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Assessing and enhancing integration in workplaces

BACKGROUND REPORT

MIGRANT WORKERS IN THE SPANISH HEALTHCARE SECTOR

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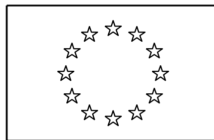

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1. The institutional and regulatory framework

The Spanish National Health System (SNHS) (*Sistema Nacional de Salud*) is the major provider of healthcare in Spain. Created in 1986, it is based on universal insurance and is mainly financed by tax allocations and assignments from general state budgets (The Fundamental Public Services Fund and the Global Sufficiency Fund). In 2011, 98.3 per cent of the population resident in Spain was insured by the National Health System (MSSSI 2012).[1] In addition to having public health insurance, Spanish resident may also take out private insurance coverage. According to information provided by the Spanish Ministry of Health, public spending for the SNHS was € 72,217 million, which corresponded to 7.1 per cent of the Spanish GDP in 2011. The private sector, by contrast, is much smaller and represents only 2.5 per cent of the Spanish GDP (MSSSI 2012).

Since the beginning of the new century, the Spanish health care sector has experienced a decentralisation process, finalised in 2005**.** This process means that health care decisions are now usually taken at the autonomic level because the Spanish Autonomous Communities (the Spanish federal units)[2] are entrusted with most health issues. Furthermore, following the restructure of the Spanish tax system, the funding for each Autonomous Community depends on both autonomic and national resources. The amount paid to each Autonomous Community out of the Sufficiency Fund is the difference between the funds required and the tax revenues raised by each Community. This means that richer Autonomous Communities are net payers, whilst the less affluent communities are net receivers of funding from the central state (García-Armesto et al. 2010). The transfer of competencies and distribution of funding have turned health "into a political instrument" for autonomous governments, as described by a member of the General Council of Spanish Medical Licensing Bodies (*Consejo General de Colegios Oficiales de Médicos en España,* CGCOM, 24/07/2013). Tax funding and a very low degree of professional corporatism make the sector highly dependent on government control and political majorities (De Miguel 1982, Finotelli 2014).

Each Autonomous Community has its own Health Service, which is the administrative and management body responsible for all the health centres, services and facilities in its territory (including provincial administrations, town councils and any other intra-regional administration). The Central Government is responsible for healthcare management in the cities that have autonomy statutes – Ceuta and Melilla – through the National Health Management Institute (*Instituto Nacional de Gestión Sanitaria,* INGESA).

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[1] It is worth mentioning that until August 2012 immigrants without a residence permit could also be treated on the Spanish NHS without any restriction related to their legal status.

[2] The Autonomous Communities are federal units with elective bodies whose government organisation is defined by the Spanish Constitution (Section 147 CE). The Spanish Constitution lists the matters in which the State has exclusive competence: Autonomous Communities have exclusive competence in matters of education and health protection according to the frame laws of the central State. Nevertheless, not all Autonomous Communities have the same competencies in the same matters. The *nacionalidades historicas* (Catalonia, Basque Country and Galicia) have wider competencies than other Autonomous Communities. Owing to these different levels of autonomy, it is not easy to define the form of territorial government in Spain. This is why constitutionalists preferred to call Spain an »Autonomic State« (*Estado de las Autonomías*), in which the unequal distribution of autonomy exhibits a clear asymmetric pattern.

The Inter-territorial Council of the Spanish National Health System (*Consejo interterritorial del Sistema Sanitario Nacional*, CISNS) is the body responsible for coordination, cooperation and liaison between the central and Autonomous Communities' public health administrations. The CISNS operates on the basis of its Plenary Meeting, an Executive Committee, technical committees and working groups (Figure 1).

The Advisory Committee answers to the Inter-territorial Council and renders social participation in the National Health System effective on an ongoing basis, as the Committee is the vehicle enabling the institutional participation of trade unions and employers' organisations in the National Health System. The specific duties of the Committee are to inform, provide advice and make proposals on matters of particular interest for the operation of the Spanish National Health System.

Figure 1: Central Government's health care responsibilities

<table>
<tr><td rowspan="7">SNHS INTERTERRITORIAL COUNCIL</td><td rowspan="4">CENTRAL GOVERNMENT</td><td>Health basis principles and coordination</td></tr>
<tr><td>Foreign health affairs</td></tr>
<tr><td>Policy on medicines</td></tr>
<tr><td>Management of INGESA</td></tr>
<tr><td rowspan="3">AUTONOMOUS COMMUNITIES</td><td>Health planning</td></tr>
<tr><td>Public health</td></tr>
<tr><td>Healthcare services management</td></tr>
<tr><td colspan="2" rowspan="2">LOCAL COUNCILS</td><td>Health and hygiene</td></tr>
<tr><td>Cooperation in the management of public services</td></tr>
</table>

Source: Ministry of Health, Social Services and Equality, 2012.

The Spanish National Health System is structured into two health care services, primary care and specialist care (Figure 2). The main care facilities are the health care centres, staffed by multidisciplinary teams comprising general practitioners, paediatricians, nurses and administrative staff and, in some cases, social workers, midwives and physiotherapists. Since primary health care services are located within the community, they also deal with health promotion and disease prevention. In 2012, the National Health System included 13,103 health care centres and local clinics.

Specialist care is provided in specialist care centres and hospitals in the form of outpatient and inpatient care. Patients who have received specialist care and treatment are expected to be referred back to their primary care doctor who, based on the patient's full medical history, provides a global clinical and therapeutic vision. This ensures the provision of continuous care under equitable conditions, irrespective of the patient's place of residence and individual circumstances, with care even provided in the patient's home if necessary.

Figure 2: Organisation of the Spanish National Health System.

	PRIMARY CARE	SPECIALIST CARE
Features	Accessibility	Technical complexity
Activities	Health promotion and disease prevention with sufficient technical resources to deal properly with common health problems	More complex and costly diagnostic and treatment resources that have to be concentrated to be effective
Access	Spontaneous	By referral by primary care professionals
Facilities	Health care centres and local clinics	Specialist care centres and hospitals
Place of health care provision	In the health care centre and at the patient's home	Outpatient and inpatient

Source: Ministry of Health, Social Services and Equality, 2012.

There are four types of hospital in the Spanish health care system that cover four different purposes: general hospitals, specialised hospitals, medium and long stay hospitals, and hospitals for treating addictions and mental health problems.

- **General hospitals:** These provide support to patients suffering from various diseases and pathologies. They have Medicine, Surgery, Obstetrics, Gynaecology and Paediatrics divisions. A hospital is also considered a general hospital even if some of these divisions are missing or if it is poorly developed but most of its daily work is not concentrated in a particular area.
- **Specialised hospitals:** These provide specialised diagnostic and treatment services. Their main activity is treating certain pathologies or helping patients who belong to a certain age group or who have certain characteristics in common.
- **Medium and long stay hospitals:** These hospitals provide care for patients who require a prolonged period of in-patient care and medical attention, generally of low complexity. Most patients suffer from chronic diseases or pathologies, a certain degree of functional disability in their everyday activities, and care cannot be provided at home.
- **Hospitals for treating addictions and mental health problems:** The aim of these hospitals is to provide diagnosis, treatment and monitoring for patients who need to be hospitalised because they suffer from mental illnesses or disorders related to drug addictions.

Depending on the kind of care provided, seven out of ten hospitals in 2012 were dedicated to the care of acute diseases, one is a psychiatric hospital and two were for geriatric and long-term care. Eight out of ten beds installed were in acute care hospitals, one in psychiatric hospitals and one in geriatric and long-term care

hospitals. According to functional dependency (that is, the organisation on which they depend), four out of ten hospitals in 2012 were public and six private.

Hospital management is organised differently in each Autonomous Community. Catalonia, for example, has a completely different system to that in other Autonomous Communities. According to data provided by the Spanish Ministry of Health, there were 763 hospitals[3] operating in Spain in 2011, equipped with 162,538 beds (352.5 per 100,000 persons). Of these, 452 belonged to the SNHS, the other 311 were private (see Table 1). Private hospitals generally provide services to persons with private insurance coverage. However, the Spanish National Health System also includes privately run hospitals, which provide the full extent of their services to an assigned population affiliated to the Spanish National Health System on the basis of special public-private partnerships. Examples include membership in the Public Use Network (*Red sanitaria pública*) and signing of the so-called 'replacement agreement' (*concierto sustitutorio*) (see Table 1).

Table 1: Hospitals by the legal entity on which they depend and their objective activity, Spain 2011.

	General hospitals	**Specialised hospitals**	**Medium and long stay hospitals**	**Psychiatric institutions and rehab centres**	**TOTAL**
Spanish National Health System	279	35	92	46	452
Public dependency	246	13	40	27	326
Replacement agreement	3	2	2	3	10
Public Use Network	28	3	50	16	97
Mutual Society of Work Accidents and Health	2	17	-	-	19
Private	184	52	35	40	311
Private non-profit-making	23	8	14	17	62
Private profit-making	161	44	21	23	249
TOTAL	463	87	127	86	763

Source: Statistics on Health Care Institutions with Boarding Facilities. Ministry of Health, Social Services and Equality, 2011.

In principle, four different types of management model can be outlined:

3 Please note that some reports state that the number of hospitals in Spain is 790. This mismatch reflects the complexity of data collection for the Ministry. Due to the decentralisation and privatisation process, it has become more difficult to obtain homogeneous statistical information on the management of the Spanish National Health System.

- Hospitals managed by the public administration (Central Government, Autonomous Communities or local councils) via social security institutions. This is the traditional form of management in Spain and the largest in the category "Public-NHS".
- Hospitals that are dependent on public funding but which are managed by companies, foundations or corporations. These are legal forms used to carry out privatisation.
- Private hospitals that are included in the Public-SNHS on the basis of a replacement agreement or as members of the 'Public Use Network'.
- Private hospitals belonging to a company that do not depend on public administration.

Table 2: Hospitals included in the SNHS by legal form and the institution on which they depend, Spain 2011.[4]

	SNHS					
	Central admin.	**Autonomous Community**	**Local admin.**	**Mutual**	**SNHS agreement**	**TOTAL**
Social Security	1	150	2	-	-	153
Public institution	6	52	5	1	-	62
Public company	-	45	13	-	-	58
Public foundation	-	9	1	1	-	11
Private foundation	-	-	-	-	58	58
Trading company	-	-	-	1	47	48
Other	-	39	3	16	2	166
TOTAL	7	295	24	19	107	452

Source: Statistics on Health Care Institutions with Boarding Facilities. Ministry of Health, Social Services and Equality, 2011.

As a general rule, private hospitals have their own practices and primarily care for insurance companies' customers. However, a considerable number of them have some kind of agreement with the National Social Security System. As Table 2 shows, for instance, a total of 107 hospitals had an agreement with the SNHS in 2011, 58 of which were managed by private foundations and 48 by corporations.

It also worth mentioning that, in some private hospitals, only some of the health care staff (nurses, guards, emergency service, etc.) are employed directly by the insurance company. Surgery, by contrast, is performed by external surgeons who use these hospitals to take care of their own patients. It is almost as if this type of hospital were renting out their facilities and staff (surgical suites, materials, nursing staff, etc.). However, this

[4] Please note that the category "other" refers to very specific forms of hospital management.

form of outsourcing is not as common as other forms of outsourcing, such as cleaning or laundry, which is quite frequent in both public and private hospitals.[5]

Some Autonomous Communities have attempted to privatise public hospitals by assigning service management and provision to private companies. In such a case, the insurance company is also in charge of determining the healthcare staff working conditions. The privatisation process commenced in the Autonomous Community of Valencia, with the introduction of the so-called "Alcira model"[6]. In this case, the insurance company was awarded public funding to build the hospital and the permit to subsequently manage it. The Community of Madrid soon followed suit, adopting the same model and building new hospitals with private management and public staff (financed) by the Community of Madrid. In November 2012, the President of the Community of Madrid announced the complete privatisation of six public hospitals, including their public staff. Not surprisingly, this process triggered widespread social protest since most Spanish citizens were against public services being outsourced to private companies. In January 2014 the president of the Autonomous Community of Madrid finally had to implement the High Court decision against the privatisation process, while the Autonomous Community's Health Counsellor backed down.

2. The employment of medical staff

2.1. The general framework

According to OECD statistics (see figure 3), Spain is one of the European countries with the highest physician/population ratio, featuring 4.1 practising physicians for 1,000 inhabitants in 2011 (OECD 2013). Furthermore, the number of physicians has increased steadily, from about 120,000 in 1996 to 180,000 in 2011.

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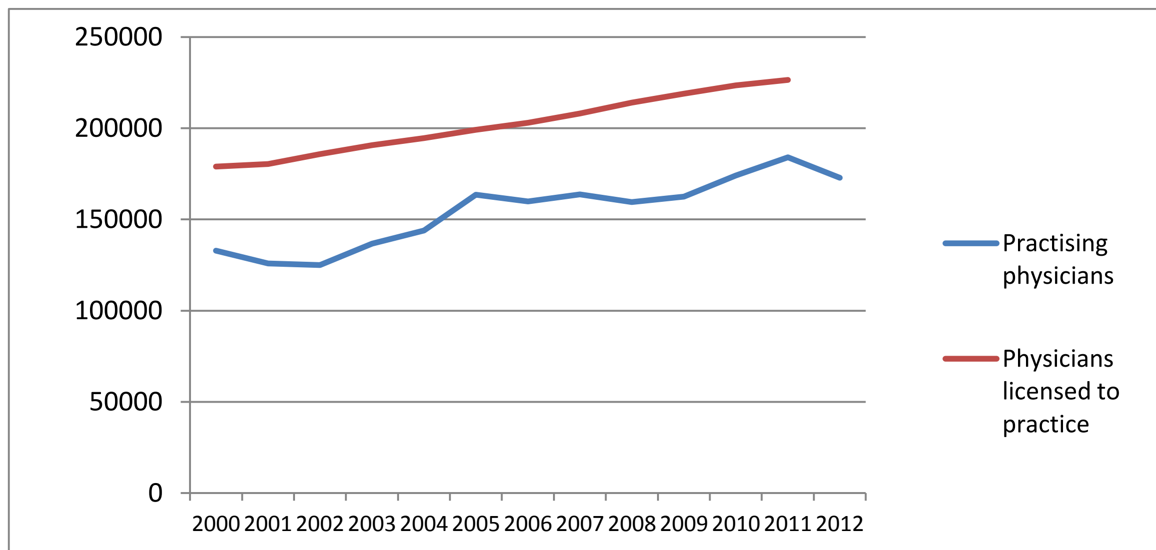
[5] Outsourcing is generally common practice in hospitals, including Social Security hospitals. For instance, the central purchasing body is in charge of simultaneously providing several hospitals with certain types of services so as to reduce prices. Other examples of outsourcing include cafeteria, maintenance and cleaning services.

[6] The term 'Alcira model' refers to the University Hospital of La Ribera, located in Alcira in the Region of Valencia. It was partially privatised in 1999, and became the first Spanish public hospital to be managed by a private company.

Figure 3: Physicians licensed to practice and practising physicians in Spain 2000-2012.



Source: OECD health data 2013.

Strikingly, OECD data based on the Spanish Economically Active Population Survey (EPA)[7] contrast starkly with national statistical sources (see table 3). Without neglecting the expansionist trend reflected by OECD figures, according to national statistics the number of practising physicians is much lower than OECD figures, with 80,000 physicians employed in hospitals and 29,000 in primary care (MSSSI 2012). The reasons for such a mismatch could be the difficulties encountered in the collection of data at the national level. In particular, a department director of the ministry of health recognised the existence of several difficulties in collecting data about practising physicians in private hospitals and in coordinating information in a highly decentralised health care sector (MSSSI, 05/06/2011).

The organisation and development of medical careers lies within the power of central public authorities. Before being employed as physicians in the Spanish health care system, young graduates must have registered with the medical licensing body (*colegio de médicos*) and completed a four or five-year medical training period (depending on the specialty) at a Spanish hospital. Most training slots are offered by public hospitals, although it is possible to undertake medical training in some private hospitals that have obtained university hospital certification for certain specialties. Physicians sign a training contract with an average gross salary of between a minimum of € 1,151 and a maximum € 1,576, depending on the Autonomous Community and the year of training. The Ministry of Health decides how many training slots for each type of medical specialities are assigned to each autonomic hospital each year. Such estimates are based on requests issued by the Autonomous Communities, which are evaluated by a mixed state commission of experts and civil servants from the Ministry of Health. Physicians' access to medical training to become a *médico interno residente*

[7] The survey was conducted by the Spanish National Statistics Institute (INE) and is available at: http://www.ine.es

(“internal resident doctor”) is dependent on the ranking drawn up after a state examination has been taken (the so-called MIR examination). The higher the score in the state examination, the greater the chances are that the candidate will be able to pursue the desired specialty in the hospital of his or her choice.

Table 3: Number of physicians according to the kind of care provided and functional dependency, Spain 2011.

	SNHS		Private		Total	
	N	Physicians per 100 habitants	N	Physicians per 100 habitants	N	Physicians per 100 habitants
General hospitals	73,775	1.60	4,970	0.11	78,745	1.71
Specialised hospitals	1,993	0.04	558	0.01	2,551	0.06
Medium and long stay hospitals	788	0.02	234	0.01	1,022	0.02
Psychiatric institutions and rehab centres	714	0.02	257	0.01	971	0.02
TOTAL	77,270	1.68	6,019	0.13	83,289	1.81

Source: Statistics on Health Care Institutions with Boarding Facilities. Ministry of Health, Social Services and Equality, 2011.

After training, physicians can either work in primary care or a public hospital, or they can apply for freely accessible employment opportunities in private hospitals. Moreover, registered physicians can also open their own practices according to the norms set by each Autonomous Community. Physicians working for the Spanish National Health System can be employed as civil servants, statutory workers or regular employees. Health care workers with a civil servant status or who are employed as statutory staff[8] usually have permanent contracts and cannot be dismissed except under extraordinary circumstances. Regular employees, by contrast, have fewer guarantees. Civil servant or statutory staff positions are generally restricted to Spanish and EU citizens; non-EU citizens may only access regular employee positions (provided that they are legally

[8] “Statutory staff” in the Spanish public health regime are regulated by the Framework Statute Law of Statutory Health Professionals (*Ley de Estatuto Marco n. 55/2003*).

resident in Spain).[9] It is worth noting that permanent positions in Spain are few and far between at present. As a matter of fact, calls for vacancies with an indefinite contract period have become increasingly uncommon, and physicians working in public hospitals are given many temporary contracts before obtaining an assignment in the hospital of their choice.

As for other permanent job positions in the public sector, staff selection in the health care sector is based on merit and public competition in the form of civil service examinations (*oposiciones*). However, some Autonomous Communities, such as the Community of Madrid, also offer positions for medical staff through public lists of unemployed physicians deployed by public hospitals to fill temporary vacancies (the so-called "bolsas de trabajo"). However, this type of recruitment is limited to temporary job positions and does not imply a secure option for civil servant or statutory positions. Despite this, working in the public sector offers employees more guarantees, although salaries are among the lowest from a comparative perspective (CESM 2013). Finally, physicians employed in the public health sector are permitted to work on an honorary basis in the private sector, which may improve their earning potential in the long term.

2.2. The demand for foreign physicians

According to the most recent data available from national statistics, about 12.5 per cent of all registered doctors in Spain were foreign-born (Barber-Perez et al. 2011b). The shortage of doctors was a hotly debated issue in the previous decade (Barber-Pérez, Gonzalez López-Valcárcel B. 2009). The impression of a mismatch between supply and demand in the Spanish health sector is rooted in the very structural characteristics of the health care sector. At the turn of the century, more attractive salaries in the private health sector drew many physicians into the private sector and reduced the number of physicians registered in public lists of unemployed physicians deployed by public hospitals to fill temporary vacancies. Furthermore, the autonomic governments started building new hospitals, sometimes in rather isolated regions, without increasing human resources (Gonzalez López-Valcárcel B. et al. 2011a). As outlined by the delegate of the Spanish Physicians' Trade Union, the *Confederación sindical de médicos* (CESM),

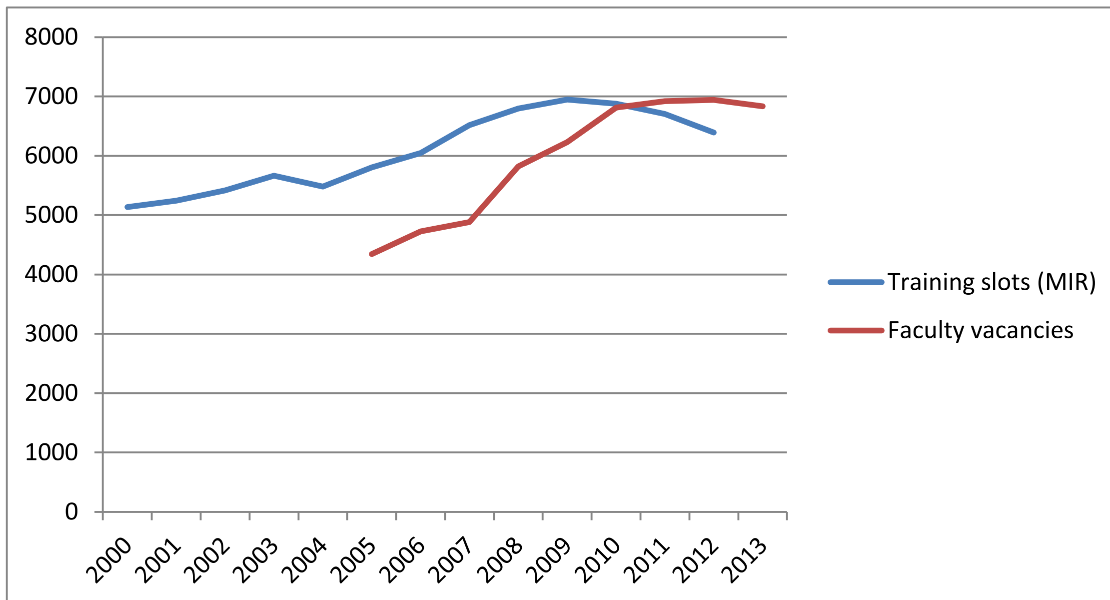
> "In 2006, the increase in the number of immigrants together with the increasing number of hospitals built in the Autonomous Communities produced the sensation that more doctors were needed […]" (CESM, 17/10/2011).

The "sensation" of an increasing demand for doctors was reinforced by the mismatch between the fairly low number of medical students on the one hand and the large number of slots available for medical training on

[9] However, the representative of the physicians' trade union CESM mentioned that offers for non-civil servant positions in the health sector are becoming increasingly frequent. Such positions are also open to foreigners with a regular residence permit in Spain. In other words, they cannot be used to recruit candidates from abroad (CESM, 17/10/2010).

the other.[10] Due to this "sensation", the Ministry of Health decided to increase the offer of training slots from 2005.

Figure 4: Number of training slots available for physicians in Spain 2000-2013.



Source: Data kindly provided by José María Romeo Ladrero. http://gangasmir.blogspot.com.es/

As a member of the CGCOM noted, the main purpose of the Autonomous Communities in applying for a large number of training slots during the economic boom was to obtain "cheap" temporary labour force in the form of internal resident doctors rather than opening more expensive positions (CGCOM, 24/07/2013). During the economic boom, slot assignments were not subject to control or filtration. As a representative of the CGCOM further noted, the ministry used to assign all slots requested by the Autonomous Communities (CGCOM, 24/07/2013). Finally, scholars argued that the increase in demand for physicians was also related to the inability of the health system to attract good physicians for less attractive workplaces (Barber Pérez, Gonzalez López-Valcárcel 2009). Physicians tended to concentrate on hospitals in Madrid or other important urban centres in Andalusia and Cataluña, whereas hospitals in interior regions such as Castilla-Léon and the islands were understaffed because of their less attractive locations (Amaya Pombo, García Pérez 2005). In addition to geographical criteria, a number of specialties were particularly undersupplied because they were considered less attractive than others by natives. Family and Community Medicine (FCM) was considered particularly unattractive because it was less prestigious than other specialties, and provided fewer chances of professional development and fewer possibilities to complement salaries with private visits. Medical students interviewed in

[10] See, among others, Gonzalez López-Valcárcel et al. 2009 as well as García Perez, Amaya Pombo 2005.

a survey conducted in 2011 valued positively the specialty of FCM in terms of the number of working hours involved and empathy with patients. However, they also declared that these factors would not prevent them from choosing a specialty, enabling them to earn at least 42.6 per cent more than a family doctor (Gonzalez López-Valcárcel B. et al., 2011b).

The "selective approach" of Spanish students directly affected how medical training slots were filled because, as was seen, the state examination results are a determinant factor in the choice of specialty. In fact, the best ranked candidates are usually awarded the specialties of their choice while all others have to make do with less attractive specialities and hospitals. In the past, candidates with a poor ranking position have repeated the examination, hoping to achieve a better score, instead of starting medical training in less attractive specialties such as FCM. This new trend triggered the phenomenon of "recirculation" (*recirculación*), in which medical students repeated the state examination several times in order to achieve a better ranking position and to gain access to the desired specialty. As a result, several training slots in unattractive specialties, often located in isolated regions of interior Spain, remained vacant. This was the case in 2007 and 2008, for example, when it was impossible to fill 244 and 301 training slots respectively after the state examination.[11] Unsurprisingly, this phenomenon further enhanced the perception that Spain needed more physicians.

2.3. The recruitment of foreign physicians

The existence of vacancies in a number of hospitals put pressure on the government to supply the health care sector with the necessary physicians. One of the first reactions of the Spanish government to meeting the demand for physicians was its decision to increase the enrolment limit in medical schools from 4,500 to 7,000 slots between 2005 and 2007 (González López-Valcárcél et al. 2011a). The Spanish Ministry of Health also increased the number of training slots from 5,200 in 2003 to almost 7,000 in 2010. Spanish scholars criticised this decision, warning that it would be difficult to absorb the larger number of medical school graduates (García-Perez, Pombo 2005). The impression among scholars was that the shortage of physicians was more of a distribution problem than a real lack of supply, and that, in such a case, structural reform was required. However, the ministry decided to use immigration to "repair" the dysfunctions in the Spanish health sector rather than to consider how to make Spain's regions more attractive or to adjust the number of training slots at the autonomous level to real demand. Physicians were included in the so-called Catalogue-of-Hard-to-Find-Occupations. This allowed hospitals to recruit non-EU physicians directly in the country of origin without them having to pass a labour market check beforehand. Not surprisingly, the "use" of immigration to correct dysfunctions in the Spanish health sector, particularly its inability to attract physicians to unattractive specialties, was sharply criticised by the trade unions: "It does not seem reasonable (and is ethically questionable) to think that the solution will proceed from professionals from third countries" (CESM,

[11] The data was provided by Fernando Rivas of the General Council of Licensing Bodies and elaborated by José María Romeo Ladrero.

17/10/2011). Similarly, a representative of the Spanish trade union UGT (*Unión General de Trabajadores*) expressed serious concerns about the inclusion of foreign medical professionals in the Catalogue,

> "Currently, we think that there are too many specialised doctors and nurses included in the Catalogue who will probably go to centres for the care of elderly or dependent people instead of hospitals or ambulatories. We have tried to organise various meetings with the Ministry of Health to clarify under which conditions these people are brought into the country and are employed in the private sector because we are convinced that their employment represents a way to reduce costs" (UGT, 27/05/2011).

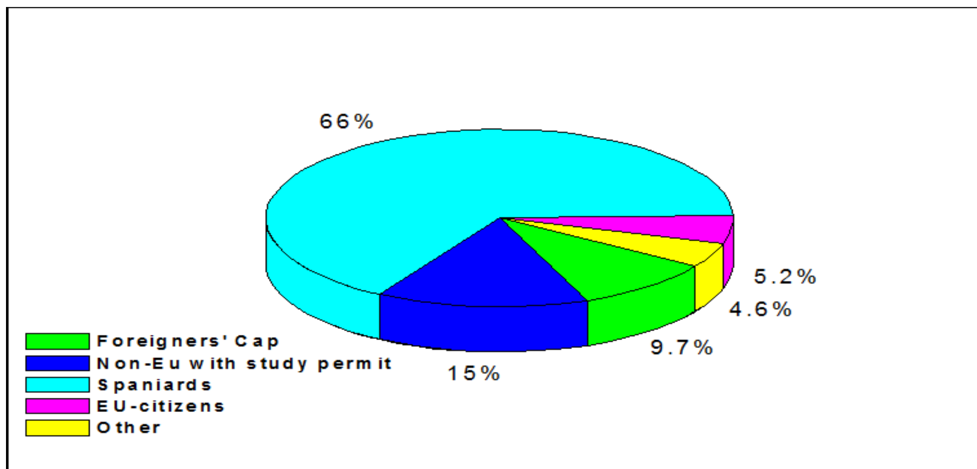
Apart from facilitating the admission of specialists from non-EU countries, another important admission channel consisted in relaxing the admission requirements for non-EU foreigners willing to do their specialty training in Spain. As a matter of fact, access to medical training was formally limited by a "cap for foreigners" (*cupo de extranjeros*) in the total slots available. The *cupo*, which may not exceed 10 per cent of all available training slots, was set each year by a mixed ministerial commission composed of members of the health and education ministries.[12] In 2007, however, the Spanish Ministry of Health modified the regulation of the medical training examination, eliminating the *cupo* for non-EU foreigners with a study permit. In this way, the legal situation of foreigners with a study permit became *de facto* equivalent to that of EU nationals because any non-EU citizen with a medical degree could then apply for a medical training slot in Spain. Foreigners belonging to a country that signed a Cultural Cooperation Agreement valid at the time of the examination with Spain were allowed to apply for a training slots without presenting any permit for work or study purposes.

After the 2007 reform, non-EU foreign students were required to present a valid residence or study permit, and their recognition of foreign credentials had to be processed at the time of the examination. Only in the case of a successful examination were applicants required to 'regularise' their position if they had no residence or study permit and to register with the licensing body according to the requirements of each Autonomous Community if they were successful. Furthermore, the legislation required a "sufficient" knowledge of Spanish corresponding to a certified intermediate level by a Cervantes Institute or any recognised language school. These new rules made the health sector more attractive to foreigners, triggering a "pull effect", especially from Latin American countries, where several training schools were opened with the sole aim of preparing applicants for the state examination in Spain while degree recognition was being processed (CGCOM, 24/07/2013). Providing all non-EU applicants with access to medical training contributed to considerably increasing the presence of foreigners in the Spanish health sector. In 2010, 34 per cent of those chosen for training slots were foreigners, most of them from non-EU countries (See Figures 5 and 6).

[12] Please note that until 1999, foreigners were entitled to participate in the state examination but were not entitled to practice as specialists in Spain after finishing their medical training (Real Decree no. 127/1984). This was changed only in 1999, when the Real Decree no. 1497/1999 established that both members of the European Union and citizens of signatory countries to the Cultural Agreement with the Spanish government could sit the MIR examination and subsequently practice in Spain.

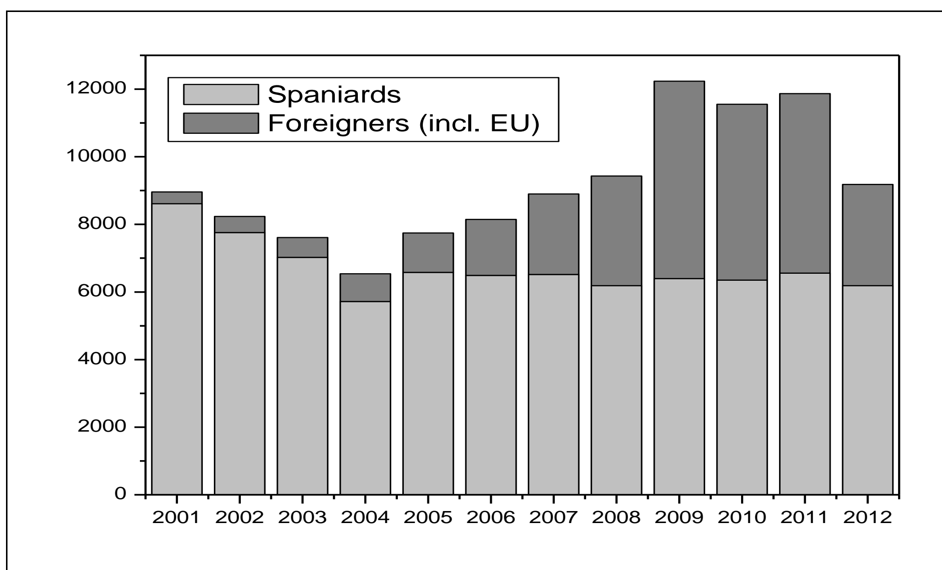
This process of internationalisation mainly affected the specialty of Family and Community Medicine. In 2010, the percentage of foreign doctors training in FCM was 44.7 per cent of all those who chose this specialty (Barber Perez, Lopez-Valcarcel B. 2012). In contrast, the presence of foreigners in other types of primary care, such as paediatricians, remained one of the lowest (13 per cent) compared to the other specialties. This was considered further proof of the fact that excess supply did not affect primary care in general, but specifically FMC (Gonzalez López-Valcárcel et al. 2011b).

Figure 5: Distribution of medical training slots by nationality



Source: Ministry of Health, Social Services and Equality data provided by the Spanish Medical Council (Consejo Oficial de Médicos) and elaborated by Jose Maria Romeo.

Figure 6: MIR participants according to nationality



Source: Data kindly provided by Fernando Rivas Navarro, CGCOM.

During the economic boom, medical training was mainly undertaken in Spain so as to find a job in Spain's private health care sector. In fact, resident doctors could convert their study permit into a residence permit in their third year of residence, which allowed them to find a job in the private sector at the end of their medical training if they were offered at least a one-year contract. By contrast, employment possibilities in the public sector were very limited due to the existence of the "nationality clause", which reserved employment for Spanish and EU citizens only. Notwithstanding this, some public hospitals informally offered temporary two- to three-month positions to non-EU nationals.

Overall, the demand for physicians in the Spanish health sector was highly dependent on economic and political contingency. It was possible to quickly implement reforms to adapt to changing "perceptions", thanks to the central role played by the Ministry of Health in the organisation of medical careers. Hence, during the economic boom (2000-2007), the sector expanded far beyond necessity (Finotelli 2014). Interestingly, data suggests that the recognition of foreign credentials was not used to block entry into the health sector because almost all candidates could apply for the medical training examination, "regularising" their position afterwards. Interestingly, and probably also because of the overwhelming presence of Latin Americans, the presence of foreigners was considered enriching, and their integration at the workplace was not a relevant debate issue. As a representative of the trade union *Comisiónes Obreras* observed:

> "They [foreigners A/N] bring new visions about clinical practice and other working practices, which are always interesting. Due to their origin, mostly from Latin America, language and culture are very similar [to the Spanish one A/N] which makes things much easier (my hospital, which is a small one, has a staff of 200 doctors, two from Uruguay, one from Argentina, a Mexican, a Peruvian has just retired and, as resident doctors, a Colombian, two Argentineans, a Peruvian and one from the Czech Republic and we never had work or integration problems) (CCOO, 09/05/2014).

With the onset of the crisis in 2008, the situation changed abruptly. The restriction of labour migration legislation also affected the recruitment of foreign doctors. As a matter of fact, the recruitment of foreign doctors in the country of origin, as of other foreign workers, had become once again dependent on a previous labour market check, while the medical profession had been fully eliminated from the Catalogue. Furthermore, the credit crunch and spending cuts in the health sector increased the number of doctors who were unable to find a job, despite having completed their medical training in Spain. The Autonomous Communities had less money to employ doctors in hospitals and primary care while physicians' salaries fell due to the spending cuts that affected all civil servants working in Spain. It also became more difficult to find a job in the private sector, despite the increase in insured citizens due to uncertainty about the future of medical assistance in the public health sector (El País, 15/12/2012). Apart from budgetary cuts, new legal requirements have considerably affected the employment possibilities of non-EU specialists. According to information provided by the Association of Resident Doctors (AMIREX, personal communication), resident doctors are no longer allowed

by the public administration to convert their study permit into a work permit in their training year, which considerably reduces their employment prospects in the private sector.[13] Most foreign physicians therefore had to return to their country of origin or they decided to emigrate to other EU Member States in search of better employment opportunities.[14]

Consequently, central and autonomous governments quickly implemented measures to restrict foreigners' access to medical training. In 2010, the Ministry of Health decided to reduce the number of medical training slots to the level of 2007 (Ordenance SAS/2158/2010). In the same year, the "foreigners' cap", which had been reduced to 4 per cent, was once again the only entry channel for non-EU foreigners. In addition, it is important to note that non-EU foreigners who obtained their medical degree at a Spanish university are also included in the cap, a decision that has been sharply criticised by social bodies, such as CGCOM. According to the information provided by CGCOM, the Ministry of Health reacted to such complaints stating that coming to Spain for medical training is an immigration matter and therefore depends on the applicant's nationality and not on where the degree was obtained (CGCOM, written information, 13/09/2013). In any case, since 2010 medical degrees must be fully recognised before the state examination. In addition, access to medical training has become more restrictive due to the introduction of a minimum grade, which must equal or exceed 35 per cent of the arithmetic mean of the ten best exams. All those who fail to achieve the minimum grade have no access to medical training. Finally, language has become an important selection criterion for the recruitment of foreign doctors who wish to start medical training in Spain.

Since 2011, physicians from a country whose official language is not Spanish must demonstrate sufficient knowledge of Spanish (Level C1 or C2) according to the classification of the Cervantes Institute or the Official Language Institute in the applicant's country of origin. This novelty has been explained by the need to improve communication skills between doctors and patients and the necessity to adapt to requirements set by the EU directive on the recognition of professional qualifications (2005/36/EC). However, it must be also noted that, specifically in the Spanish case, it also represents a form of positive discrimination because Latin Americans are implicitly favoured by the language requirement. The economic crisis, however, not only affected the norms regarding foreigners, but also native physicians' expectations. According to a recent survey, young natives who graduated recently in medicine are more likely to choose unattractive specialties than in the past in order to avoid the risk of unemployment. At present, in fact, a growing number of Spanish doctors appear to be interested in practicing FMC compared to the past (Harris et al. 2013). Such a reverse trend is also related to the government's decision in 2008 to put a stop to the "recirculation" phenomenon, establishing that those who wish to repeat the state examination despite having chosen a specialty must first give up their former

[13] This information was also confirmed during informal discussions with foreign physicians who recently completed their medical training in Spain.

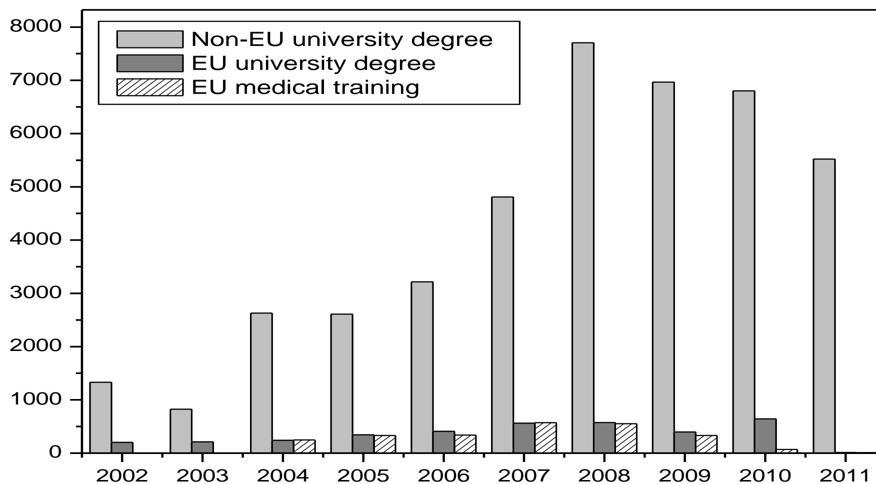
[14] However, the medical profession remained the most popular profession in the Autonomous Communities of Madrid, Castilla-Léon and Murcia until the beginning of 2011 (Barber Pérez et al. 2011, p. 168).

specialty.[15] Overall, the aforementioned restrictionist trend together with changes in natives' expectations is certainly bound to affect the presence of foreign doctors in the Spanish National Health System in the future.

2.4. The recognition of foreign credentials

In Spain, too, foreign credential recognition is the *conditio sine qua non* for gaining access to the medical profession. As is often the case, associations of foreign physicians often complain that recognition processes are too slow – it usually takes about a year for medical degrees to be recognised (Finotelli 2014). The length of the process was clearly due to the need to establish the equivalence between Spanish degrees and foreign degrees. As the sub-director of the department of the Ministry of Education responsible for this process declared in 2009: "The issue of the degree does not depend on the sectors' demand but on the strict equivalence between the studies conducted abroad and the courses in Spanish medical schools" (Lezcano-Mújica, quoted in "El periodic", 16/12/2009).

Figure 7: Recognition of foreign medical degrees (excluding specialty recognition for non-EU citizens)



Source: Statistics of the Spanish Ministry of Education

Notwithstanding this, the figures suggest that the recognition of foreign credentials was not driven by protectionist goals. As can be seen in Figure 7, the number of applications for the recognition of foreign

[15] See decree n. 183/2008. Further changes are envisaged, such as the ban on resitting the examination for two years after having failed three times.

medical degrees increased considerably between 2002 and 2011.[16] The total number of medical degrees recognised between 2001 and 2011 (50,205) was higher than the number of physicians who graduated in the same period (46,194).[17]

The recognition of medical specialties proved to be slower and much more cumbersome than the recognition of medical degrees. For this reason, some small public hospitals decided to hire foreign doctors whose specialty recognition was still being processed in order to meet the high demand for physicians during the economic boom (González López-Valcárcel et al. 2011a; La Vanguardia 16/10/2007).[18] Certainly, the employment of specialists who had not been recognised yet as generic doctors was a small and geographically limited phenomenon.[19] Notwithstanding this, it caused widespread concern among the professional organisations, which called for more control over such practices (http://www.levante-emv.com). The situation has changed very little, since the specialty recognition for non-EU doctors depends on the Ministry of Health, which relies on the advice of an Evaluation Committee designed by the medical licensing body. According to recent reports, the ministry is pursuing a restrictive approach involving the rejection of 80 per cent of applications (Gaceta médica, 24/05/2013).[20] At the same time, there still seem to be some 5,000 non-EU foreigners working in the private health sector whose specialty has not yet been recognised (Gaceta médica, 24/05/2013). Such a situation is unlikely to improve very soon, bearing in mind that the Ministry of Health still has to process a backlog of 10,000 applications (CGCOM, 24/07/2013).

The aforementioned bulky procedures and associated backlog with respect to specialty training recognition further confirms the argument that most foreign doctors entered Spain through the medical training channel, while full employment for specialists from non-EU countries is much more difficult to achieve.

[16] Until 2008, recognition of the foreign credentials of physicians from both the EU and non-EU countries was the responsibility of the Spanish Ministry of Education. However, since the implementation of European Directive no. 2005/36/CE on foreign credentials recognition for regulated professions by Royal Decree no. 1837/2008, the competence distribution has changed. The Ministry of Health is responsible for recognising the specialisation degrees of non-EU specialists, while the Ministry of Education is responsible for recognising the medical degrees of both EU and non-EU citizens as well as EU citizens' specialisation degrees. An expert committee at the Ministry of Education is in charge of examining the applications submitted.

[17] http://www.diariomedico.com/2013/05/20/area-profesional/profesion/titulos-homologados-superan-licenciados , last accessed on 05/06/2014.

[18] Such a strategy seemed to particularly affect physicians who had obtained the specialty of Family Medicine abroad and who could only be employed as generic doctors in Spain. However, the representative of the Spanish medical trade union admitted knowing about cases in which Argentinean anaesthetists had been employed as generic doctors until their titles were officially recognised (CESM, 17/10/2011).

[19] According to the representative from the medical trade union, the limited dimension of the phenomenon applies to both the public and private sector. "This (*the recognition of the right to perform as a medical specialist, A/N*) is obligatory in public health services. In private health services, the recognition of the specialty is theoretically unnecessary if the doctor concerned does not use his or her specialist title to practice. Nonetheless, something like that is very unlikely to happen because it would directly affect the institution's prestige (CESM, 17/10/2011).

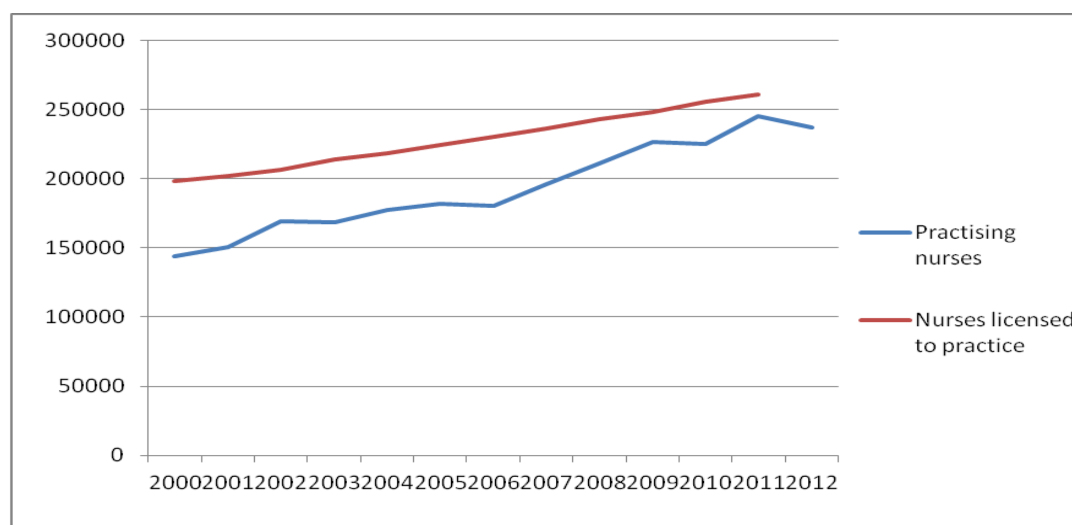
[20] It is important to note that institutions still fail to provide figures about the number of applications and their outcomes.

3. The employment of nursing staff

3.1. The general framework: functions, professional categories and the training required

Spain has one of the lowest ratios of nursing staff per capita in the entire European Union. In 2013, there were 528 nurses per 100,000 inhabitants, while the average in OECD countries was 759 (OECD 2013). [21] However, in line with the case of physicians, the number of nurses increased considerably between 2006 and 2011, according to same statistics.

Figure 8: Nurses licensed to practice and practising nurses in Spain 2000-2012.



Source: OECD Health Data 2013.

In total, according to OECD data there were 237,400 practicing nurses in 2012 (see Figure 8).[22] By contrast, according to the most recent data provided by the Ministry of Health, there were 41,690 nurses working in the SNHS primary care in October 2009, while 148,943 nurses were employed in hospitals in 2011 (see Table

[21] Please note that, according to the coordinator of an important medical association in Spain (quoted as MEDAS), the unequal ratio between doctors and nurses in Spain may be one of the reasons for the current controversy between the College of Nursing and the College of Physicians about the role of specialised nurses in the Spanish Health care System.

[22] Also in this case, OECD data is based on information provided by the Survey on Economically Active Population, National Statistics Institute (INE), based on the Economically Active Population Survey. http://www.ine.es.

4).[23] The reasons for the discrepancy between national and OECD data are related to the lack of official information about health professionals in private health care services.

Table 4: Ratio of nurses for every 100 beds, Spain 2011.

	SNHS		Private		Total	
	Nº	*Nurses per 100 beds*	*Nº*	*Nurses per 100 beds*	*Nº*	*Nurses per 100 beds*
General hospitals	128,391	139.01	11,286	64.94	139,677	127.28
Specialised hospitals	2,868	101.56	1,407	45.34	4,275	72.13
Medium and long stay hospitals	2,636	26.19	552	15.90	3,188	23.55
Psychiatric institutions and rehab centres	1,357	16.41	446	8.65	1,803	13.43
TOTAL	135,252	119.15	13,691	47.03	148,943	104.42

Source: Statistics on Health Care Institutions with Boarding Facilities. Ministry of Health, Social Services and Equality, 2011.

In Spain, nursing staff are responsible for the management, evaluation and delivery of nursing care aimed at the promotion, maintenance and restoration of health. Nurses are also responsible for the prevention of diseases and disabilities. Within the nursing staff, we have to make a clear distinction between generic and specialised nurses (including midwives) on the one hand and nursing assistants on the other.

- **Nurses**

Nurses are university graduates. Until the Bologna Plan was implemented, aspiring nurses had to complete a three-year Bachelor programme. Now, they must study for four years, corresponding to 240 credits. The first

[23] Please note that in the Community of Madrid it is mandatory to register with the professional association, which facilitates access to this type of statistics. This is not the case for other Autonomous Communities, where registration is not mandatory. In April 2013, the official Nursing College of Madrid had 38,924 active registered nurses. 36,246 of these were Spaniards (94 per cent) and 2,478 foreigners (6 per cent).

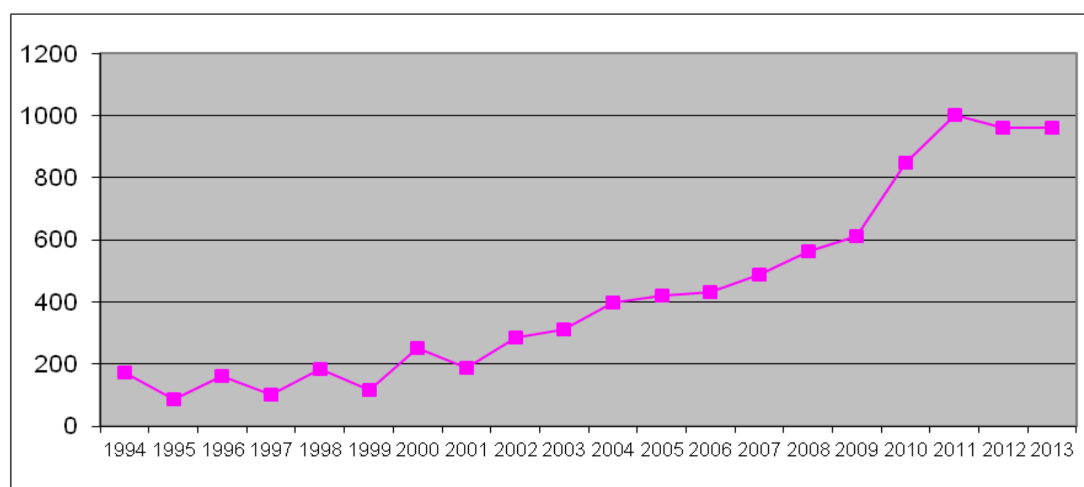
graduating class of nurses who followed the Bologna Plan will complete their studies in 2014. However, nurses who completed the three-year diploma only may take a levelling course to qualify for the graduate degree.

Nurses perform care, administrative, teaching and research duties. Their care functions are independent. A number of other duties (medication administration, special bandages and invasive techniques, such as venepuncture, essentially) are dependent or delegated by the physician.

Specialty training is the *conditio sine qua non* for working as specialised staff in both the public and private sector (see Royal Decree n. 450/2005). Nurses can only practice as specialised nurses once they have passed a national examination to start the corresponding specialty training as an *enfermero interno residente* (internal resident nurse). However, nurses can work as "generic nurses" without specialty training. This is not the case for doctors, who always need some kind of medical training to be employed in a hospital.

The duration of nursing training depends on the chosen specialty, but the usual period is two years. Internal nursing residents (*enfermeros internos residentes*, EIR) working in the Spanish National Health System have an exclusivity agreement with the Administration, and may not work elsewhere. During the first year, they receive 70 per cent of the standard salary, followed by 80 per cent in the second year. They are also paid extra for guard duties. According to OECD data, the salary of Spanish nurses is about 20 per cent higher than the average country salary, and comes off quite well from a comparative perspective (OECD 2013).

Figure 9: Availability of training slots in specialised nursing in Spain (internal nursing residents), 1994-2013.



Source: Report on nursing staff. Offer-demand 2010-2025. Ministry of Health, Social Services and Equality, 2012.

According to the Trade Union of Nursing (*Sindicato de Ayudantes Técnicos Sanitarios de España*, SATSE), the first training slots offered by the new specialty training modus (EIR) were for midwives. This is also the

specialty for which there are currently more vacancies and therefore more specialty slots available (SATSE, 29/04/2014). Calls for surgical nursing have not yet been published, although most nursing staff who work in hospitals work in this specialty field. Labour demand for the other specialties is increasing slightly each year, but none is are important as midwifery. The latest call for specialty training in nursing (2013-2014) offered 961 internal nursing resident positions: 953 in the private sector and 8 in the public sector. These were distributed as follows:

- Midwives: 395
- Mental health nurses: 182
- Occupational and environmental health nurses: 21
- Paediatric nurses: 106
- Family and community care nurses: 244
- Geriatric nurses: 13

- **Nursing assistants**

Nursing assistants have to achieve an average diploma after studying two academic training courses. Training is provided by special public courses financed by the Autonomous Communities or by private academies offering different types of vocational training. They are not university graduates and they are subordinated to nurses and physicians. They focus on disposal, hygiene and nutrition, as well as on oral and rectal medication administration and checking vital signs under supervision. However, they are not permitted to administrate intravenous or parenteral medication, and they may not make any diagnoses, use preventive techniques, perform scarification or punctures.

As members of the nursing staff, nursing assistants are present in the same workplaces as nurses and doctors, complementing their work either in hospitals (including services such as Intensive Care Unit or Administration), doctor's offices, dental clinics or health centres. For the same reason, as nurses, they are qualified for care and administrative functions, but not for teaching or researching.

There are no official schools for nursing assistants, so the only data available is provided by the Ministry of Health. According to the ministry, the number of nursing assistants working in the National Health System in 2011 was 114,748, 91,901 of whom worked in hospitals of the National Health System and 13,312 in private hospitals. If we compare the ratio of nursing assistants for every 100 beds, it can be seen that this ratio is much lower in private hospitals than in public ones.

Table 5: Ratio of nursing assistants for every 100 beds, Spain 2011.

	SNHS		Private		Total	
	Nº	*Nursing assistants per 100 beds*	*Nº*	*Nursing assistants per 100 beds*	*Nº*	*Nursing assistant per 100 beds*
General hospitals	89,048	96.41	10,516	60.51	99.564	90.72
Specialised hospitals	2,050	72.59	1,738	56.01	3,788	63.91
Medium and long stay hospitals	5,052	50.20	1,355	39.03	6,407	47.34
Psychiatric institutions and rehab centres	3,418	41.34	1,571	30.45	4,989	37.16
TOTAL	91,901	87.71	13,312	52.14	114,748	80.45

Source: Statistics on Health Care Institutions with Boarding Facilities. Ministry of Health, Social Services and Equality, 2011.

3.2. The demand for and hiring of foreign nurses

Statistical information about the presence of foreign nurses is scarce. However, the latest statistics indicate that there are few foreign nurses compared to native nurses. According to the latest survey by the Ministry of Health on the demand for foreign nurses, the total number of foreign nurses working in the Spanish National Health System in Spain in October 2009 was 279, or 0.2 per cent of the total number of nurses. Of these, 20 were midwives. This means that only 0.4 per cent of midwives working in the Spanish National Health System in 2009 were foreigners. As far as nursing assistants are concerned, only 172 were foreigners (0.2 per cent of the total).

The small number of foreign nurses may be related to the fact that foreigners' access to specialised training in nursing is currently limited by a cap of 2 per cent. This corresponded to a maximum of 19 specialty slots for non-EU foreigners in the 2013-2014 call (Ordenance SSI/1694/2013). Despite the small numbers, interviewed experts stated that the construction of new public hospitals during the economic boom had produced an increase in the demand for foreign nurses. Spanish students graduating from nursing schools were seeking employment in the new public hospitals, whereas they considered the private sector less attractive. Yet, nurses in public hospitals seemed to have better working conditions than in private hospitals, where employment is more precarious and nurses are subject to more rigid schedules, have fewer days off, and so on (SATSE 29/04/2014; CCOO 09/05/2014).

> "Working conditions in the public sector and the private sector cannot be compared. Sometimes a nurse earns half the salary of that in the private sector. Three years ago, in the public sector, the established workweek was 35 hours. Now it is 37.5. In the private sector, however, working hours may be extended to 40 or 42. The employer stipulates the conditions and the worker simply accepts them or not." (SATSE, 29/04/2014).

Moreover, private hospitals have fewer nurses employed than public hospitals, which means that each nurse is responsible for a larger number of patients (see again Figure 11). This puts private hospitals under greater pressure, leading to excessive amounts of work and more requirements from the client/patient (SATSE 29/04/2014; CCOO 09/05/2014). In this respect, the representative from a large medical association also stated that nursing staff are sometimes hired to work in private hospitals "just for a few days or hours". One of the problems generated by this type of contract is that temping agencies do not usually have enough information about professionals' expertise , which makes their adaptation to hospital demand more difficult (MEDAS, 14/04/2014). This is consistent with one of the few studies on the nursing profession in Spain, which points out that private hospitals used temporary employment to meet labour market needs in private hospitals (Ramió Jofre, 2005).

During the economic boom, the Spanish government tried to cope with the demand for nurses in the private sector by including this category in the Catalogue of Hard-to-Find-Occupations. Furthermore some private hospitals hired nursing staff directly from their countries of origin on the basis of bilateral agreements[24] (SATSE, 29/04/2014). In such cases, private hospitals also offered free accommodation to foreign nurses in exchange for their willingness to do double shifts (MEDAS 14/04/2014). In general, foreign nurses are assumed to be integrated quite well in Spanish workplaces. As a SATSE representative observed, it is assumed that foreign nursing staff's language skills are enough to interact with peers. This is also why hospitals' hosting protocols make no difference between native and foreign nurses:

> "In most cases, the centres' hosting protocols do not distinguish between nationalities since it is assumed that health professionals have sufficient language skills to interact with peers and do their job […] In the trade union we have not received any complaints related to this [diversity management A/N] since foreign nurses integrate quite well" (SATSE 14/04/2014).

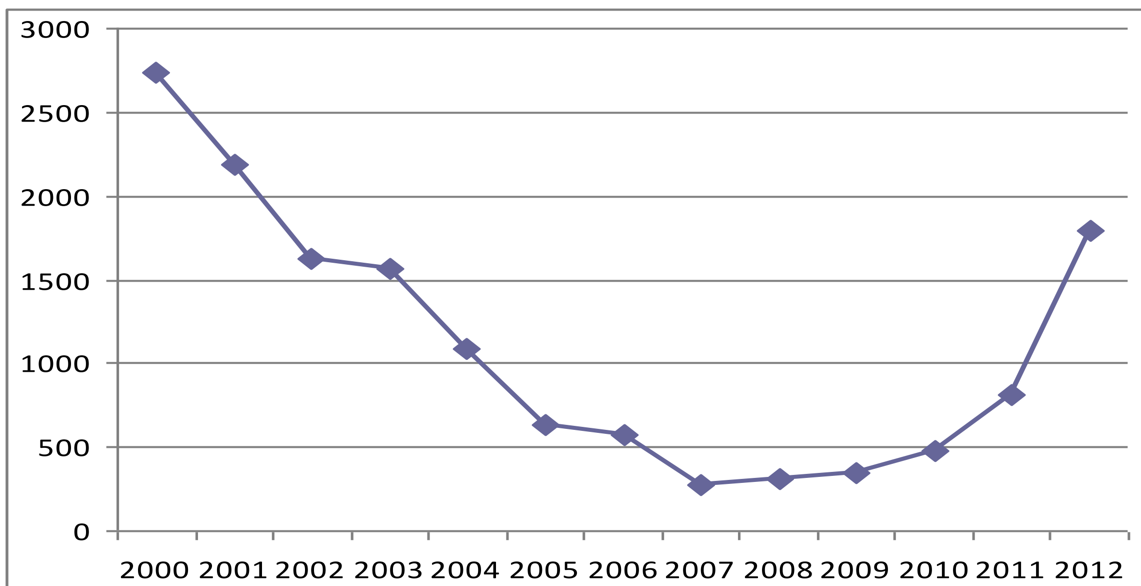
[24] The Spanish government signed bilateral agreements for the regulation of migration flows with the Dominican Republic (2001), Colombia (2001), Ecuador (2001), Romania (2001), Poland (2002), Bulgaria (2003), Ukraine (2009), Morocco (2001) and Mauritania (2009) and a cooperation agreement with Peru (2004). Spain signed the WHO-Codex in 2010, when collective recruitment on the basis of bilateral agreements had been already stopped because of the outbreak of the economic crisis.

3.3. The recognition of foreign credentials

Spanish nurses have a broad and varied scope of action, covering hospitals (all specialties), primary care centres, community health centres, and so on. Spanish nursing training is rated among the best in Europe; nursing training in other European countries is not as comprehensive (Revista de enfermería y desarrollo 2013). This means that Spanish nurses are in high demand compared to others. Especially after the crisis, the number of Spanish nurses emigrating to other countries seems to have increased considerably, as data on the accreditation of Spanish nursing degrees to work in other EU countries show (see figure 10).

However, this also implies that nurses who migrate from Spain to another country sometimes get their professional status downgraded considerably when forced to perform tasks that would apply to nursing assistants in Spain.

Figure 10: Accreditation of Spanish nursing degrees for the EU

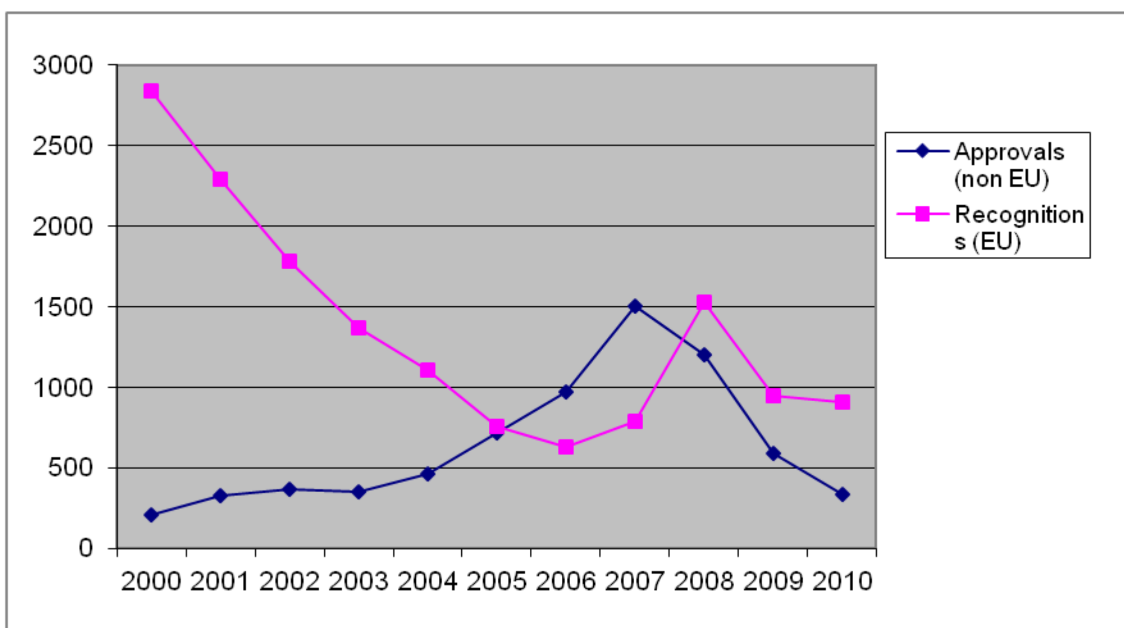


Source: Ministry of Education.

Regarding the recruitment of foreign workers in Spain, the recognition and certification of diplomas and qualifications from other countries undoubtedly represents a fundamental step. According to the director of the Observatory on Health Systems of the Trade Union CC.OO. (*Comisiones Obreras,* CCOO 09/05/2014), the recognition and approval of foreign university degrees is relatively simple compared to the recognition and approval of specialties, which can take several years.

The following graph shows the evolution of foreign credential recognition and approvals in nursing for EU and non-EU citizens, respectively. As can be seen, the recognition of EU degrees experienced a sudden and brief growth after 2007. By contrast, approvals of non-EU degrees started to decrease after the same date. Such an evolution could be linked to the fact that Romanian and Bulgarian citizens were entitled to apply for recognition after the accession of Romania and Bulgaria to the European Union in 2007. Overall, the recognition trend confirms that this employment field was less affected by immigration than the medical sector during the economic boom.

Figure 11: Recognition and approvals of degrees in nursing, Spain 2000-2010. (Number of degrees (head counts)



Source: Report on nursing staff. Offer-demand 2010-2025. Ministry of Health, Social Services and Equality, 2012.

Final remarks

Analysis has shown that the Spanish health care sector is still predominantly public, with a growing segment of public-private partnerships and a very high physicians/population ratio. Quite strikingly, the large number of physicians did not prevent the debate on the recruitment of foreign physicians. The 'segmented' character of the Spanish health sector, where demand for physicians was limited to certain specialties and geographic regions, promoted foreign recruitment during the economic boom. As was seen, lifting the foreigners' cap for medical training contributed to a considerable increase in the presence of foreigners among physicians in their specialty training, while access by non-EU specialists remained difficult. Notwithstanding this, the possibility of

young non-EU doctors to obtain a permanent job after training was limited by nationality criteria since most of these positions are reserved for Spanish and EU nationals. Moreover, cumbersome recruitment procedures represented an obstacle for non-EU specialists, despite the inclusion of physicians in the Catalogue of Hard-to-Fill-Occupations. In fact, specialty recognition seems to be much more restrictive and difficult to achieve for non-EU doctors, while the recognition of medical degrees takes about one year. However, growing unemployment in the Spanish health care sector due to the crisis shows that the international recruitment of foreign physicians in particular was characterised by a short-term perspective that failed to tackle the structural problems in the health sector while a large number of medical trainees were hired without considering their real long-term possibilities of being integrated into the labour market after completing their training.

The presence of foreign nurses is less remarkable than the presence of foreign physicians. However, interviews indicated that during the economic boom private hospitals had to recruit foreign nurses while natives sought jobs in the more attractive public sector, where exploitation is less frequent and salaries are quite fair in international comparison. Overall, it can be argued that the presence of foreign nurses seems to be particularly relevant in private hospitals, while specialty training in the public sector seems to be the most relevant entry channel for foreign doctors in Spain. Interestingly, the novel presence of foreign workers in the Spanish health sector never raised the issue of workplace integration. In particular, the language issue was never very prominent in the debate about the recruitment of medical and nursing staff in Spain due to the overwhelming presence of health workers from Latin America, who are thought to integrate easily into the Spanish health care sector.

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Gaceta Medica, 24/05/2013

El País, 15/12/2012

El Periodic, 16/12/2009

La Vanguardia, 16/10/2007

Levante-emv.com, 27/01/2009

Online sources

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- Ministry of Health, Social Services and Equality. 2012. Informe sobre profesionales de enfermería. Oferta-Necesidad 2010-2025. http://www.mspsi.gob.es/novedades/docs/Estudio_necesidades_enfermeria.pdf
- Ministry of Health, Social Services and Equality, 2012. National Health System. Spain 2012. http://www.msssi.gob.es/estadEstudios/estadisticas/sisInfSanSNS/home.htm
- National Health System of Spain. Annual Report 2010. Ministry of Health.
- Revista de Comunicación y desarrollo 2013.
- Social Services and Equality, 2011. https://www.msssi.gob.es/home.htm

- Spanish ministry of Health, Social Services and Equality: https://www.msssi.gob.es/home.htm
- Statistics on Health Care Institutions with Boarding Facilities. Ministry of Health, Social Services and Equality, 2011. https://www.msssi.gob.es/estadEstudios/estadisticas/bancoDatos.htm
- Orden SSI/1694/2013, de 12 de septiembre, por la que se aprueba la convocatoria de prueba selectiva 2013, para el acceso en el año 2014, a plazas de formación sanitaria especializada para graduados/diplomados en Enfermería.
- Orden SAS/2158/2010, de 28 de julio, por la que se modifica la Orden de 27 de junio de 1989, por la que se establecen las normas reguladoras de las pruebas selectivas para el acceso a plazas de formación sanitaria especializada.

Expert interviews

No.	Department	Day and Place of the Interview	Quoted as
1	Unión General de Trabajadores (UGT), Trade Union, Immigration Section	Madrid, 27/05/2011	UGT 27/05/2011
2	Confederación Española de Sindicatos Médicos (CESM) / Spanish Confederation of Medical Trade Unions, Department of Research	Madrid, 17/10/2011	CESM 17/10/2011
3	Consejo General de Colegios Oficiales de Médicos / General Council of Physicians professional corporations	Madrid, 24/07/2013	CGCOM 24/07/2013
4	Consejo General de Colegios Oficiales de Médicos	Madrid, 13/09/2013	CGCOM 13/09/2013
5	Consejo General de Colegios Oficiales de Médicos	Madrid, 08/04/2014	CGCOM 08/04/2014
6	Medical association	Madrid, 14/04/2014	MEDAS 14/04/2014
7	Sindicato de enfermería / Nursing trade union	Madrid, 29/04/2014	SATSE 29/04/2014
8	Observatory of Health Policies of the trade union *Comisiones Obreras*	Madrid, 09/05/2014	CCOO 09/05/2014
9	Ministry of Health, Social Services and Equality	Madrid, 05/06/2014	MSSSI 05/06/2014