M.A. Thesis

Migration decision-making: Narratives of Polish and Swedish nurses in Norway

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Chapter 1. Introduction

Research questions

In fall 2015, at the beginning of my master's program, I decided to focus on the migration of health care personnel. In fall of 2016, I narrowed my interest to the recruitment of health care personnel from low- and middle-income countries to high-income countries. Intrigued by the concept of the Nordic Welfare State, I chose Norway as my case study to explore the intersection of the welfare state and international nurse recruitment.

During my preliminary literature review into the topic, I discovered that the majority of immigrant nurses in Norway came from other high-income countries, primarily other Nordic countries. However, my search for qualitative research on immigrant nurses in Norway revealed a lack of literature on nurses from other Nordic countries. This was surprising in light of statistical data highlighting Swedish-educated nurses as the largest group of foreign-trained nurses in Norway (OECD 2017a). The combination of wanting to contribute to the growing body of literature on intra-Nordic nurse migration and an interest in critical whiteness theory shaped my initial research questions: *What role do nationality, ethnicity, and race play in the concept of competence in the Norwegian healthcare sector? Are there graded experiences of discrimination for immigrant nurses in Norway and, if so, what are the bases for such experiences?*

I proposed to compare the experiences of foreign-trained nurses from three separate socio-political/geographic regions: other Nordic countries, the Europe (EU/EES), and non-European countries. After being advised that my proposed project would require more time than was available to me, I decided to narrow my focus to nurses from Sweden and Poland. I chose Poland due to my previous research on Polish immigrants in Norway, and because Poles are the largest immigrant group in Norway.

While searching for a supervisor with research experience in the field of health migration, I was directed to a recently-initiated project, "Migration for welfare: nurses within three regimes of immigration and integration into the Norwegian welfare state" (WELLMIG)[1]. The objectives of WELLMIG greatly overlapped with my interests. I contacted the head researcher in hopes that we

[1] At Norwegian Social Research Institute (NOVA) at Oslo and Akershus University College of Applied Sciences (HiOA).

would be able to work collaboratively. She agreed to supervise my thesis and provided me the opportunity to work within research frames identified in the WELLMIG project. This opportunity lead me to refine my research scope to explicitly include a structure-agency perspective. With this perspective in mind, my research project uses narrative accounts to investigate the link between social structures and Polish and Swedish nurses' decisions to work in Norway. I aim to answer the following questions:

- *What are the most significant influences on Polish and Swedish nurses' decisions to work in Norway?*
    a. *What effects do Norwegian recruitment and labor immigration policies have on Polish/Swedish nurses' decisions and experiences?*
    b. *What role does Norway, as a destination, play in their decision to work abroad?*
    c. *What is the importance of other factors, such as networks, culture, and imaginations?*

Brief background: global health shortage, migration, and policy responses

Health is internationally recognized as a human right. According to the Human Rights Watch (2017), "every country in the world is now party to at least one human rights treaty that addresses health-related rights." While the meaning of "health" stretches far beyond the provision and access to healthcare services, such services are a core element in the right to health. However, as it stands now, there are not enough health workers to provide health services to the global population. The World Health Organization (WHO) (2017) has described the "human resources for health crisis" as "one of the most critical constraints to the achievement of health and development goals." According to a study commissioned by the WHO and the Global Health Workforce Alliance (GHWA) Secretariat, there was a global deficit of about 7.2 million skilled health professionals as of 2013, including physicians, nurses, midwives, and dentists (Campbell et al. 2013). Based on a projection model driven by population growth, the study concluded that there would be a global deficit of about 12.9 million skilled health professionals by 2035 (Campbell et al. 2013). Although the most critical shortages are mainly in sub-Saharan Africa and Southeast Asia (World Health Organization, 2006), concerns regarding health care shortages on the European continent have also grown over the past 35 years (Dumont and Zurn 2007).

Upward demographic shifts in high-income countries play a pivotal role in the increasing demand for health workers. The combination of post-World War II baby boomers entering retirement age, low fertility rates, and increasing life expectancies is contributing to the growing percentage of 60+ populations in high-income countries (Kapur and McHale 2005). Studies examining the effects of aging populations on the healthcare sector have found that the increased number of elderly has increased the demand for technological advancements in the prevention and treatment of non-communicable diseases, as well as nurses in home and palliative care sectors (UNDESA Population Division 2015; Dumont and Zurn 2007). Furthermore, Dumont and Zurn (2007) state that the number of nurses entering retirement age in most Organization for Economic Cooperation and Development (OECD) countries is greater than that of new, domestically trained nurses. Therefore, there is simultaneously an increasing demand for and a decreasing supply of domestically trained health care professionals.

Other studies focus on the economic consequences of aging populations, bringing attention to the financial strain aging populations put on social security systems. Reich et al. (2016: 814), report that health insurance payroll premiums in France and Japan "are no longer generating sufficient revenue [to support their universal health care programs] as a consequence of aging populations," pushing the governments to seek alternative tax revenue sources. However, Bloom et al. (2015: 649) argue that such assertions about the negative economic effects of population growth are "overblown," stating that behavioral and policy changes have potential to mitigate the negative effects. One possible behavioral response is the "increased workforce participation from women, immigrants, and older people" (Bloom et al. 2015: 655). Further studies support this assertion, suggesting that the immigration of highly-skilled people spurs economic growth and productivity as well as increases domestic wages (See: Czaika & Parsons, 2015; Boubtane, Dumont, & Rault, 2014; Czaika & de Haas, 2015; Papademetriou, 2013). I will return to the topic on women in the workforce and how it relates to the recruitment of health workers from aboard when I discuss health worker migration in the Norwegian context.

The perceived shortage of health workers in many high-income countries and the potential economic benefits such migrants can provide have prompted many countries to take measures to attract and/or recruit health professionals trained abroad. In turn, health professionals have taken advantage of the high global demand for health workers and the opportunities provided by

globalization processes (Aluttis, Bishaw, and Frank 2014). However, a lack of reliable data on the migration of health personnel makes it difficult to present an accurate picture of migration flows. Dumont and Zurn (2007) attempt to quantify and map the migration of healthcare workers to OECD countries. They report that both the overall number and percentage of foreign-trained healthcare workers in most OECD countries increased dramatically between 1970 and 2005, with the percentage of foreign-trained doctors in France and the Netherlands increasing six-fold[2]. Furthermore, the study reports a sustained increase in foreign-trained nurses in OECD countries from 1990 to 2002 (Dumont and Zurn 2007).

In recent decades, the recruitment of health professionals from economically poorer to richer countries has been highly criticized as unethical. Critics have argued that active recruitment by rich governments creates a "brain drain" effect: "[A]cting like a vacuum cleaner, unethically sucking in labour from some of the poorest countries in the world that can ill-afford to lose health sector staff" (Stephen 2006: 1). In contrast, advocates of health mobility have pointed to both economic benefits for the source country in the form of remittances, and to the transfer of knowledge, or "brain circulation" (Stephen 2006). Furthermore, the freedom of mobility is a fundamental human right and health workers —as individuals— should be able to choose where they live and work (de Mesquita and Gordon 2005). This debate culminated in the WHO Global Code of Practice on the International Recruitment of Health Personnel. The Code, finalized in 2010, aims to establish and promote ethical international recruitment practices and "discourages the active recruitment of health personnel from developing countries facing critical shortages of health personnel" (World Health Organization 2010: 1). All 193 Member States of the World Health Assembly, including Norway, has adopted the Code (World Health Organization 2010). I will discuss Norway's recruitment of health personnel further in chapter four.

Structure of the paper

I begin chapter two by reviewing migration theories on decision making, highlighting the arguments for and against certain approaches. After a brief outline on a geographical imaginations approach to nurse migration, I develop my stance on structure and and agency in migration

[2] This data includes both intra- and inter-OECD migration. It is based on data from Meija A. and Royston (1979), and data collected by the authors.

decision making. Chapter three serves to contextualize nurse immigration in Norway, including the shortage of nurses, recruitment from abroad, and immigration policies. In chapter four, I detail the methods used in the recruitment, interview, data collection, and data analysis phases of my project, as well as my methodology for choosing these methods. After providing a summary of the informants' profiles, I then present and analyze the narratives of my informants in chapter five. In this chapter, I include sections on the broader contextual framework of Polish and Swedish nurses working in Norway, using my informants' statements as the point of departure. While these sections would typically be included in a "background" section earlier in the thesis, I use them to broaden the perspective of my interviews. In the concluding chapter I summarize my findings and make closing comments.

Chapter 2. Approaches to nurse migration

The purpose of this chapter is to inform my subsequent analysis of interviews with Polish and Swedish nurses. I begin by briefly presenting the strengths and weaknesses of contemporary theoretical approaches to migration decision-making, focusing on the structure-agency dichotomy. The following section presents a geographical imaginations perspective on nurse migration as an alternative to the push-pull framework. In the final section, I identity my stance on the interaction between structure and agency.

Migration decision-making: theoretical review

Many social scientists tackle the task of detailing and categorizing the numerous migration theories. For example, in their thorough examination of contemporary theories of international migration, Massey et al. (1993: 432) make a distinction between theories "that describe the initiation of international movement and […] theories that account for why transnational population flows persist across space and time." Theories belonging to the former include neo-classical, new economics of labor migration, dual labor market, and world systems. Network, institutional, and cumulative causation theories belong to the latter. Goss and Lindquist (1995), on the other hand, categorize approaches as either functionalist, structuralist, or integrative. These categories are better suited for the purpose of my research as they clearly identify the structure-agency dichotomy. However, the functional distinction made by Massey et al. is also useful for conceptualizing the temporal aspects of migration decision-making.

Functional approaches to migration rely on neoclassical development economics, in which wage differentials between two countries presumably drive international migration (Goss and Lindquist 1995). Individualist neoclassical approaches are based on the assumption of individuals as "rational maximizers of human capital," who "weigh up the attractiveness of [migration and] potential destinations by comparing the costs and benefits" (Czaika and Parsons, 2015: 8). In this approach, individuals—as rational actors—assess the financial, social, and psychological costs of migration. Migration occurs when individuals expect a positive net return on their investment, usually monetary (Massey et al. 1993). Neoclassical approaches are often criticized for methodological individualism—not recognizing the role of social structures in migration decision-making. For example, Goss and Lindquist (2013: 320) state: "The [neoclassical] model also

reduces migrants, a social category that is structured by gender, ethnicity, and social class, to mere embodiment of labor power and fails to adequately take into account the political and other structural barriers to mobility."

Neoclassical studies are often applied within a "push-pull" framework of migration, in which the decision to migrate is determined by positive factors in the country of destination, negative factors in the country of origin, mitigating factors, and personal factors (de Haas 2007). This framework is consistent with the neoclassical perspective of migration as an individual choice and the outcome of a cost-benefit calculation. Although the push-pull model has gained popularity in migration studies, it is also widely criticized, as de Haas (2007: 18) states:

> As they are applied in practice, push-pull models tend to have the character of ad-hoc explanations forming a rather ambiguous depository of migration determinants. More problematic is the tendency of push-pull models to confuse different scales of analysis (ranging from individual to global) and do not allow for assigning relative weights to the different factors affecting migration decisions.

Just as in neoclassical approaches, the push-pull model tends to ignore political, economic, and social constraints on individuals' mobility, and assumes that everyone has equal access to resources and information.

At the other end of the spectrum from the methodological individualism and rational choice of functionalist approaches are structuralist approaches. In opposition to neoclassical migration theory, structuralists state that individuals "do *not* have a free choice, because they are fundamentally constrained by structural forces" (de Haas 2007: 15). This approach, rooted in Marxist political economy and world systems theory, asserts that historical political and economic power is distributed unequally among countries, and the inequality is further reinforced by capitalist expansion (de Haas 2007). Individuals located in "peripheral" nations are, according to this theory, exploited by "core" capitalist countries that rely upon cheap immigrant labor (de Haas 2007). In contrast to functionalism, rigid structuralism has been criticized as too determinist and for ignoring individual agency.

There is widespread criticism of the divide between functionalist and structuralist explanations of migration (See Massey, 1993; Goss and Lindquist, 1995; Bakewell, 2010; Castles, 2010). Massey et al. (1993: 455) express their skepticism "both of atomistic theories that deny the importance of structural constraints on individual decisions, and of structural theories that deny agency to individuals and families." Furthermore, neither the functionalist nor structuralist approaches to migration explain why the majority of individuals do not migrate across international borders. They also do not explain, for instance, why many Polish nurses working abroad do not choose to work in Norway, or why many Swedish nurses—including three that I interviewed—decided to move back to Sweden (or stop working in Norway, for those who never took up residence in Norway).

A number of theories attempt to address these issues and bridge the gap between structure and agency. The networks approach, for instance, highlights the importance of family and friend connections as "a form of social capital that people can draw upon to gain access to foreign employment" (Massey et al. 1993: 448). This theory contributes to the non-economic explanation of individuals' choice of destination country, suggesting that friend and family ties in a specific country influence people's decisions. This contributes to the idea that, over time, "international migration becomes institutionalized through the formation and elaboration of networks, [becoming] progressively independent of the factors that originally caused it, be they structural or individual" (Massey et al. 1993: 450).

The cumulative causation approach, according to Massey et al. (1993: 451), contends that "[c]ausation is cumulative in that each act of migration alters the social context within which subsequent migration decisions are made, typically in ways that make additional movement more likely." Within this theory, the concept "culture of migration" emerges. This concept aims to explain why the prevalence of international migration is higher in some communities than others, despite their similar economic and political contexts. Massey et al. (1993: 452-53) explain:

> Although migrants may begin as target earners seeking to make one trip and earn money for a narrow purpose, after migrating they acquire a stronger concept of social mobility and a taste for consumer goods and styles of life that are difficult to attain through local labor. Once someone has migrated, therefore, he or she is very likely to migrate again, and the

odds of taking an additional trip rise with the number of trips already taken. At the community level, migration becomes deeply ingrained into the repertoire of people's behaviors, and values associated with migration become part of the community's values.

As shown in this section, migration is a complex, multi-dimensional process. A seemingly endless number of factors can affect an individual's decision and process of migration. With the narratives of my informants as a point of departure, I adopt a critical realist informed perspective of the structure-agency link in order to understand the complex migration processes of some Polish and Swedish nurses. I develop this analytical approach further in the last section of this chapter.

Departing from "push-pull" in nurse migration

Typically, studies on nurse migration tend to adopt the push-pull framework. The determinants of nurse migration are generally linked to economic factors, work-related conditions (career opportunities, work environment, workload, and insufficient resources), socio-economic and political conditions (respect, discrimination, and quality of life), and personal reasons (family, friends, and aspirations) (de Mesquita and Gordon 2005; Szpakowski et al. 2016; European Commission 2013; Dumont and Zurn 2007). As discussed above, such studies assume that individuals make rational decisions and that they have equal access to resources and information. These studies contribute little to the understanding of why many people do not migrate and why certain destinations are chosen over others. Furthermore, they lack historical context and ignore the gendered, classed, ethnic, and racial structures of migration.

Based on a survey of 987 European-educated nurses (EU/EEA) working in the Netherlands, de Veer et al. (2004) found personal circumstances, such as moving with a spouse, to be the main factor for migration (60%). However, for Belgian nurses, personal factors were less influential. Instead, 42% of the Belgian nurses reported that the working environment in the Netherlands was their main motivation for working there (de Veer, den Ouden, and Francke 2004). This was explained by the high level of cross-border employment, with 58% of the Belgian-trained respondents maintaining their residence in Belgium and commuting across the border for work (de Veer, den Ouden, and Francke 2004). Although Germany also shares a border with the Netherlands, only 8% of the German nurses commuted between the two countries (de Veer, den

Ouden, and Francke 2004). I find the difference in cross-border commuting of Belgian and German nurses relevant for my study as Sweden and Norway share a long border. Unfortunately, the article provides little to no explanation of the difference. By simply reporting on the self-identified determinants of migration and not connecting or discussing possible explanations, such articles are not very useful in my analysis.

In her article on Filipino nurses in the UK and the Philippines, Thompson (2016) outlines a geographical imaginations approach to studying migration decision-making. This approach offers an alternative perspective to individual decision-making, which is not based on individuals as rational maximizers of human capital. Thompson (2016: 81) argues that, as the majority of international migrants are "middle-classed, well educated and able to afford the financial costs associated with migration," greater emphasis needs to be placed on the role of imagined culture and place on migration decision-making. A geographical imaginations approach emphasizes the influence of imaginations of life in certain places on the decision to migrate and the choice of destination. Such imaginations may include geographical qualities, such as landscape, climate, and distance, as well as perceptions of the standard of living and cultural characteristics (Thompson 2016). In the article, Thompson connects the imaginations Filipino nurses have of the UK and other destinations to broader structural components, both macro and micro, and explains how these imaginations influence their decisions. A number of sources influence imaginations, such as social networks, personal experiences, national education and media sources, and global popular culture (Thompson 2016). For example, some nurses in the study alter their choice of destination after gaining information from friends about the physical characteristics or pace of life in the UK (Thompson 2016). Such imaginations can also be formed about one's own home, which may in turn impact their desire to leave, their choice of destination, or their desire to stay. Thompson (2016) gives examples of two nurses, one who views the Philippians as "hopeless" and wants to move, and another who views the Philippians as a beautiful place and does not want to move.

My analysis is informed, in part, by the geographical imaginations approach presented by Thompson. I find it allows for a more nuanced understanding of migration decision-making than is possible with the traditional push-pull model. Rather than simply listing determinants of migration, this approach suggests evaluating them as contributing factors to the imaginations of place, which in turn inform decisions. As Thompson (2016) states, "[a geographical imaginations

approach] is flexible enough to account for the myriad of influences" on migration decision-making, including the traditional economic, social, and political structures.

Structure and agency

Defining my perception of structure and agency is crucial to the understanding of my analysis and conclusions. An atomistic view of agency refers to "the capacity for social actors to reflect on their position, devise strategies and take action to achieve their desires" (Bakewell 2010: 1694). This is the view adopted by neoclassical theorists, which as discussed, does not acknowledge the influence of social structures on individuals' actions. Social structures can generally be defined as "any recurring pattern of social behavior; or, more specifically, to the ordered interrelationships between the different elements of a social system or society" (Scott and Marshall 2009: 'structure'). Bakewell (2010: 1695) points out that this definition of structure, when unexamined, may lead to "reification in which social structures- such as states or cultural norms- come to be seen as rigid and beyond the reach of human agency." Rather than viewing migration processes as dominated by either structure or agency, I understand the two to be relational.

Attempts to reconcile the two metaphorical concepts has spurred an ongoing theoretical debate about the "nature and properties of structure and its relationship to agency" (Bakewell 2010: 1695).

On one side of the debate is Anthony Giddens' structuration theory, which assumes the "duality of structure," as both the "medium and the outcome of the social practices they recursively organize" (Giddens, 1984: 25 in Bakewell, 2010: 1695). Bakewell (2010: 1695) clearly summarizes the main premises of structuration:

> Structure not only shapes social practice but is in turn reproduced and possibly transformed by this practice. Hence, social structures are seen not just as constraints on individual actors but also enabling their actions. Social actors are self-aware in the sense of continual monitoring of the effects, both intended and unintended, of action and the modification of their behaviour accordingly. While their action may be constrained, people's agency ensures that they always have some degrees of freedom some room to manoeuvre.

> The duality of structure ensures that structure is not slavishly replicated but is re- produced; it only has existence insofar as it is 'instantiated' in social practice. Apart from practice, it only has a 'virtual existence': the potential to shape practice at the time of action.

Margaret Archer has been the main critic of Giddens' structuration theory. From a critical realist perspective, she argues that Giddens' notion of the "duality of structure" does not allow for a distinction between structure and agency, and therefore makes it impossible to study the relationship between the two (Bakewell 2010: 1696). She asserts the need for "analytical dualism," or a temporal distinction in the relationship between structure and agency (Bakewell 2010: 1696). Archer suggests a three-stage "morphogenetic cycle" for analyzing the temporal relation between structure and agency. Bakewell (2010: 1696-97) summarizes this cycle:

> In the morphogenetic cycle, the consequences of past actions contribute to structural conditions that have a causal influence over subsequent social interaction. While action may be structurally conditioned, it is not structurally determined, as actors come with their own agency. This social interaction sets in train structural elaboration which modifies the previous structural properties and may introduce new ones.

Within the debate over dualism and duality, I locate myself more on the side of Archer's dualism. While I adopt the view of analytical dualism, I do not attempt to apply the morphogenetic cycle in my analysis. Rather than explicitly examining the temporal, causal relationship between nurses' actions and social structures, I use Archer's analytical dualism as a theoretical basis for my analysis. In order to gain a deeper understanding of the factors influencing some Polish and Swedish nurses to work in Norway, I attempt to link the narrated experiences, views, and decisions of my informants to pre-existing social structures. However, in addition to analyzing how the nurses' actions may be structurally conditioned, I also discuss how their personal goals, motivations, and aspirations are mobilized within those structures, and in some cases, against those structures.

Chapter 3. The Norwegian context

This chapter serves to contextualize the immigration of nurses to Norway. In the first section, I discuss the nursing shortage in Norway and the gendered and ethnic dimensions of the perceived shortage. In the second section, I give an overview of the policies affecting the recruitment of health personnel from abroad, followed by a summary and discussion of the graded labor immigration policies in Norway.

Perceived nursing shortage

As most European countries, Norway's population is aging and the number of new nurses entering the profession is lower than that of nurses nearing retirement. Reports of "critical shortages" of health personnel in Norway first began in the 1990s (Straume and M. P. Shaw 2010). Despite having one of the highest nurse-to-patient ratios in the world, the perceived shortage of nurses in Norway has persisted over the past decades (Straume and M. P. Shaw 2010; OECD 2017b). As of 2016, news articles are still reporting on the "stor sykepleiermangel i Norge" (my translation: major nurse shortages in Norway) (Roang Bostad and Kjernli 2016). According to a model created by Statistics Norway to project the supply and demand of healthcare personnel (HELSEMOD), there will be an estimated shortage of 28,000 nurse labor-years in Norway by 2035 (Roksvaag and Texmon 2012). But how accurate are these claims? And what are they based on?

In a study testing nurses' assumptions about working abroad, Zander, Blumel, and Busse (2013) question the perceived shortage of nurses in Norway, the Netherlands, and South Africa. Of the nine countries[3] included in the study, Norway has the second best patient-to-nurse ratio, with only 4 patients per nurse. However, 60% of the Norwegian nurse respondents perceived there to be an inadequate number of nurses to provide quality care (Zander, Blumel, and Busse 2013). Comparatively, around 50% of nurses in Sweden perceived there to be a staff shortage, despite a higher patient-to-nurse ratio of 6 patients per nurse (Zander, Blumel, and Busse 2013). In identifying these discrepancies, Zander, Blumel, and Busse (2013: 217) question whether nurses in countries such as Norway are being "put to the best possible use."

[3] Includes 9 countries: Germany, United Kingdom, the Netherlands, Sweden, Norway, Switzerland, Poland, Greece, and South Africa

This question leads into the discussion of part-time work. According to the OECD (2017b), Norway has the second highest nurse-to-patient ratio of all OECD countries; over three times higher than in Poland and Spain. These statistics are based on both the number of nurses working full-time and the number of employed nurses, which would include part-time nurses (Seeberg 2012b). Due to the prevalence of part-time work in Norway, it is difficult to determine if such comparative statistics are accurate (Seeberg 2012b). In Norway, around 40% of nurses work part-time and it is seen as essential to sustaining a flexible workforce and filling shifts (Østby 2013).

Another possible explanation for the perceived shortage is in the social and political developments in Norway. The hierarchy of healthcare professions and institutions in Norway is both gendered and classed (Seeberg 2012a). Hospitals occupy the top of the hierarchy and nursing homes the bottom, with "[t]he lowest paid and lowest status jobs in nursing homes [being] most closely associated with working-class women, while male doctors occupy the summit" (Seeberg 2012a: 178). However, in a study on immigrant careworkers in Norway, Seeberg (2012a: 178) argues that Norwegian nurses have distanced themselves from carework through technologization and academization, with less and less women willing to occupy the lower-status nursing home positions. Those positions are being increasingly filled by immigrant careworks, whose bodies "are perceived as the right kind of bodies for this sort of work and the wrong kind for many other sorts of work" (Seeberg 2012a: 178). Seeberg (2012a: 181-82) concludes:

> The presence of immigrant careworkers has become a necessity to uphold a Norwegian gender regime where Norwegian women increasingly distance themselves from the lower status carework occupations. Immigrant nurses and other job seekers from immigrant background willing to take on the less attractive work are welcomed as cheap, often highly qualified careworkers. […] It becomes increasingly clear that [Norway's] strongly ideological egalitarian welfare state has based the services to its inhabitants on the exploitation of working-class women, much like it now continues to exploit women and men from immigrant background.

Based on this argument, the demand for health personnel in municipal health institutions, such as nursing homes, is not necessary based on an actual shortage, but an unwillingness of

Norwegian nurses to occupy these positions. For example, the HELSEMOD model, mentioned above, bases the demand for health professionals on a business survey (Norwegian: bedriftsuntersøkelse) conducted by the Norwegian Labor and Welfare Administration (NAV) (Roksvaag and Texmon 2012: 16). According to NAVs 2017 survey (Kalstø and Sørbø 2017: 5), labor shortages are determined by asking businesses three questions:

> 1) [I]f they have failed to recruit labor over the past three months or if they have had to hire someone with lower or other formal qualifications than they were looking for. If the answer is yes, the businesses are asked 2) to state if this is due to too few qualified applicants. If this is the case, the business is asked 3) to state the number of posts and the occupations. Lack of labor in the individual business is equal to the number of people the company chooses to provide in the last question. Using the answers to the third question, the lack of labor is estimated within the individual professions.[4]

Ruhs and Anderson (2010: 4) suggest a critical view of such surveys, arguing that employers' inability to fill vacancies does not necessarily imply a shortage of domestically-trained employees: "In other words, [shortage calculations based on employer demand] refer to employers' difficulties with finding the 'right' workers to fill vacancies at *current* wages and employment conditions." Professional, formal qualification is not the only "skill" employers look for in potential employees, and "soft" skills are increasingly important. For instance, gendered, national/ethnic, and class based stereotypes could influence who is seen as the "right" worker for specific positions (Ruhs and Anderson 2010).

To conclude, while there is an increasing demand for health personnel in Norway, it is not due solely to demographic changes. The structure of nursing work and the opportunity for Norwegian nurses to avoid lower status care positions also contribute to the perceived shortage, and subsequent demand, of nurses in Norway.

[4] My translation with the help of a mouther-tongue Norwegian speaker.

Recruitment of nurses from abroad

One solution to the growing demand for health personnel has been to recruit nurses from abroad. In the 1990s municipalities began flying in short-term replacement nurses from Denmark and Sweden in order to alleviate immediate staffing shortages (Straume and M. P. Shaw 2010). The Norwegian Directorate of Labor, previously called Aetat, established a health recruitment program in 1998, focused on recruiting nurses from abroad (Widding Isaksen 2011; van Riemsdijk 2008). Aetat, along with municipalities and employers, began recruiting nurses from former East Germany and Finland in the late 1990s and from Poland in 2001 (van Riemsdijk 2010; Widding Isaksen 2011). Studies on immigrant nurses in Norway found that Aetat's recruitment practices exploited countries with poorer economies and targeted single females. In her doctorial dissertation on Polish nurses working in Norway, van Riemsdijk (2008: 18) states that Aetat targeted lower-income countries with a lower standard of living, based on the expectation that migrants from these countries "were more likely to stay in Norway." In her master's thesis, Savides found that Aetat also preferred to recruit single female nurses based on the assumption that families diminished the nurses' energy, flexibility, and concentration (Savides 2005 in Widding Isaksen 2011). However, by the early 2000s the Norwegian Government's stance on recruiting health personnel from abroad began to change (Seeberg 2012b).

Aetat's recruitment program ended in 2003, amidst national and international debate on the ethics of actively recruiting health personnel from abroad (Seeberg 2012b). In 2007, the Norwegian Government issued a policy asserting its commitment to promoting global health equality (Helsedirektoratet 2007). In this policy, the Norwegian Government "pledged to pursue policies that counteract the flow of qualified health workers from poor countries"[5] (Helsedirektoratet 2007: 5). Norway further solidified its stance on the ethical recruitment of health workers in 2011, signing the WHO Global Code of Practice on the International Recruitment of Health Personnel (World Health Organization 2010). Despite these public commitments, the

[5] My translation with the help of a mother-tongue Norwegian speaker. Original quote: "[…] forpliktet seg til å føre en politikk som motarbeider strømmen av kvalifiserte helsearbeidere fra fattige land."

recruitment of foreign-trained nurses continues to be a solution to the demand for health professionals in Norway.

As a traditionally social democratic state, the task of providing healthcare services falls upon the Norwegian government. However, a combination of economic, political, and social pressures resulted in a series of neoliberal reforms in the 1990s and 2000s (van Riemsdijk 2010). These marketization strategies have affected the healthcare sector. In 2001 the ban on temporary staffing agencies was lifted and "quickly institutionalized and accepted in the Norwegian health sector as a way to accommodate shift work" (Friberg 2013: 209). This allowed private firms to hire nurses (both from Norway and abroad) and "rent" them to Norwegian health facilities. Therefore, although the Norwegian government is no longer actively recruiting nurses from abroad, they have implemented policies which have allowed recruitment to persist anyway. Seeberg (2012b) argues that this development has simply transferred the responsibility and negative consequences of recruitment from the government to private companies.

Norwegian labor immigration: a graded system

Labor migrants in Norway are separated into three classifications: Nordic citizens, EU/EEA citizens, and citizens of third countries. Nurses from third countries face considerably stricter restrictions to immigration than those from Nordic or EU/EEA countries, depending on their country of citizenship. However, as my research focuses on Swedish and Polish nurses, I will only discuss the policies regulating the immigration of Nordic and EU/EEA citizens.

Nordic citizens experience unrestricted access to the Norwegian labor market. The Agreement Concerning a Common Nordic Labor Market (in Norwegian: Overenskomt om felles Nordisk Arbeidsmarked) dictates "that it is a fundamental right for nationals of the Nordic countries to be able to freely take up employment and settle in another Nordic country" (Nordic Co-operation 2017a). This agreement was signed by the Governments of Denmark, Finland, Iceland, Norway and Sweden in Copenhagen on March 6, 1982, and was enacted on August 1, 1983 (Nordic Co-operation 2017a).

Under the regulations of the single European market, EU/EEA citizens who want to work in Norway are allowed to move to Norway both as employed persons and as job seekers (UDI

2017). The website of the Norwegian Directorate of Immigration (UDI) (2017) outlies the following regulations for EU/EEA citizens' labor immigration:

- They must register with the police within the first three months, regardless of their employment status.
- Job seekers are allowed to stay in Norway for six months while looking for a job. If after six months they have not found a job, they must leave Norway (they can return after a certain period of time).
- For those with a job prior to moving: If they become unemployed after a year of working in Norway, they can register as a job seeker with the Norwegian Labor and Welfare Administration (NAV) and remain in Norway in search of a job for as long as they wish. If, however, they have not worked for one year, they can only remain in Norway for six months. Furthermore, in order to apply as a job seeker, they cannot have resigned from their job.

This graded system of immigration favors Nordic citizens over EU/EEA citizens. Therefore, Polish citizens, as members of the EU, face more restricted access to the Norwegian labor market than Swedish citizens. This trend of graded, nationality-based regulations also extends to the authorization of nursing degrees, albeit to a lessor extent. The Norwegian Directorate of Health is responsible for approving and administering authorization and licenses for all degrees within the legally regulated health sector. Authorizations grant the applicant full and permanent approval of their degree, while licenses place restrictions on the right to work (Helsedirektoratet 2017). Authorization procedures for Swedish nurses in Norway are regulated by the agreement on a common Nordic labor market, which stipulates that Nordic citizens, who have received authorization as a health professional in one Nordic country, have the right to authorization in the other Nordic countries (Nordic Co-operation 2017a). Swedish nurses are only required to submit their nursing diploma to the Norwegian Directorate of Health (Helsedirektoratet 2017).

Authorization for Polish nurses in Norway is regulated by the Professional Qualification Directive of the European Parliament, which mandates the automatic recognition of nursing education from one EEA state in all others (Helsedirektoratet 2017). Despite the similarities in the

two governing regulations, Polish nurses are required to submit more documents than Swedish nurses: diploma, transcript, and authorization from Poland (Helsedirektoratet 2017).

Chapter 4. Methodology

In this chapter, I discuss and outline the methods I have used throughout the research process and the methodology informing my decisions. I begin by justifying the use of qualitative research methods. This is followed by a description of the processes of establishing initial contact and building trust with informants. A review of ethical considerations is followed by an overview of the data collection and analysis methods. To conclude, I reflect on my positioning within the research and discuss the advantages and challenges of working with an interpreter.

Qualitative research and the critical realist approach

While qualitative research is not a new development in social and behavioral sciences, it really began gaining prominence in the early 1990s, after what Teddies and Tashakkori (2009) term the "paradigms debate or paradigm wars" of the 1970s and 1980s. Constructivist philosophy challenged the prominence of positivist, quantitative methods in social sciences. Constructivists asserted the need for qualitative research methods, diverging from the positivist assumption of "truth" as independent from individual perceptions and bias (Denzin and Lincoln 2011: 2). In line with the aim of my study, qualitative research methods allow for an investigation into the structural and cultural contexts within which migration or non-migration decisions are made (Iosifides 2011). However, I also view quantitative data as a valuable addition to qualitative research and use statistical data to contextualize the narrated stories of Polish and Swedish nurses in Norway. Most of the statistics came from the following sources: Statistics Norway (SSB), the Norwegian Register for Health Personnel (Helsepersonellregisteret), EuroStat, and the OECD.

I have approached this research with the belief that individual experiences and decisions are formed through social interactions and structural influences, but also that individual's assert their agency within those structures. This perception guided my decision when it came to selecting an appropriate qualitative approach for my research. Initially, I thought to take a phenomenological approach, but upon further research, realized that my views align more with the critical realist perspective presented by Archer et al. (2016) in their article "What is critical realism?" The authors describe critical realism as a meta-theoretical position, or "the theory and the philosophy behind our theories" (2016). Without claiming to fully adhere to all aspects of critical realism, I identify with some of its main philosophical standpoints, summed up by Archer et al. (2016) as follows:

> […] critical realists do not reject either interpretivism or statistical modeling wholesale. Instead, combining explanation and interpretation, the aim is an historical inquiry into artifacts, culture, social structures, persons, and what affects human action and interaction. However, critical realists approach causation critically, using the partial regularities, facts, and events we encounter in the social world as a springboard or gateway to understand the complex, layered, and contingent processes or structures which cause those regularities, facts, and events. This must be done without reducing causation to constant conjunction forms in which event A is always followed by event B […]

I find that this perspective allows me to not only report what my informants tell me, but to investigate the complexity of structures and factors influencing and conditioning their migration decisions.

In choosing an appropriate qualitative method, I needed a method that would elicit the depth and complexity of migration decision-making and fit realistically into the time-frame for this thesis. Theses criteria lead me to narrative interviews. In his book "Qualitative Methods in Migration Studies: A Critical Realist Perspective," Iosifides (2011) suggests biographical/narrative interviews for data collection in critical realist studies. Biographical/narrative methods of studying migration place individuals' subjective perceptions, experiences, and views at the center of the research. Iosifides and Sporton (2009: 104) state that, from a critical realist perspective, "biographical methods may lead to to detailed and comprehensive reconstructions of linking chains between events, meanings/interpretations, actions and practices." I discuss the development of my interview methods later in this chapter.

Access to informants and rapport

The first step in gaining access to possible informants required seeking permission to conduct this study from the EMMIR Examination Board and the Norwegian Data Protection Official for Research (NSD). For the latter, it was necessary that I provide a detailed project description, information about data protection, and a consent form to be reviewed by the informants. After receiving approval from both governing bodies, I began the process of recruiting informants.

Establishing contact with my informants required multiple methods. I initially chose to use social media platforms, such as Facebook and LinkedIn, to search for potential informants. The rationale behind this choice of recruitment method involved both theoretical and practical considerations. I did not want to approach possible informants through formal gatekeepers, such as employers or supervisors, for fear that this might negatively affect our rapport, the interview style, and/or their responses. Gatekeepers are "those who have influence with or power over potential participants and who can either serve to facilitate contact or prohibit participation" (Given 2008: 744). In order to mitigate informants' skepticism about discussing their work experiences with me, I did not want them to associate me with their employers or supervisors. In addition, I was unsure of the population size of Swedish and Polish nurses working in Rogaland, Norway (the region I was living). I wanted to be able to search for informants beyond my physical boundaries in order to cast a wider net. Searching for potential informants through public social media sites allowed me to contact possible informants directly and did not restrict me geographically.

Following a criterion sampling method, I searched in English, Norwegian, Polish, and Swedish for online groups related to "Swedish/Polish nurses in Norway." I was able to identify multiple people whose public employment, education, and current/pervious places of residence suggested that they fit the criteria for my study. I was aware that approaching possible informants as a stranger on social media would come with challenges. I wrote to the possible informants on both Facebook and LinkedIn messenger (depending on where I located them). I introduced myself as a master's student writing my thesis on the moving and work experiences of Polish and Swedish nurses in Norway. I explained how I came across their profile, and sent an information sheet about my project. Some of the nurses I found through LinkedIn did not seem to use the platform often, based on their profile activity. After a few days without a response, I tried to locate the Facebook page of those individuals and, if found, I sent them a message there also. My rationale for this was the thought that Facebook might be more frequently used and checked than LinkedIn. From these initial efforts, I received responses from two possible informants, one Swedish and one Polish. An advantage of Facebook messenger is that I was notified of the status of the message, whether it was sent, delivered, or read. Depending on the individual's security settings of Facebook, they may not be notified of messages received from people they are not "friends" with on the platform. I could see that some people had not received the message, suggesting that their security settings

did not allow the message to go through, or had received it, but not read it, perhaps due to suspiciousness or lack of interest.

Realizing the importance of trust, I decided snowball sampling would be more effective in recruiting informants to participate in interviews. Snowball sampling involves asking informants if they can put you in contact with other individuals within the target population (Babbie 2017: 196-97). This method was successful in helping me contact further Swedish nurses. I found that when informants were first contacted by a friend who briefly explained my project and what participation entailed, they were easily reachable and willing to participate.

I had greater difficulty establishing initial contact with Polish nurses than Swedish nurses. As no Polish nurse responded to my messages (the Polish individual who responded to my message was a physiotherapist), I decided to ask a contact from my internship at the Center for Intercultural Communication (SIK) in Stavanger, Norway for advice. My contact at SIK was able to provide me with information on possible informants and health care institutions I should contact. Through this information, I was able to contact two Polish nurses directly by telephone. In both cases, I explained to them how I obtained their phone number, told them who I was, and what my project was about. At the end of each interview, both informants asked me if I was looking for anyone else to interview and offered to contact some of their friends and colleagues. I was, once again, able to use snowball sampling to identify further informants.

Ethical considerations

As this study involves the collection of personal information regarding nurses' migratory and work experiences in Norway, I took ethical considerations into account throughout the data collection process. The qualitative nature of this research allowed for the disclosure of sensitive personal information, such as personal motivations, family relations, financial situation, and employer/colleague relations. In order to protect the identity and private information of my informants as much as possible, I have taken the following steps: (1) In January 2017, I reported the study to the Norwegian Data Protection Official for Research (NSD). In February 2017, I received formal approval from NSD. (2) Prior to data collection, participants were provided both oral and written information regarding confidentiality, handling of personal information, freedom to withdraw at any point without repercussion, and freedom to refuse discussing certain topics. After reviewing these issues, written informed consent was obtained. (3) The collected data was summarized, anonymized, and stored on a password protected personal computer. (4) Within this

document, possibly identifiable information was altered or made vague. Informants' real names were substituted for pseudonyms. Specific cities, places of employment, and dates were replaced with less precise references, such as "Northern Norway," "municipality in Rogaland," "a large hospital," "a municipal nursing home," "early 2010," etc. In addition, as family composition can indirectly identify a person, the age and sex of informants' children, if applicable, were not disclosed. Furthermore, the ages of my informants on the date of the interview are skewed up to five years of their actual age.

Data collection

The data in this research is based on seven in-depth interviews with seven informants. I began searching for possible informants in January 2017 and the interviewing took place between February-April 2017. Six of the seven interviews were conducted in English and one was held in Polish with a family member interpreting to English. On average, the interviews lasted between 60-120 minutes. As some of the informants do not reside in Norway, three of the interviews took place over Skype. For those nurses who were able to meet in person, the location and time of the interview was decided by them. Locations varied, with one being held at my apartment, one at a café, one at a hospital, and one at the informant's home. All informants seemed to be comfortable in the place they chose to meet, even those over Skype, and there were rarely issues with communication, such as interruptions, poor internet connection, or noisy environment. The interviews were initially recorded on my password protected phone before being transferred to my password protected personal laptop, and subsequently deleted from my phone. I decided to use my phone instead of a voice recording device to make it less obtrusive during the interview, as phones are a common object to have sitting on a table during a conversation.

I began the interview process by creating an interview guide. The guide contained rough topics I was interested in exploring and carefully worded questions. However, after conducting a pilot-interview on a fellow student, I noticed that the flow and quality of the interview improved when it took a more narrative form. Narrative interviewing allows the informant more freedom to express themselves and "reveal thoughts and memories that they would not and could not express in response to direct questioning" (Hopf 2004: 207). By allowing informants' narratives to dominate the interview, narrative interviewing minimizes the researcher's influence (Jovchelovitch and Bauer 2000).

Numerous outlines exist on the phases of a narrative interview (Hopf 2004; Jovchelovitch and Bauer 2000; Flick 2011; Schütze 1983; Fischer-Rosenthal and Rosenthal 1997). Drawing on information from Fischer-Rosenthal and Rosenthal (1997), Flick (2011), and Jovchelovitch and Bauer (2000), the following is an outline of the narrative interview procedure I followed:

> (1) Following a narrative-generating question, the informant produces the main narrative. During this phase the researcher should not interrupt the narrative and should take the role of an active listener, giving supportive gestures to encourage the informant. The researcher should wait for a narrative coda (So, that is pretty much it…) before moving to the second phase.
> (2) The "narrative probing phase," in which the researcher can ask follow-up questions about topics mentioned during the narrative and external questions. The questions should be phrased in an open manner and stimulate further narratives; "why" questions should be avoided.
> (3) In the final phase, the "balancing phase," the informants are addressed as experts and asked theoretical "why" questions and to make generalizations.

I found that most topics on my interview guide were covered during the narrative interviews without me having to initiate the topic into conversation. I did, however, adapt certain aspects of the interview procedure throughout the data collection process to enhance the quality of the interview. After reflecting on the lack of personal details in one interview, I decided to alter my narrative-generating question. Initially I had asked informants to tell me the story of their lives with a focus on their migration and nursing history. Once I began prompting informants to include any information they found relevant, their childhood, their studies, and the role family and friends played in the narrated events, the narrative scope broadened from "professional life" to "life, including profession."

Additionally, reflecting on my first interview led me to include my personal biography at the beginning of the interviews. At the end of my first interview, Frida began asking me questions about my migration history and how I came to be in Norway. After briefly explaining my background, where I grew up, my studies, and my path to Norway, a new narrative began. It seemed that Frida was inspired by my story and began telling me more personal stories about her

migration experiences, including feeling and emotions. Unfortunately, these insights were coming at the end of a two-hour interview and we were out of time. I then decided that, as tactic to gain the trust of my informants, I would give a brief overview of my background and migration experiences before inviting the informant to tell me about themselves. I found that this not only improved rapport between my informants and me, but also eased any nervousness about being recorded. I was able to set the tempo and style of the recorded conversation which they could then follow.

Data analysis

After each interview, I listened to the recording and complied a detailed report of the interview. Although I included many quotes in these reports, they are not verbatim transcriptions. When I found the discussion particularly relevant, I quoted it, but I also made summary notes of the topics/individuals/stories that did not seem relevant at the time. I noted the time every two-three minutes. These reports served both as a form of reflection and a type of table of contents.

Once I completed all of the interviews, I decided to transcribe the three longest interviews, two Swedish and one Polish—Frida, Sophie, and Joanna. I was worried about how time consuming transcription is, and after transcribing the three, decided that I did not think it was necessary for the purpose of my study. For the four remaining interviews, I re-listened to the recordings, compared them to my reports, and filled in information. After completing the reports, I read over the transcriptions and reports multiple times, highlighted themes and topics of interest, and complied an Excel spreadsheet including both themes and quotes. I then organized the information according to temporal distinctions: prior to working in Norway, during the first process of working in Norway, while working in Norway, and after working in Norway (if applicable).

Once the themes and quotes were organized temporally, I wrote one-two page summaries of the narratives, not including direct quotes. I sent these summaries to my informants to look over and encouraged them to let know if I had gotten anything wrong, was missing important information, or if they did not want me to include certain information. All seven nurses responded positively to opportunity to look over the summaries. Only one of them had a correction to make, regarding a date. Many of them told me to feel free to contact them again if there was anything else they could do. This process reassured me that I was not misrepresenting what the nurses shared with me.

Role of the researcher and establishing trust

My experiences with migration influenced my perspective on the topic and my dialogue with informants. I grew up in the United States and completed most of my bachelor's degree there. I moved to Germany in 2014 as an exchange student and finished my degree there. Afterwards, as I wanted to remain in Germany, I signed up for a one-year intensive German language course. During this time, I applied for the Master in Migration and Intercultural Relations (EMMIR) program. Within the EMMIR program I lived in Germany for four months (total of two years in Germany) before moving to Norway for seven months, Uganda for two months, Czech Republic for two months, and back to Norway in January 2017. Throughout my time living outside of the US, I have faced difficulties with language, finding housing, establishing residency (mainly due to financial requirements), making friends, and missing family and friends in the US. Therefore, even though being a student entails a different context than working abroad, I believe that many social and personal experiences may overlap.

My experiences living in multiple countries has affected my perception of and opinions on migration issues, both at macro- and micro- levels. I have become more sensitive to different ways of living and thinking, and more critical of barriers to mobility (both territorial and social). My experiences with living outside of my home country allowed me to relate to informants on a personal level. I was able to share stories about migration decisions, difficulties of learning a new language, and the process of establishing residence. One of my Polish informants was surprised when I told her of the challenges I had establishing residence in Germany and that I might have to leave Norway if I am unable to find a job. She commented that it is strange to think of a US citizen as having trouble with residence while she, a Polish national, did not. I believe that this interaction contributed to minimizing power relations between interviewer and interviewee. By beginning the interviews with a brief account of my migration history and allowing informants to ask me questions, I established trust based on our shared experiences.

Although my position experiences with migration helped me establish an important level of trust with informants, other aspects of my personal biography were varyingly influential in interactions with informants. Informants' biographies varied in such aspects as age, gender, "race," sexual orientation, and social status. Depending on the individual identity of the informant, my social positioning as a young student seemed to have different effects. In interactions with informants who were also studying or had completed their studies recently, my social positioning seemed to facilitate an open dialogue, while hampering it in interactions with "older" informants. Although I was younger than all of my informants, I noticed that the informants who were closer to my age tended to speak more openly about their personal, non-professional lives. In these situations, the conversation was casual and friendly and revealed the complexity and depth of the life of the informant. Comparatively, the informants who were 20+ years older than me revealed little about their family relations and tended to explain situations from a purely

professional point-of-view. This difference could be due to my inability to successfully adapt to the situation and challenge my personal inhibitions to pushing people to speak about their personal lives. It could also be explained by informants' view of me as a young, inexperienced student (both socially and professionally), who they do not relate to generationally. It could be that I am around the age of their children, nieces, or nephews which made it strange or inappropriate for them to share personal information with me.

Therefore, while my experience with migration granted me "insider" status in a way and facilitated my rapport with informants, my "outsider" status as a young student was sometimes difficult to overcome. However, my "outsider" status as non-Norwegian, Swedish, or Polish and not medically educated allowed me to ask questions about Norwegian society, Polish/Swedish society, the nursing profession, and the work environment that might have been strange for an "insider" to ask. In this way, my position as a cultural and professional "outsider" enabled me to establish rapport with informants who then might feel more comfortable and willing to express their experiences with and perception of Norwegian social life and workplace practices.

Reflections on interpretation

As one of the informants was not comfortable with her level of English language ability, it was necessary to solicit the help of an interpreter. The participation invitation form given to interested nurses stated that interviews would ideally be conducted in English; however, if they did not feel comfortable conversing in English, a family member or friend with whom they felt comfortable and trusted could accompany them to the interview as an interpreter. Although there are numerous methodological drawbacks inherent in the use of family and friends as interpreters, the benefits were determined to outweigh the risks in this case. As not speaking English could influence nurses' experience of working in Norway, where English is widely spoken, I found it important not to exclude non-English speakers from participating. However, due to the high cost of professional interpreters, it was not possible to use this method. Therefore, I decided utilizing the language abilities of informants' family and friends was the best possible option. I contemplated asking a fellow student who speaks Polish if he would mind interpreting, but concluded that the informant would most likely feel more comfortable with someone they know.

In the one situation in which an interpreter was needed, the husband of the informant was willing to act as interpreter. The interpretation was done consecutively. Before the interview I explained to the husband that he should feel free to ask both me and his wife to clarify anything if the meaning was unclear to him, in order to improve the quality of the interview and the

communication process. While the husband's English language skills were adequate in communicating his own opinions, it was difficult for him to interpret from English to Polish and vise-versa. For this reason, the interview did not flow well and therefore lacked depth. Furthermore, I experienced that the husband would begin answering my questions for his wife before telling her what I said. When this occurred, she stopped him, and from what I could gather from context, asked him to tell her what I had said. Despite these drawbacks, this interview still provided insight into the experiences and migration of a Polish nurse working in Norway and is included in the analysis.

Informants' profiles

The criteria for recruiting potential informants for this study was that they possess either Polish or Swedish nationality, have obtained their nursing education in their respective country of nationality, and have past or present work experience as a nurse in Norway. As the aim of this research is to develop a deeper understanding of the complexities of individuals' experiences and decisions, rather than to produce representative results, the number of interviews was kept intentionally low, with 10 informants set as the maximum.

As I was recruiting two groups of informants, I tried to ensure that the ratio of Polish-to-Swedish nurses was as equal as possible. I was able to interview four Swedish and three Polish nurses. Of the Swedish nurses, three were female and one was male. All three Polish nurses were female. The age of my informants ranged from 30-55. The age diversity of Polish nurses was low, with the youngest being 30 and the oldest 37. The age diversity was greater among the Swedish nurses, with the youngest being 34 and the oldest 55. Of the Polish nurses, all were married with children and lived with their families in Norway. Of the Swedish nurses, one was a single-mother living in Norway, two were in a relationship and living in Sweden, and one was divorced with independent children and living in Sweden.

In order to familiarize the reader with the nurses and to facilitate understanding in the study, I summarize their individual profiles, in regards to work and migration, in the following sections.

Polish nurses

Patricia

Thirty-three-year-old female, born and educated in Poland, living with her husband and children in Norway. She works as head nurse in a municipal health center. Her younger sibling also moved to Norway five years ago.

Patricia has a bachelor and master's degree in nursing from Poland. While getting her master's degree, the held two part-time positions as a nurse in a hospital. She had been thinking of moving abroad to work even before she started her bachelor's degree, but she did not start the process until after receiving her master's degree. She found a job in Norway through a large recruitment agency and moved there 2010. Her husband joined her after one-two months. The nursing agency placed her in a nursing home in a small city in Norway where she had to work nights. She remained in this position for nine months before finding a position on her own at a municipal health center in a larger city.

After six months in this position, she applied for an assistant head nurse position and was chosen for the job. During this time, she and her husband had two children. In 2017, she was selected from 11 applicants to be head nurse at the municipal health center. This is the position Patricia held at the time of the interview. She told me that she had recently applied for a one-year course in healthcare leadership in order to improve her salary. Furthermore, although she initially thought to stay in Norway for 5 years, she does not want to return to Poland and is in the process of applying for Norwegian citizenship.

Barbara

Female, 38 years old, born and educated in Poland, living with her husband and children in Norway. She works nights as a nurse in a municipal nursing home.

Barbara has a bachelor and master's degree in nursing from Poland. She worked for one year in a private clinic in Poland before moving to Norway in 2008. She and her husband had been thinking about moving abroad since Barbara began her bachelor's degree. Their initial thought was to move to either England or Ireland, but changed their minds and decided to move to Norway instead.

Barbara first found employment in Norway through a large recruitment agency. They flew her to Oslo to attend a one-month Norwegian language course before giving her options of cities to work in. Barbara chose a large city in Norway and was placed in a nursing home in a neighboring municipality. For the first four months, she worked at a reduced salary and with reduced responsibility due to her low Norwegian language ability. After these four months, she was given a higher salary and full responsibility. She held this position for the full two-year contract period with the agency.

Once her contract had expired, the municipality offered her to remain in the same position and she accepted. Barbara remained in this position for three-four years, until she "got bored" and decided to apply for other positions. She was offered two jobs at nursing homes in nearby municipalities, but chose the one which was closer to their house. After three-four years in this position, Barbara once again "got bored" and applied for a position as night nurse with the same municipality.

At the time of the interview, this is the position Barbara held. She and her husband said that their initial thought was to move to Norway for a couple of years and then move back to Poland, but this plan changed over the years. They do not see themselves moving back to Poland, and rather hope to move to a southern European country in the future.

Joanna

Thirty-year-old female, born and educated in Poland, working and living in Norway with her husband and child.

Joanna has a bachelor and master's degree in nursing from Poland. Right after completing her bachelor's degree, she moved to England to work as a nurse. However, due to her lack of experience and education level, she did not have many responsibilities in England and was often bored. After one year there, she decided to move back to Poland to gain work experience and further her education.

In Poland, she began working in a surgical ward at a hospital, and after a year, began her master's degree. She maintained her position at the hospital throughout her two-year master's program and remained there a year after as well, while looking for further opportunities. During this time in Poland, Joanna met her husband. Although she had been thinking of returning to England to work, as she already knew the language, her husband (boyfriend at the time) wanted to move to Norway.

She found a Norwegian language course in Poland and began taking classes twice a week. Unlike Patricia and Barbara, Joanna did not go through a recruitment agency. Instead, she was able to find a job at a municipal health center through a friend she knew already working in Norway. She moved to Norway in 2012 with her husband. At the time of the interview, Joanna was still working as a full-time nurse in the same municipal health center. Since moving to Norway, Joanna and her husband got married and had a child.

Although they did not have any plans for how long they would stay in Norway, Joanna and her husband have not thought about moving back to Poland any time soon. Instead, they would eventually like to move to a southern European country, but are not making any set plans due to their young child.

Swedish nurses

Frida

Thirty-five-year-old female, born and educated in Sweden. She is living and studying medicine in Sweden, but works at a hospital in Norway on weekends.

Frida's first experience working in Norway was in 2010. She had been working for a couple of months at a surgical ward in a hospital in Sweden, but decided to quit and move back to the city she grew up in after a break-up with her long-time boyfriend.

Unemployed, Frida decided to work in Norway and went through a recruitment agency to find work there. On her first trip to Norway, she worked for two-three months in a nursing home before returning to Sweden for about a week. One of the nurses from the nursing home was going to be on leave for a while and the agency offered her the position, which she gladly accepted. At the time her contract with the agency was ending, the agency was banned from the city she had been living and working in.

Frida then decided to search for positions independently. She was able to find full-time employment at a hospital and a room in a shared-flat close to the hospital. Her contract with the hospital was for one year, but she ended up working there for two years, from 2011-2012. During that time, she met a boyfriend from Norway and they decided to move to Australia together. Frida said it was difficult to get her nursing qualifications recognized in Australia and was only able to find part-time employment as an assistant nurse. Her boyfriend had similar difficulties, and after 7 months, they decided to move back to Norway. Frida was able to get a position as a nurse in the hospital again, but this time on two part-time contracts in different departments.

Frida then decided to apply for medical schools in Norway and was accepted to medical school in Oslo. She moved there and found a job at a hospital. Her boyfriend joined her after five months, but they broke up within the year. Frida then decided to move back to Sweden and apply for medical schools there, but she continued to work as a nurse in a hospital in Oslo on the weekends. At the time of the interview, Frida was in medical school in Sweden and still working in Oslo. She had not dismissed the possibility of moving back to Norway after her studies.

Sabine

Fifty-five-year-old, born, educated, and living in Sweden. She has past work experience as a temporary nurse in Norway.

Sabine first began working in Norway in 2009 as a temporary nurse (Norwegian: vikar). She completed her bachelor's degree in nursing in the late 1990's and had extensive work experience in Sweden before she began working in Norway. A few years before she started working in Norway, she looked into working in California, USA, but said the requirements for authorization and her children's wishes to stay in Sweden stopped her from pursuing it further.

As Sabine had children and a husband in Sweden, she did not intend to move to Norway. For her, working through nursing agencies allowed her to work back and forth between Norway and Sweden. Sabine worked in Norway over a six-year span and described her general working pattern as: two weeks in Norway, two weeks in Sweden. She was employed at multiple recruitment agencies over those six years, often working for two or three agencies at once. She has worked in various cities all over Norway and in various institutions, such as psychiatric wards, oncology wards, nursing homes, and home care.

In 2015, Sabine stopped working in Norway, and at the time of the interview, she was employed at a hospital in Sweden. She explained to me that she has not dismissed the possibility of returning to Norway someday and finding a position on her own, without going through an agency.

Hans

Fifty-year-old male, born, educated, and living in Sweden. He has past work experience as a temporary nurse in Norway.

Hans completed a bachelor's degree in nursing and a master's degree in music education in Sweden. He began working night shifts in a hospital after graduating with his nursing degree until completing his master's education. After that, he began working for a nursing agency in Sweden that rents nurses to different medical facilities. He decided to try working in Norway, but never intended to move there. Hans found a job through the agency he had already been working for, and in 2013, he went to work in Norway on three separate occasions, each time in the same city, hospital, and ward. The lengths of his stays were between two-three weeks. At the time of the

interview, he was living in Sweden with his partner, working for the same recruitment agency, and playing his music. He explained that he has loose plans to live abroad in the future, maybe Thailand, and work as a nursing consultant over the phone.

Sophie

Thirty-two-year-old female, born in Northern Africa, educated in and a citizen of Sweden, living in Norway. She works part-time at a municipal health center.

Sophie moved to Sweden when she was a teenager from a Northern African country. After about five years, she became a Swedish citizen. In high school, she took the nursing program and became an assistant nurse in a nursing home. After high school, she began her nursing education at a university in Sweden. She graduated with a bachelor's degree in nursing and began working at a hospital.

After working two years in Sweden, she decided to look for position abroad. At first, she thought of going to Saudi Arabia to work, but later decided against it. Instead, Sophie decided to try working in Norway through a recruitment agency. She first began working in Norway in 2007, but was also working in Sweden, spending a few weeks in each country at a time. In 2008 she decided to work solely in Norway, but was still working as a temporary nurse and traveling back to Sweden every few weeks. She was employed at three-four recruitment agencies at a time, but one was her standard.

From 2009-2011, Sophie worked primarily at one hospital in a large Norwegian city. This hospital offered her a full-time position, and in 2012, she decided to take up residence in Norway. She had met a man in Norway in 2011 and after dating a while, they decided to move in together. They had a child together not long after, but split up a few years later. After the split, Sophie moved to a neighboring municipality and began working part-time in a nursing home. At the time of the interview, this is the position she held. She wanted to work full-time, but her responsibilities as a single mother did not allow her to work nights and weekends. Sophie expressed her hopes to travel and move again some day, but her main priority at that time was to raise her child.

Chapter 5. Nurses' experiences, views, and decisions

In this chapter, I turn my attention to the narrative accounts of my informants. In order to gain a better understanding of the complex migration decision-making process for Polish and Swedish nurses who choose to work in Norway, I present their thoughts and experiences as accurately as possible–through their narratives. From their narratives, I discuss the nurses' own perspectives in light of the aspects of the Norwegian nursing shortage discussed in Chapter three. I return to the research questions for guiding my presentation and discussion of the interviews:

- *What are the most significant influences on Polish and Swedish nurses' decisions to work in Norway?*
    a. *What effects do Norwegian recruitment and labor immigration policies have on Polish/Swedish nurses' decisions and experiences?*
    b. *What role does Norway, as a destination, play in their decision to work abroad?*
    c. *What is the importance of other factors, such as networks, culture, and imaginations?*

I present the narratives of the Polish nurses first. This is followed by a contextual elaboration and discussion of the migration of Polish nurses based on my informants' statements. I then follow the same procedure for the narratives and contextual discussion of the Swedish nurses. Within the contextual elaborations, I discuss the research questions in light of the interview material. I cite the nurses extensively in order to communicate the basis of my analysis with the reader.

Polish nurses

PATRICIA

Patricia began her story:

> I got my bachelor degree in [2000s], and then I got my master degree [two years later], and the same year I got it I was like…I had two years of practice in nursing, because when I was getting my master's degree, I was working at two hospitals in Poland, and I thought that it was quite difficult. I had two jobs at the same time, so I was like, "Where is my husband?" I was seeing him about two days a week. Then I thought that I have to try something new.

Patricia viewed working abroad as a way to reduce the number of hours she worked, allowing her to spend more time with her husband. Despite liking her job in Poland, she did not think she would be able to meet her aspirations in Poland:

> I liked this job [in Poland] because it was intensive care and I always dreamt about it. I had a very great team at that job, they were just amazing people. But, to be able to buy a house or to make enough money to get a new car, was very difficult, and I couldn't do it. And then I thought, “How many years do I have to work so much to get an apartment?” Not a house, only an apartment. So I thought it would take about 50 years, the next 50 years, to buy something of my own. And then I thought, "No, I just can't do it anymore."

Additionally, the low professional status of nurses in the workplace added to her frustrations with working in Poland:

> Taylor: So it was too much working in Poland…
> Patricia: It was everything. It was doctors, who were just a pain in the ass for us. They were like, “You're a nurse, you're shit. I'm the doctor, I'm the boss.” It was like that.
> Taylor: So really hierarchical?
> Patricia: Yes, very, very much. One doctor yelled at me because I called him to tell him that I thought one of our patients was having a heart attack. But he [the doctor] was watching TV, so he was busy, he didn't come. And he yelled at me! He yelled at me, and then I thought, “No. I was studying five years. He was studying six years, and he's ... This is not that kind of respect I want to have after so many years at school! I know what I do, and I want to get respect.”

Although she described negative social, financial, and professional experiences working in Poland as spurring her decision to seek work abroad, Patricia had considered working abroad even before she began working as a nurse:

> I knew that to be a nurse in Poland was not that good, so I was thinking about leaving Poland from the start of my bachelor's degree, but I wasn't thinking about Norway.

Taking language into consideration, Patricia initially thought to work in England. Two friends, one who had been working in Norway and another who had decided to find work there, influenced her change in destination country:

> I was thinking more about going to England because I speak clear English, but I have a friend who was in Norway, at that point [she had been in Norway for] one year, and she was very, very, very ... She said to me, "No, [Patricia]. You have to come here. This is so great. This is the best place we can work." And then I thought, "Okay, why not?" And I meet my best friend, and she said she's also heading off. She also had two [nursing] jobs at that point, and she said, "No, this is too much, and I'm trying to get a place in some Norwegian course, to learn Norwegian." And she said to me, "You should come with me!" And I said, "Okay. I have to think about it," but it was two days, and I just sent my papers, and my CV to [a large nurse recruitment agency].

The language course offered by the recruitment agency was quite time consuming and required her to stop working during that time, but Patricia viewed the agency as a major factor in her, and other Polish nurses' access to the Norwegian labor market:

> So we got in, and then we took these Norwegian lessons. They lasted three months. We couldn't work because it was from Monday to Friday, from 8 [AM] to 3[PM]. So it was only Norwegian, Norwegian, Norwegian. It was the best thing that could have happened to us, working with that company. [The company] was hiring Polish nurses, and they have helped us very much to get here [to Norway].

The agency handled most of the "costs" of migration, as they provided her a language course, found her a job, paid for her flight, provided accommodation, and applied for her authorization in Norway. Speaking about the ease of working with the agency, Patricia stated: "I didn't have to do anything; I could just go and work. So, bye bye." I interpret this statement to highlight that the

ability to work through a recruitment agency, which eliminates many of the mitigating factors of migration, makes the decision to work abroad much easier.

The wage offered by the recruitment agency was also appealing for Patricia, as it was much higher than she had been making in Poland:

> When I was in Poland and they told us how much money we will get, it was like, "Wow! So much?" It was like going from ... I got 20 or 24 Krone an hour [in Poland], and here they paid me 130 Krone, so it was like, "Whoa!" But we didn't know how much Norwegian nurses earn.

She quickly realized once she was in Norway that the salary offered by the agency was below the standard Norwegian salary for nurses. She wanted to leave the agency and find work on her own, but perceived the agency as her only option:

> I wanted to leave from [recruitment agency] as soon as possible. I knew that they were paying bad, but I knew that it was my only chance to get here.

As an EU citizen, she had the legal right to move to Norway as a job seeker for up six months, but she clearly did not view that as an option. She stressed the importance of knowing the Norwegian language and she perceived the language course offered by the recruitment agency to be better than private courses. In response to the many questions she gets from nurses in Poland about working in Norway, she still suggests working through the agency she did, despite the sub-standard salaries:

> I get many questions on Facebook from my friends who live in Poland now. They are nurses and they're thinking about, or they're actually doing something to get here [to Norway]. And I'm telling them that the most important thing now is Norwegian [language], that it's not worth it to come here and to try to get work if you don't know Norwegian, because it's so difficult to get a job. You have to know Norwegian. […] And I'm still saying that [the recruitment agency] is the best company that can help nurses. But, I'm also telling them that they don't pay you well, but I'm saying that the Norwegian course is the best on

> earth. So, I'm always telling them that they should just try to get here with [the recruitment agency].

Due to the importance of learning the Norwegian language before working in Norway, Patricia advises other Polish nurses to accept the sub-standard wages offered by the recruitment agency in exchange for the language course.

JOANNA

Norway was not Joanna's first experience working abroad. She had been to the United States (US) three times during her summer holidays in high school and at university. While there, she worked as a babysitter, waitress, and a housekeeper. As mentioned earlier, she also moved to England for a year after getting her bachelor's degree to work as a nurse. Joanna explained that working abroad was a common thing to do in her family:

> It was actually popular in my family for people to travel for work. My mother, when she was young, she worked in [European country] for two years as a house keeper. My father […] worked as well in America. My [sibling] also migrated […]. But for them, it was common to go back to Poland. For me and my husband, we are not sure if we want to go back to Poland. It's not that we don't like Poland, but we really like to travel. So, we are thinking even of moving to [Southern European country], maybe when we have another child, I don't know, we will see. But, yeah, we don't want to, for example, buy a house and pay the mortgage, so we are kind of an open family to travel. So my parents they were actually happy about [me moving to Norway].

Joanna's family's openness to moving abroad for work and her general desire to travel seem to have impacted her career choice:

> I decided to study nursing because I always liked to help people, and I was actually already thinking about migrating before I studied it, because I think that this occupation gives you a lot of opportunities. There is a shortage of health care staff, of nurses, so you can actually pick the country you like and you will always find a job, so it's brilliant I think.

She continued:

> [t]raveling was the main reason [for choosing the nursing profession] and the second reason was to have job security. And the third thing was that I was actually aware of the fact that in Poland you don't earn much as a nurse, so I didn't want to work there for good, because its difficult to make ends meet as a nurse there.

Joanna's perception of the nursing profession spans national borders. She knew of the low remuneration for nurses in Poland, but did not see this as an issues because she perceived finding work in another country as a nurse to be easy. Her perception of job security was not limited to Poland, but was based on the global demand for nurses.

However, despite wanting to travel and knowing that it is difficult to live off of a nurse's salary in Poland, Joanna enjoyed her job in Poland. She explained that it was very busy, but she did not mind because she enjoyed the work and never got bored, unlike in Norway. She attributes this to both the difference in institutions and the higher nurse-to-patient ratio in Norway compared to Poland. In Poland, Joanna was working at a surgical unit in a hospital, while in Norway she was working at a municipal rehabilitation center:

> Taylor: How was your experience working in Poland?
> Joanna: It was busy. You cannot compare it with work in Norway. It can be busy here [in Norway] where I work as well, but it changes here. One shift is busy and the next day it can be quiet, but in Poland it was *always* busy. […] Yeah, it was a lot of things to do. It was busy, but it was nice, because I liked the work actually, so I was never bored in Poland. Here it's sometimes like I have to find something to do, so it's very strange, different. But it's because of the staff, as I said. Here [in Norway] we have more nurses per patient.

While she did not mind the business of working in Poland, she wanted her salary to reflect the amount and quality of work she did. She described how the low remuneration affected her life in Poland, pressured her to seek an alternative, and shapes her opinion of her future:

> I know it can sound a bit silly, or awkward for me, but the fact that nurses earn so little in Poland, I think this influenced my decision the most [to move abroad]. I remember when I worked for four years in Poland, it was in the surgical department and it was really hard work, because there was always a shortage of nurses and you have to work shifts. For example, I had a long shift, 12 hours one day, a long shift the next day, and a night shift the next day. Then, I got one day off before going to work again, and then two days off. When you work so hard and when you try to give your best for the patients and you don't get equal payment, its really frustrating. I think this influenced my decision the most. I thought before about traveling, but I think I could work in Poland at some point in my life, but the fact that nurses are so low paid…I was just really pissed off. I have to say. You are tired and… Actually, I used my saving from England to live, to rent a flat and buy food. It wasn't something, I don't know, over [excessive]. It was basic things which I had to pay for, and having only my job, I couldn't afford to pay my rent or for all of the basic things. So it was sad. It is sad, in Poland.

During her time working in Poland, Joanna met her husband, and although she had been thinking of returning to England to work, her husband had been to Norway and loved the nature there. He wanted to move there and Joanna agreed:

> Taylor: Was there any particular reason he [her husband] wanted to go to Norway?
> Joanna: We knew that the standard of living here in Norway was, and is, really high. My husband also traveled to Norway before, so…He's the kind of person who likes to [go for nature walks][6], so he liked the views and nature and I just said, "Okay." I'm not a difficult person, so I followed him.

However, before she left Poland she tired to get a raise, but was told it was not possible. When she decided to quit her job and go abroad, her supervisor came back and told her she could get a raise, but it was too late:

[6] "Gå på tur" in Norwegian. This translation was done by me.

> I had to fight in Poland, actually, to get a raise. It was sad. I remember I decided to quit my job, and it was the last week of my work, and the head nurse came to me and said that she talked to the owner of the hospital and, because it was a private hospital, that I could get a raise in my salary because of the [master's] degree I had. I said to her that it was too late, because I had already made my decision to go abroad. She was kind of disappointed, but you can't make everybody happy. She was disappointed, because at this time when I quit my work, they began to have some problems with staff in Poland as well. It was kind of always like, yeah, there were almost too many nurses and too few positions, but now it has changed, very much. It's due to the fact that there are more and more elderly people.

In this situation, Joanna was able to use the mobility of her professional skills as a source of power in fighting against unfavorable conditions in Poland.

After that, she found a Norwegian language course in Poland and began taking classes twice a week. She had also gotten in contact with a Polish friend who was already working as a nurse in Norway:

> I have a friend who had been working before me in Norway, so I asked her what I had to do to get work in Norway, what kind of documents I needed and where I could actually find a job. She gave me some tips and after one week she asked me if I would be interested in a job at the same place she was working, so I said, "Yeah. Why not?" And I had an interview on the telephone with two women from Norway and with my friend in the background. It went really well. They were happy about giving me the opportunity to come to Norway and get a job, so I decided straight away that I would take it. And one month from that interview, I was in Norway. So it was quite fast.

Due to her friend's help and the absence of a language requirement, Joanna described the job seeking process as very easy:

> Joanna: So it was really, really, really, easy. I had a lot of luck with this, and that I knew her [her friend], so I didn't actually have to come to Norway to have an interview, it was

on the telephone, so it was easy. And the people on the other side of the telephone were really friendly.

Taylor: Was the interview in English?

Joanna: In Norwegian, but when I had some problems [friend's name] used her Polish-Norwegian, if you know what I mean? She repeated the sentence, but in slow-motion and with a Polish accent, and it was really, really easy. So, yeah. So it went well.

Taylor: So they didn't say that you had to have a certain level of Norwegian?

Joanna: No. That was because they were so desperate to have staff that they didn't have any requirements.

As Joanna informed me that her friend in Norway had gone through a nurse recruitment agency, I asked her if she had also considered that as an option. She explained that she wanted to come through a large recruitment agency, but that she did not have the possibility. At that time, the agency was having legal troubles and had stopped recruiting from Poland. Joanna described this as a "pity," because she knew that the agency helped her friend a lot a with learning Norwegian and with authorization. I then asked how it was receiving authorization on her own. She described the process as follows:

Taylor: How was it for you with the documents?

Joanna: You know, it was also [friend's name] that gave me some tips and she gave me, I don't remember those web-addresses, but I had to register on a website and send some documents to NOKUT[7], it's [the agency responsible] for medical staff. I was surprised because it took me only three or four days to collect everything and send it to them. They say that they send an answer after three months, but I got an answer after one month, so everything was perfect and I didn't have to wait so long. So it was easy-peasy. But I think it was because I…Yeah, we have a bachelor's degree in Poland now that is the same type [as the rest of the EEA countries]. It would be more difficult for nurses who went to the high-school before, I don't know how many years ago.

[7] (NOKUT 2017) "NOKUT (the Norwegian Agency for Quality Assurance in Education) is an independent expert body under the Ministry of Education and Research." NOKUT is responsible for the recognition of "foreign higher education."

Joanna recognized that Poland's education reforms to the uniform bachelor's degree in the EEA made the authorization process much easier than it would have been for nurses educated under the previous vocational system.

It was also necessary for Joanna and her husband to find housing themselves. She described this process as rather difficult in the beginning and explained that they had to stay in a cabin (Norwegian: hytte) for two weeks before finding an apartment:

> It was difficult, because we had to try to find a place to live, something to rent, and we tried while we were in Poland, but it was impossible. And at that time prices were really high and there were a lot if immigrants. It has changed over the years very, very much. Because when we came here four years ago, it was really difficult finding a place to live actually being in Norway, so over the telephone, or through e-mail, it was impossible. What we did, it was really quite fun, we found a hytte, a cabin, that we rented for two weeks.

Furthermore, she gave the following advice to nurses who do not want to go through an agency:

> Joanna: It's really expensive here [in Norway], and if you have savings from Poland, they melt down really quickly, so it's better to get a job before you come. Also, they don't accept handing in CV's in person, so everything happens through the internet, and it can take some time, so you have to be really patient. […] If you don't have anyone in Norway, any contacts, it's best to fill out all the applications, wait for the answer, and *then* go to [Norway for] the interview. If you get the job, then try to find a place to live, because when you have to live here and pay the rent, it's expensive.

Although Polish nurses can legally come to Norway to look for a job, Joanna points out that due to the high cost of living in Norway and the low salaries in Poland, it is not practical for nurses to move to Norway before securing a job. Also, it is not necessary as most application processes are online. However, finding a job in Norway from Poland could be quit difficult, even if the application processes are mainly online, due to language. The best option if you do not work

through a recruitment agency would then be knowing someone already working in Norway, as Joanna.

BARBARA

Barbara explained that she did not want to work in Poland for "ethical reasons." She did not feel respected as a nurse in Poland and was frustrated with the hierarchy between doctors and nurses. Similar to Patricia and Joanna, Barbara and her husband planned to move abroad at the beginning of her bachelor's degree:

> Taylor: Can you tell me a bit about your experience working in Poland?
> Husband: She doesn't want to work in Poland because of ethical issues. In Poland it is little bit different with that because there is a big, big hierarchy between doctors and nurses. And doctors usually are looking down on other personnel. But we were prepared to move to another country, actually from the beginning when she started studying. It was like a plan. We started to plan to move to another country.

Barbara and her husband initially thought they would try to find work in England. However, unlike the other two Polish nurses, Barbara's choice of England was not due to prior knowledge of the English language. The reasons for choosing England were not mentioned in the interview, but Barbara had already contacted an agency recruiting nurses to England and was attending an English language course before she and her husband changed their minds. Barbara explained that the larger salaries offered in Norway and the opportunity to go somewhere not many other nurses were going motivated them to change their minds.

> Barbara's husband: First choice was England and then Norway came in the picture and we decided to take Norway instead of England.
> Taylor: What made you change your minds?
> Barbara's husband: A part of our preparation was an English course and we were in contact with a few companies who were recruiting nurses to England, but then came Norway and we decided to choose Norway because, we didn't know so much about Norway, but we knew that the salary is good in Norway. So, mainly because of money. Most people are

> coming to Norway because of money. That's the truth, for everyone. And many people at that time were moving to England, Ireland, and other countries, but not so many to Norway and it was a little bit…she was interested in how it is in Norway.

They decided to move to Norway with the goal of saving money and moving back to Poland:

> Taylor: Did you have any plans for how long you would stay?
> Barbara: First, three years.
> Barbara's husband: Most people who are coming to Norway, they are thinking to earn enough money to build a house and then move back to Poland. Most people from Poland are thinking like that, and people from other countries as well. Yes, so we, she was thinking the same

Barbara first found employment in Norway through a large recruitment agency. She chose to go through an agency because they took care of the necessary requirements for moving: language courses, housing, job, authorization, and personal identification number. Her husband explained that because they did not have any family or friends in Norway, it was necessary for them to have assistance from an agency:

> Husband: [Moving to Norway] on our own would have been very difficult because of the starting costs [flight, accommodation, authorization fee, language course], and we didn't have any family or friends [in Norway] who could help us at the beginning. We couldn't stay here without any assistance.

Barbara explained that she knew she was not receiving the same salary as a "normal nurse," but that she was okay with this because she knew that she needed to learn the language. After learning the language, she knew she would be able to look for better opportunities on her own:

> Husband: She knew at the beginning that the normal nurse salary is more [than she was earning], but it was okay, because she knew that language was important and that she would

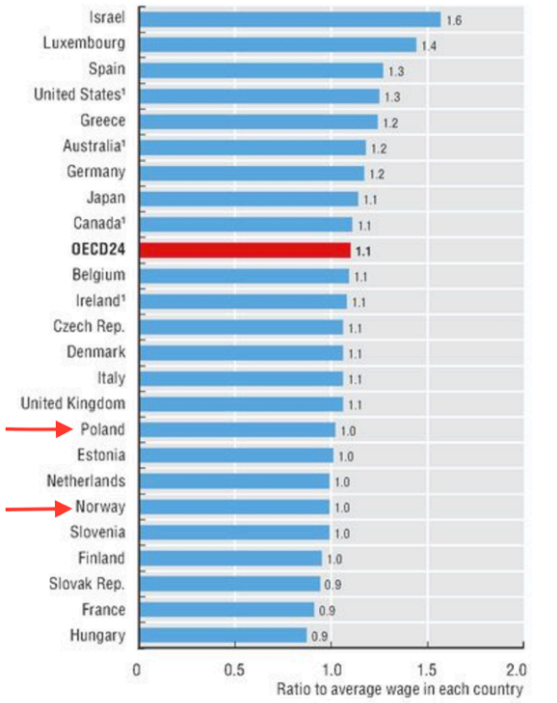
> get it…. She knew that when her language got better, she would be able to take another position, find a job on her own.

In this way, Barbara used the recruitment agency to take care of the practical aspects of moving to Norway in exchange for a lower salary. Similar to Patricia, Barbara saw this as a way to access the Norwegian labor market, but planned to leave when she was able.

Polish context and discussion

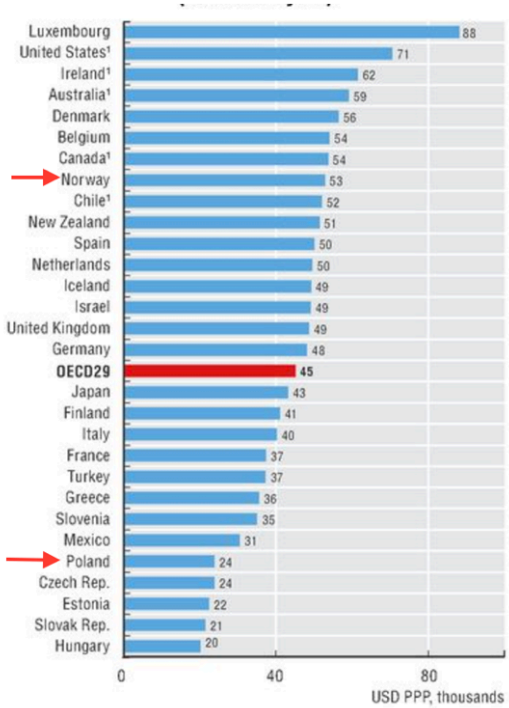
The working conditions for nurses in Poland have contributed to the profession's unattractiveness. Polish nurses experience low salary, over-working, low job security, and a lack of respect. OECD (2015) statistics on the remuneration of nurses indicate that, as of 2013, hospital nurses in Poland earned a salary roughly equal to the average wage of all workers in Poland; however, when converted to US dollars (USD) and adjusted for purchasing power parity (PPP)[8], the average Polish nurse's gross annual income is listed at 24,000 USD. As shown in Figure 2, of the 29 OECD countries included in the study, only 3 countries ranked below Poland (Estonia, Slovak Republic, and Hungary; Czech Republic is equal to Poland) (OECD 2015).

[8] Adjusting for PPP "provide[s] an indication of the relative economic well-being of nurses compared with their counterparts in other countries."



1. Data refer to registered ("professional") nurses in the United States, Australia, Canada and Ireland (resulting in an over-estimation).
Source: OECD Health Statistics 2015, http://dx.doi.org/10.1787/health-data-en.
StatLink http://dx.doi.org/10.1787/888933280951

Figure 1. Remuneration of hospital nurses, ratio to average wage, 2013 (or nearest year). Taken from OECD (2015), Remuneration of nurses. *Health at a Glance 2015: OECD Indicators*. http://dx.doi.org/10.1787/health-data-en.



1. Data refer to registered ("professional") nurses in the United States, Ireland, Australia, Canada and Chile (resulting in an over-estimation).
Source: OECD Health Statistics 2015, http://dx.doi.org/10.1787/health-data-en.
StatLink http://dx.doi.org/10.1787/888933280951

Figure 2. Remuneration of hospital nurses, USD 2013 (or nearest year). Taken from OECD (2015 Remuneration of nurses. *Health at a Glance 201 OECD Indicators*. http://dx.doi.org/10.1787/hea data-en

The nurse-to-patient ratio in Poland is one of the lowest in Europe. According to Eurostat (2016) statistics, Poland had around 500 nurses per 100,000 inhabitants in 2014, showing little change from the 2009 number. Norway however had over 1,500 nurses per 100,000 inhabitants (Eurostat 2016). Although this data is an estimate and does not reflect the prevalence of part-time nursing positions in Norway, or the average number of working hours in each country, the incongruities between the nurse-to-patient ratio of the two countries, depicted in Figure 3, is still worth mentioning.

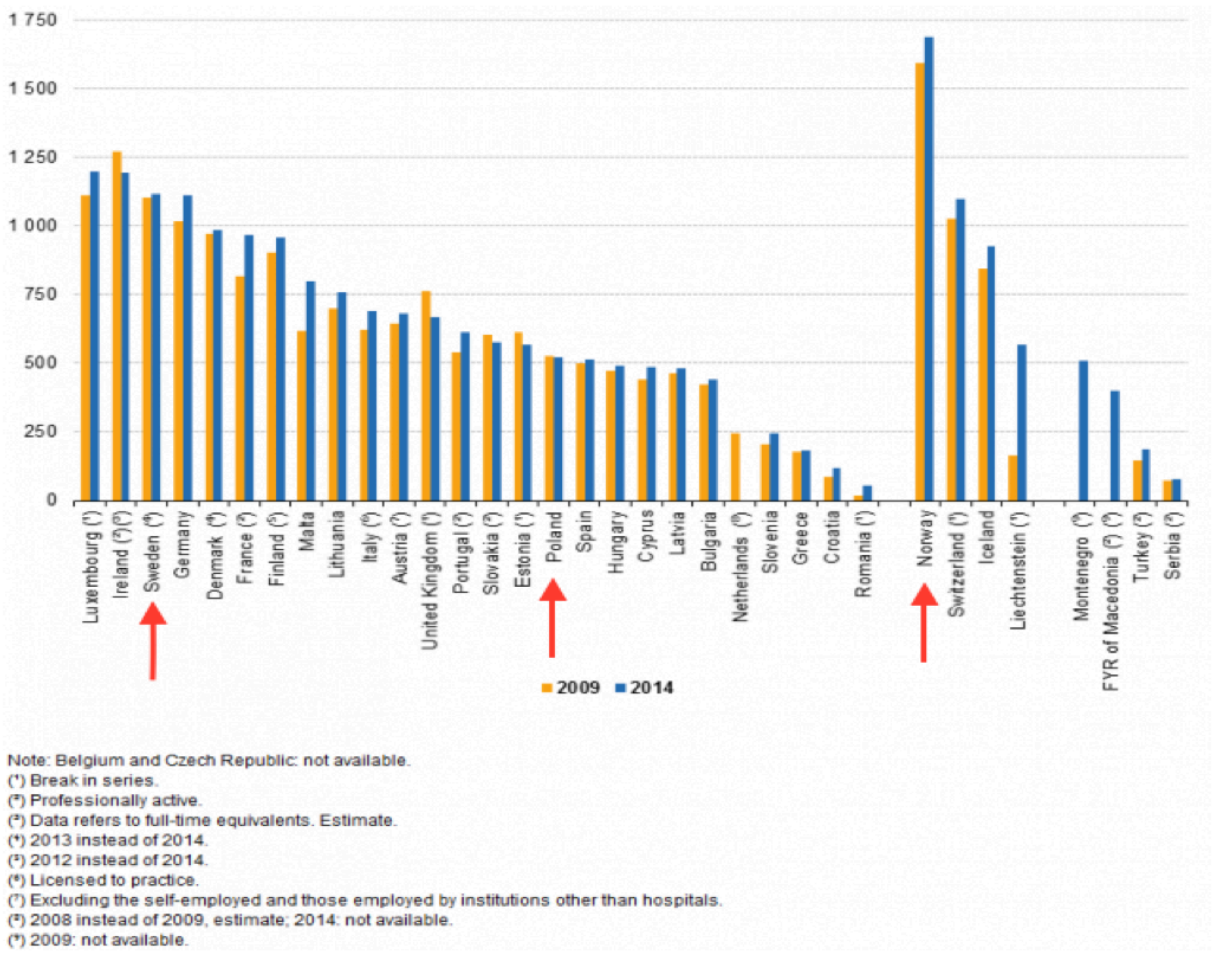


Figure 3. Practicing nursing professionals, 2009 and 2014 (per 100,000 inhabitants. Take from Eurostat (2016), *Healthcare personnel statistics- nursing and caring professionals*. http://ec.europa.eu/eurostat/statistics-explained/index.php/Healthcare_personnel_statistics_-_nursing_and_caring_professionals

Based on the information provided by my informants, the low nurse-to-patient ratio becomes an issue only when equated to the salary earned for the work. In comparing their work experiences in Poland to Norway, all three informants stated that they enjoyed the work they were doing in Poland; it was busy, but they were never bored. In Norway, the comparatively high number of nurses working at one time contributed, in part, to feelings of boredom. Joanna's statement that she would consider working in Poland if it were not for the inequity between workload and salary highlights this opinion.

This view is also supported by the finding of Szpakowski et al. (2016: 81) in a study on the intentions of Polish nurses to migrate for work. Respondents were requested to "[p]lease, indicate one major phenomenon which makes practicing the profession of a nurse in Poland hardly attractive." They found that "73% (423/581) [of respondents] believed that it is disadvantageous to practice the profession of a nurse in Poland due to the inadequacy of earnings against the scope of their duties" (Szpakowski et al. 2016: 81). Comparatively, the answer regarding mental and physical load due to a low patient-to-nurse ratio was selected by 15% of respondents (Szpakowski et al. 2016).

The current structure of nursing education in Poland, in line with the Bologna Process and European Union Directives regarding higher education, was established in 2000 (Marcinowicz et al. 2016). This model includes a 3 year bachelor's and an optional 2 year master's degree in nursing (Marcinowicz et al. 2016). By the 2001/2002 academic year, "all Medical Academies and some Higher Vocational Schools [began] offering a Bachelors degree in nursing and midwifery," but the complete halt on recruitment to vocational schools did not take place until the 2003/2004 academic year (Zajac 2004: 116).

Figure 4 shows the number of nursing graduates from Poland and Norway per 100,000 inhabitants from 1998-2014. As the pre-2000 nursing education in Poland was a vocational training program, it could be that it does not register as nursing education in the OECD data. Goździak (2016: 192) reports that "[o]nly about 28% of Polish nurses trained before the new educational programs were established fulfilled the requirement for acquired rights, which meant that the vast majority of Polish nurses were allowed to work only as health assistants or as private caregivers in EU member states after 2004." However, the OECD site states that the data "include[s] graduates from both higher level and lower level nursing programmes," suggesting that the vocational nursing education might be incorporated into the data (OECD 2017c). Regardless of the pre-2004 accession data, the proportion of nursing graduates per 100,000 inhabitants in Poland from 2004 to 2014 began increasing significantly, more than quadrupling from 2004 to 2006 and peaking at 45.5 in 2011.

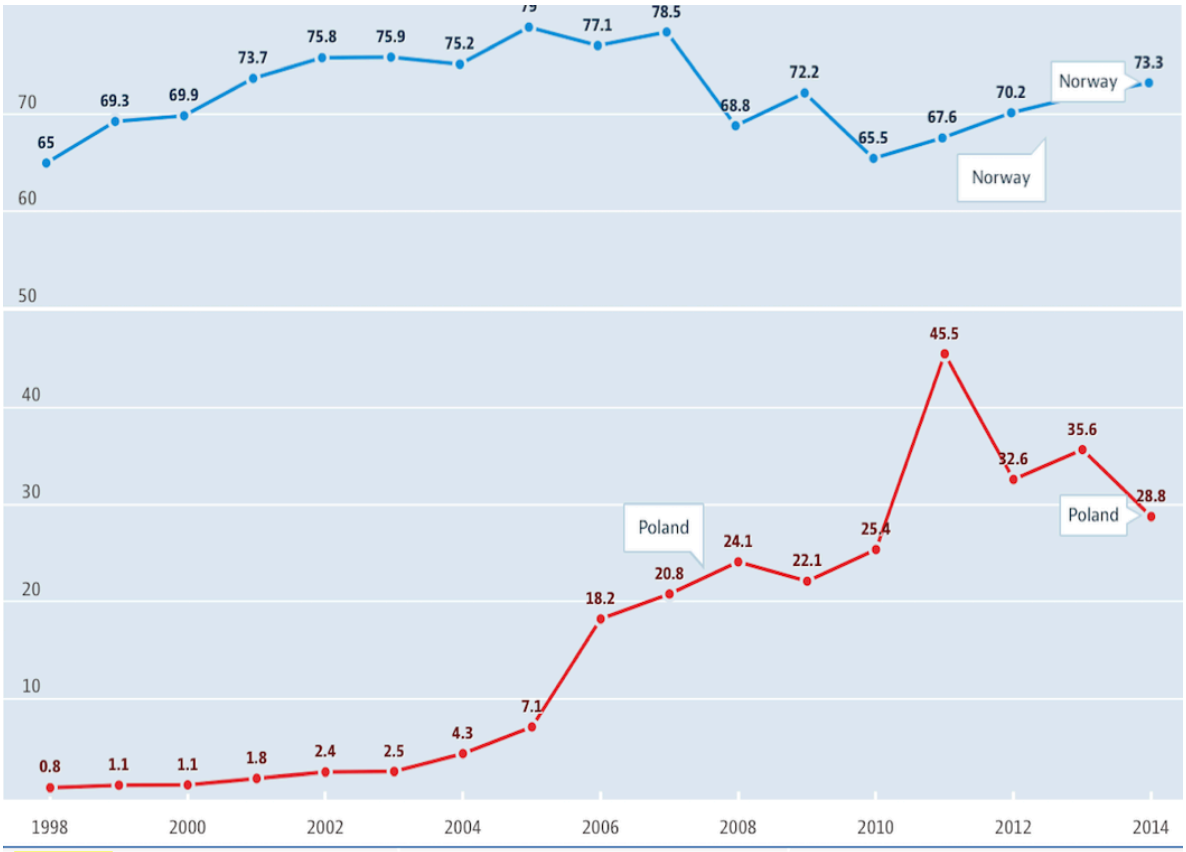


Figure 4. Nursing graduates in Poland and Norway- total per 100,000 inhabitants 1998-2014. Taken from OECD (2017), Nursing graduates (indicator). doi: 10.1787/c54611e3-en. https://data.oecd.org/healthres/nursing-graduates.htm

The fairly stable nurse-to-patient ratio in Poland from 2009 to 2014 (Figure 3) appears contradictory to the significant increase in the number of nursing graduates in Poland within those years. One possible explanation for this discrepancy is an increase in overall population size. However, according to OECD data, the overall population of Poland has remained between 38-39 million from 2004-2014 (OECD 2017d). Goździak (2016) also indicates that nursing graduates are choosing to work outside of the nursing field and that the number of nurses retiring is greater than the number entering the profession.

Another contributing factor to this discrepancy may also be found in the stories of my informants. All three nurses mentioned thoughts or plans of working abroad even before beginning their nursing education, indicating that those who enter nursing school do not necessarily stay to work in Poland. While there is no solid data on the number of nurses who leave Poland to work

abroad, Szpakowski et al. (2016: 82) found that nearly 30% of their respondents (n=581) "intended to emigrate from Poland for professional reasons." Intentions to leave are, however, generally higher than the number who actually leave. Studies on Polish health workers' intentions to leave conducted prior to the 2004 EU expansion caused serious concern of mass emigration and staff shortages. However, post-expansion studies report that the numbers were not as significant as estimated (Goździak 2016; van Riemsdijk 2008; Buchan and Perfilieva 2006).

From the perspective of my informants, the reforms to the Polish nursing education have made it significantly easier for nurses from Poland to work in Norway. Joanna explicitly mentioned this in her interview, but it also seems that the mobility enabled by these reforms have attracted my informants to the nursing profession–or at least not deterred them. From their stories, it seems that the possibility of migrating and working abroad was a sort of insurance for entering into the nursing profession. They chose the profession despite having prior knowledge of the negative aspects of being a nurse in Poland, confidant that they would be able to find jobs abroad.

Joanna's statement about the attraction of the nursing profession due to the opportunities it provides for working abroad is interesting to note here. Her narrative highlights a transnational perspective on the nursing labor market; she views nursing as a secure profession, but refers specifically to the international job opportunities, not opportunities in Poland. Could it be that access to the European labor market and the high demand for nurses abroad are drawing more Polish students to the nursing profession? A recent study by Marcinowicz et al. (2016) seems to support this theory. In their study on Polish nursing students' perception of the nursing profession and their reasons for choosing the profession, the authors report that some respondents explicitly identified the desire to go abroad as their reason for choosing the nursing profession (Marcinowicz et al. 2016). While this is likely a minor influence, it suggests the importance of studying migration on a broader regional or global level, rather than as a nationally contained phenomenon (Wimmer and Schiller 2003).

In reference to my research questions, Norway– as a destination– did not play a role in my informants' decision to work abroad. Each of them intended to work abroad, England specifically, before deciding to work in Norway. Multiple factors influenced them to alter their trajectory. Joanna and Patricia gained information from their social networks about the salary, standard of living, and physical geography of Norway, contributing to their perception of Norway as an attractive destination. Furthermore, each of them had a friend/boyfriend who wanted to go to

Norway at the same time. Because they were both planning on going abroad anyway, it was probably appealing to go where people you know are going, to have someone to share the experience with. For Barbara, in addition to the higher salary, she was intrigued by the opportunity to go somewhere not many other Polish nurses were going–to be different.

The possibility to work through a recruitment agency was seen by Barbara and Patricia as integral to their access to the Norwegian labor market, they both mentioned it as their only option to get to Norway. Many of the mitigating factors of migration are surpassed through recruitment agencies: language acquisition, finding a position, flight costs, housing, and authorization. Patricia commented that the eased process of working in Norway through a recruitment agency made it easier for her to leave Poland: "I didn't have to do anything; I could just go and work. So, bye bye." Barbara and her husband pointed out that without friends or family in Norway, it was necessary for them to have assistance. Their narratives suggest that the Norwegian policy on recruitment agencies attracts individuals and families who might otherwise find it too difficult to work in Norway.

Going back to the nurse-to-patient ratios in Poland and Norway (Figure 3), Norway has three times as many nurses per 100,000 inhabitants than Poland. Once again, these comparisons should be viewed critically, but it is fairly safe to assume that Norway's nurse-to-patient ratio is higher than Poland's. This calls the Norwegian governments commitment to ethical recruitment into question. Although they have stopped actively recruiting nurses from abroad, in line with the WHO Code of practice, the neoliberal restructuring of the healthcare system still allows the recruitment of nurses from countries facing shortages of their own. The only difference, as pointed out by Seeberg (2012b), is that the Norwegian government can now claim compliance without losing the supply of foreign-trained nurses– shifting the responsibility to private actors instead.

Swedish nurses

FRIDA

Frida began her narrative:

> I think that my story is a little bit different from many [other nurses] you will interview. For me, I had some personal reasons. I started working in Sweden in 2010, and I had moved to a [new] town with my boyfriend. And then we split, so I just moved back to the town where I'm from, where I have my friends. And I moved in with my parents again. That's

> not something you want to do when you're an adult, of course. And I was very heartbroken. I had no job. I had no place to live. [...] And we had been together for almost eight years, so it was a big thing. But anyhow, I lost a big part of my friends and family, like his family. So I was really heartbroken. And I have a very good friend, a female friend, she's a nurse as well, and we started our education together, but she convinced me to get this job in Norway, because it was a very hype thing to do then. In 2010 there was a lack of nurses in Norway, maybe even more than there is now. And I think that it was also the currency, it was quite high in Norway before, or higher than it is now. And we were both spring nurses [recently educated], so I didn't care what kind of job I got; I just wanted to work as a nurse. I wanted to get away from Sweden. And it's very easy when you apply for authorization in Norway as a Swedish nurse.

Frida elaborated on her friend's influence: "She pushed me a lot. She was like, 'You need to get away. Just look at me, I am applying for this company now. We will do it together.'" Furthermore, she perceived her life situation in Sweden at the time as non-binding:

> Because most of the people I've met that have been working in Norway, they have a family, and they have an apartment, and a life in Sweden. But I had only my parents. I do have friends, but, it's not like this daily life when you have your work and your apartment, stuff like that.

Frida knew that she could register as unemployed and receive assistance in looking for a new job in Sweden, but did not think her chances of finding a nursing position were high:

> We have this Arbetsförmedlingen [Swedish Public Employment Service], it's where you go when you're unemployed. You go there and you would get registered, and all the service people there can help you find things out, about what you want to do. But there was really no lack of nurses in Sweden at that time; there were a lot of nurses. But for me, I was just newly employed, so I didn't have…I had experience as an assistant nurse, but I hadn't worked as a nurse for a long time, it was like three months or something.

In addition to the simple authorization process for Swedish nurses who want to work in Norway, Frida also perceived the cultural and linguistic similarities between Sweden and Norway to ease the migration process:

> There were opportunities for nurses [in Norway], and the filing process was very easy. Also, Norway used to be a part of Sweden until 1905. I don't know how much you know about that history, but the culture and the language are quite similar. That will help when you move to a new place. I had never been to Norway before, I just decided to go there. And I tried to read a book in Norwegian before I went, that was it. I didn't understand much of it. I was just like, "Okay, I want to do this."

> Because, of course there's a difference in being Norwegian compared to being Swedish working in Norway, you always feel like this immigrant, but I think that compared to other immigrants, the Swedish have it very easy. Because the culture is alike and the language is alike and the system is quite alike. [...] And your Swedish driving license is approved in Norway. Many things are quite easy.

Frida recognized that Swedes have many advantages when it comes to working in Norway. When discussing the ease of working in Norway, Frida described the history between Sweden and Norway and the cultural and linguistic similarities. This perception of sameness, or similarness, whether accurate or not, lead Frida to imagine working and living in Norway as fairly unproblematic. She also knew that, as a Swede, she could easily obtain authorization as a nurse in Norway.

Frida's situation in Sweden, professionally, personally, and socially opened her up to the idea of working in Norway. She stated that working in Norway was a "hype thing to do" at the time, suggesting she was aware of the possibility but had not considered it until her life situation drastically changed. She felt that without a relationship, job, or apartment, she had no life in Sweden, despite having friends and family there. She perceived living with her parents as an adult to be an undesirable situation, and as a newly educated nurse, did not think her career prospects were high in Sweden. Frida's friend clearly played significant role in her assessment of her life and what action she should take to improve it. Her friend suggested she needed to get out Sweden, supporting Frida's perception of having no reason to stay in Sweden. Would Frida have thought

of or decided to work in Norway if her friend had not encouraged her? Furthermore, would she still have wanted to get out of Sweden if working in Norway was not an easy or popular thing to do?

SABINE

A few yeas before she began working in Norway, Sabine wanted to get a job in California, United States, but her family situation deterred her:

> I wanted to try and work in California because the weather suits me fine. I had been to California for a few months back in the 80s and I wanted to go back there. But I really wanted to learn more about trauma, because you have more trauma in the emergency rooms in the US than you have in Sweden. So that is what I wanted to do, and at first my children wanted to do that, but my eldest child got a [girl/boyfriend] and then they didn't want to go to the US, so I put that on ice. And so it has been on ice ever since.

She continued working in Sweden until a colleague told her about the opportunity to work in Norway: "I met another colleague and we were talking and she said, 'Oh, you have to work in Norway! You get paid much more.' So I did that." The high salaries offered in Norway attracted her, but as she still had two dependent children and a husband at the time, she did not want to move to Norway. For her purposes, she found going through a recruitment agency to be the best option:

> I had my family here [in Sweden] and I wanted to try it first. I didn't want to move to Norway; then you have to buy an apartment, or have someone there to rent a place with, so that's why I decided to go through an agency. If you go through an agency, which is the smartest way to do it if you don't know where to go, you contact an agency and they hire you. They pay for your stay- your room in an apartment and so on.

Gaining authorization in Norway was "quite a process" for Sabine. She applied for authorization on her own before applying for a job with an agency:

> You have to apply through two websites. You send in every paper you have to get the authorization, and then you pay it. It was, I think, NOK 1000 to get the authorization. Then

> you contact an agency in order to find work in Norway, and you send all of your papers to them also. […] I wanted to apply [for authorization] myself, because if you do that through the agency, the agency owns you more. Because they are fixing it, you owe them that, and I don't want to be owned by anyone.

Sabine's reasons for wanting to work in California and Norway are distinctively different. She had positive personal experiences in California from a trip she took there twenty years prior. Both the weather and perceived professional opportunities made her want to return. Although she described how difficult the process of obtaining authorization is in the US, this was not the reason she decided not to work there. Instead, it was her children's desire to stay in Sweden that changed her mind. Comparatively, she conveyed her motivation for wanting to work in Norway as purely financial. She knew she could also find temporary positions directly with health institutions, but perceived this option to be less practical than working through a recruitment agency.

HANS

After working in a hospital in Sweden, Hans decided that working for a recruitment agency that "rents" nurses to various healthcare institutions within Sweden was more profitable, flexible, and relaxed:

> When I work for a private company, I have a higher salary and I can totally control my time, when I'm working and when I'm not working. If you work in the hospital, in public healthcare, then it is very, very low salary and it's very, *very* hard work. You work three shifts- daytime, evenings, and nights- and you have to mix all of these, and that is not very good. So there is a very big difference between working for public healthcare and a private company, very big difference. You do the same work, but your ability to influence your salary and working hours is very different.

Hans also explained that working for an agency "suits him very well" because it allows him to adjust his nursing schedule according to his music schedule:

> Hans: This work suits me very well, because when I have a lot of music activities, then I don't work as much as a nurse, but when I don't have any music activities I can work as much as I want.

In addition to the flexibility working with an agency provides, Hans also took advantage of the opportunity to work abroad. The nursing agency he was working for in Sweden offered positions in Norway and some of his colleagues who had already been there encouraged him to "try it":

> Hans: I heard about positions in Norway through the company that I am working for. They rent out nurses to Norway as well, and I had been there several times before. I really love Norway, so that's why I wanted to go there, and…I had colleagues who had been working in Norway and they said, "Just go. It's very good. You should go there. You should try it." So, that's why I went.
> Taylor: Very good in which way?
> Hans: It's very easy work. You only work 35 hours a week, and in Sweden we work 40 hours a week, so it's shorter hours that you work. The salary is very good. Now it is not as good as it was before, because then it was *very* good money. So some people would work one week and then stay home [in Sweden] for like two weeks, without working, and get the same money as if they had worked full-time here. It was very good money.

He stated that he never intended to take up residency in Norway, but saw working there temporarily as an opportunity to explore the country.

> I wanted to go to Norway just for the experience. I love Norway, because it is a very beautiful country, and that was the main reason to go there; to explore the country. If you can work there and live there as well, it's a bonus.

From his experience as a tourist, Hans viewed Norway as a physically beautiful country and planned to return again. However, he was only interested in visiting and never wanted to move to Norway. Therefore, when he heard of the opportunity to work temporarily in Norway, he recognized it as a way to accomplish his pre-existing goal. By doing this, he would be able to explore the country while also making extra money- an added bonus. He knew that the working hours in Norway were lower than Sweden and thought to use this "extra" time exploring.

SOPHIE

Sophie's narrative began with her move from Northern Africa to Sweden as a teenager:

> I went to school in Sweden, but I went to school in [Northern African country] as well, but I just had to start from the beginning, which was frustrating. I thought about all of my friends and about how far along they were and I was way behind. And the language of course [Swedish], it sounded crazy. I was like, "Oh, I will never manage this!" I was so frustrated. I just wanted to move away. I was saying, "No, we have to go to the UK," or something like that, where we can speak English, or learn how to speak more English. But after a while, you get used to it. Especially ... I think I'm the kind of person that always had goals in life. "I want to do this, I want to do that, I want to finish school, and I want to work." So that kind of helped me to have a clear vision and focus. I had to go to high school for three years, and before that I went to the language course for two years. And in high school, I took the the health care program. After that I became an assistant nurse. […] I thought, "Yeah, I definitely want to be a nurse." I always dreamt of becoming a nurse, but when I started working with the elderly during high school, I just felt like, "This is where I belong." There's something special, just being there and taking care of these weak, old, and fragile people. […] After that, I just went ahead. Actually, I never took any time off, I just went ahead and studied in the university. So everything was in Swedish. That one took ... It really almost made me go crazy, because I had to study *so* much, all the time. I remember I used to sleep with my dictionary under my pillow, that's how bad things were. But I was just like, "I have to make it, I have to!" When I reached this level, it was too high, so I really had to push myself. But anyway, I made it. So I was finished, thank god, within the timeframe. I didn't relapse or anything, everything went fine. From there, I worked for three years in a hospital in Sweden. After something like two years, I started feeling this panic attack. Like, "No. This is not good enough. I need to further my world, and just throw myself out there. I just want to see something more. I just felt like, "It's time. I need to do something. I need to get out of Sweden, it's enough." I've always felt like I was tied down in Sweden- with doing all the language courses, high school, and university. So I just went like, "No, no that's it. I got what I wanted." Because it has always been in my mind that I need to get out and do something else. I just felt like that wasn't all of it and there's much more than this. That's how I felt, and I thought, "I just have to not waste much time. It's enough. I have three years of experience, let me just do something else and see the world before starting to have these ideas of settling down and things like that." So it was very important to me just to leave from there and do something else.

Sophie's decision to work abroad was not made with Norway in mind. Instead, she began searching the internet for possibilities around the world. She described this process and how she ended up working in Norway:

> I was looking everywhere on the internet. “Oh, where do they need nurses?” The good thing at that time, was that they were after nurses everywhere. They needed us in Saudi Arabia, the UK, Australia, America, everywhere. So I was submitting my CV *everywhere*, and they were calling steadily. I just said, “Okay, I will just choose Saudi, and see how it goes.” Because it was nicer for me, closer to home [in Northern Africa]. And I can speak Arabic, and that's one of the things they wanted from those who were coming there, English as well. But the rules were so strict: “You can't have this, you must wear that, and nobody can see ... Your boyfriend can't come over here, you have to be married,” and things like that. So I just had to quit. I got the contract, but when I saw all the rules, it was too much for me, so I just declined. Said, “No, that's okay. We try some other time.” So I just tried Norway because it was very convenient for me to go back and forth. I still had my place in Sweden up to, let's say 2012.

As she mentioned, Sophie did not want to “settle” at that time, and stated that “the goal was to go to as many different hospitals as possible, the first year anyway.” She knew of the recruitment agencies in Sweden offering positions in Norway and viewed this as the “smartest” way to work in Norway, both economically and practically:

> I had seen [recruitment agencies’] advertisements everywhere. But of course that's the smartest way to start working in Norway. That's how you go to places, you see, and from there you can take your own step. And you just back out and say, “Okay, now I'm done.” You start negotiating with the wards by yourself, one to one. So it's smartest that way, because they cover everything; they cover the transportation, accommodation, everything, which is very practical and economical as well.

Working through a recruitment agency allowed her to try working in Norway without the effort or commitment of changing residency. She planned to work in Norway for a prolonged period of time, but not to move there:

> I wanted to be here just for the summer [at first], a short period- three weeks. And for sure, get experience and know how it is to work here [in Norway]. My plan was definitely just to continue working here, so that was like the first taste of Norway, of how it is to work in Norway.

The opportunity provided by recruitment agencies to work in different cities and health care institutions while maintaining her residence in Sweden was “perfect for [her].” In addition to the short travel time between the two countries, the good living standard and high salary in Norway

made it an attractive destination for Sophie. She elaborated that, "The contract was very good. I could benefit [financially] much more from doing this, even more than going to Saudi Arabia."

Sophie began her narrative with her move from Northern Africa to Sweden, as this was clearly a significant point in her life. She described the move as initially exciting, but quite difficult at the same time. She was leaving family and friends in Northern Africa and had to learn a new language and culture. In order to get through these difficulties, she set goals for herself to accomplish, mainly academic goals. Once she completed those goals, she felt like she had gotten want she wanted from Sweden and that she needed to leave.

Swedish context and discussion

Working in Norway is viewed as easy and convenient for Swedish nurses. The close geographical proximity, the ability to work temporarily, and the high salaries make Norway an attractive destination. Based on data collected by Berge et al. (2011), Figure 5 shows the number of authorizations granted to nurses by the Norwegian Health Directorate per year from 2000-2010, divided into citizenship[9]. Of all the authorizations issued in 2009, 40% were to non-Norwegian citizens. Of that 40%, only 20% of the authorizations were issued to non-Nordic citizens, while 70% were issued to Swedish citizens alone (Berge et al. 2011). The number of Swedish nurses with Norwegian authorization increased steadily from 2004 to 2008. Of all nurse authorizations issued in 2008, 33% were to Swedish nurses, compared to 12% in 2004. The percentage decreased only slightly in 2009 and 2010, to 32% and 28% respectively.

The number of authorizations issued does not necessarily reflect the number of Swedish nurses working in Norway within a given year. It can, however, be assumed that nurses applying for authorization and paying the application fee (NOK 1,665 as of June 2017)[10] are at least interested in working in Norway. Based on this assumption, Frida's statement that working in Norway was a "hype thing to do" in 2010, is also reflected in the statistical data— with the number of authorizations issued to Swedish nurses at its highest between 2008-2010.

[9] The data for 2010 are estimates and the country of education is not taken into account. Therefore, a Norwegian citizen educated in Sweden is included in the Norwegian total, not the Swedish.
[10] (Helsedirektoratet 2017)

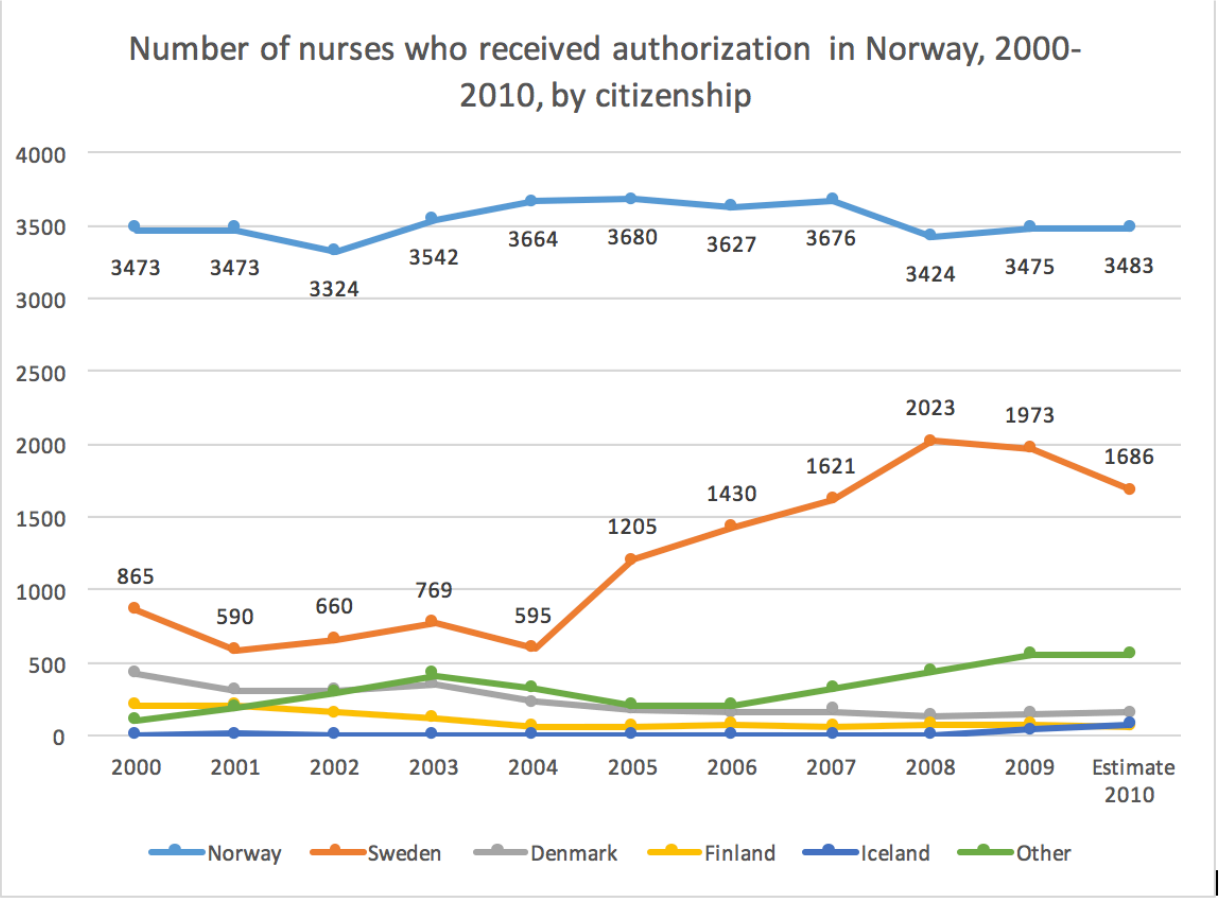


Figure 5. Number of nurses who received authorization in Norway, 2000-2010, by citizenship. Taken from Berge, Øyvind M. , et al. (2011), 'Skaff oss dem vi trenger: Om arbeidskraftstrategier og forebygging av social dumping i helse og omsorg', *Fafo-rapport 2011* (20).

From Frida's perspective, the "hype" around working in Norway was mainly fueled by two factors: an abundance of job opportunities and higher wages. All four of my informants mentioned the higher wages in Norway as attractive. As of August 2012, the minimum wage for nurses in Norway without prior work experience was around NOK 29,400[11] a month (Norsk Sykepleierforbund 2012). In 2011, the entry-level wage for nurses in Sweden was around SEK 21,000 a month in large hospitals, which would have been approximately NOK 18,125[12] (Kiil and

[11] Average exchange rate for 2012: EUR 1 = NOK 7.4744; EUR 3,933 = NOK 29,400 (http://www.norges-bank.no/en/Statistics/exchange_rates/currency/EUR)

[12] Average exchange rate for 2011: SEK 100 = NOK 86.31; SEK 21,000 = NOK 18,125 (http://www.norges-bank.no/en/Statistics/exchange_rates/currency/SEK)
Average exchange rate for 2011: EUR 1 = NOK 7.7926; EUR 2,326 = NOK 18,125

Knutsen 2016). Based on these numbers, Swedish nurses could earned over NOK 11,250 (EUR 1,607) more a month by working in Norway instead of Sweden.

The "Not below 24,000" movement, which took hold in 2011, clearly indicates the frustrations of Swedish nursing students and recent graduates with the entry-level nursing wage (Kiil and Knutsen 2016). As the name suggests, movement participants were initially fighting for a minimum entry-level wage of at least SEK 24,000[13] a month. The movement quickly "evolved into a large wage protest involving representatives at universities and university colleges that educate nurses" (Kiil and Knutsen 2016: 108). By 2013, the closed Facebook groups created for the movement had more than 6,000 followers, an impressive figure "considering that nursing is a three-year education and some 4,000 students graduate annually" (Kiil and Knutsen 2016: 108). The popularity of the "Not below 24,000" movement suggests that the "hype" of working in Norway, mentioned by Frida, may only be one element in a broader social effort of Swedish nurses to improve their wages and working conditions, both individually and collectively.

The conditions of the work offered in Norway are also appealing to many nurses, in particular the temporary aspect of the positions. Recruitment agencies are vital to the temporary employment of Swedish nurses in Norway. The number of Swedish nurses working in Norway through recruitment agencies rose from 93 in 2004 to 2,530 in 2009 (Friberg 2013). In 2009, Swedish nurses accounted for 76% of all nurses working in recruitment agencies, while Norwegians account for only 16% (Figure 6) (Friberg 2013).

(http://www.norges-bank.no/en/Statistics/exchange_rates/currency/EUR)

[13] Exchange rate as of June 2017: EUR 1 = SEK 9.7443; SEK 24,000 = EUR 2,463 (https://www.ecb.europa.eu/stats/policy_and_exchange_rates/euro_reference_exchange_rates/html/eurofxref-graph-sek.en.html) accessed June 2017.

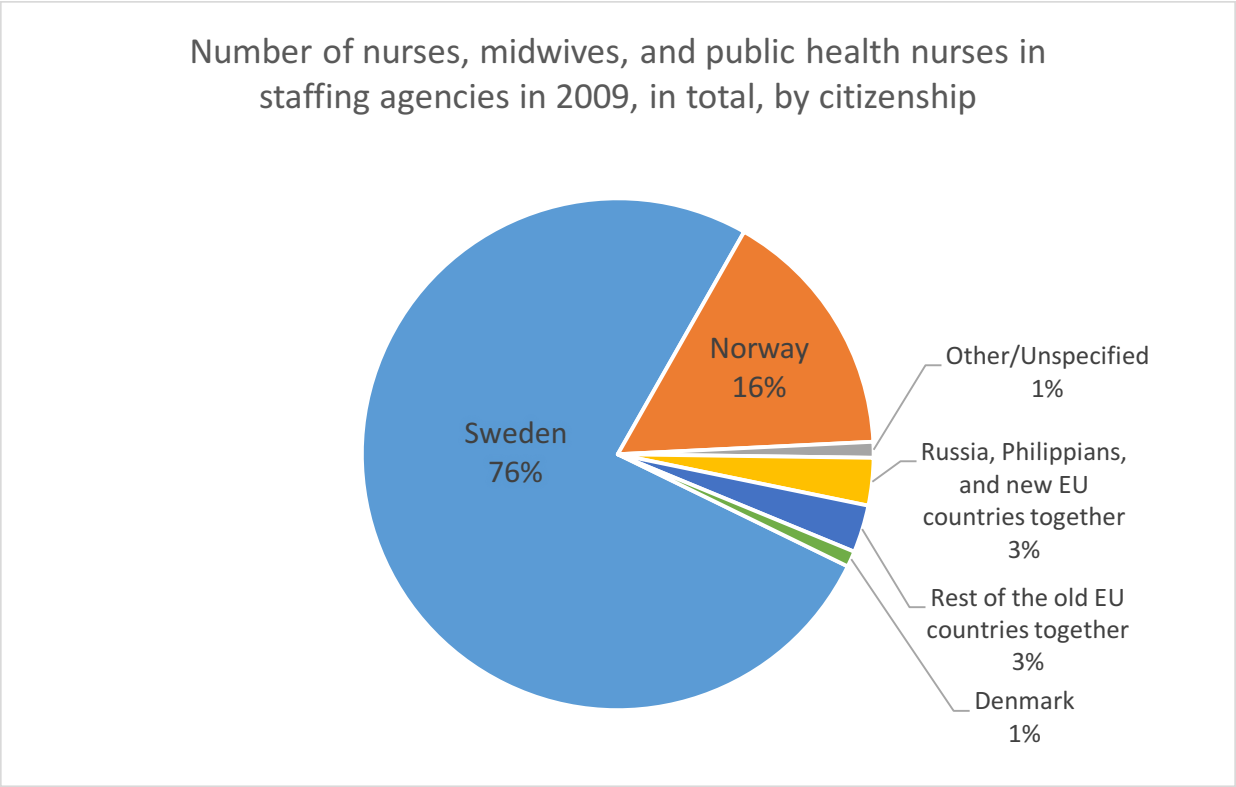


Figure 6. Number of nurses, midwives, and public health nurses in staffing agencies in 2009, in total, by citizenship. Taken from Berge, Øyvind M. , et al. (2011), 'Skaff oss dem vi trenger: Om arbeidskraftstrategier og forebygging av social dumping i helse og omsorg', *Fafo-rapport 2011* (20).

Two of my informants would not have worked in Norway if it were not for the ability to work through a recruitment agency. They had families and friends in Sweden and did not want to live in Norway (or circumstances did not allow). Working through a recruitment agency gives nurses access to a wide number of positions, allowing the nurses to choose the amount of time they would like to stay in Norway. Additionally, recruitment agencies often pay for the flight to and from Sweden and provide the nurses with housing while they are in Norway. These are important factors considering the prevalence of cross-border commuting among Swedish nurses working in Norway. Cross-border commuting occurs when an individual resides in one country and works in a neighboring country (Pedersen, Røed, and Wadensjö 2008: 73). This can also include working temporarily in a neighboring country without changing residence, a method made easy by the use of recruitment agencies. I was unable to find data on the number of nurses commuting across the border, but Figure 7 shows the number of Swedish cross-border commuters to Norway in the five

largest industries. The number of commuters recruited to jobs through temporary work agencies began to rise drastically in 2004, surpassing all other industries by 2008. The number of commuters in the healthcare and medicine industry, on the other hand, remained relatively stable over the years. This pattern reflects that of Swedish nurses working in Norway through recruitment agencies. While it cannot be concluded from these figures that the majority of Swedish nurses working for recruitment agencies are cross-border commuters, information from my informants' narratives suggests that it is prevalent.

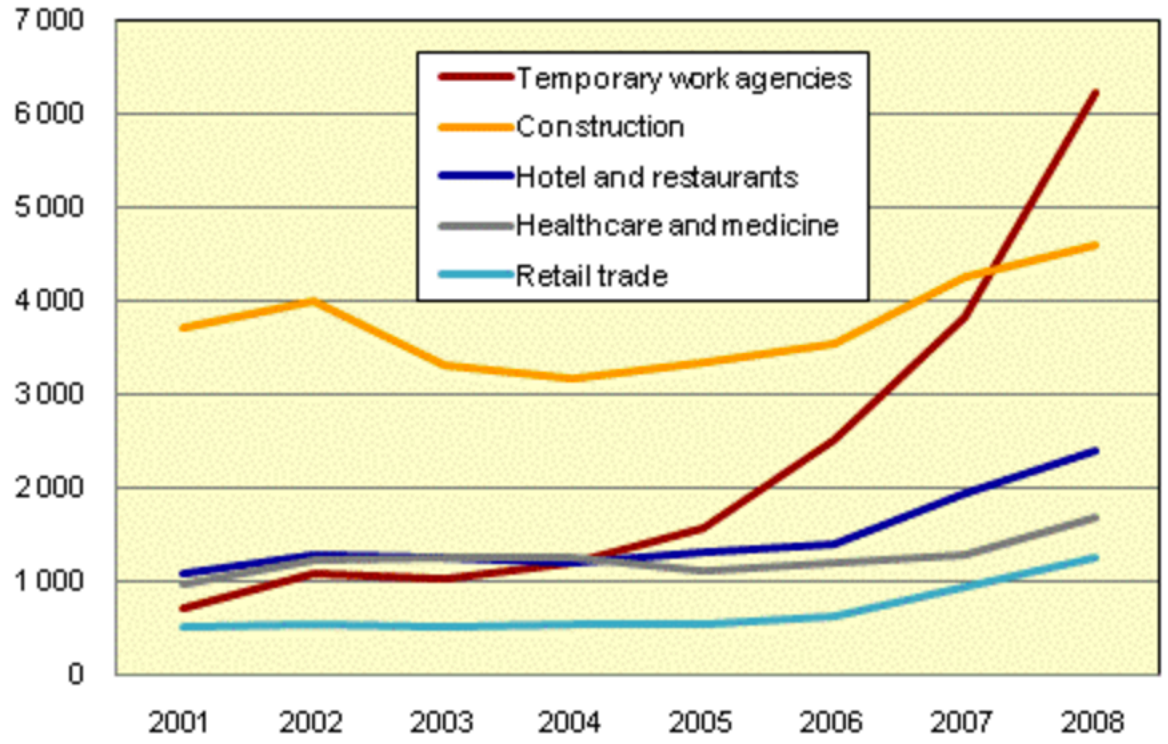


Figure 7. Number of Swedish cross-border commuters to Norway, years 2001-2008, for the five largest industries of 2008. Taken from Statistics Sweden (2010). Cross-border statistics 2008: 14,000 young persons commute to Denmark and Norway.

Another significant factor in the decisions of Swedish nurses to work in Norway is the perceived political, social, and cultural similarities between the two countries. The perception of a similar language and culture was mentioned by all four of my informants, two of whom had never been to Norway prior to working there. Frida stated that she tried to read a book in Norwegian before moving but did not understand much of it. However, she still decided to go.

Norway was under Swedish rule from 1814 until it gained its independence in May 17, 1905 (Nordic Co-operation 2017b). The two governments, along with the other Nordic countries, have a long history of cooperation. In addition to the common Nordic labor market, there are also a number of language and culture agreements between the Nordic countries: the Helsinki Treaty (1962), the Cultural Agreement (1972), the Language Declaration (2006), and the Nordic Language Convention (1987) (Nordic Co-operation 2017c). The first three agreements aim at promoting language, culture, and social understanding between the Nordic countries and target children and youths (Nordic Co-operation 2017c). For example, Article 8 of the Helsinki Treaty mandates (Nordic Co-operation 2017c):

> Educational provision in the schools of each of the Nordic countries shall include an appropriate measure of instruction in the languages, cultures and general social conditions of the other Nordic countries.

The goal of promoting a mutual understand of each other's languages and cultures is to "[promote] mobility between the Nordic countries and [enhance] the sense of affinity between the peoples of the Region" (Nordic Co-operation 2017c). These agreements suggest that perception of similarness between Swedes and Norwegians is engrained into the politics and education of the countries. It is not uncommon to hear Swedes and Norwegians refer to Norway as Sweden's "little brother," highlighting the sense of relation between the two.

Returning to my research questions, Norway– as a destination– played a major role in my informants' decision to move abroad. For Frida, Hans, and Sophie there was no temporal distinction between the decision to work abroad and the decision to work in Norway. For Frida, working in Norway was seen and an easy and convenient way to escape her undesirable situation in Sweden, as well as an opportunity for her to find work. Hans already planned on returning to Norway as a tourist because he loves the physical beauty of Norway. It was Norway specifically that lead him to working abroad.

For Hans, Sophie and Sabine, the ability to work temporarily through a nurse recruitment agency was highly important. Neither Hans nor Sabine intended to reside in Norway, as they both had family and friends in Sweden. Despite Sabine's stronger personal and professional motivations for working in California over Norway, the geographic proximity and temporary work structure in

Norway allowed her to bypass the restrictions her family situation put on her mobility. Her narrative highlights how Norwegian policy on recruitment agencies and the demand for temporary nurses to fill shifts, mobilizes individuals who might otherwise be obligated to remain.

Hans' narrative highlights how he was able to exploit the structural demand for temporary workers in Norway to accomplish his personal goal. However, it also shows how the marketization strategies in Norway were able to convert tourism into labor migration. If it were not for the possibility of temporary work through an agency, Hans (most likely) would not have worked in Norway. Despite Sophie's desire to get out of Sweden, she also had family and "home" there. The ability to work through recruitment agencies allowed her to balance her interests, maintaining her life in Sweden while also "getting out of Sweden."

Discussion on the "brain drain" of Swedish nurses in Norway generally conclude that it is not an issue. Due to the structure of recruitment agencies and shift work, many nurses are able to work both in Norway and in Sweden (Friberg 2013). Therefore, nurses working in Nroway is seen as "brain circulation" instead. A quote from an employee at the job center Arvika, Sweden (a region characterized by cross-border commuting) highlights this view (Wallin 2012):

> Nurses who work in Norway don't tend to move, they only try it for a while before they return. For many this is a chance to earn some extra money and to try different jobs. It is also an achievement to have dared to work in a different country. It demonstrates an ability to show initiative and allows people to contribute with new knowledge.

However, a Statistics Sweden article based on the 2016 Labour Market Tendency Survey reports that health and medical care employers have continued difficulties recruiting staff. Nursing positions have been the most difficult to fill (Statistics Sweden 2016): "The largest shortage is among specialist nurses, with a focus on anesthesia, intensive care, surgical care and in other specialist training. There is also a large shortage of district nurses and first-level nurses." Assessing the implications (both nationally and internationally) of the shift work work structure, recruitment agencies, and cross-border commuting of nurses on the Swedish health sector is not possible in this study. It is worth mentioning, however, that Swedish employers also report nursing shortages.

Chapter 6. Conclusion

The primary aim of this thesis has been to understand the factors influencing some Polish and Swedish nurses to work in Norway. Many studies on nurse decision-making adopt a push-pull mode, which I argue provides little room for understanding. In order to avoid this issue in my thesis, I have approached this research from a structure-agency perspective. I aim to understand the ways in which my informants' decisions relate to broader social structures, particularly Norwegian immigration and recruitment policies. However, I also acknowledge the nurses' agency in their interactions and decisions.

In order to address my research aims, I have contextualized the nurse immigration situation and system in Norway, including political, social, and historic dimensions. This information serves to inform the subsequent analysis of my interviews. As I want to gain a deeper understanding of the factors influencing my informants' experiences and decisions from their perspective, I use their narratives as the main point of departure. From their narratives, I draw links between their statements and broader contextual frames.

The perceived nursing shortage in Norway has persisted throughout the 1990s and 2000s. While shortages are typically attributed to population aging and the unattractiveness of the nursing profession, I have argued that there are also structural and social dimensions to the shortage of health professional. In Norway, there is a prevalence of part-time work among nurses (Østby 2013). Employers often find it difficult to fill shifts, and thus creates a demand for temporary workers. Employers need nurses who will work on a time-basis, which is often difficult to find among the domestically-trained nurses (van Riemsdijk 2008). Another aspect of the perceived shortage is related to the social hierarchical structure of health institutions and positions. With nurses trying to distance their profession from care work towards a more technical and academic field, nurses themselves are avoiding the lower-status municipal health institutions– typically associated with care work (Seeberg 2012a). As Seeberg (2012a) argues, employers are relying increasingly on immigrant nurses to fill these low-status and undesirable shifts and positions.

This increasing demand for immigrant nurses resulted in a number of political strategies and agreements in the 1990s. The Norwegian Directorate of Labor (Aetat), along with municipalities and employers, began actively recruiting nurses from Germany, Finland, and Poland (van Riemsdijk 2008). However, with the national and international debate on the ethical recruitment of health personnel, the Norwegian government ceased recruitment and committed to

implementing policies for the promotion of global health. During this same time period, the financial and political pressures on the Norwegian social welfare system to implement market liberalization reforms grew. The lifting of the ban on recruitment agencies in 2001 has significantly impacted the health sector. The number of private recruitment agencies hiring nurses from abroad and "renting" them to Norwegian health institutions has increased considerably over the years (Friberg 2013).

One of my main goals is to understand what role these recruitment agencies, and the Norwegian policy regarding them, play on Polish and Swedish nurses' decisions to work in Norway. From the perspectives of my informants, I found recruitment agencies to be crucial in the decision of most nurses to work in Norway. For the Swedish nurses, the temporality of the positions, the ability to maintain residence in Sweden, and the provision of transportation, accommodation, and jobs were necessary for their ability/choice to work in Norway. For the Polish nurses, recruitment agencies were seen as the only option. Although they are, as EU citizens, allowed to move to Norway in search of work, this was not seen as an option.

These findings call the Norwegian government's pledge on ethical recruitment into question. Although they are no longer actively recruiting nurses from abroad, the neoliberal reforms have allowed it to persist. In fact, the number of foreign-trained nurses working in Norway has actually increased over the years, with a large number of them working through recruitment agencies (Friberg 2013). As Poland and Sweden both experience lower patient-to-nurse ratios than Norway, is it important to understand the implications recruitment have on those countries. Furthermore, as nurse migration is part of a larger globalized labor market, I suggest that future studies on nurse migration adopt a global perspective. It is clear from the narratives of my informants, especially the Polish, that nurses perceive of the nursing profession on a global scale and researchers studying their movements will need to adopt this perspective as well.

Lastly, as there is little research on intra-Nordic health migration, despite Swedish nurses being the largest group of non-Norwegian nurses in Norway, this thesis servers to contribute to the growing, but still limited, research on Swedish nurse migration to Norway. Future research on this topic would benefit from a study investigating the perception of Swedish nurse immigration in Norway–both from the Norwegian and Swedish perspective. My informants highlighted how a sense of similarness between Swedes and Norwegians shapes their perception on and decision to work in Norway, but often their perceptions did not match the reality. I was unable to address this

topic in my thesis, but I think it is an important place to start in understanding Swedish nurses experiences working in Norway.

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