2013) offers an important gendered critique of these circular migration programs.

The extensive privatization of nursing education in both examples further limits the extent to which the state can 'ensure equal access for all women and men to affordable and quality technical, vocational and tertiary education' (SDG 4.3). Governments struggle to set or influence fees in these cases, and therefore their role is reduced to monitoring quality by regulating licensing. Moreover, in both India and the Philippines the privatization of hospitals restricts the ability of the state to implement and check labor policies at the workplace. While states still have scope to improve labor policies, it appears the lucrative nature of migration generally, and of nurse migration specifically, reduces the incentive for government bodies to secure better labor rights, as improved rights would likely result in a reduction of emigration, particularly for higher earning professionals (Imperial, 2004).

In order for the state to ‘facilitate orderly, safe, regular and responsible migration...through the implementation of planned and well-managed migration policies’ (SDG 10.7), as well as ‘substantially increase health financing and the recruitment, development, training and retention of the health workforce’ (SDG 3.c.), the Philippines and India must secure international participation. The Philippine state has taken some action by introducing policies that seek to exclusively protect migrants, and to ensure safe and regular migration. The Philippines also has a longstanding commitment to lobbying for international change, contributing to various international policies, and are the current pilot for the ILOs Fair Recruitment program. While their policies are not perfect, the biggest problem faced is generally that of getting the global North on board (Calenda, 2016). In general the global North has appeared as unwilling to ratify international conventions that would provide broader rights to women, migrants and their families (Ruhs 2013). The Indian state has made efforts to address recruiter exploitation of nurses in Gulf migration corridors by regulating female migration rather than recruiters, which has the effect of discriminating against women and denying them their mobility. This is not an equitable or effective solution.

There are also additional concerns regarding how nations can assess if they are meeting the SDG goals. This aspirational development agenda needs indicators, data collection and outcome measures, and international co-operation in order to determine how effective states are at addressing these various goals, and in all three areas (access to education, migration management and health worker retention) the collection of and access to reliable and comprehensive data is variable at best. Riley et al (2012) have discussed the issue of data collection for the earlier MDGs with specific reference to healthcare workers and found there were 57 resource limited countries identified as needing Human Resources Information Systems (HRIS). In response to this a Health Workforce Information Reference Group (HWIRG) was formed in 2010. It found that only 44% HRH crisis countries reported collecting data on

health workers qualification and credential numbers. Only 23% of all systems gathered data on workforce attrition, and even when countries have some data, it is rarely used for workforce planning. Whilst implementing adequate measures to collect reliable data is an important means by which to assess the current situation and to develop appropriate plans to meet the SDGs, it is also an incredibly costly endeavor, and one which requires huge levels of coordination between local and national and public and private actors. It is therefore unlikely to be considered a priority in developing countries such as the Philippines and India. Again, this points to the benefits of a global commitment to address the SDGs, as organizations such as the WHO are well placed to provide funding and assistance (in the form of training researchers to collect and analyze data, and making policy recommendations). Indeed, the presence of a WHO office in Manila has contributed to recent data collection efforts and the resulting health workforce planning initiatives.

6. Conclusion

This paper maps the connections between India's and the Philippines' increasing role in the provision of nurses for international markets and the sustainable development goals related to training and migration governance. SDGs are imagined as a national goal, but in the case of education and migration intersections they are shaped by global demands and discourses of the global professional status of nursing. The ability of states to meet SDGs is curtailed by global operations, practices and desires; but nation states do and should have a role moving forwards. Both Indian and Filipino women are in part pushed into training and then migrating as a nurse due to national and regional practices which frame women as natural caregivers, which frame overseas opportunities as preferential, and which seek to regulate the bodies and actions of their women migrants. We are witnessing the global integration of nursing labor markets through the export orientated activities of states and markets, and this has implications for regulatory frameworks. The internationalization of the labor force demands

internationalization of regulatory frameworks to manage their protection and the protection of health systems. The paper calls for greater attention to the *global* structuring of feminized migrant mobility in the area of nursing in order to highlight the limited ability of *national* policies to address SDG goals.

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