WORK→INT

Assessing and enhancing integration in workplaces

BACKGROUND REPORT

MIGRANT WORKERS IN THE ITALIAN HEALTHCARE SECTOR

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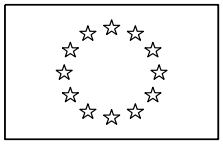

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Table of contents

List of tables and figures

Introduction

This paper is aimed at providing a background analysis of the institutional and regulatory framework of the health system in Italy and of the composition of the labour force in this sector, with a focus on both EU and non-EU migrant health workers (MHWs).

The paper is written in the frame of the "WORK-INT. Assessing and enhancing integration in workplaces" project[1]. The WORK-INT project has as its key objectives to better understand, increase awareness and stimulate action-oriented measures targeting the integration of migrant health workers in the health sector at a workplace level.

In order to achieve these goals, the research component of the project seeks to shed light into the structural integration of MHWs within this sector, highlighting the conditions of access to the health professions in Italy and their increasing contribution to some segments of the sector. Here we will briefly outline the main characteristics of the Italian health system, its institutional and regulatory framework (part 1), the rules and conditions of access to the labour market of health care services for EU and non-EU health professionals (part 2), as well as the contributions of MHWs to the Italian health care system (part 3).

1. The National Health System

1.1 The institutional and regulatory framework

Since **1978** Italy has introduced a **National Health System** (*Sistema Sanitario Nazionale, SSN)*,[2] articulated in **territorial branches** (Local Health Units, *Unità Sanitarie Locali – USL*), which was explicitly inspired by the British model and aimed at granting universal and free access to standardised health services. Before that paramount reform, the Italian health system was characterized as a typical corporatist system, where health care was granted primarily through insurance-based schemes (Esping Andersen, 1990).

Since the introduction of the NHS many reforms have been enacted that went in the direction of **decentralizing health policy and management (i.e. regionalization)**, on the one hand, and **introducing elements of new public management in the health sector (i.e. managerialization)**. In particular, since the early 1990s[3] the process of regionalization of health services was strengthened and new functions have been attributed to the Regions in the fields of health policy planning, of administration and funding, as well as in the control of health services' quality and management. By then Regions could enforce their health policies within the framework of

[1] www.workint.eu
[2] See law 833, 23 December 1978.
[3] See Legislative Decrees 502/1992 and 517/1993.

national health policy planning enacted by the Ministry of Health in its National Health Plans (*Piano Sanitario Nazionale – PSN*) adopted every three years, which sets minimum health care standards.

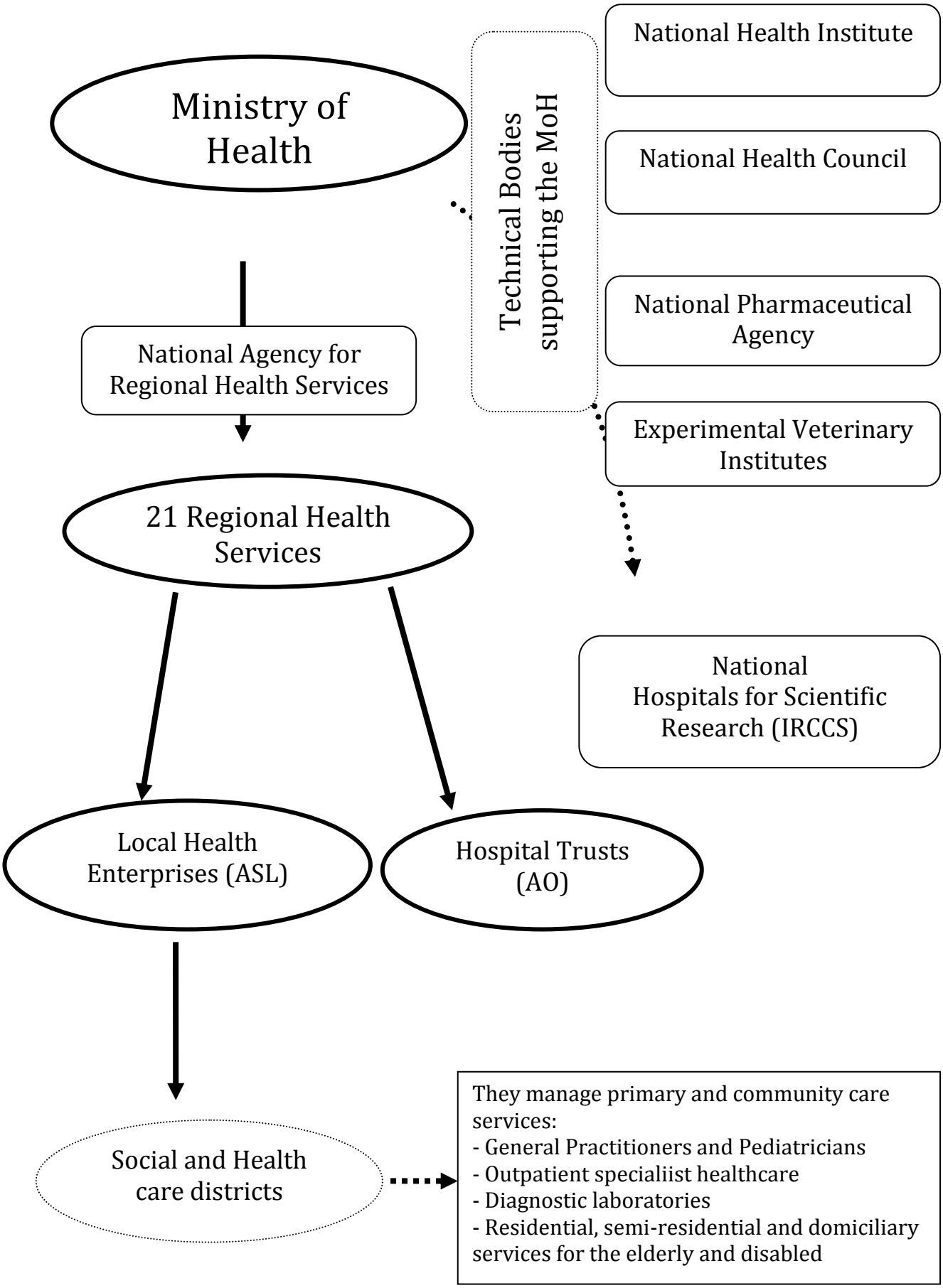
At the same time the nature of territorial units of the health infrastructure (USL), as well as public hospitals, was changed by turning them into public enterprises (Local Health Enterprises, *Aziende Sanitarie Locali – ASL* and Hospital Trusts, *Aziende Ospedaliere* – AO), endowed with financial, organisational and administrative autonomy and responsibility but under the control of regional health departments (i.e. managers are appointed by regional health care authorities). Concurrently, the role of private health care providers was strengthened with the introduction of new norms concerning their authorization and accreditation for the delivery of health services on behalf of the SSN (see paragraph 1.1.3 below). Furthermore, co-payments by health services users were introduced, based on standard tariffs established by each region. These reforms had the ultimate goal to rationalize and reduce health expenditure in a phase when Italy was coping with a dramatic debt crisis and economic recession, while at the same time improving the quality of health care services.

The process of decentralization and re-organization of health care services was strengthened by the **Constitutional reform** enacted in **2001**, introducing elements of federalism in the national institutional framework. This reform established that **health policy** (as well as many other relevant fields) was by then a **shared responsibility of the State and the Regions**.

The current institutional structure of the Italian NHS is illustrated in figure 1 below.

The Ministry of Health has the main responsibility of setting out the national health policy through its National Health Policy Plan (PSN) in which it establishes: minimum standards for health care services defined as Basic Benefit Package (*Livelli Essenziali di Assistenza, LEA*), the criteria for the allocation of national health funds, the bio-medical research programme, labour and skills shortages in healthcare staff and strategies to address them, etc. The Ministry of Health is supported by 5 main technical bodies, responsible for providing advice and support in the elaboration of national health policy: the National Institute of Health (*Istituto Superiore di Sanità*) which performs research, trial, control, counselling, documentation and training for public health; the National Health Council (*Consiglio Superiore di Sanità*) with advisory tasks; the National Pharmaceutical Agency (*Agenzia Italiana del Farmaco*) which performs regulatory and monitoring tasks related to pharmaceutical products; 10 Experimental Veterinary Institute (*Istituti Zooprofilattici Sperimentali*) in charge of epidemiological surveillance, research, staff training, laboratory diagnostics for the control of foodstuffs; finally, the National Agency for Regional Health Services (Agenzia Nazionale per i Servizi Sanitari Regionali) acts as a link between national and regional health authorities and has monitoring and control responsibility over health expenditure and costs and the implementation of LEAs.

Figure 1: The institutional setting of the Italian NHS



Following the progressive regionalization of the NHS, the Regions have acquired key legislative, executive, technical and evaluative functions (Lo Scalzo et al., 2009). The twenty-one regional health systems enjoy a good deal of autonomy in granting a fair delivery of Basic Benefit Packages set by the central government, while defining their own organisational and financial terms. Indeed, **Regions,** through their **healthcare departments,** have **major competences** in the **management and organization of healthcare services** in their territories: in particular they establish the number and delimit the territorial base for each ASL and allocate health funds accordingly; they set the level of co-payments by healthcare users and tariffs for each type of health care service; they assess, monitor and control both public and private health structures; they defines standards for the accreditation of private healthcare providers and conclude contractual agreements with those entitled to provide healthcare services at the same level (and price) of public providers (see below).

At the **local level**, **healthcare services** are delivered through a network of Local Health Enterprises (*Aziende sanitarie locali*, **ASL**) and Hospital Trusts (*Aziende Ospedaliere*, **AO**). ASLs are the organisations responsible for meeting comprehensive care needs of a geographically defined population. They provide health care either through their own facilities or through services supplied by AO, university hospitals and accredited private providers (hospitals for acute and long-term care, diagnostic laboratories, nursing homes, outpatient specialists and general practitioners). ASL are further disaggregated in local **health districts** responsible for coordinating and providing (or purchasing, see par. 1.1.3 below) **primary and rehabilitative care, out-patient specialist medicine and residential and semi-residential care** to their population. The recent trends towards the re-organization and rationalization of the NHS, notwithstanding significant inter-regional differences, have implicated the strengthening of local health districts, responsible for primary healthcare and social care (the latter in coordination with municipalities), as well as outpatient and domiciliary care. The supply of territorial health structures (different from hospitals, namely diagnostic centres, nursing homes or mental health semi-residential structures) has increased by 45% between 1997 and 2009, for the most part thanks to increase in privately owned healthcare structures (Ferrè and Ricci, 2012 p. 54).

According to latest available data there were 146 ASL, 64 AO and 429 local health districts at the national level in 2010[4]. The fragmentation of the NHS in sub-national Regional Health Systems and the great autonomy granted to regional authorities in regulating and managing health care services has determined **a significant heterogeneity in the actual configuration of the health system at territorial level**, especially in terms of (i) the number and dimension of ASL and AO; (ii) the number of hospitals under direct control of ASL and the diffusion of "quasi-market" mechanisms (i.e. presence and role of private health providers); (iii) the presence and weight of public health providers (Ferrè and Ricci, 2012, p. 29).

[4] See: http://www.salute.gov.it/imgs/C_17_pubblicazioni_1933_allegato.pdf

1.2 Health care funding and expenditure

Total health expenditure in Italy amounted to over 143 billions of Euro in 2012, or 9.2% of national GDP. Around 80% of the total expenditure is covered by public funding, while the remaining 20% comes from private health expenditure, for its most part stemming from private households out-of-pocket co-payments[5]. Only about 1% of total health-care expenditure is funded by private health insurance (Ferré, De Belvis et al, 2014)

The transition toward federal reform of the state brought about by the Constitutional reform of 2001 paralleled fiscal federalism transferring the funding of SSN from the central to the regional offices, and strengthening the fiscal autonomy of the regional health departments. Public health funds mainly come from regional budgets, complemented by national co-funding. The main sources of funding are local taxes and national co-funding drawing on VAT collected by the State. Beside public resources, private households co-payments are asked to healthcare users (i.e. so-called *tickets*) mainly for diagnostic procedures (laboratory tests and imaging), pharmaceuticals, specialist visits and for non-urgent interventions provided in hospital emergency departments (Armeni and Ferré, 2013).

Reforms introducing a regionalisation of health care management were initially aimed at rationalising and reducing public expenditure on health, but recent developments in the last decades have showed that these were far too ambitious goals: total health expenditure has soared and a number of Regions have faced serious deficits that put them at risk of financial failure, which has forced the central government to regain control over regional spending on health care. While total health expenditure has increased considerably from 2000 to 2009, at an average yearly growth rate of 4.7%, a substantial containment to public health expenditure expansion has been imposed since 2009, with an average yearly growth rate of 0.9% between 2009 and 2012 (Armeni and Ferré, 2013). Such containment efforts are mainly related to government attempts to place stricter control over regions' health spending after a few regions incurred in considerable deficits. In order to prevent regional health systems' financial failure, the **adoption and implementation of formal regional 'financial recovery plans'** (*Piani di Rientro*) to reduce overspending was imposed by the central government to ten out of the twenty-one regional health systems since 2007, including the Piedmont region where our fieldwork has concentrated. Such financial plans include actions to address the structural determinants of costs and have had important consequences on the dynamics of public spending for health care in recent years, also in the field of staff management. Recent dynamics in health care and health personnel management must be then seen in light of these provisions. In particular, in the Piedmont region substantial limitations to staff turn-over (i.e. the possibility to replace retired staff by hiring new personnel), to purchase external professional services by health professionals and to salary progression have been imposed to public health care providers since 2010, when the regional financial recovery plan was adopted.

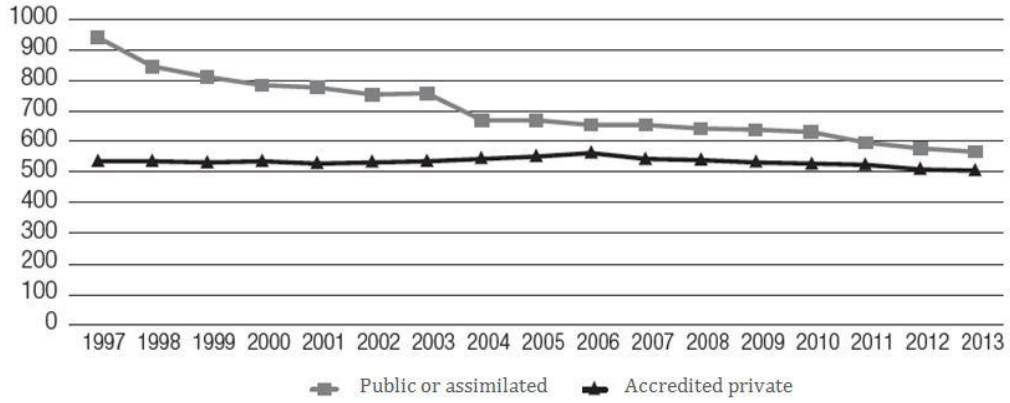
[5] See: http://stats.oecd.org

1.3 The Public-Private Mix

Beside trends towards the decentralization of health care policy and administration, other major transformations in the Italian NHS concerned the steadily expanding role of the private sector in health care provision and, more in general, the introduction of the market logic in health care management and provision. Structural reforms introduced in the early 1990s aimed at setting up a **quasi-market for health care** (Le Grand, 1991) where both public and private health care service providers were to be paid by the public on the basis of tariffs and fee-for-services established by health authorities and were expected to compete to attract patients, who were thus free to select the best provider. Indeed, beside objectives related to preserve the financial sustainability of the NHS, the trends towards the privatization of health care services were inspired by new public management principles[6]. In fact, one explicit goal of these reforms was to grant health care users freedom of choice over the public or private providers available, on the one hand, and to make health administration and management more efficient through market-based management mechanisms and increased competition between the public and the private sector.

Since the early 1990s reforms, both public and private providers are subject to authorization and accreditation procedures that set up minimum and additional health care quality standards (related to infrastructure, staff and equipments, organisational management). Accredited private providers may then sign contractual agreements with regional health authorities stating the volume, price and quality of the services to be delivered. Regions hold the primary responsibility in defining rules and procedures related to authorization and accreditation of health care providers and in monitoring and evaluate their implementation.

Figure 2. Evolution of public and private hospitals for acute care, 1997-2013



Source: Guerrazzi and Ricci, 2013.

[6] The new public management ideology is based on the basic idea that market oriented management of the public sector and enhanced competition between public and private service providers will lead to greater cost-efficiency for governments, without having negative side-effects on other objectives and considerations (Hood, 1991). A corollary of this basic idea is that users of public services (patients in the case of health care users) should be granted freedom of choice, and power of control over their choices, in deciding whether using public or private services (Le Grand, 2007).

Over the years, the **weight of private providers** in the overall health care sector **has increased considerably**, mainly due to a downsize of public health care facilities. With the ultimate goal of rationalizing the health care industry and hence reducing public health expenditure, while at the same time maintaining good health care quality standards, the number of publicly owned health care facilities has been constantly reduced, either by merging different hospitals or ASLs within a single administration, or by totally dismissing them (See figure 2).

Currently the **private healthcare** sector represent around **20% of the overall supply**, though it is worth noting that significant differences in the extent and characteristics of the private health sector exist across regions and sub-sectors. Looking specifically at hospital beds for acute care, available data show that only in the three largest regions (i.e. Lombardy, Latium and Campania) the share of hospital care by private providers exceed 30%: while private accredited providers provided around 32% of the total in Campania, the share is 4.4% in Liguria (data 2009, in OASI 2012, p. 52-53). However, the segments of the health care sector where the presence of private providers is larger are those related to rehabilitative and long-term care services, in particular **residential and semi-residential homes for long-term care**: in 2010 private providers owned respectively 75,4% and 62,8% of the total facilities available in this segment of the healthcare market.

1.4 Education and training of health professionals

Latest data available show that the Italian NHS employed overall 715,992 workers in 2011 (93% in permanent employment), of which over 70% are health professionals. Of these, 243,855 were doctors and 332,857 nurses, with an overall nurses/doctors ratio of 1.4.[7] Among health staff, 23.7% are medical doctors, 58.3% are nurses and the remaining 18% include other health professionals[8]. The overall number of health professionals has increased considerably in the last two decades, especially with regard to professional nurses and midwives. Only in the last ten years an increase of 18% in the number of nurses and midwives has been registered (Ferré and De Belvis, 2014).

The Italian Ministry of Health recognizes and regulates **35 health professions**, grouped into **7 main categories**: medical professions (surgeons and physicians, psychologists, pharmacists, veterinaries); nursing and midwifery professions, rehabilitation professions (physiotherapists, speech therapists, etc.), technical health professions, health prevention professions, health auxiliary professions (OSS, "*Operatore Socio-*

[7] The NHS staff is made up of employees who work in the ASLs (in both hospitals and not), in AOs and in university hospitals. It also includes the employees of the University but who work for the local health authorities, the staff of the facilities equivalent to that of the public institutions, that is private university polyclinics, IRCCS, or clinical research bodies. Since it contributes to the provision of health services on behalf of the NHS, data on staff of private accredited nursing homes is taken into account. As for non-hospital services the staff of psychiatric rehabilitation facilities, doctors in emergency medical service, the general practitioners and paediatricians are also detected. Self-employed health professionals, employees of cooperatives and work agencies and employees of not accredited private hospitals are excluded.
See https://www.salute.gov.it/imgs/C_17_pubblicazioni_2191_allegato.pdf

[8] See: http://www.salute.gov.it

Sanitario" or nurse assistants). For most of them a university degree and relative qualifications are needed to practice, while health auxiliary professions only require lower qualifications (regional vocational training).

Health professions, and especially non-medical ones, have been deeply reformed since the early 1990s. Here we will describe more in depth the **evolution of the regulatory framework concerning nursing and other auxiliary health professions**, where the largest part of the foreign workforce in the health system concentrate.

1.4.1 Nursing and midwifery professions

The most significant changes have concerned in particular nursing and midwifery professions, which have witnessed a substantial enhancement of their professional role, especially face to medical doctors. While until recently nurses were considered as subject to doctors and expected to perform merely executive tasks, they are now assigned greater responsibility and a more active clinical role in managing patients' health needs.

The professionalisation of nursing occupations has been prompted by the gradual shift from vocational to tertiary education during the 1990s. Indeed, since the reforms enacted in the early 1990s **tertiary education for nurses and other non-medical health professions** has been introduced and, after a short transition period, the previous regionally-based vocational training system was abandoned.[9] The overall goal of these reforms has been to transform the profile of nurses towards a greater degree of autonomy and responsibility to make their professional role more independent from doctors. In 1994 a new professional profile for nurses and midwifes is introduced through the ministerial decree 739/1994[10], which recognizes **full autonomy and responsibility to professional nurses**, defines their role also in relation to other health professionals and identify **5 main areas of specialization** (public health, paediatrics, mental health, geriatrics and critical care). The new professional profile, is definitely and fully acknowledged as an **health profession** (i.e. no longer an auxiliary profession) with the laws 42/1999 and 251/2000. The latter also introduces new rules concerning education and training of professional nurses. Indeed, the changes concerning the regulation of nursing professions have come along with substantial reforms of the university system following the Bologna process. In particular, since the early 2000s educational paths for professional nurses (as well as other non medical health professions) are inscribed in the so-called "3+2 system" with first-level degrees corresponding to bachelor's degrees (*Laurea Triennale*) achieved after 3 years (first courses started in 2001) and a more specialized master's degree (*Laurea Magistrale*) lasting 2 years (since 2004). The latter degree is a key pre-requisite for the access to managerial positions as well as to work as trainers or researcher. Finally, as already mentioned since 2006, new PhD programs for nurses have been created.[11]

[9] This is in line with EU Directive 85/595/ECC on the upgrading of the nursing profession.
[10] www.ipasvi.it/archivio_news/leggi/179/DM140994n739.pdf
[11] See: http://www.ipasvi.it/chi-siamo/note-di-storia.htm

Throughout the transition process serious shortages of professional nurses were detected: while the new educational system for nurses was gradually implemented, the need to hire new trained nurses with due credentials has been met through recruitment from abroad to a large extent (Chaloff, 2008; IDOS, 2009), as we will show in greater details here below.

1.4.2 Auxiliary Health Professions

Another occupation in the Italian NHS, highly relevant in what concern the migrant workforce, is a new auxiliary health occupation, introduced in the early 2000s: the *Operatore Socio-Sanitario* (OSS), or nurse assistant.

In general terms, qualification as OSS is obtained through regional-based vocation training, organised in both theoretical classes and practical traineeship, of an overall duration of 1000 hours, which may be split into three different modules. The final qualification is obtained after completion of the three modules.

This new occupational profile was introduced in the framework law 328/2000 reforming the institutional and regulatory framework of social policies in order to consolidate the wide range of profiles in social and health care services introduced by regional regulations in the previous twenty years (Iseppato and Ricchini, 2013). Besides, the definition of the OSS profile was also urged by the process of professionalization of nursing occupations: while nurses' role was deeply transformed to get closer to that of health professionals, with important medical tasks and lessening involvement in basic personal care needs of the patients, the need for auxiliary occupations providing basic assistance to patients in acute or long-term care services, under close supervision of professional nurses, emerged. Soon after the 2000 law, the skill profile of the OSS along with minimum training standards (i.e. qualification obtained after a minimum of 1000 hours courses and traineeship), identification of the working fields and relationships with other professional profiles were defined in the Joint Agreement between the State and the Regions of 22 February 2001.[12] The main task of the OSS were identified in taking care of the basic need of the care-recipient as well as ensuring his/her physical and mental wellbeing and autonomy, both in health care and social care activities and contexts. Afterwards, a new Joint Agreement of January 2003 has introduced the complementary figure of OSS with a specialization in nursing tasks, obtained after additional 300 hours of training, meant to act as assistants to professional nurses in health care structures and therefore subordinate to them.

In both cases the general national framework established at national level had to be implemented through regional norms setting the actual content and organization of professional training as well as the inclusion of OSS in the framework of regional social and health care services. Also in this case a great variations in the forms and contents of regulations concerning the qualifications, organization of training and utilization of these

[12] http://www.governo.it/backoffice/allegati/13404-148.pdf

occupational profile in health and social care services has to be underlined. In fact, beside the fragmentation of health and social care policies across different Regions, a further line of variation concern the organisation, management and funding of training policies, which fall under responsibility of Regions and Provinces. For instance, the Piedmont Region, where our target city is located, has not regulated the profile of the OSS with specialization in nursing tasks through specific regional norms. This means that the OSS working within health structures of the region have not a specific training in health care activities.

In general, a lack of sound and reliable information on such low-skilled occupation in the health and social care sector has to be underlined, both on the normative and regulative framework and on the actual size, distribution across type of health and social care services, dynamic evolution, and, most importantly here, presence of immigrant workers.

1.4.3 Medical professions

Differently from all other health professions, medical professions have undergone only **minor changes in the past twenty years**. While tertiary education for all other health profession has been organised in the "3+2 system", medical training is still achieved after 6 years single-cycle university courses followed by specialty courses of variable duration, from 3 years for general practitioners and family doctors up to 6 years for some specific medicine specialties.

However, the most significant changes concern measures adopted in the last decades to keep under control the surplus of medical doctors that characterise the Italian system. Since 1999 **access to university medical education programs has been based on a competitive assessment exam and subject to quantitative caps** yearly set by the Ministry of Education (after consulting the Ministry of Health) (Ferrè, De Belvis et al, 2014). National caps are defined on the basis of the potential demand estimated by the Ministry of Health, on the one side, balanced with the estimated capacity of the university system to train the necessary number of medicine graduates. The overall yearly cap is subsequently distributed between individual universities at local level. A quota of places is reserved to non-EU foreign students resident abroad[13]) within each university.

Training quotas at undergraduate level are set by the Ministry of Education, based on recommendations of the Ministry of Health after consultation with regional authorities. At the specialty level, quotas are set by the Ministry of Economy who sets the total budget, thus the number of people that can access specialty training. As for undergraduate programmes there is a single admission test at the national level, which is prepared by the Ministry of Education, University and Research. It consists in 60 multiple-choice questions that relate to general knowledge and logic (30), biology (14), chemistry (8), maths and physics (8).

[13] http://www.studiare-in-italia.it/studentistranieri/

For the 2013–2014 academic year, there were 9,897 slots available for medicine and surgery training. However, it is worth noting that despite these efforts to control the national supply of medical doctors, there is still an over-supply in the country, resulting in an outflow to other EU countries, especially to the UK and Germany(Wismar et al., 2011).

Right after the conclusion of their studies, graduates in Medicine have to pass **a licensing exam** (so-called *Esame di Stato*) **as a precondition for the enrolment in locally based professional registers** hold by the medical professional association (*Ordine dei Medici*). Licensed doctors may then choose to specialize in a given discipline by attending, after having passed an entrance exam, a specialty training school in medical or surgical treatment of varying duration (three to six years, depending on the type of specialization). In the case of specialty training for general practitioners, the planning of available places in specialty school is based on the needs of each Region whereas for all other specialties the Ministry of Health together with the Ministry of Finance is responsible for setting the number of annually available training slots. Physicians-Surgeons can also enrol in PhD programs, which develop very specific and advanced skills and are oriented to university or private-company research.

Once obtained all the necessary credentials, doctors can work either as independent professionals with their own private practice or as employees of the NHS. In general, doctors employed by the SSN are salaried and have civil servant status: this is one of the major barrier to the access of non-EU doctors to permanent public employment in the NHS. GPs and paediatricians usually work as independent professionals but they also have a special contract with the NHS and are paid via a combination of capitation (with a ceiling for the number of patients) and fee-for-services for some specific interventions. Hospital-based doctors are salaried employees and they are subject to terms and conditions set in national collective agreements, usually reviewed every 3-5 years. Reforms introduced in the late 1990s has allowed doctors employed by the NHS to practice privately within NHS facilities (so-called *intra-moenia* activity) also introducing financial incentives for those that decide to do so. Recent legislation (Law 189/2012) promotes the creation of ad hoc facilities within public hospitals to practice intra-moenia activities (See Ferrè and De Belvis, 2014).

2. Conditions of access to the health care sector for EU and non EU foreign workers

The access to the health-care profession in Italy for foreign professionals, especially for those who hold a non-EU medical degree, is a lengthy and cumbersome process, regardless of whether they are going to work in a public or private health structure or as self-employed. The eligibility to practice as a doctor or a as nurse implies multiple steps. Those who have a professional title obtained abroad and wish to pursue in the health care profession in Italy must:

- Obtain the recognition of the educational title (i.e. recognition of the equality of value and effectiveness)

- Carry out an internship or practice;

- Pass an exam assessing the acquired skills (national competition)

- Enrol in the local branches of the physicians' or nurses' professional associations.

2.1 Recognition of professional titles

Those who have a health professional qualification obtained abroad and intend to practice their profession in Italy, must obtain recognition of their titles from the Ministry of Health.

All EU and non-EU citizens holding titles obtained in a non-EU country in order to obtain authorization to practice a health profession in Italy, have to submit an application for recognition of the title, even if already approved in another country of the EU.

The procedure for approval of the educational titles in the health is different depending on whether the holder of the title is a EU or non-EU citizen.

a. Titles obtained in EU countries

For doctors, medical specialists, general practitioners, veterinary surgeons, pharmacists, dentists, nurses and midwifes, the EU legislation has established common rules for the harmonization between EU countries, according to which the recognition procedure consists of a verification of the validity of the documentation presented. In general terms recognition procedures for titles obtained in another EU country are far simpler and less lengthy than for non-EU titles.

b. Titles obtained in non-EU countries

The Ministry of Health takes into account any additional training and professional activities carried out in other EU country. The Ministry of Health may determine that the recognition of the health professional title is subject to passing compensatory exams to be carried out in an Italian university or training centre.

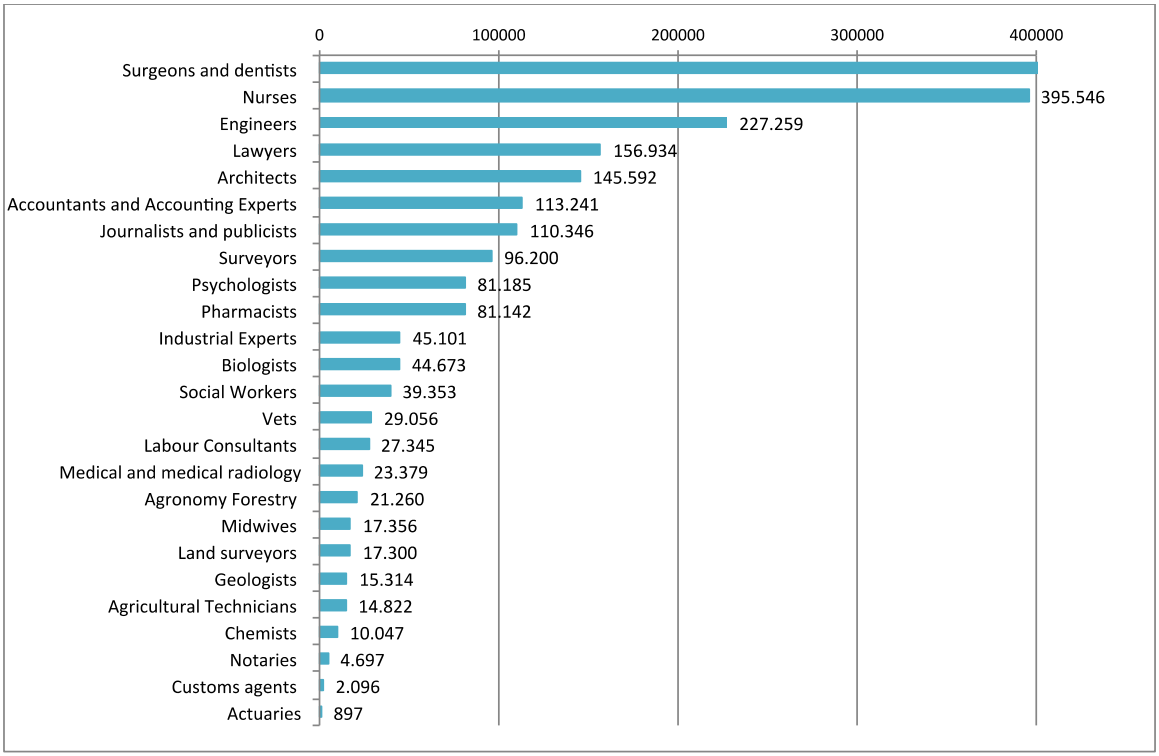
In particular, nurses and medical technicians in radiology who intend to work in 8 specific regions (Calabria, Campania, Tuscany, Sardinia, Liguria, Piedmont, Lombardy, Valle d'Aosta) or in the autonomous province of Trento and Bolzano, are given the possibility to apply for the recognition of qualifications directly to the relevant regional offices which directly follow up the proceedings.

2.2 Enrolment in professional registers

Following the recognition of educational titles, foreign workers willing to perform one of the regulated health professions must enrol in professional registers maintained by professional associations of doctors, nurses or other health technicians and recognized by the Ministry of Health. Doctors and Dentists must thus enrol in the local branch of the National Federation of Medical Associations (i.e. *Ordine dei Medici, FNOMCEO*) while nurses and midwives at the local offices of the National Federation of Nurses Associations (*Collegio IPASVI – Infermieri Professionali, Assistenti Sanitarie visitatrici, Vigilatrici d'Infanzia*).

In Italy high levels of regulation persist, both related to the access and the practice of professions, and professionals represent an important part of the workforce, according to CENSIS data on individuals enrolled in 2011 in several professional registers in Italy, among which those registered at the associations of physicians and dentists and of nurses are the most numerous.

Figure 3: Professionals enrolled in the professional registers in Italy (2011)



Source: CENSIS, in (Forte, Giacomello, 2012).

In the case of immigrant workers, the general procedure for having access to the regulated health professions is made up of the following steps:

- Acquisition (or recognition) of a degree or a professional qualification; if the enrolment in the relevant professional association is not undertaken within two years after the graduation or the title recognition, the title loses effectiveness;
- Once obtained the official recognition, the person must go to the office of territorial jurisdiction of the national association (usually at the provincial level) and, before enrolling in the register, must pass an examination to ascertain the knowledge of the Italian language;
- Completion of an internship.
- Passing an exam assessing the acquired competences (the exam for foreign-trained doctors is held every 6 months. As an alternative they may enrol in the 6th year of medicine, take 7 exams and receive an Italian degree, converting the non -EU degree into an Italian degree.

After the recognition of the professional title, the foreign citizen can practice the medical profession and are authorized to apply for membership in the National Federation of Medical Associations through the corresponding local branch, subject to the evaluation of the Italian language skills.

In order to work as licensed nurses, non-EU nurses must enrol in the IPASVI, paying a licensing fee and annual dues afterwards. Non-EU-trained nurses are required to pass an exam at the local offices of the IPASVI association on subjects related to professional code of conduct and ethics. The IPASVI also require all non-Italian nurses to pass an Italian language exam before they are allowed to enrol. Prior to 2007, EU nurses were exempt from the language requirement but this is no longer the case. This exemption started to create concern in 2004, when Poland entered the EU and Polish nurses were exempted from the language exam. The national federation of IPASVI lobbied to eliminate this exemption before the accession of Romania.

According to data presented by the National IPASVI the recent trends show a decreasing weight of newly enrolled foreign nurses over the past years: foreign nurses enrolled in professional registers in 2012 were 2,152 that is 15.3% of the total (they were 35.3% of the total in 2007) and around half of them had obtained their qualifications abroad (while this was the case in 70% of cases five years before). At the national level slightly less than half of newly registered nurses in 2012 hold a non-EU nationality, that is 46.4% of the total. The presence of foreign licensed nurses is stronger in north-west regions of Italy, where they represented around a third of the total (28%), while it is weaker in the south of the country, where only 4-5% of newly registered nurses were foreigners.

2.3 Access to public and private employment

One of the main institutional obstacles to a full integration of foreign health workers in the health sector in Italy was the ban imposed to public employment for non-EU citizens (as a general rule in all economic sectors). This, however, did not prevent foreigners from working in the health sector, either being recruited in private health structures, as self-employed or working within public health structures through external employment,

namely being employed by cooperatives or work agencies sub-contracted by public health structures.

The situation changed since September 4, 2013, when the Law 6 August 2013, n. 97 entered in force for the fulfilment of the obligations arising from the participation of Italy to the European Union, according to the European Law 2013, whose art. 7 disposes the terms of access to jobs in the public administration. This law rules that certain categories of non-EU foreign nationals (and in particular: long-term residents or holders of refugee status or of the status or subsidiary protection) are allowed to participate in public competitions and to access public employment on permanent terms.

Beside statutory constraints for migrant health workers, public employment in the health care sector has been subject to substantial restrictions in the past decade due to policies of cost-containment implemented by national and regional health authorities (See paragraph 1.2 above). Turn-over of medical and nursing staff in public health structures has been strongly limited and new inflows of personnel in public health institutions have been of a limited extent.

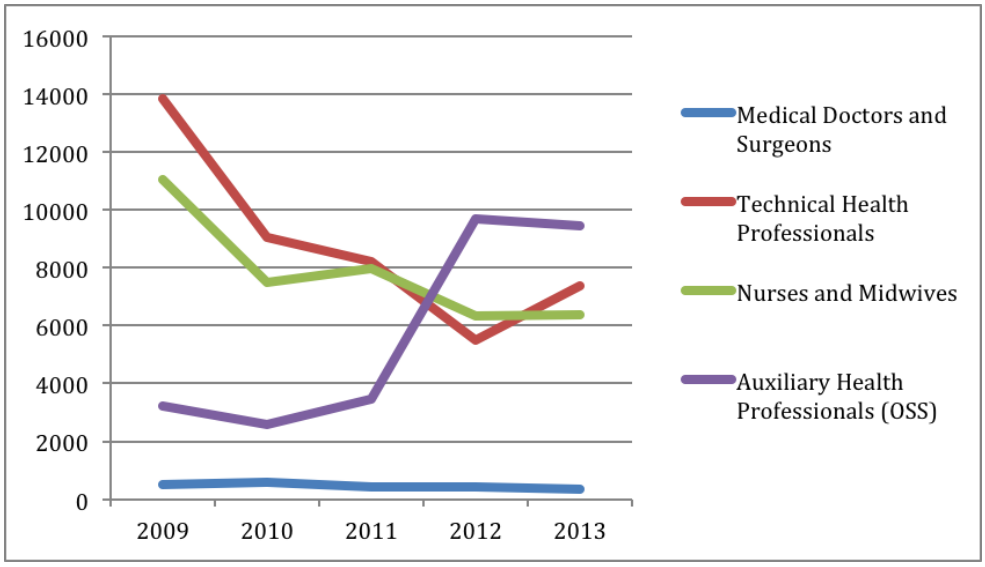
As a consequence of legal barriers to public employment and cost-containment strategies addressing the NHS, a large part of MHWs, and especially non-EU citizens, are employed in the private sector or are self-employed or, alternatively, work in public health structures as employees of cooperatives and private companies to which many services are externalised (often on temporary job contracts). Private employment for MHWs is less subject to institutional barriers, the only strict requirements being the possession of necessary titles and credentials.

2.4 Highlighted labour shortages in the health sector

The Italian health labour market has been traditionally characterized by a surplus of physicians and a shortage of nursing staff. The health workforce planning in the NHS is carried out jointly by the national and regional level: following a bottom-up approach: regions identify their own labour needs in health occupations and transmit them to the NHS human resources forecasting department. National health workforce needs are thus the sum of regional needs, with medical and health professional associations' estimations taken into account as well. Ministry of Health makes its time and geographical data consistency analysis and comparison, also on the basis of independent data collection. A top-down phase follow, with data check and central government proposal to the regions during discussion and agreement between national government and regions. Results are communicated to Ministry of Education, which defines number of entrants in university courses for medicine faculties (European Commission, 2012).

Labour demand in the private sector is forecasted by the national Excelsior survey carried out annually by the Union of the Chambers of Commerce[14]. It surveys a sample of around 100,000 private business in the industrial and service sectors asking questions related to forecasted labour demand by type of employment (whether permanent or temporary), level of education or previous experience required; besides, the survey investigates whether prospective employers rule out or not the possibility of employing migrant workers (regardless of whether they reside in Italy or abroad). Forecasted labour needs in the private health sector in the period 2009-2013 is shown in figure 4 below. These data show that labour needs in the private health sector have undergone a severe decrease over the crisis years. Auxiliary health professions show an opposite trend, with a steady increase between 2011 and 2012, while forecasted migrant labour needs in medical and other technical health professions are negligible in comparison to the other professions.

Figure 4. Forecasted Labour Demand of Health workers in the private sector, by profession, 2009-2013.



Source: Excelsior Database, Unioncamere Excelsior (accessed online 5 June 2014)

Before the crisis displayed its negative effects on the national health funding, namely from the early 1990s until very recently, serious shortages have been identified for nursing staff. As a matter of fact, the reforms in nursing education programmes and the skill-mix changes implemented within the health workforce have been also aimed at enhancing the attractiveness of these professions for the domestic workforce. However, these strategies could not display the expected effects in the short term and international recruitment of professional nurses has been adopted to fill existing gaps in nursing staffing since the early 2000s.

[14] See: http://excelsior.unioncamere.net/

Nevertheless, the situation has slightly changed to date: on the one hand the number of professional nurses has considerably increased in the past decade, mainly due to an increase of nationals completing their education and enrolling to the official registers for nurses. The overall number of professional nurses has increased by 25% between 2003 and 2013. While the rate of foreign nurses registered in 2007 reached 35% of annual enrolments in 2007 it has fallen to 15% in 2012; 46% of which holding a non-EU nationality. And while 70% of newly registered foreign nurses in 2007 had obtained their degree abroad, the rate falls to 50% among those registered in 2012 showing that an increasing number of foreign nurses have completed their nursing education in Italy (IPASVI, 2013[15]). As a matter of fact, it seems that the shortage of nursing staff has been progressively absorbed, due to the investments made in education and training in the past decade, but also to reduced labour demand in the health sector brought about by public budget cuts.

Conversely, some concerns related to emerging shortages of medical staff have been highlighted in the latest National Health Policy Plan 2011-2013. Here the MoH has forecasted a negative balance between inflows and outflows of doctors employed by the NHS starting in 2013, mainly due to ageing of the current medical staff of the NHS and gradual retirement of older cohorts. Emerging shortages of doctors is actually one of the hot issues in the debate on the future of the Italian health system. However, the current crisis and its impact on public finances does make the elaboration of solution a quite challenging task. Indeed, whereas the number of slots to access education in Medicine has steadily increased in the recent years, substantial cuts have been imposed on the funding of specialty training. There is thus a gap between the number of graduates leaving medicine faculties every year and the number of places available in specialty schools. Today emigration of both native and foreign-born young doctors and medicine graduated in Italy, starts to be a relevant phenomenon. This might help to explain why recruitment of doctors from abroad has been never conceived as a strategy to tackle such emerging shortages. Rather, national health authorities called for increasing investments in medical education and training, namely raising the number of students admitted to post-graduate specialty programmes. Besides, strategies aimed at rebalancing territorial unbalances in the distribution of medical staff, by developing incentives to geographical mobility of doctors within the national territory were also envisaged as solution to local shortages.[16] At present, recruitment of foreign doctors from abroad is still not foreseen as an option.

2.5 The recruitment and employment of migrant health workers in Italy

The presence of migrant workers in the Italian health sector has considerably increased in the past decade, although the crisis is currently inducing substantial changes in this labour market sector. Migrant health workers concentrate in particular among nursing professionals and lower-level health auxiliary occupations (OSS), while the number of foreign doctors employed in Italy remain overall low (See the WORK-INT paper:

[15] http://www.ipasvi.it/archivio_news/pagine/96/IPASVI%20-%20Albo%202012%20-%20Analisi%20dei%20nuovi%20iscritti.pdf
[16] See http://www.salute.gov.it/imgs/c_17_pubblicazioni_1454_allegato.pdf pag. 18-20.

Migrant workers in the health sector in 5 European countries: a quantitative overview from EU-LFS). As a response to structural labour shortages in the nursing categories, active recruitment of professional nurses from abroad was adopted as an explicit strategy in the past years. Whereas no such strategy was adopted for all other health workers categories: foreign doctors or other health professionals usually enter Italy for study or other non-labour reasons (i.e. family or humanitarian migrants).

2.5.1 The international recruitment of non-EU MHWs

As noted before, given the substantial shortage of professional nurses identified since the late 1990s, immigration from outside the EU was targeted as one part of the solution to the shortages identified in these segment of the health care labour market. Therefore **preferential entry channels for professional nurses have been introduced in the early 2000s** to facilitate their international recruitment.

Since the adoption of the Immigration Act in 1998 (still largely unchanged), the general rule for labour admissions in Italy is the nominal hiring from abroad (i.e. recruitment conditional upon a specific request by individual employers) subject to quantitative caps set in annual quotas. Work permit applications are filed by employers once the annual quota decree is published in the official bulletin and the procedures are officially open. The use of labour market tests to check the availability of legally resident workers, though formally inscribed in the law, is de facto scarcely implemented (Salis, 2012). With the 2002 immigration reform the category of professional nurses was included in the list of those admitted beyond the numerical caps of the annual quotas, thereby easing their recruitment procedures. Extra-quota entries, regulated by article 27 of the Immigration Act, allow the recruitment of specific categories of workers in any moment of the year (i.e. not waiting for the opening of the work permit application procedures foreseen for all other categories subject to the official quotas). However, the admission of professional nurses remain conditional upon the work permit's request by a specific employer. Before entering Italy and accomplishing hiring procedures with their Italian employers professional nurses must request the recognition of their educational titles. Once arrived in Italy they have to enrol in professional nurses registers (managed by the professional nurses association, IPASVI) after passing a mandatory Italian language test (See par. XXX above)

Temporary work agencies have played a key and often controversial role in managing recruitment procedures from abroad and employment of foreign nurses. Indeed given the ban to public employment for non-EU workers, raised only in September 2013 (See par. 2.3 above), direct recruitment from public health structures was not a viable option.

2.5.2 The recruitment of international students in Italy

While the employment of foreign health professionals has been addressed by active policies of international recruitment through preferential entry channels for professional nurses in particular, the so-called 'non-economic migrants', among which primarily students, can represent a sizeable source of foreign labour force into the health sector.

Looking at the "efficiency" of matching between supply and demand of skilled labour, students in fact have a competitive advantage over qualified labour migrants who obtained their educational title in the countries of origin. Foreign students in destination countries are in fact in a better position to acquire destination-country specific language skills, training and labour market experience, that empirical findings suggest to be more valued as compared to education and training acquired in the country of origin (Friedberg, 2000). In addition, local employers can better value and understand their credentials as compared to those of immigrants admitted through other immigration channels (Hawthorne, 2008).

In the Italian system, in order to pre-enrol to the admission test to the Faculty of Medicine, foreign citizens having completed secondary education in a foreign country have to submit an application form for non-EU citizens living outside Italy where they declare to hold a High School diploma obtained at the end of at least 12 years of education.

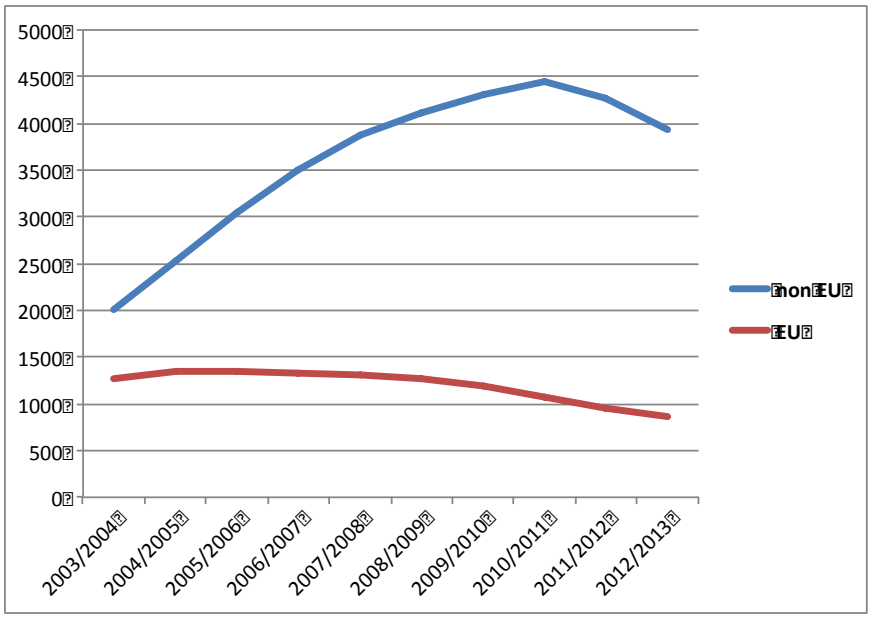
Based on rules established by the current immigration law, the Italian University system grant ad hoc quotas for foreign students living abroad, which are distributed by each University, conditioned to passing the test for admission to access university courses with planned national cap.

The majority of foreign students enrolled in the Faculties of Medicine in the Italian Universities (which include a variety of teaching programmes, including in nursing and midwifery) are from non-EU countries. The number of foreign medicine students has undergone a steady growth in the last decade, from around 2,000 in the academic year 2003/2004 to 4,500 in 2010/2011. However, a reversal of the growth trend starting from a.y 2011/2012 is shown in the graph.

Despite the health sector is among the ones that until recently provided the best job opportunities, data on students enrolled in the Medicine faculty in the years 2013 and 2014 (available on the website of the Ministry of Education[17]), show an overall decrease by 17%, i.e. a decline of about 16 thousand units.

[17] http://anagrafe.miur.it/index.php

Figure 5: Foreign students enrolled in the Faculty of Medicine holding a foreign high school diploma



Source: MIUR, Anagrafe Nazionale Studenti

The residence permit for study or training reasons has a maximum duration of 1 year and is renewable for the whole legal duration of the course of study. It is possible to renew the residence permit for study purposes even if students are enrolled in a degree program other than the one for which they entered Italy - prior approval of the new university of enrolment.

International students who complete their studies in the Italian university system can convert study permits into work permits within 12 months since the attainment of the degree[18] following a procedure that is exempt from the quotas system of recruitment and may therefore be submitted at any time of the year.

Eurostat data (2012) show that globally the conversions of residence permits from study reasons into other types (work, family, etc.) have been very limited in Italy, despite the growing share of the study-to work conversion of total conversions has increased from 4.0% in 2008 to 19.9% in 2011. In 2011 the total registered study-to-work conversions were 825, accounting for 77.5% of the whole conversions undertook by international students (the rest were for family reasons or for other reasons), while in the previous years just only 27 cases in 2008, 44 in 2009 and 46 in 2010 were recorded.

[18] New norms have been recently adopted that introduced more favourable conditions for international students in Italy: the law n. 99 of 2013 has made possible for non-EU foreign students who have obtained a bachelor's or master degree in Italy (i.e. *laurea triennale* or *laurea specialistica*), the possibility of extending their stay in Italy for a further year to look for a job, at the end of which they can convert their study permit into a work permit. So far, this possibility was limited to foreigners in Italy who obtained a PhD or a second level master's degree.

At our best knowledge, no disaggregated data is available on such conversions for international Medicine students, nor on the recruitment of former international students enrolled in medical courses in the Italian health structures.

3. Presence and role of MHWs in the Italian health sector

A significant paucity of empirical knowledge and data on the presence and characteristics of MHWs in Italy has to be underlined here. Let alone the few studies produced by policy-oriented research some years ago (See Chaloff, 2008, IRES, 2008 and IDOS, 2009), there has been a significant lack of scientific attention to the role of MHWs in the Italian health care sector, especially in more recent years.

The relatively small presence of migrant workers in the Italian health sector is certainly a good, though partial, explanation to the relatively small attention devoted to this phenomenon. Based on recent analysis of labour market data elaborated in the WORK→INT statistical report (Villosio, 2015[19]), MHWs are underrepresented in the health sector in Italy relative to all other economic sectors: in the period 2011-2011 only 3.5% of health workers held a foreign nationality, against 10.3% in non-health occupations. However a slight increase in the presence of MHWs over the past years is observed, with MHWs representing only 2.1% of the total health workforce in 2006. Within health occupations, MHWs in Italy are for a large part professional nurses, which represents over 5% of the occupational group, whereas foreign doctors less than 3% of the total. The higher presence of foreign nurses with respect to foreign doctors is certainly related to past shortages emerged in the past years and now progressively absorbed thanks to the implementation of the new educational system and the impact of the financial crisis. A vast majority of MHWs in Italy holds a European nationality, that is 80% of the total migrant health workforce, either of other EU countries (over 60% of the total, mostly from Romania) or other non-EU European countries. The relatively low diversity of the migrant health workforce is indeed one of the factors that could possibly explain the scarce attention given to the role of MHWs in Italy.

While sound empirical data on stocks of MHWs in Italy are presented in the statistical report mentioned above (Villosio, 2015), we will focus here on trends and dynamics observed in the health labour market over the past years. In fact, a valuable source of information on labour market dynamics is represented by administrative data drawing on the compulsory communications (*comunicazioni obbligatorie*) that every public or private employer must send to public authorities (public employment centres, national social security institute, etc.) relative to new job contracts and every further modification, including termination of the employment relationship.[20] It is worth noticing that compulsory communications data measure flows into and outside the labour market for employees and assimilated workers (such as apprentices, non-standard employees). Therefore, they are not a measure of stocks and they do not provide information on self-employment and other

[19] See the WORK-INT project web-site: www.workint.eu

[20] Compulsory communications include relevant information relative to: hiring date and supposed or actual date of end of the job contract, type of occupation and sector of employment, type of job contract and national collective agreement applied, etc.

types of non-subordinate employment. Furthermore, looking at the target of this study, they do not include self-employed doctors or nurses. Besides, the unit of observation and analysis is the single job contract, not the individual worker.

Here below we present compulsory communications data relative to the period 2009-2013 concerning health occupations, categorized into the four main groups of doctors, nurses, nurse assistants (OSS) and all the others. Table 1 shows the dynamics of the labour market for the selected health occupations between 2009 and 2013. An overall increase of new job contracts for health workers by 20.5% in the period considered is observed. However, new labour demand has addressed especially low-skilled workers in the nurse assistant category, with a spectacular increase by 1,114%, and, to a much lesser extent, doctors. An overall decrease in new job contracts for professional nurses by 8% is observed. During the same period jobs contracts for health workers that were terminated increased by 20.9%, showing hence a general balance in the labour market dynamics (see table 2).

Table 1. Total number of new job contracts, by occupation and year, and annual variations (2009-2013).

		Year					Total
		2009	**2010**	**2011**	**2012**	**2013**	**(2009/2013)**
Doctors	*A.V.*	873	712	858	1,241	1,195	4,879
	Annual change (%)		-18.4%	20.4%	44.6%	-3.7%	36.8%
Nurses	*A.V.*	12,402	11,023	10,916	11,643	11,383	57,366
	Annual change (%)		-11.1%	-1.0%	6.7%	-2.2%	-8.2%
Nurse Assistants	*A.V.*	536	483	1,149	6,817	6,657	15,642
	Annual change (%)		-10.0%	138.1%	493.3%	-2.4%	1,141.4%
Other Health Occupations	*A.V.*	3,102	2,873	2,880	1,455	1,149	11,459
	Annual change (%)		-7.4%	0.3%	-49.5%	-21.1%	-63.0%
Total	*A.V.*	16,913	15,090	15,803	21,157	20,383	89,346
	Annual change (%)		-10.8%	4.7%	33.9%	-3.7%	20.5%

Source: Campione Integrato delle Comunicazioni Obbligatorie (CICO), http://www.cliclavoro.gov.it

Table 2: Total number of terminated job contracts, by occupation and year, and annual variations (2009-2013).

		Year					Total
		2009	2010	2011	2012	2013	(2009/2013)
Doctors	*A.V.*	628	712	812	1,065	1,164	4,382
	Annual change (%)		13.4%	14.0%	31.1%	9.4%	46.1%
Nurses	*A.V.*	11,130	10,808	10,647	11,306	10,931	54,823
	Annual change (%)		-2.9%	-1.5%	6.2%	-3.3%	-1.8%
Nurse Assistants	*A.V.*	337	260	758	4,688	5,622	11,666
	Annual change (%)		-22.7%	191.2%	518.2%	19.9%	94.0%
Other Health Occupations	*A.V.*	2,880	2,850	2,727	1,555	1,203	11,214
	Annual change (%)		-1.1%	-4.3%	-43.0%	-22.7%	-139.5%
Total	*A.V.*	14,975	14,631	14,945	18,614	18,920	82,085
	Annual change (%)		-2.3%	2.1%	24.6%	1.6%	20.9%

Source: Campione Integrato delle Comunicazioni Obbligatorie (CICO), http://www.cliclavoro.gov.it

Table 3. Total number of new job contracts, by health occupation and nationality (2009-2013)

		Italian	EU	Non-EU	Total
Doctors	*A.V.*	4,780	69	31	4,879
	%	98.0%	1.4%	0.6%	100.0%
Nurses	*A.V.*	51.828	2.650	2.888	57.366
	%	90.3%	4.6%	5.0%	100.0%
Nurse Assistants	*A.V.*	13.803	636	1.203	15.642
	% over citizenship	88.2%	4.1%	7.7%	100.0%
Other Health Occupations	*A.V.*	11.168	176	115	11.459
	% over citizenship	97.5%	1.5%	1.0%	100.0%
Total	*A.V.*	81,579	3,531	4,236	89,346
	% over citizenship	91.3%	4.0%	4.7%	100.0%

Source: Own elaborations, Campione Integrato delle Comunicazioni Obbligatorie (CICO), http://www.cliclavoro.gov.it

Looking at the composition by nationality of new inflows into health occupations, table 3 clearly shows that migrant workers are concentrated among nurses and health assistants: in the period considered, around 12% of new job contracts for nurses have concerned EU (4.6%) or non-EU (5%) workers, while nearly 12% of workers hired as health assistants hold a foreign nationality, more often non-EU (7.7%), than EU (4.1%).

Conversely, new job contracts of foreign doctors represented only a negligible share of the total and almost the totality of new job contracts for doctors concerned Italian workers (98%).

For its most part, labour demand on health professionals in the period 2009-2013 has concentrated in specific sub-sectors of the health industry, in particular hospitals and nursing homes, or in other non-health sectors (See table 4).

Table 4. Distribution of new job contracts, by by nationality and sub-sector, (2009-2013).

		Hospitals	Residential health care services	Other health care services	Other non-health care services	Total
Italian	Doctors	70,0%	1,3%	4,0%	24,7%	100%
	Nurse	42,4%	15,9%	14,8%	26,8%	100%
	Nurse Assistants	30,7%	29,1%	19,9%	20,3%	100%
	Other Health Occupations	34,0%	6,6%	19,2%	40,3%	100%
	Total	40,9%	16,0%	15,6%	27,4%	100%
EU	Doctors	77,8%	11,1%	0,0%	11,1%	100%
	Nurse	32,9%	26,3%	19,7%	21,1%	100%
	Nurse Assistants	15,7%	45,8%	21,7%	16,9%	100%
	Other Health Occupations	34,8%	13,0%	26,1%	26,1%	100%
	Total	30,8%	28,9%	20,0%	20,4%	100%
Non-EU	Doctors	75,0%	0,0%	0,0%	25,0%	100%
	Nurse	23,6%	37,1%	19,6%	19,6%	100%
	Nurse Assistants	18,5%	48,4%	17,8%	15,3%	100%
	Other Health Occupations	20,0%	0,0%	53,3%	26,7%	100%
	Total	22,4%	39,1%	19,9%	18,6%	100%
Total	Doctors	70,2%	1,4%	3,9%	24,5%	100%
	Nurse	41,1%	17,5%	15,3%	26,2%	100%
	Nurse Assistants	29,2%	31,2%	19,8%	19,7%	100%
	Other Health Occupations	33,8%	6,6%	19,7%	39,9%	100%
	Total	39,6%	17,6%	16,0%	26,7%	100%

Source: Own elaborations, Campione Integrato delle Comunicazioni Obbligatorie (CICO), http://www.cliclavoro.gov.it

Looking at the overall distribution of the three categories it is worth observing that labour demand for doctors is largely concentrated in hospitals (70,2%) and other non-health sectors (24.5%) whereas a substantial share of the overall demand for nurses is also found in nursing homes (17.5%) as well as in other non-health sectors (26.2%), beside hospitals (41.1%). As for health assistants, over half of the overall demand has been concentrated in nursing homes (31.2%) and other sectors (19.7%).

Relevant differences are found in the distribution across sectors and sub-sectors of new job contracts concerning different nationalities. In particular, in the period considered the share of EU and non-EU MHWs hired by hospitals is significantly lower than among Italians (respectively 30.8% and 22.4% against 41%). This may be explained by existing barriers for non EU workers to public employment in NHS hospitals (see paragraph 2.3 above). Besides, MHWs are more often hired to work in long-term residential care services compared to Italians: over a third of new job contracts for MHWs (respectively 29% and 39% for EU and non-EU workers, against 16% for Italians). As reported above, most long-term care services are privately owned and thus less constrained by existing barriers in public employment.

This is also confirmed by the table below describing the labour dynamics across public and private employment in the health sector (see table 5). Whereas around 16% of new job contracts for Italian health professionals were concluded with a public employer, the same percentage drops to respectively 8.5% and 9% for EU and non-EU health workers, mostly for non permanent positions. In fact, MHWs are employed on a temporary basis more often than Italians.

Table 5. Distribution of new job contracts, by nationality and type of employment. (2009-2013).

		Private Employment		Public Employment			
		Permanent	Temporary	Permanent	Temporary	Other	Total
Italian	Doctors	23.7%	30.4%	18.6%	13.8%	13.5%	100.0%
	Nurses	18.4%	57.7%	7.8%	8.6%	7.5%	100.0%
	Nurse Assistants	17.4%	65.4%	6.5%	4.3%	6.3%	100.0%
	Other Health Occupations	24.2%	48.8%	6.4%	5.6%	15.0%	100.0%
	Total	15,772	45,814	6,572	6,365	7,055	81,579
UE	Doctors	22.2%	66.7%	0.0%	11.1%	0.0%	100.0%
	Nurses	24.9%	57.8%	5.8%	4.3%	7.2%	100.0%
	Nurse Assistants	10.8%	81.9%	1.2%	1.2%	4.8%	100.0%
	Other Health Occupations	17.4%	52.2%	0.0%	4.3%	26.1%	100.0%
	Total	774	2,191	161	138	268	3,531
Non-UE	Doctors	0.0%	50.0%	0.0%	0.0%	50.0%	100.0%
	Nurses	24.7%	65.0%	0.8%	2.1%	7.4%	100.0%
	Nurse Assistants	8.3%	86.6%	0.0%	1.9%	3.2%	100.0%
	Other Health Occupations	40.0%	33.3%	0.0%	0.0%	26.7%	100.0%
	Total	858	2,972	23	84	299	4,236
Total	Doctors	23.5%	31.1%	18.2%	13.7%	13.5%	100.0%
	Nurses	19.0%	58.0%	7.4%	8.1%	7.5%	100.0%
	Nurse Assistants	16.5%	67.7%	5.8%	4.0%	6.0%	100.0%
	Other Health Occupations	24.3%	48.7%	6.2%	5.5%	15.2%	100.0%
	Total	17,404	50,977	6,756	6,588	7,622	89,346

Source: Own elaborations, Campione Integrato delle Comunicazioni Obbligatorie (CICO), http://www.cliclavoro.gov.it

Distribution of terminated job contracts, by nationality and motivation (2009-2013).

			Reason for job termination					
			Dismissal	Resignation	Retirement	Expiration of temp. contr.	Other	Total
Italian	Doctors	%	0.5%	27.9%	22.4%	33.0%	16.2%	100.0 %
	Nurses	%	3.5%	28.1%	9.8%	45.1%	13.5%	100.0 %
	Nurse Assistants	%	5.1%	21.5%	7.8%	53.8%	11.8%	100.0 %
	Other Health Occupations	%	5.3%	30.8%	6.4%	43.6%	13.8%	100.0 %
	Total	A.V	2,857	20,774	7,384	34,271	10,172	75,459
		%	3.8%	27.5%	9.8%	45.4%	13.5%	100.0 %
EU	Doctors	%	0.0%	0.0%	0.0%	100.0%	0.0%	100.0 %
	Nurses	%	5.2%	39.2%	1.6%	44.3%	9.7%	100.0 %
	Nurse Assistants	%	1.8%	17.5%	-	61.4%	19.3%	100.0 %
	Other Health Occupations	%	3.6%	39.3%	-	50.0%	7.1%	100.0 %
	Total	A.V	138	1,088	38	1,455	329	3,049
		%	4.5%	35.7%	1.3%	47.7%	10.8%	100.0 %
Non-EU	Doctors	%	0.0%	0.0%	-	0.0%	100.0%	100.0 %
	Nurses	%	8.4%	33.1%	-	42.4%	16.1%	100.0 %
	Nurse Assistants	%	6.6%	13.2%	-	72.6%	7.5%	100.0 %
	Other Health Occupations	%	0.0%	38.5%	-	46.2%	15.4%	100.0 %
	Total	A.V	276	1,026	-	1,762	513	3,577
		%	7.7%	28.7%	-	49.3%	14.3%	100.0 %
Total	Doctors	%	0.5%	27.6%	22.2%	33.4%	16.3%	100.0 %
	Nurses	%	3.8%	28.8%	9.0%	45.0%	13.5%	100.0 %
	Nurse Assistants	%	5.1%	20.7%	7.0%	55.4%	11.8%	100.0 %
	Other Health Occupations	%	5.3%	31.0%	6.2%	43.8%	13.7%	100.0 %
	Total	A.V	3,271	22,888	7,423	37,488	11,015	82,085
		%	4.0%	27.9%	9.0%	45.7%	13.4%	100.0 %

Source: Own elaborations, Campione Integrato delle Comunicazioni Obbligatorie (CICO), http://www.cliclavoro.gov.it

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