Assessing and Enhancing Integration in Workplaces

POLICY BRIEF

Diversity and Integration in Workplaces: Focus on Healthcare Sector in the EU

Anna Platonova and Eva Pons
International Organization for Migration

INTRODUCTION

Employment is widely considered a key stepping stone to successful integration of migrants in the economies, but also wider societies of their new residence. Work supports independence and self-reliance, as well as fosters interaction with community residents beyond migrants' immediate household. However, limited evidence exists on the exact nature of workplace processes and their impact on migrant socio-economic integration on the one hand, and on the capacities of European economies to attract and retain skilled workers on the other hand. In fact, at times effective integration in the workplace is taken for granted in the broader policy discourse.

WORK-INT is a research and advocacy project aimed at better understanding, increasing awareness and stimulating better policies and practices targeting workplace integration of migrant workers in the EU. The project focused on the healthcare sector and targeted five European cities hosting large numbers of migrant workers: Dublin (Ireland), Hamburg (Germany), Oxford (UK), Madrid (Spain) and Turin (Italy). Primary research was carried out in public and private hospitals in these five cities respectively by the Trinity College of Dublin, Hamburg Institute of International Economics (HWWI), Centre on Migration, Policy and Society (COMPAS) University of Oxford, Complutense University Madrid, and the International and European Forum of Migration research (FIERI). To draft this policy brief, the International Organization for Migration (Brussels-based Regional Office for EEA, EU and NATO) compiled and further analyzed key policy-relevant findings of the national reports produced by the five project research partners.[1] The proceedings of the final project conference in Brussels on 9 June 2015 helped finalize this document.

Healthcare sector was selected for its crucial importance in employment of migrant workers in the EU, and the projected growing future labour needs due to ageing population in the EU. According to the European Observatory on Health Systems and Policies (2010), healthcare

[1] WORK-INT regional and national research reports are available at project website: http://www.work-int.eu

sector jobs account for 10 per cent of overall employment in Europe. The European Commission (2012) estimates that in 2020 over five million healthcare jobs will require highly qualified people, followed by around 3 million openings for medium-skilled staff and some 200,000 jobs for low-qualified workers. At the same time, the projected shortages of healthcare workers by 2020 in all groups range between 13.5 per cent for physicians and for dentists, pharmacists and physiotherapists and 14 per cent for nurses.[2] Thus, healthcare sector provides jobs for various occupations and at various skill levels, ranging from medium to highly skilled. In addition, focusing the research on healthcare allowed for analysis of workplaces (public and private hospitals and a nursing home in Italy) where skilled migrants are employed alongside native workers, thus enabling the research team to better reflect on aspects of skill development and workplace interaction and socialization.

SPOTLIGHT ON EVIDENCE

1. RELIANCE ON MIGRANT HEALTH WORKERS

The European Center for Development of Vocational Training (CEDEFOP) identifies healthcare as an area of high priority for future skills and occupational needs[3]. In the ageing European Union, Member States are facing an increasing pressure on their health and social care systems, where rising demand for healthcare services meets growing shortages of skilled healthcare workers, including nurses, medical specialists, and health technicians. Indeed, at the EU level, health professions are at the same time the occupational group with the fourth most important reported shortage of workers[4] (with 21 Member States reporting shortages) and one of the five sectors identified as having the most significant future growth potential[5].

To address these shortages and the anticipated future growing needs for professionals in the healthcare sectors, healthcare institutions have increasingly resorted to the recruitment of foreign health workers, both within and from outside the European Union. Over the past decade, new immigrants in Europe have represented 15 per cent of entries into strongly growing occupations, such as health, science, technology and engineering[6]. Today human health and social work is the second sector for employment of foreign female citizens within EU countries (13% of total female foreign citizens[7]).

Countries surveyed by WORK-INT project have been facing diverse health worker shortage levels in various occupations, and subsequently have adopted varied policies to address growing needs of healthcare professionals.

[2] European Commission (2012). Commission Staff Working Document on an Action Plan for the EU Health Workforce, Accompanying the Document Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions: Towards a Job-Rich Recovery. SWD(2012) 93 final.
[3] CEDEFOP (2009), Sectoral flash on healthcare.
[4] EC (2014), Mapping and Analysing Bottleneck Vacancies in EU Labour Markets, Overview report, Final: p. 10
[5] European Commission (2014), European Vacancy and Recruitment report 2014. Healthcare sector is cited next to ICT, Engineering, Teaching and Finance.
[6] OECD / European Union (2014), Matching Economic Migration With Labour Market Needs In Europe – Policy Brief; new immigrants defined as all new entrants (EU and non-EU) residing in the country for 10 years or less.
[7] In comparison Human Health and Social work occupation employ 17% of female nationals - Eurostat, LFS 2008 as cited in Migrants in Europe; page 95.

The UK and Ireland have been relying on foreign recruitment for quite some time to mitigate the staff shortages and the presence of migrants in the healthcare system is already significant. In the United Kingdom, non-UK born health workers represent around one fifth of all nurses and one third of all medical practitioners, which is considerably above the share of non-UK born people in total employment of 15.2 per cent. According to 2014 data, 10 per cent of doctors in the General Medical Council (GMC) medical register obtained their primary medical qualifications in an EEA country, while just over a quarter (26%) were (non-EEA) medical graduates.

Likewise, Ireland has turned to overseas recruitment to mitigate the staff shortages that the country has been experiencing for a number of years, partially a result of the continuing emigration of native doctors and nurses to countries such as UK and Australia for better pay and working conditions, and improved career opportunities. While nurses can find better earnings abroad, doctors usually leave the country due to obstacles to career progression and an insufficient number of consultancy posts available. It is important to highlight that Ireland witnessed an increase in immigration in the mid-90s and 2000 which means that the country, as most of its hospitals in the country became multicultural within less than a decade.

The German healthcare sector is marked by a significantly lower unemployment rate than the overall economy. The sector faces growing labour shortages of skilled health workers and some initiatives for recruitment of migrant health workers abroad were launched, Active recruitment abroad is still at an initial phase and migrant health workers mostly come by their own initiative. To facilitate their migration, the regulatory framework for both immigration and recognition of qualifications was recently improved. In 2012, some 150,000 foreign nationals worked in healthcare in Germany, comprising 5.4 per cent of all workers in the sector.

The crisis-hit Spanish national healthcare system has been undergoing important spending cuts in recent years. Recruitment of professionals in this heavily public system is strongly regulated and accessible mostly to nationals and to some extent EU citizens. While some recruitment of foreigners was indeed possible prior to the crisis, avenues for migrations of third country health professionals have been shut down in the current downturn, leading to a minimal presence of migrant health professionals (less than 5%) in the Spanish healthcare system.

In Italy, substantial shortages of professional nurses have arisen in the late 1990s, as a result of in-depth reforms of the educational system for nurses. Active recruitment of nurses from abroad was adopted as a deliberate strategy to fill existing shortages since this period up to the mid-2000's. In addition, the subsequent increase in the supply of both native and foreign-born nurses graduated from the Italian universities has further reduced the supply shortages for this group. The nursing assistant occupation was introduced in Italy in 2001, and since then has been increasingly filled by migrant workers, representing today between one fifth and one fourth of the total employment in this occupation. Nursing assistants, in particular, are mostly employed in long-term care facilities for the elderly. The number of foreign doctors in this country remains relatively low both in absolute terms and if compared to other European contexts.

2. ACCESS TO LABOUR MARKET AND RECRUITMENT PRACTICES

Countries studied by the project have shown a range of approaches to recruitment of foreign healthcare professionals in the past years. In the 1990s and the 2000s many countries saw through liberalization of immigration provisions, in some cases accompanied by active international recruitment strategies on behalf of employers. In the UK, the non-EEA qualified doctors could enter the UK on a short-term non-work visa and apply for jobs within the UK

prior to 2008. Ireland issues foreign healthcare professionals with Critical Skills Employment Permits below the usual earning threshold. In early 2000s, Italy introduced a preferential admission channel for direct recruitment of nurses from abroad, exempting this occupation from the quantitative caps imposed by national quotas for labour immigration. In Spain, physicians were included in the catalogue of shortage occupations that allowed hospitals recruiting non-EU physicians abroad without a labour market test.

The economic crisis that started in 2008 led to the reversal or reform of many of these policies for admission of healthcare workers from outside the EU, resulting in greater reliance on mobile EU workers.

In the UK, the recent tightening of migration laws[8] has strongly affected the possibilities for third-country medical staff to advance and pursue a career in the country. Some migration and career paths that were possible some time ago have been completely strained. Hence third-country doctors can now be hired in the framework of the Migration Training Initiative[9] or short-term posts with very little possibility to remain in the country.

In Spain, in the wake of the economic crisis some health care professions were removed from Catalogue of Shortage Occupations, the cap for admission of non-EU resident doctors was lowered, and residence permits after completing specialty training were no longer granted. For most interviewees in Spain, the administrative burden of immigration procedures and the need to renew residence and work permits frequently were central complaints, which also had an adverse effect on their sense of social belonging.

In Italy, the ban on public employment of non-EU workers was introduced and has only been lifted in September 2013 for selected categories of non-EU workers. The large majority of migrant (non-EU) health workers are thus found to be employed mainly in the private sector, or to work within public health facilities through private employment arrangements, as outsourced staff. This broad category includes all staff working within the hospital but employed, thus working under the conditions of external agencies, either by social cooperatives and temporary work agencies or as self-employed (through specialized professional agencies). Both for professional nurses and nursing assistants, the financial constraints in the health sector brought about by the economic crisis have substantially affected patterns of recruitment and employment. Whereas those that obtained their qualifications some years ago did not wait too long before finding stable employment in the health sector, both in public and private facilities, professionals entering the job market in the last few years struggle to get access to permanent jobs and often find themselves trapped into precarious forms of employment.

In Germany, foreign-trained doctors often come for specialty training. Reasons for choosing Germany are reputation for good specialty training and research opportunities, possibilities for scholarships and previous experience in the country. Some nurses were recruited in periods of shortages in nursing in the1970s, 1990s and in the 2010s. Nurses often migrate for non-economic reasons and do the vocational training in nursing in Germany. Interviewed migrants particularly from non-EU countries reported initial difficulties to obtain their work and residence

[8] Introduction of a requirement of a firm job offer on the basis of the Resident Market Test (RLTM) and a Certificate of Sponsorship from the employer; removal of most nursing and many medical and allied health posts from the Home Office shortage occupation lists compiled by the Migration Advisory Committee.

[9] The Medical Training Initiative (MTI) is a national scheme designed to allow a small number of doctors to enter the UK from overseas for a maximum of 24 months, so that they can benefit from training and development in NHS services before returning to their home countries.

permit that was often related to the capacity of administrative staff of public agencies who were perceived by migrants to be insufficiently competent or lacked English skills.

The project sample revealed extremely diverse past experiences and practices of foreign recruitment among the analyzed Member States. Some countries have engaged in active recruitment abroad, dedicating staff or concluding agreements with recruitment agencies in the countries of origin (Ireland, UK, Italy). In some cases, fraudulent practices by private recruitment agencies were reported in relation to recruitment from outside the EU. Germany mostly filled the vacancies by workers already present on the national labour market, with some targeted initiatives on recruitment of nurses and care workers carried out in the framework of bilateral agreements with the countries of origin.

The analysis highlighted the convergence in recruitment strategies in the context of intra-EU mobility that occurred in the past years as a result of both EU enlargement (with freedom of movement and automatic mutual recognition of medical qualifications) and crisis-driven restrictions on recruitment of healthcare workers from outside the EU. Indeed, in all project countries – regardless of the history and level of reliance on foreign recruitment – these factors have significantly shaped recruitment preferences and practices in the healthcare sector towards EEA medical workers. Past practices in recruitment of third country nationals that were often influenced by bilateral agreements or common history between host and sending countries, have been gradually replaced by employment of migrant health professionals from Southern, Central and Eastern EU Member States. Burdensome administrative procedures for hiring of third country nationals and considerations of brain drain additionally supported this shift in recruitment practices.

German participants in particular reported that the lack of reliable partners for international recruitment complicates hiring of migrant workers in their countries of origin. Managers in both hospitals studied receive frequent offers from private recruitment agencies but in many cases mistrusted their competences. Hence, having reliable partners that support the recruitment procedure in the countries of origin appeared to be needed. For instance, cooperation with state institutions such as the Central Placement Office of the Federal Employment Agency was well perceived.

In contrast, Irish public hospitals have experience in operating the recruitment directly, while the private hospital surveyed rather relied on local agencies in the country of origin to organize interviews during their recruitment trips to Eastern or Southern EU countries.

Nevertheless, several countries continue their efforts to attract international students in medical studies, though with varied success in terms of retention. In the case of Italy, direct recruitment of staff trained in Italy has replaced the international recruitment processes for nurses.

3. INDIVIDUAL INTEGRATION PERSPECTIVES OF MIGRANT PROFESSIONALS

3.1. RECOGNITION OF QUALIFICATIONS

In all countries participating in the study, for EEA/EU doctors and nurses alike automatic recognition of competences was in place and recognized by all managers as an incentive to recruit within Europe. For non-EU trained doctors and nurses the situation and requirements vary depending on the combination of factors pertaining to countries of origin and destination.

In the UK, medical doctors with qualifications obtained outside the EEA have to sit a professional and linguistic assessment board exam and pass a standardized language test. In addition, non-EEA doctors are less likely to have their qualification recognized. An adaptation period of between three to six months in a hospital working at a supernumerary or less than registered nurse level – e.g. unregistered nurse or healthcare assistant – has, until a few months ago, been a longstanding requirement for nurses coming to the UK from outside the EEA.[10]

Recognition of qualifications appeared to be less of an issue to Irish participants, and the main procedure mentioned was the adaptation or shadowing period. However, there was evidence of some downward occupational mobility upon their first access to the health sector in this country. This implies that individuals' credentials are recognized and they are able to be employed in their professions, but their previous practice would not be fully taken into account, leading them to practice below their original level/capacity. Such downgrading was mentioned as a serious issue for some of the physicians, especially if they aimed to achieve consultancy posts in Ireland. Nurses trained outside the EEA have to undergo an "adaptation period" of at least six weeks, which can take place in another hospital than the one they are hired by. Non-EEA doctors who were trained outside of Europe on the contrary did not require such a formal process of adaptation. They rather had to undertake what they called a 'period of shadowing' or 'attachment'. Their colleagues trained in Europe, and their EEA nationals colleagues do not undergo a period of shadowing and are put on the job directly (they actually declared lacking adaptation time as a disadvantage).

In Germany, recognition of competences was a key concern for third-country migrant health workers. Participants perceived the procedure as burdensome and lacking transparency, particularly before the Recognition Act of 2012. Until 2012, non-EU doctors were only entitled to temporary licences to practice their profession that tied the doctor to the specific state (*Land*) and did not allow being self-employed. The 2012 Recognition Act abolished the legal difference between doctors from EU and non-EU countries and since then, non-EU doctors can obtain a full license to practice their profession and set their own medical practice. They still undergo individual assessments of equivalence of foreign qualifications and in case of non-equivalence with German standards have to pass an exam. Some attend courses for foreign trained doctors in order to prepare for the recognition exam, which are costly, but well valued by the doctors. Foreign-trained nurses also have to recognise their qualification from abroad and during the recognition procedure, they often work as nursing assistants. Despite being employed below their qualification, this period is mostly perceived as a valuable experience. In cases, where lack of recognition of the qualification prevented migrants from working in their profession, interviewed foreign health workers felt deskilled, but eventually successfully changed to other health-related occupations.

In Spain, foreign credentials recognition is a condition *sine qua non* to participating in the central examination for residency or working as a specialist doctor. For Latin American doctors, the procedure depends on the agreement of the Spanish authorities with their country of origin. Some of the interviewees stated that the procedure could be cheaper, faster and less cumbersome in order to accelerate the issue of the corresponding visa. Interviewees would appreciate more information and transparency on recognition criteria and procedure, the lack of

[10] Since October 2014, new applicants from outside the EEA for nursing posts need to sit a theory and clinical examination similar to the examination for doctors qualified outside the EEA, to obtain registration in the Nursing and Midwifery Council and seek to practice. They do not then require an adaption period (see UK background report).

which currently creates vulnerability and uncertainty for migrant health workers. Nurses from outside the EU also need to have their credentials recognized, however this affects mostly nurses with university degrees and not so much nursing assistants.

While in the past the system of recognition of foreign qualifications in the health sector in Italy was burdensome, lengthy and expensive, and characterised by a certain degree of arbitrariness, in more recent years it has become more transparent and efficient – shifting from a central to a regional organizational management – and has become much faster and more streamlined, in particular for new EU members. As for the relatively new nursing assistant profession, local authorities hold a great deal of autonomy in setting the rules related to training and employment in health and social care services of this category. Credentials for nursing assistants can only be acquired locally, once in Italy, and other qualifications acquired abroad are not recognized.

While automatic recognition of qualification has strongly promoted mobility of EU mobile health professionals, there are still some shortfalls within the system. While EEA nurses benefit from recognition of qualifications, the different system of regulation of competencies in the UK means each skill has to be demonstrated and formally signed off before a nurse is allowed to perform certain procedures, though clinical training in some European countries may in fact be more extensive. The formal requirements do not allow the nurses to undertake procedures that they may already be competent in, and this is a significant source of frustration for migrant staff. In Germany, EU mobile workers see their medical degree smoothly recognized, but may experience difficulties with the recognition of their specialty training if the latter is not fully comparable to the German training.

3.2. DIVERSITY MANAGEMENT POLICIES AT A WORKPLACE LEVEL

A variety of approaches have been identified in the five countries with regard to integrating migrant health professionals in the hospital workforce, depending on the duration of experience in employing such workers and prevailing management practices.

In the UK beyond the traditional equality and diversity initiatives for the wider workforce, increasing attention has been paid in last five years to developing targeted support measures for migrant health professionals in their transition into the British health sector. The need for specific induction packages and extra support in the initial work period has been increasingly recognized. NHS Employers, the organization that supports employers in the National Health Service, have had a particularly active role providing guidance to employers and promoting best practice. Although online advice and information pages are available from many organizations[11], there is a general recognition that more could be done. In the UK public hospital surveyed, nurses underwent an induction period during which they received training in order to have certain skills recognized and their competencies signed off. This was followed by a four to eight week supernumerary period. These nurses were also offered a ten-week free English language course and were provided with more practical pastoral support. In the case of overseas doctors entering the Migrant Training Initiative programme, once again a more specific package is put in

[11] For instance the British Medical Association has an online guide for doctors new to the UK covering immigration, registration, access to training, indemnity, contracts and working conditions, as well as where to seek further information. Members can also seek advice from the BMA's immigration services. The Royal College of Nurses (RCN) offers a similar service to nurses and midwives: an online 'frequently asked questions' page for nurses and midwives from overseas is complemented by an immigration advice service offered to members. In 2013, the General Medical Council (GMC) ran a pilot programme: Welcome to UK Practice (http://www.gmc-uk.org/doctors/WelcomeUK.asp)

place. This includes a workshop on communication, a designated contact person to provide practical and pastoral support, and a slower induction period with a few days observing, then a period of buddying before being put on the rotation directly. Interestingly the private hospital did not institutionalize special support, it was rather provided on an *ad hoc* basis.

The Irish public hospital surveyed also has practices put in place to support foreign incoming staff. During the former recruitment rounds for foreign nursing professionals, there was for instance a dedicated officer supporting the incoming overseas nurses. On the whole, in Ireland integration of foreign staff appears very much tied to the broader concerns of managing diversity in a multicultural workplace. The surveyed public hospital employed a Cultural Diversity Officer until 2008 who was responsible for raising cultural awareness around the hospital. This included organizing a cultural diversity day with presentations about different countries and nationalities, but also providing a cultural diversity module as part of the induction for new staff. This module focused on working with people of different cultures as well as caring for patients of different origins. Nonetheless the current focus of diversity management is primarily on patients and the quality of care delivered to those coming from different cultural backgrounds.

In Germany as well, the question of migrant health workers is marginally linked with diversity in the workplace. Both surveyed hospitals signed the Charter of Diversity and commit to diversity in the workplace without having a detailed diversity management strategy in place. The presence of migrant health workers has not yet led to any notable institutionalized integration practices, except in the case of specific pilot programmes for recruitment of trainees in nursing from Tunisia and Italy. Participants in these programmes attended language courses and received support in administrative proceedings. Migrant health workers benefit from the general support measures for new workers in the beginning of employment such as orientation days, information materials and mentoring. Integration is thus put at team level: head doctors or head nurses are trained team managers and are expected to take care of the integration of the migrant health workers in the team. Challenges can occur particularly in a context of frequent staff turnover, staff shortages and overstretching of teams or when the qualifications of the migrant are mistrusted by the team.

In Spain, active measures towards supporting ethnic and cultural diversity did not appear to be an institutional priority, neither at governmental not at hospital level. Presence of migrant health workers is seen as primarily as an organisational and staffing question: "diversity is relevant in terms of human resources planning". Migrant health workers are "a minor part" of the workforce, hence the hospitals believed there was no identified need for particular integration measures. Integration is supported through "distribution of the hospital guide, welcoming and farewell parties". All newcomers are introduced to hospital life by their new supervisors and receive the human resources' introductory day, but no measures focus specifically on diversity management. It is also important to note that the ministry and hospitals' action protocols take into account the cultural and linguistic diversity of immigrant patients to only a very small extent.

In Italy neither explicit, nor implicit diversity management practices have been observed in either of the surveyed health facilities. The need to envisage ad hoc measures to address the cultural diversity of staff was generally underplayed and the fact that workers should be treated equally, regardless of their nationality or cultural origin was generally stressed in the first place. Such lack of attention over the cultural diversity of the foreign workforce was explained by interviewees by the overall cultural and social homogeneity of migrant health workers in the health facilities. Most of them are in fact of European or Latin American origin; therefore they speak foreign languages which are usually very close to Italian, which facilitates their communication skills. As a

result, no specific introduction initiatives for migrant workers was foreseen, nor presented as necessary.

3.3. ACCESS TO TRAINING

In the UK, the career of recently arrived overseas doctors seems stuck in either fixed-term or permanent posts that disadvantage them in many ways, but are useful to the hospital for filling gaps in staffing. These posts generally have fewer straightforward opportunities than training posts for career progression, study leave, conference funding, personal development, regular appraisal, and updating of skills. A very recent General Medical Council (GMC) online report showed that doctors with an undergraduate medical degree from outside the EEA were less likely than UK graduates to obtain a specialty or general practitioner training place. The work histories of WORK-INT diverse interviewees suggest that this may only partially be explained by immigration regulations, such as the application of the labour market test for entry to training schemes. Efforts have been made to try to improve the situation of these doctors. There are patient safety issues at stake in not promoting updating of skills, and the recent GMC requirement for revalidation of fitness to practice of all licensed doctors may eventually provide more opportunities for doctors in 'service' posts in the hospital to gain access to training courses and appraisals more routinely.

In Ireland, according to interviewee nurses, training was available in both hospitals. However, it was not always recognized by employers in terms of pay (in the private hospital) and it was in general very difficult to be allowed time to take the training. Foreign trained medical doctors reported facing institutional discrimination on access to training posts ie. national regulation prioritizing Irish and EU doctors in accessing higher specialty training.

In Italy the access to training opportunities at work is heavily constrained for health workers who are employed by social cooperatives or are self-employed. The latter are in fact less constrained than public employers to provide training to their employees and less keen to invest their own resources in training their workforce. However, migrant health workers permanently employed by public hospitals that participated in the study have the same opportunities of their Italian colleagues to receive training at work.

3.4. CAREER OPPORTUNTIES

In the UK there is evidence that migrant health workers are disadvantaged in accessing the linear training pathway and posts with a built-in career mobility. Doctors from non-EEA countries are more likely to get stuck in short-term position and slow career progression, even though it is recognized that being educated in the Commonwealth countries, their training is closer to that in the UK. Likewise, for nurses from the EEA the automatic recognition of qualifications means that it is easier for them than for nurses from outside the EEA to start working upon arrival at the level of their qualifications. This has impact on the speed at which they can achieve career progress. In the UK, migrant health workers also noted that family constraints – exacerbated by the lack of social network to support them and the distance to travel home – were an important obstacle to their career advancement. It was perceived that in the private hospital the smaller and more intimate working environment offered a greater opportunity for individualized, innovative working practices which are more visible to and rewarded by the management.

In Ireland, it was felt that non-EEA doctors recruited to fill positions that were unattractive to natives (though not supported by hard evidence) and mostly in "service posts" that are not part of any formal training schemes and offer limited opportunities for career and professional development. The few who succeed in securing consultancy posts have had to find their own niche training path. For nurses however, good promotion opportunities were offered, and in fact several nurses who had arrived in the 2000s were now in higher posts. However it is interesting to note that many migrant nurses refused promotions in order to keep the possibilities for extra and week end shifts which are well paid and allowed them to send more money back. The raise in pay for a management position would not compensate this loss.

Migrant health professionals in surveyed German hospitals are usually employed corresponding to their level of qualification. Career opportunities depends on the level of qualification of the individual and vary among occupations. Some doctors and nurses were concerned about possible difficulties in access to learning opportunities. Dissatisfaction was expressed by some foreign-trained nurses with university degrees who in Germany tasks primarily in basic care, which is atypical for the healthcare systems in their countries of origin, and could potentially complicate their employment upon return.

In Spain migrant health professionals considered that they could face issues having their speciality and experience in Spain recognized upon return to their country of origin. However, most interviewees did not aim to return to their country of origin which reinforces the imperative to create sustainable professional conditions for them in the host country.

In Italy evidence suggests that long-term labour trajectories of foreign nurses consist of mainly horizontal mobility paths, e.g. professional transitions within the same functional status. The most recurrent forms of nurses' mobility imply shifts from private to public employer, often within the same hospital, by obtaining access to permanent employment through public competitions. However, this option is only available to the EU mobile citizens or naturalised workers. The reverse path was also registered among the interviewees who, after having obtained a permanent job in public hospitals, decided to go back to self-employment by joining professional associations for economic (higher gains) and personal reasons (more flexibility to better balance work and family life). Career opportunities seem overall quite limited for both professional nurses and nursing assistants, and both in public hospitals and private structures. For this same reason, increasing outflows of Italian professional nurses and doctors are registered, mainly to Germany and the UK.

4. WORKING TOGETHER: MIGRANTS AND NATIVES IN THE WORKPLACE

4.1. TEAM WORK

In the UK, most doctors and nurses had positive working relationships with their multicultural teams, stating that getting along is imperative due to the nature of the working environment (long shifts, pressure, decision making, staff shortages). The diversity of staff teams in both the National Health Service and private hospital was generally welcomed. Senior staff of whatever nationality felt that often migrant nurses especially brought in new skills and new ways of working that were beneficial for teams. Contribution in terms of filling gaps and catering for a diverse population was also mentioned. Migrants themselves on the other hand spoke of frustration they sometimes felt when confronted with team working practices in the UK hospital they felt were less positive for both staff and patients.

In Ireland, diversity was highly valued by colleagues and perceived as an asset, among other things for ensuring quality care for diverse population.

In Germany, qualifications of migrant health workers were considered the most important factor for successful integration in the team. There was some emphasis on the added value of diverse healthcare workers to address an increasingly diverse clientele. Still in German interviews, unlike in UK, much attention was placed on the personal characteristics and qualifications more than any cultural background ("*integration depends on personal characteristics*"). Working in multicultural teams is rather appreciated and seen as an asset to the working atmosphere and the working process. Migrant health workers declared to prefer working in multicultural teams so that they were not the only foreigners.

In Spain, supervisors did not state that "being an immigrant" or diversity were of value *per se*. However, the migrant health workers argued that they were perceived in the teams as non-problematic and non-conflictual. They were also recognized as an asset in terms of experience and language, and for facilitating human resources planning (different leave preferences and so on). Lastly, they at times provided a new vision and some constructive criticism for its improvement thanks to their knowledge of different healthcare systems. Particularly nurses and doctors from Latin America were recognized as excellently trained and trustworthy. As mentioned above, Spanish managers saw no need for diversity management measures since there were not very many perceived differences between native and migrant health workers. Interestingly, almost all of them interpreted the lack of difference as the absence of Muslim staff. Native staff members explained diversity management measures were unnecessary, because of their perception of the lack of racism in Spanish society and of Spain as a very multicultural country.

Italian colleagues and supervisors mostly declared to be very satisfied with collaboration with their foreign colleagues, acknowledging appreciation of their professional abilities and showing some sympathy for the difficulties they experience, especially when facing hostility or openly racist attitudes on the part of patients. However, the good level of relational integration emerging from the interviews carried out with foreign and Italian workers is not the outcome of *ad hoc* measures undertaken at the workplace level, but rather of informal and spontaneous interaction in everyday work, depending more on individual attitudes and willingness – on both parts – to collaborate in the best and most harmonious way.

4.2. LANGUAGE AND COMMUNICATION

Communication plays a key role in health care and was consistently raised as one of the main challenges for migrant health professionals. In all interviews from the field studies, language and communication were the first and main difficulty expressed by migrant health professionals and by their colleagues. In Germany, mostly foreign-trained health workers that usually come from non-German speaking countries reported language difficulties at the initial stage of employment and the need to put much effort in learning the language on the job, whereas migrants who obtained their qualification in Germany used the time in education to obtain good language skills before taking up employment. In the UK and Ireland, this issue could also emerge with regard to EEA/EU medical staff (often from Southern Europe), while overseas migrant health professionals usually originated from English-speaking countries (India, Philippines, Pakistan). In Spain most non-EU migrant health workers came from Latin America, so the emphasis was rather on different accents and variations of the language than language skills per se.

The 'language barriers' went well beyond simple language competences in all national reports. Challenges included cultural forms of communicating (politeness, empathy display); knowledge of idioms, colloquialisms and terminology; and accent. In the UK and Ireland, accent came up as an issue both in that it affected understanding between colleagues, but also in how patients reacted to migrant workers with accents. Whilst accent can impair communication, it is also important to recognize that people can speak a language to a very, very high standard and still retain an accent.

In the UK, issues around language and broader 'cultural communication' identified by interviewees included receiving society expectations of polite forms of speech and body language, but also using languages other than English in the workplace. It was also highlighted that different habits / culture regarding learning and training could harm the performance (or perceived performance) of migrant health workers in learning settings. Measures of support included tailored induction, mentoring, compilation of lists of medical and common English abbreviations. In Ireland, where a lot of the migrant health workers were trained in English, language barriers and cultural communication were also mentioned as the prominent difficulty to overcome.

The use of country of origin languages by some migrant staff in the UK and Italy was raised as an issue. Subsequently, in the surveyed UK hospital measures were introduced that tried to balance freedom of expression in break times and language use that might impair team work. In the Italian nursing home, the management addressed the issue by forbidding communication in foreign languages.

It was also recognized in the UK and Ireland that in order to improve cultural communication, migrant staff might need some guidance from native colleagues. Awareness of these issues, including on the part of native colleagues could undoubtedly help to smooth and speed this process of adaptation and to ensure understanding that such challenges should not simply be assumed to be part of someone's personality or an attitude/lack of competence problem.

In the German report, interviewed migrants particularly emphasised job-related language skills as demanding and requiring time, for instance, for writing documentation in German. Support was received from colleagues, but also language courses were assessed as useful. Migrants reported that in some cases language difficulties were considered by employers/supervisors as a sign of lacking professional qualification, thus foreign workers would wish for more understanding during adaptation period.

Based on interviews with Italian health workers or with managers, migrant health workers appear to generally have good communication skills, and a satisfactory level of Italian. Minor problems with language and communication were mentioned, which typically arise in the first phases of insertion at the workplace level, but are usually adjusted quite rapidly and smoothly, with close collaboration of Italian colleagues.

4.3. CONFLICTS IN THE WORKPLACE

In Germany, the help of colleagues and superiors was considered crucial for administrative proceedings and for adapting to the workplace; however wishes for more institutionalized support were expressed. Conflicts in the workplace were not reported to be related to the cultural background of workers but rather to hierarchy and personal characteristics.

Interestingly, in Ireland several native staff members interviewed had themselves undergone some training of worked abroad, particularly among senior staff. This international experience of both doctors and nurses not only enhanced their career options after coming back, but also allowed them to get a better understanding of working as a 'foreigner' in a multicultural environment elsewhere. Both Irish hospitals were described as "truly multicultural", with at least a few professionals of foreign background in each ward, white Irish-born staff could even be a minority on some occasions.

In Irish case studies, relations in the workplace were usually seen as smooth. Participants were also occasionally involved in conflict situations at work; however the majority had a professional or personal character rather than cultural or ethnic reasons. Some foreign nurses claimed to be victims of a 'subtle bullying' (less favorable shifts, tasks). However, though these participants claimed that such actions were clearly related to their nationality, the same issues were reported by the Irish-born respondents. Doctors reported that they did not experience any conflict that was not professional.

In Spain hierarchic relationships were seen as more important than ethnic origin in defining patterns of socialization, work accomplishment and any possible conflicts. In conflicts occurred, they usually affected relationships between medical and nursing staff irrespective of their origin. The peculiarities of the work organization seem to affect workers' relationships more than ethnic difference. A medical director of the private hospital observed: "*you cannot choose your team; the type of job forces you to work with everyone, and inevitably you get along well after a while*".

Conflicts within the public hospital in Italy are more related to the interaction of the different professional profiles: in the framework of general contracts established between the hospital's administration and the subcontracting agency, as a general rule, outsourced staff cannot interact with permanent staff except in extraordinary cases. Thus, at least in principle, the interaction between the hospital's staff and external staff is very limited. In the perspective of the hospital's interviewed managers, this creates unnecessary tensions among workers and makes the overall management a particularly cumbersome process.

4.4. SOCIALIZATION AMONG COLLEAGUES

All reports suggest that migrants' inclusion in workplace socialization depends to a larger extent on the overall patterns of socialization among colleagues in each country. Occasionally network penetration can be more difficult when other colleagues had formed earlier links as a result of training together. In countries where the prevailing social norm was perceived to be high level of work and private life separation (Germany), some migrant health workers wished for more social relationships with colleagues outside the workplace.

In the UK, social elements of work were seen as fundamentally important particularly in health care, which is a high-pressure work environment. Whilst most of interviewees did not feel any challenges in this respect, and there was no evidence of deliberate exclusion, there did seem to be differences of expectations on both sides. Some migrant health workers did not experience equally high level of socializing that they would expect in their country of origin, which they put on the account of "British reticence". British colleagues in turn could accuse migrant peers of socializing predominantly among themselves (cliques). Overall it nevertheless seemed that occupations were the main factor for group/socializing rather than ethnic background.

In Ireland, after-work socializing was rather rare due to the length of shifts and the difficult schedules.

In Spain the hospital was an important provider of social life, in particular for non-Madrid natives and migrant staff. Colleagues reported the tendency to create personal relationships because of the intensity of the work, but this intensity was also a terrain for frictions where discriminatory attitudes may occasionally have come in.

In Italy good interpersonal relationships were registered among foreign and national colleagues, also outside the workplace.

5. DISCRIMINATION IN THE WORKPLACE

Project interviews revealed that discrimination coming from patients were the most blatant form of discrimination experienced by migrant workers. This highlights the need for support from all levels of management and clear institutional guidelines on how to respond to such discriminations. In the absence of institutional response, individuals are left to address incidents at team level. Native professionals appeared sometimes to be more appalled than foreign-born professionals for whom coping with such comments seemed to be accepted as an unpleasant but inevitable part of their job, not least due to patient illness and/or advanced age. From an institutional point of view, patient prejudices were identified as the greatest challenge linked to the hiring of foreign staff, including from other EU Member States.

On the contrary, experience of institutional discrimination was quite diverse depending on the European country considered and the personal experience of the participants. In the UK and Ireland, due to the longer term presence of migrant health professionals in the national health care systems, notable numbers of migrant professionals had advanced to senior positions – both in the case of nursing staff and doctors. Nonetheless, they tended to highlight the barriers to their structural integration, training and advancement opportunities more than in other countries. This could also be interpreted by probable better awareness of their actual rights and general opportunities in the respective workplaces.

By and large, while migrant workers in all project countries did realize that they faced particular challenges (short term contracts, deskilling), only rare interviewees identified themselves as victims of institutional discrimination. In Germany for instance, the complaints of migrant workers were overall identical to those of their native colleagues and very particular to the German context (unattractive remuneration considering work conditions, culture of extra hours). Institutional factors, seen as a conscious policy on the part of management, were mostly mentioned as playing a part in the responses of principals and managers to the patient prejudice cases.

In the Spanish case, there was a clear tendency both by native and migrant staff to downplay the importance of comments with ethnic components or xenophobic connotations in order to alleviate tension or/and conflict. Migrant health workers were generally not in favour of specific communication channels to report discriminatory attitudes or to resolve conflicts between foreigners and natives, arguing that complaints against discrimination would be considered a sign of weakness, and may turn out to be counter-productive. They rather recommended extending the duration of the induction period for all new personnel, giving newcomers the right to ask questions and voice doubts, and formalizing the relevant roles of colleagues and supervisors. Additionally, migrant health workers asked for channels to voice their ideas on potential

improvement of their work environment and processes so as to mitigate the frustration that can arise from adapting to host country practices.

In Italy tensions between colleagues related to cultural differences or explicit racist/discriminatory attitudes or behaviour were reported as very rare. More often, racist attitudes were reported on the part of patients or their relatives and were faced more often within the nursing home than in the public hospital. Most respondents reported to have witnessed episodes of open racism only in regards to black workers (though no black interviewees participated in the study in Italy). Globally a certain degree of tolerance towards racist attitudes or forms of hostility towards migrant workers is registered by the health structures' managers. Reported episodes were usually tackled on a case-by-case basis, usually without any explicit intervention by managers or supervisors. The responsibility of dealing with these situations was usually put on workers themselves, who were asked to endure and not react to any racist behaviour adopted by patients, while the need to adopt ad hoc measure to address these situations was usually neglected. Patience and tolerance, even of aggressive behaviours related to racism or hostility towards foreigners, were indicated as key skills pertaining to care work.

6. MIGRANT HEALTH WORKERS AND TRANSNATIONALITY

In Germany transnational ties with the countries of origin seemed quite important for doctors. In the UK however, most doctors and nurses considered themselves either settled, or had intentions of settling in the UK at least for the time being. There was relatively limited professional engagement with home countries, although many migrant workers maintained personal ties with colleagues back home. Intentions to return or move on were also limited. In the UK, but also in Germany and Spain some interviewees mentioned that efforts to have their qualifications recognized had been difficult, so that they did not want to start the process all over again in another country.

In Ireland also most migrant workers had settled with their close family in the country, however onward mobility was contemplated due to unsatisfactory prospects in Ireland. The UK was often mentioned as a more attractive destination, but returning to the country of origin was also considered a viable option, especially for doctors. This was especially the case for doctors who felt that their career progression in Ireland was unsatisfactory. Medical skills were also perceived as international and consequently the transferability of skills was not considered a challenge. In terms of diaspora activities, there was an interesting example of a Filipino nurse mobilizing her colleagues after the typhoon and being allowed by the hospital to part take in recovery work in the Philippines.

Notably, the Government of Spain had initiated the mapping of presence of foreign medical professionals and their migration patterns, in order to assess the extent to which foreign resident doctors leave Spain after their specialty training to return to their country of origin or to move to another country. Migrant health workers saw return as the less attractive option. Both in Spain and in Italy none of the nurses or nursing assistants interviewed had any intention of returning to their country of origin, mostly due to the worse employment conditions. Physicians' and nurses' mobility paths or intentions are undoubtedly embedded in a complex mix of factors made up of personal reasons, the legal situation and structural factors such as employment opportunities.

KEY POLICY IMPLICATIONS

FOR REGIONAL AND NATIONAL POLICYMAKERS

- Consider the **complex links between the framework for healthcare migrant worker admission, employment and stay and provisions for recognition of qualifications** on the one hand, and **attracting, retaining and further developing the skills of foreign health workers** in the destination country on the other hand. Provisions on admission and labour market access, as well as arrangements for recognition of qualifications play a key role in determining the geographical preference in hiring foreign workers in healthcare sector, as evidenced by the considerable shift towards employment of EU mobile workers compared to third-country nationals. However, intra-EU mobility exacerbates labour shortages in the healthcare sector in the EU countries of origin, and as such does not substantially alleviate the overall regional shortages in healthcare occupations. Given the future growing labour demand projects in the ageing Union, one may expect that urgency employment of third-country healthcare professionals would gain prominence eventually, imposing additional challenges on the process of their hiring and workplace integration. This may put pressure on the authorities to (re)open admission channels for these workers and include more incentives. Notably, there is evidence that the current restrictions and instability of residence have negative impact on third-country health workers career progressing and access to training opportunities, but also has adverse influence on their sense of societal belonging.

- **Assess the need to support employers in legal and fair recruitment of foreign healthcare professionals** within and outside the EU, including better regulations and incentivizing of good recruitment mediators, as well as strengthening bilateral relations with priority countries of origin on labour mobility management and facilitation. Social partners at origin and destination can be crucial partners in these efforts.

- **Improve recognition of qualifications** for migrant health workers, including awareness and use of recognition outcomes by employers. Interviewees also mentioned the need to promote pre-departure recognition possibilities, streamlining the application process and centralizing related advice and counselling provision. Other suggestions included provision of bridging trainings to help workers achieve necessary credentials. Importantly, concerns over recognition of foreign qualifications and experiences upon possible return to the country of origin were also voiced by some interviewees. Further bilateral and multilateral state efforts are needed to build skill partnerships between educational institutions and employers, as well as to facilitate comparability of curricula and mutual recognition of credentials. Measures in the course of worker career, such as nation-wide efforts towards revalidation of fitness to practice may have further positive impact on the training opportunities of migrant doctors in particular.

- Work with sectoral representatives on **designing public-private partnerships** on a range of issues including **improving language instruction** support relevant to

migrant occupations, developing **guidance and counselling measures for employers** on recruitment and managing of diverse workforce, designing **sectoral induction/orientation tools for migrant workers**, implementing **public awareness campaigns highlighting contributions of migrant workers** to ensuring healthcare provision to the EU residents.

- Take steps towards **improving overall working conditions** in healthcare sector, and address particular aspects influencing migrant vulnerability in the sector, including access to longer-term contractual arrangements and vertical career progression.

- Work with **diversity charter organizations** and social partners to incentivize and support the development of **concrete workplace policies in signatory companies**.

- Together with social partners, **analyse sector-specific challenges and needs regarding legal and fair recruitment of migrant workers and their successful integration**. The study revealed that much of the success of inclusion of migrant workers in healthcare sector workplaces stems from the strong ethical dimension of healthcare work, highly codified professional ethics and high level of skills and substantial need for collaboration in everyday tasks. Different workplace realities in other sectors may require fine-tuning of responses of policy and practice.

FOR EMPLOYERS IN HEALTHCARE SECTOR

- Consider introducing **standardized induction measures** focusing on the needs and challenges migrant health workers in a diverse workplace, and **supporting intercultural competence-building for all staff**. Measures of support to improve language capacities of migrant staff and communication in the workplace could include tailored induction, mentoring, and compilation of lists of medical and common abbreviations in the work language. It is also important to **build capacities of managers** to build successful and motivated diverse teams, and ensure relevant institutional support to their needs.

- **Develop measures to monitor career progression and access to training** by staff, both important factors for skill development and retention of workers. Yet migrant healthcare professionals, partly due to the type of shortages they fill in the surveyed countries, experience notable difficulties in these areas. Challenges in recognition of qualifications can postpone migrant entry into jobs in line with their level of competences. Employers and sectoral organizations could play a supporting role to migrant workers in the procedures towards full recognition.

- **Address discrimination and negative attitudes**, particularly from patients, which was reported as the key challenge both for recruiting migrant health workers and for their employment. There is a clear need for stronger organizational policies to address cases of discrimination against staff and to provide adequate support and guidance to workers and managers involved in such situations. In addition, employers could consider collaboration with governments, sectoral organizations and civil society on implementing public awareness campaigns on contribution of migrant health workers to the well-being of EU residents.

WORK-INT regional and national research reports are available at project website: http://www.work-int.eu

For more information on the project contact:
Dr. Eleonora Castagnone (FIERI) at castagnone@fieri.it

Co-funded by the European Fund for Integration of Third-Country Nationals