WORK→INT


Assessing and enhancing integration in workplaces

RESEARCH REPORT

# WORKPLACE INTEGRATION OF MIGRANT HEALTH WORKERS IN EUROPE

## Comparative report on five European Countries

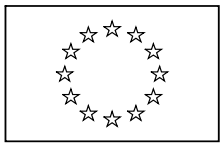
**Eleonora Castagnone**

**Ester Salis**

**(FIERI)**

**July 2015**


Co-funded by the European Union



**Co-funded by the European Union**

*This project has been funded with support from the European Commission. This publication reflects the views only of the authors, and the European Commission cannot be held responsible for any us which may be made of the information contained therein.*

**Table of contents**

## Introduction

Based on job vacancy analysis provided in the past years health occupations represented the fourth most important occupational group reporting severe shortages among 21 EU countries (European Commission, 2014). At the same time occupations in the health and care sector are estimated to show the largest job growth potential in the years to come. How current and future labour and skill shortages will be filled will have a substantial impact on the future functioning and quality of health care delivery. Immigrant workers have been playing an increasingly crucial role in filling such gaps over the past years, although with significant differences in the magnitude and characteristics of the migrant health workforce according to the various national and local contexts. In fact, healthcare is one of the few sectors where active recruitment policies of foreign labour were implemented at large scale at an international level. At the same time, European countries show substantial differences in terms of national policies and measures concerning the strategies of recruitment, the conditions of access and the policies and measures of integration of MHWs in the national and local labour markets.

While past research has increasingly looked at the role and integration patterns of the migrant labour force in the healthcare sector in European countries, most of the **studies** have been concentrated on the macro level, mainly using quantitative approaches (Wismar, Meier et al, 2011). **Little empirical evidence is available on the micro-level**, namely on workplaces (Erdogan-Ertorer, 2014). The processes of effective immigrant integration at the workplace level are, for the most part, simply taken for granted. However, the actual context where the integration into the receiving economies and the interaction between immigrant minorities and native majorities takes place – and can primarily be tackled – is within firms and specific workplaces. Indeed, according to the Luhmann's theory of social systems (1989), which inspired integration theory developed by Bommes (2004), modern societies are structured in functionally differentiated social systems, such as education, health, economy, religion, welfare or housing, which are essentially inclusive and operate according to own distinct codes, programmes, logic and modes of integration (Boswell, D'Amato, 2012). According to this perspective, integration of migrants does not take place in the society as a whole, but at the subsystem level and within its specific organisations (Bommes, 2004). As a result, firms and specific workplaces, as a subsystem of the modern economy, are the relevant contexts for analysis of integration processes into the labour market.

Furthermore, the available research on the foreign labour force in European countries has mainly been focused on the **supply side**, i.e. on the analysis of the processes and outcomes of insertion of immigrant workers in European labour markets, while the **perspective of the demand**, i.e. of **employers**, has been often overlooked, or it has not been sufficiently matched with the point of view of the workers. At the same time, the **concurrent role of other actors**, such as trade unions, recruiting agencies, professional associations and other civil society organisations has been generally downplayed. All these actors do instead play an important role in the dynamics of labour market integration of migrant workers at different levels and their perspective needs to be integrated more systematically in the study of migrants' integration in

workplaces, in order to have a more complete and in-depth overview of the workplace scenarios and of the interacting roles and perceptions of all the actors involved. In particular, beside macro-level institutional frameworks regulating the admission and recruitment of migrant health workers, it is important to look at the **integration measures and diversity management policies at the workplace level** implemented by employers and managers.

This report is written in the framework of the research and advocacy project "WORK-INT. Assessing and enhancing integration in workplaces". The project is funded by the European Commission through the European Integration Fund (EIF) and is aimed at better understanding, raising awareness about and stimulating better policies and practices targeting workplace integration of migrant workers in the EU in the health sector. In particular, the research produced by the WORK→INT project aimed at providing a better and more in-depth knowledge of integration processes at the micro level of workplaces, by embracing a multi-stakeholder perspective.

This paper is aimed at comparing research results stemming from national case studies carried out in 5 European countries (Italy, Spain, Ireland, UK, Germany) and is based on background analysis and on qualitative in-depth research carried out in these countries between 2014 and 2015.

The paper will be structured as follows: **chapter 1** will present the research objectives and methodological approach. It will provide the analytical framework and the methodology adopted for the analysis of workplace integration in this research. **Chapter 2** will explore how labour shortages emerged in the 2000s in the five target EU countries (Italy, Spain, Germany, Ireland, UK), both as a result of the general ageing of the labour force and of context-specific mismatches between staffing needs and national labour supply. This section will compare the different approaches adopted by each country to fill such gaps and to provide access to migrant health workers (MHWs) to the national labour markets, highlighting common patterns, and suggesting how the outburst of the crisis in 2008 marked new trends. Furthermore, it will be highlighted how such recruitment preferences and strategies, as well as conditions of access of migrant health workers into the health sector, play a crucial role in shaping the national, cultural, social, linguistic and professional profile of the foreign labour force and the related integration challenges into receiving labour markets and workplaces. The **third chapter** will move from a macro to a micro level, by focusing on hospitals as multicultural workplaces. Challenges and opportunities of employing a diverse staff in the health facilities will be analysed, in particular from the perspective of managers and employers, on one side, and considering the lived experiences, the perceptions and representations of native and migrant colleagues on working in multicultural teams, on the other side. Equality policies, affirmative action programs, diversity management policies and measures targeting workplace integration of migrant health workers adopted in the 10 selected hospitals across Europe will be presented. Some **concluding remarks** will be finally provided, putting into perspective the main research findings of this report.

## 1. The WORK-INT research objectives and method

### 1.1 The research objectives

WORK-INT targeted in particular five European cities hosting large numbers of migrant workers: Dublin (Ireland), Hamburg (Germany), Oxford (UK), Madrid (Spain) and Turin (Italy). Research was carried out between 2014 and 2015 in public and private hospitals in these five cities, respectively by the Trinity College of Dublin, the Hamburg Institute of International Economics (HWWI), the Centre on Migration, Policy and Society (COMPAS) of the Oxford University, the Complutense University of Madrid, and the International and European Forum of Migration research (FIERI). The International Organization for Migration (Regional Office for EEA, EU and NATO) was in charge of the project's policy dialogue activities at the EU level.

The project aims at contributing to the broader scientific debate on the labour market integration of migrants in the health sector in Europe, by adopting a research approach, which is:

- *multi-level*, i.e. integrating in the analysis the structural macro level, the local meso level and the micro level (workplaces). The main focus of the research is however on workplaces, as a context of observation of integration processes.

- *multi-method*, the research used primarily qualitative research tools and methods, allowing in-depth insights on the phenomenon. At the same national background reviews were compiled in each target country, framing the institutional and regulatory framework of the health system, past and present shortages of national staff in the health sector and national policies aimed at filling this gap, in particular active admission policies of non-EU MHWs, policies regulating the recognition of educational and professional titles of EU and non-EU MHWs, regulations concerning the access of MHWs to the health labour market at a national level. Finally, one comparative quantitative paper was drawn on integration of MHWs in the 5 target countries, based on LFS-EU data (Villosio, 2015).

- *multi-stakeholder*, i.e. looking at the roles, perspectives and professional and inter-personal relations of the different involved actors within hospitals (managers, private employers, national, EU and non-EU employees, trade unions, etc.) and at a broader level (experts outside the hospitals, professional associations, key practitioners, etc.).

- *comparative*, i.e. putting into perspective the research results on the selected countries and cities. In the current context of internationalization of the health labour market, cross-national comparisons of human resource policies and practices are increasingly recognised as beneficial to a more accurate understanding of management of international labour force in the health sector (Rechel, Dubois, McKee, 2006).

The key objective of the research is to study the **workplace integration processes, outcomes and impact of migrant health professionals** in 5 European cities, drawing on the broad definition of integration formulated by Zincone (2009). While multiple definitions of integration have been developed, the one provided by Zincone has the advantage of providing a comprehensive and structured framework, which includes and harmonizes the models and strategies of integration previously elaborated by various scholars (Esser, 2004;

Heckmann, 2006; Entzinger, 2000; Killias, 2005; Bolzman e Fibbi, 1991; Flückiger, Ramirez, 2001).

In Zincone's definition (2009), integration is considered as a two-ways process (where both national majorities and new minorities are actors involved in this process, cfr. Council of Europe 1995; 2000) based on three main dimensions,[1] which correspond also with the three areas that integration policies should attempt to address:

**1** The *wellbeing of immigrants and the native-born population.* This dimension is reflected primarily in the effective enjoyment of civil, social and political rights, in adequate living conditions and as respect for personal dignity and culture. For immigrants this means, for example, being able to express their opinions freely, organising and exercising their religion publicly, participating in the civil and political life of the host society, not being subject to work or housing segregation, and not being the target of offensive public speeches. For the native population this can mean not seeing their effective rights reduced following a fall in the quality of welfare services, or suffering a worsening in their working or housing conditions, or living in a less safe environment, owing to immigration.

**2** The *positive interaction or, at least, a low level of conflict* between immigrant minorities, and between the latter and native majority. This consists of complying with the conventions that regulate coexistence, acceptance of diversity unless infringing on the fundamental rights or being perceived as destroying civil life, and in the belief that others do not pose a danger, not just to one's own physical safety but also with respect to one's social and working position and to the spaces of public life. However, positive interaction is more than just tolerating: it means building social networks that are not ethnically segregated.

**3** The *positive or, at least, not harmful impact of immigration on the host environment*, understood as the social, economic and political system. For instance, in the short-medium term, immigration helps to restore the demographic balance, increasing the population of young and adults but, in the longer period, it can lead to an increase in the elderly whose financial situation is fragile and who do not have a strong family network owing to having migrated. Immigration can also influence the contents of policies. For example, in workplaces, the presence of a significant proportion of foreign workers in Italy has led to reformulate the use of paid leaves for all the workers, allowing to assemble longer periods of vacations, in order to be able to (eventually) go back to the origin country for longer periods.

The WORK-INT project adapted such general definition of integration to its main scientific objectives, by translating the three general dimensions above into the workplace level:

1. The **structural dimension**, focusing on: (i) the **macro/national/local level**, which includes local and national policies and measures directly or indirectly hindering or facilitating the migrant workers' access into

[1] A transnational dimension is also included in Zincone's definition (2009), targeting *the limitation of damage to the countries of origin and other countries*, i.e. different from the country of arrival, such as the 'brain drain' and the loss of human capital. Such transnational dimension is not part of the priority objectives of the research, thus was not included as a relevant dimension in our study.

the health sector and their integration in the workplaces; (ii) **the micro/workplace level**, which refers to health structures' policies or specific measures concerning the recruitment of MHW, diversity management policies, explicit or implicit forms of institutional discrimination at a firm level, etc.; and (iii) to the **impact of MHWs on the organisational settings** and on the provision of services of health structures.

2. The **relational dimension,** which considers both **vertical** (i.e. relationships between superior and subordinate foreign and national colleagues within the workplace) **and horizontal integration** (i.e. relationships between foreign and national colleagues or workers of the same occupational level within the workplace), as well as with service **users** (i.e. the patients).

3. The **individual dimension**, which relates to **subjective wellbeing**, **perception and degree of satisfaction** of own integration within the workplace, in terms of valorisation of own skills, perception of receiving an adequate retribution, careers perspectives and professional development opportunities, non discrimination on the base of own cultural and religious background, etc.

### 1.2 The research design

In each target city, two health structures (hospitals) were selected as **workplace case studies**, one public and one private hospital, with some specificities according to the different countries[2]. In each sampled health facility, non-EU/EU/national workers (doctors, professional nurses and nursing assistants), managers and human resource officers were interviewed using a common research protocol, which settled common definition of health workers,[3] tentative number of interviews, qualitative guides for interviews for national/foreign workers, managers and other stakeholders.[4] The profile of the interviewees, in terms of nationality, length of stay in the receiving country, working seniority, professional role, employer, etc., reflect the structural differences of the countries considered and, at the same time, of the specific health structures selected for the study. Furthermore relevant stakeholders were interviewed, such as local or national policy makers, representatives

[2] In Germany and in Spain the selected public health structures were university hospital. This lead to include in the sample of interviewees resident/guest doctors and researchers, who are temporarily employed for training purposes. In Italy, the team selected a nursing home for elderly care as a case study for the private sector. The decision was mainly justified by the fact that segment of health sector where the highest concentration of foreign health workers is found is in the private services for elderly care, with foreign migrant health professionals in Italy (mainly nursing assistants and secondarily nurses) largely employed in this kind of workplaces.

[3] Health workers in the qualitative research included: h*ealth professionals* (generalist medical professionals, specialist medical practitioners, nursing professionals, midwifery professionals, etc.); h*ealth associate professionals* (medical imaging and therapeutic equipment technicians, medical pathology laboratory technicians, ambulance workers, physiotherapy technicians and assistants, etc.); he*alth management and support personnel* (health service managers, health management personnel, etc.). P*ersonal care workers, such as health care assistants* privately employed by an assisted person or his/her family, or h*ealth services providers and* other workers whose function is not inherently correlated to "promote, restore or maintain health", such as building cleaners or security staff, were not included in this group in our research.

[4] Methodological details on the fieldwork undertaken in the 5 target cities are available in the national research reports.

from trade unions, professional associations, counselling centres at local and state level, and experts.

## 2. The crucial relevance of the structural level

Where the migrant health workforce is found (namely in which specific occupations, sub-sectors, workplaces, or local areas), the profile of MHWs (in terms of nationality, migration status, forms and conditions of employment), as well as their labour market and workplace integration outcomes are largely – though not exclusively – determined by institutional and context-specific factors. The regulatory and institutional framework concerning the organization, management and funding of health services, as well as norms and policies related to education, labour market access and employment of health workers say a lot of how and why labour shortages in health occupations have emerged in the different countries. At the same time, looking at the role and articulation of immigration policies, or policies in the field of labour market and education acting as functional alternatives to them (see paragraph 2.2 below), contributes to understand how migrant workers have accessed jobs and specific workplaces in the health sector or their prospects of long-term inclusion, among else. All in all, what emerged from research produced by the WORK→INT project points out to a crucial role of structural factors in affecting patterns of workplace integration of MHWs across the five target countries. However, as will be shown in greater details in the second part of this report, the structural and relational or individual dimensions of integration must be kept separated and may reflect different, if not contrasting, outcomes in terms of workplace integration. In other words, the structure of opportunities and constraints faced by MHWs in their integration processes are to be analysed in combination with the agency of the actors involved, namely their motivations and personal aspirations, as well as the resources available to face existing barriers to settlement and mobility, their every day practices etc.

In the next two paragraphs we will analyse the structural elements which affect the role and position, as well as the prospects for integration, of MHWs across the five surveyed countries.

### 2.1 Labour shortages in health sector across Europe

In the last decades, the healthcare sector in Europe has undergone **growing labour shortages** in a context of **increasing demand for health** due to economic expansion, population ageing, technological advances, and higher patient expectations (Simoens, Villeneuve, Hurst, 2005; Tjadens, Weilandt, Eckert, 2013, among others). Such gaps are more likely to be exacerbated rather than attenuated in the future. Most EU countries are forecast to have a net increase in the number of health jobs from 2013 to 2025. Recent figures on the health associate professionals' share in health sector employment across the EU-28 show that employment is expected to rise by 13 per cent in absolute terms over this period (equivalent to 0.7 million newly-created jobs) (European Commission, 2014)

In absolute terms, over 300,000 new jobs are expected to be created in France, Italy and the United Kingdom, while in Spain a decrease in health staff shortages is expected (-4 per cent). While the predicted growth of the

sector is much smaller for Germany, this country has the largest number of total job openings (2 million). There are just under 2 million job openings in France, a forecasted 1.7 million job openings in the United Kingdom and 1 million jobs to be filled in Italy.

Indeed, the magnitude and characteristics of labour needs in the health sector differ considerably across EU countries, both geographically and by specialty area, as this report will highlight: while in some countries there may be substantial shortages in one profession, these may not exist, or may be much smaller, in other countries.

At a first, general level, the emergence of such shortages is explained by a generalised phenomenon of **shrinking health workforce** in receiving countries, which is the result of demographic factors, but also of a broader set of economic, social and institutional factors: the raising age of retirement associated with replacement staff gaps due to limitations to turnover (often due also to budgetary constraints); fewer young people entering the health workforce due to a greater range of alternative professional opportunities; the low social value given to some professions, such as nursing or nursing assistance as well as negative perceptions of related working conditions all play a substantial role in affecting the overall size and age structure of the health workforce (Simoens, Villeneuve, Hurst, 2005), limiting the staff turnover and preventing employers to cope with growing labour demand.

On the other side, specific shortages are driven by **mismatches between staffing needs and national labour supply**, which are rooted in different national and local contexts: in particular, the configuration of the national health systems and the regulations concerning education and access to health professions, as well as working conditions in actual health facilities, all concur in explaining the configuration of specific labour shortages in the target countries. For instance, in **Germany** a structural surplus of medical doctors reversed to a shortage after a reduction in training capacities of the educational system introduced during the 1990s and currently the most severe needs are recorded among general practitioners, especially in specific regions and rural areas (Kovacheva and Grewe, 2015a). The negative balance between emigration and immigration of health workers, particularly doctors, related to limited opportunities for career progression largely explains the shortage of medical professionals in **Ireland** (Devitt, Bobek, Kingston, 2015). The decline of nursing as a career choice for British school leavers in the **UK** and the emigration of British-born doctors to other countries, such as Ireland, New Zealand or Australia, contribute to understand the structural shortages of both nurses and medical doctors in the UK (Jayaweera, 2015). Before the crisis, **Spain** experienced an increasing number of unfilled vacancies in the public health sector, especially in less attractive specialties (Family Medicine) and some autonomous communities. On the other hand, the demand of foreign nurses and physicians in the private sector was mainly due to the fact that natives traditionally prefer to work in the public sector (Finotelli and Mateos, 2015). Structural and persistent imbalances among categories of health professionals are witnessed in **Italy**, where the highest ratio of doctors is combined with the lowest ratio of professional nurses per inhabitants in Europe. In Italy, a thorough reform of the educational system for nurses has produced a substantial change in the skill mix in health professions and a temporary but severe shortage of nurses and lower grade occupations (i.e. nursing assistants) in the years between the late 1990s and early 2000s (Salis

and Castagnone, 2015a).

All in all, all the five countries targeted by the WORK→INT project have faced substantial shortages of health professionals, with important national and local specificities. Nevertheless, while the distribution of labour needs across different occupational categories or sub-sectors has been varied, all countries have resorted to foreign labour as a primary pool to fill existing shortages. The actual mixes of policies (both in the immigration policy fields as well as in other sectorial fields) which have been adopted to source foreign labour and meet the existing health staff shortages have been highly varied everywhere and they have changed significantly since the outburst of the economic crisis at the end of the past decade.

### 2.2 Strategies for filling labour shortages through the employment of foreign health professionals

In the last two decades a **mix of policies** has been introduced in EU countries **aimed at increasing inflows of nurses and doctors into the domestic workforce** thus reducing the staff shortages. Some of them explicitly facilitate the immigration of health professionals from third countries, while others are meant to reduce the need to import foreign labour, by either raising the participation to the health labour market of natives and of settled immigrant workers, or by managing intra-EU mobility flows (Pastore, 2014). Albeit the combination of such strategies and their role over time differed substantially across the EU surveyed countries, some common patterns can be highlighted.

In order to apprehend the complexity and underlying rationale for the adoption of such articulated mix of policy responses to labour shortages in the health care sector we will adopt here the analytical framework proposed by Pastore (2014) and centred upon the concept of "*migrant labour supply policies*". Such broad and comprehensive concept is particularly useful here in grasping the articulation between three different sets of policies: first, those identified as **"labour migration policies stricto sensu"** namely all those policies and norms regulating the admission and access to the national labour market of third country nationals for reasons of remunerated activity, encompassing measures as diverse as entry quotas, shortage occupation lists or point-based systems. Secondly, the crucial policy dimension of **intra-EU mobility**, especially relevant in the last decade after the different waves of enlargement to the East (in 2004, 2007 and 2013), which has granted (almost) unlimited access to older Member States' labour markets to a massive number of workers, including health professionals. Third, what have been defined as "**functional equivalents to labour migration policies**", namely all policies giving access to and boosting participation to domestic labour markets of immigrants admitted for reasons other than work, including family and humanitarian migrants, international students or so-called co-ethnics (as *Spätaussiedler* in Germany): we might include under this umbrella all measures aimed at facilitating and enhancing recognition of foreign credentials or norms allowing the conversion of study permits into work permits. Finally, a fourth set of policies that is included in the mix of measures aimed at managing the migrant labour supply within each country is the broader range of **"functional alternatives to labour migration policies"**, defined as all policies and measures (mainly

situated in the fields of employment, education or training policies) which are explicitly meant to reduce the dependency on immigrant labour and to increase the presence of native and settled immigrant workers in given employment sectors. In all the five target countries all these four sets of policies have played a crucial role in addressing existing labour shortages of health staff, though with a differentiated role of each of them in individual countries. Furthermore, the outburst of the crisis in 2008, with its heavy impact also on the functioning of national health systems (see Thomson, Figueras et al, 2014) has considerably altered the picture with a substantial re-orientation of the migrant labour supply policy mix towards a greater role of functional equivalents and alternatives in the most recent years (Devitt, 2014).

In the first part of the past decade some of the WORK→INT target countries have adopted ad-hoc labour migration policies aimed at easing the access of health professionals from third countries to domestic labour markets. Especially in Ireland and the UK, and to some extent also in Italy and Spain, **active international recruitment strategies** and **fast-track visa channels** for health professionals have been adopted. For instance, normative changes were introduced in **Italy** in the early 2000s - when severe shortages of nurses were emerging in the national health system: in particular, a preferential entry channel for the direct recruitment from abroad of professional nurses was set by including them in the list of occupations exempted from the quantitative caps imposed by national quotas on admission of TCNs for employment reasons (Salis and Castagnone, 2015a). In **Ireland** immigration regulations were introduced to facilitate the immigration of non-EEA[5] medical professionals willing to come to Ireland, by issuing Medical practitioners or specialised nurses with a Critical Skills Employment Permit below the usual earning threshold (Devitt, Bobek and Kingston, 2015). In **Spain** physicians were included in the so-called Catalogue-of-Hard-to-Find Occupations in between 2006 and 2007. This allowed hospitals to recruit non-EU physicians in the country of origin without passing a labour market check beforehand (Finotelli and Mateos, 2015). In the **UK** before the points-based system was introduced in 2008, it was possible for non-EEA qualified doctors to enter the UK on a short-term non-work visa and apply for jobs while in the UK (Jayaweera, 2015). In **Germany**, migration opportunities for migrants from non-EU countries have been improved by the transposition of the Blue Card directive in 2012, especially relevant for doctors, and the inclusion of nurses in the so-called White List of shortage occupations in 2013, that is relevant for nurses (Kovacheva and Grewe 2015a, Kovacheva and Grewe 2015b). Alongside normative changes facilitating the admission of health professionals, some countries opted for running recruitment campaigns in third countries, which assumed different configurations according to the receiving country. The **UK** is the country with the longest experience in international recruitment of both nurses and doctors, particularly those trained in former British colonies. The Labour government's expansion of and investment in the NHS in the early 2000s led to continuing labour shortages which were filled by active international recruitment, particularly of Filipino and Indian nurses. In **Italy** the main actors in the international recruitment of professional nurses were recruitment agencies, social cooperatives or individual intermediaries,

[5] The EEA stands for the European Economic Area, which provides for free movement of goods, persons, services and capital among 27 of 28 members of the European Union and three out of four member states of the European Free Trade Association.

which travelled mainly to Eastern European countries (most of which at that time were advancing in their process of accession to the EU) or Latin America, to get in contact with potential candidates to immigration and support for the titles' recognition or visa application procedures. In **Italy** and in the **UK** the services of private recruitment agencies, often took place in a grey legal area (Jayaweera and McCarthy, 2015; Salis and Castagnone, 2015b). In Italy controversial, deceitful, or even fraudulent practices were often reported. Also in **Ireland** active recruitment processes involved representatives of agencies, travelling to India and Philippines. In addition, the Irish national health system built a relationship with the Philippines in order to attract skilled nurses from this region (Lorenzo, 2007). **Germany** has represented a partial exception in this regards as it has invested considerably less in active international recruitment: here employment of migrant health workers took place mostly through initiative applications or job advertisement, with vacancies mainly filled with applicants from the German labour market. Though Germany has some experience of actively recruiting nurses and care workers from abroad, such channel was activated mainly in the framework of bilateral agreements or local pilot projects with specific countries. Partners for recruitment, such as private recruitment agencies, are considered little reliable and have played a minor role in this country (Kovacheva and Grewe, 2015a and 2015b). Beside Germany, **bilateral agreements** in the regulation of cross-border mobility of health workers, intended as "all forms of arrangements between countries, regions and public institutions that provide for the recruitment and employment of foreign workers" (Bobeva and Garson, 2004: 11), have been a common tool also in other countries, especially until the early 2000s (Plotnikova, 2014: 325).

**International recruitment** has been **progressively downscaled as a shortage-filling strategy since the outburst of the economic crisis in 2008,** as a result of the economic downturn, the consequent cost-containment pressure in many health systems and because it revealed some intrinsic inefficiencies. The managers of a private hospital in **Ireland** reported that this channel proved to be extremely costly: the hospitals had to cover the costs of work permits and green cards for the overseas recruits, as well as their initial accommodation while staff members from abroad required time to professionally adapt to their new settings (Bobek and Devitt, 2015). The economic downturn has had a severe impact on the functioning and funding of the national health systems, especially in those countries affected by sovereign debt crisis and where austerity measures have been implemented, among which three out of five of our target countries (Ireland, Italy and Spain). Hence, the **crisis** has entailed **substantial changes of strategy in the mix of policies** previously adopted to source needed health professionals from abroad. In general terms, a tightening of labour immigration policies, with raising barriers to new inflows of migrant health workers from third countries and reduced opportunities for mobile workers to stay in the domestic labour markets have been observed. In turn, a greater recourse to intra-EU mobility as a recruitment pool and a renewed emphasis on what we have identified above as functional equivalents and alternatives of labour migration policies is to be highlighted.

For instance in the **UK**, the recently introduced requirement of a firm job offer on the basis of the Resident Labour Market Test (RLMT) and a Certificate of Sponsorship (CoS) from the employer has had the effect of a

reduction in the employment of non-EEA doctors in the surveyed hospitals and a focus on very specific modes of entry. At the same time, most nursing and many medical and allied health posts were removed from the Home Office shortage occupation lists compiled by the Migration Advisory Committee (MAC), an independent public body providing evidence-based recommendations to the government. As a result of such changes, it is now largely 'home grown' doctors who can enter a linear training pathway in the hospital. Mechanisms for reducing the reliance on migrant labour has recently included increasing restrictions on entry and stay of high skilled migrants through the points-based system (PBS). (Jayaweera and McCarthy, 2015). In **Spain**, too, after the economic breakdown, changes in immigration legislation considerably restricted access of third country nationals to the medical profession: health care professions were deleted from the Catalogue of Hard-to-Find Occupations, implying that employers, including public hospitals, now have to undergo a labour market check before initiating a recruitment process in a non-EU country. Moreover, it seems that recent legislation changes had particularly negative spill-over effects on resident doctors' (i.e. doctors in specialty training) careers. For instance, non-EU resident doctors can no longer have their study permits converted into residence permits, with consequences on resident doctors who complete their specialty training but cannot be employed subsequently (Finotelli, Mateos and De Montbel, 2015).

Hence, since the late 2000s alternative policy strategies have arisen for coping with increasing staff shortages, in particular those aimed at **raising the participation to health labour market of native and settled immigrant workers** (see Devitt, 2014). In the **UK**, measures for achieving self-sufficiency, rather than relying on international overseas recruitment of health professionals, have included expanding medical schools and nurse training opportunities for UK nationals, raising wages, creating more support roles such as healthcare assistants and cadet schemes to encourage young people with fewer formal qualifications into nursing or allied health professions, attempts to attract former nurses back into the profession, promoting flexible working practices to achieve better work-life balance, measures to retain older workers beyond retirement age, and greater usage of temporary workers (Bach, 2008). In **Germany**, activation of the workforce already in the country is considered as the main strategy for dealing with labour shortages and the population with migration background is one of the target groups of special measures such as language courses and advisory services (Kovacheva and Grewe 2015a). For the healthcare sector, the Federal Government launched a training initiative in 2012 that aims at fostering training in elderly care and increasing the attractiveness of the profession (Kovacheva and Grewe 2015a).

In **Italy** with the shift of the nursing education from vocational training to the university level, an increase in the supply of workers – including migrants - graduated in Italian universities was registered, thereby expanding the existing basin for local recruitment. As a result, recruitment of – both native and foreign - nurses trained in the national universities increasingly replaced the international recruitment practices, while nursing assistants have been always trained in local vocational system (Salis and Castagnone 2015b). Before the crisis one of the strategies adopted in **Spain** to meet the demand for physicians consisted in easing the admission of non-EU foreigners willing to do their specialty training in Spain by increasing the enrolment limit in medical schools from 5,200 in 2003 to almost 7,000 in 2010 (González López-Valcárcél et al. 2011a). Furthermore in 2007, the Spanish Ministry of Health modified the regulation of the medical training examination, eliminating the cap for non-EU

foreigners with a study permit. The new rules made the health sector more attractive to foreigners, thus 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 (Finotelli and Mateos, 2015).

Also in **Ireland,** which was involved in active recruitment of foreign staff since the early 2000s, there currently are no national policies aimed at filling the gap in the health sector (Talbot, 2013). In recent years, the reform of medical education and training in 2006 has sought to increase the supply of medical doctors by expanding medical training via the introduction of graduate entry medical programmes and also by increasing the number of medical places at undergraduate and postgraduate level available to EEA students (HSE MET, 2012). This measure, however, proved to be insufficient in addressing the shortages problem. A high number of Irish medicine graduates emigrate to other countries after finishing their degree, due to a lack of career paths in Ireland, as well as bad working conditions. At the same time non-EU students tend to leave Ireland after graduation (Humphries at al., 2009), also because of a lack of stability in terms of citizenship and family reunification (Devitt, Bobek and Kingston, 2015).

Furthermore several EU countries are increasingly **attracting international students in their universities**, with specific focus on sectors where severe shortages are recorded and with a view to subsequently transform these into **qualified workers**, either in the course of their studies or through subsequent recruitment. From the point of view of efficiency of the matching between demand and supply of skilled labour, international students hold competitive advantages, compared to immigrants with foreign-obtained educational titles (Hawthorne, 2008; Castagnone et al., 2013). The former, in fact, have the opportunity to learn or refine the language skills of the country of destination during their period of study, to gain initial professional experiences during their studies, as well as to have a better understanding of social and cultural norms of the receiving context (Bijwaard, 2010; Ho, 2011). For employers, it is also easier to assess and valorise the qualifications obtained by foreign students in the host country, compared to those obtained in the countries of origin by foreigners admitted through other immigration channels. Results of previous research reinforce these considerations, demonstrating how international students who have completed a period of study at destination have more chances to get a job corresponding to their skills and to achieve better professional outcomes, compared to skilled migrants who come to Europe as economic migrants (King, Ruiz-Gelices, 2004; Castagnone et al., 2013; Castagnone et al., 2014).

Intra-EU mobility has been – and increasingly is – another crucial recruitment pool for health professionals in all the surveyed countries. In fact, EU enlargements of 2004, 2007 and 2013 endowed health professionals from new Eastern member states with the right to work and settle in another EU Member State, providing new mobility opportunities for health professionals and reducing options for Member States to limit or selectively contain these cross-border flows. The mobility of EU health workers, mostly from new Eastern member states, has been boosted by the adoption of the **Directive 2005/36/EC on the recognition of professional**

**qualifications**, which has been revised in 2013 (2013/55/EU). In fact, the implementation of this new tool has substantially facilitated the recognition of educational titles and credentials acquired within the EU, with a specific attention to titles in medicine and other health care disciplines: the directive targets a subgroup of seven professions which enjoy automatic diploma recognition thanks to a minimum level of harmonization of educational and training standards. Five out of these seven "privileged" professions are from the health care sector: doctors (with basic training or specialized), nurses responsible for general care, midwives, dental practitioners (specialized or not) and pharmacists.[6] The health professions thus form a privileged group that host countries can not subject to extra tests or adaption periods if they produce an official diploma validated by the EU country of training (Buchan, Wismar, Glinos, Bremner, 2014: 141). As for **language skills,** the directive settles that professionals shall have the necessary language skills to practice the profession in the host country. However, when it concerns health professionals, there are few control standards. Member States' competent authorities have a great margin of discretion as to how (e.g. language testing or evidence of language competencies) and when (before or after the registration) they will check out the linguistic obligations. This can be considered one of those general health workforce policies that don't focus primarily on mobility of health professionals, but that can have a substantial effect on mobility.

At the same time, recognition of credentials obtained in non-EU countries remains significantly more difficult to obtain, with long and generally burdensome bureaucratic procedures as a general rule. In parallel, since 2008 the financial crisis has contributed to redefine opportunities for individual health professionals, the health systems in which they practise and the priorities of health professional regulators. In all project countries – regardless of the history and level of reliance on foreign recruitment – freedom of movement and automatic recognition of qualifications of EU nationals, coupled with the enlargement of the European Union and the current economic crisis in some EU Member States, have significantly re-oriented **recruitment preferences and practices in the healthcare sector towards EU health workers**, as a mean to increase the supply of skilled foreign labour. As a result, past practices in recruitment of third country nationals have been gradually replaced by employment of migrant health professionals from Eastern - and to some extent Southern EU Member States hardly hit by the crisis – for whom the regulatory framework is much less restrictive than for countries outside the EEA.

### 2.3 The profile of migrant health workers in the 5 EU countries

Receiving countries' recruitment preferences and strategies as well as conditions of access of migrant health workers into the health sector play a crucial role in shaping their national, cultural, social, linguistic and professional profile and the related integration challenges into receiving labour markets and workplaces.

As a first issue, the national composition of MHWs in European countries is the result of multiple factors highly

[6] The other two are veterinary surgeons and architects

varying according to the receiving country. For instance, recruitment of foreign nurses in **Italy** concentrated mainly on professionals from Eastern Europe (especially Romania and Poland) or Latin America (Peru), where cultural and linguistic gaps are considered less significant in comparison to other areas or countries. In this country the majority of migrant workers in the health sector concentrate in lower grade health occupations, namely **nurses** and **nurse assistants**, while the number of foreign doctors remains relatively low both in absolute terms and if compared to other European contexts. Most of the currently employed nurses were **recruited from abroad** during the 2000s, while in the last few years the recruitment freezes slowed down the entry of new workers into this sector. Nurses entering the sector in the last few years, mainly after having obtained their professional title in the Italian universities, struggle to get access to permanent jobs and are mostly found in precarious forms of employment. The nursing assistant occupation (*Operatore Socio-Sanitario, OSS*) was introduced in Italy in 2001 by an inter-institutional agreement between the national government and regional authorities and since then has been increasingly filled by migrant workers, representing today between one fifth and one fourth of the total category. Nursing assistants, in particular, are mostly employed in long-term care facilities for the elderly. Besides, in Italy the **ban to public employment of non-EU workers**, only lifted in September 2013 for selected categories of non-EU workers, allowed only EU citizens to access to permanent posts in public hospitals, being recruited through official public competitions. On the contrary, the **large majority of non-EU health workers are 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 either by social cooperatives and temporary work agencies or as self-employed (through specialised professional agencies) (Salis and Castagnone, 2015a, 2015b; Chaloff, 2008).

The share of foreign national health workers in **Germany** rose from 4.7 per cent to 5.4 per cent in the period 2005-2012.[7] With 54 per cent, nationals from non-EU countries prevail over EU nationals (Kovacheva and Grewe 2015a). Besides foreign-trained persons, the number of those who obtained their training in the field of health in Germany is not negligible (Kovacheva and Grewe 2015a). MHWs in Germany take up employment in the hospitals mainly through initiative applications or reacting to a specific job advertisement and are employed as dependent salaried workers. Internationally recruited professionals represent a minority in this country, as beneficiaries of bilateral agreements or local pilot projects with specific countries. Employment grew much faster for foreign nationals than for German nationals in the period 2008-2011. As data on employees subject so social security contributions show, the growth rates are 7.7 per cent for German nationals, 19.4 per cent for non-EU nationals and even 22.8 per cent for EU nationals (Kovacheva and Grewe, 2015a).

In the **UK,** before the 2000s MHWs were mainly from ex-British colonies: nurses came especially from the Caribbean and doctors from South Asia. From the 2000s nurses have been actively recruited from the Philippines and India and increasingly from European Economic Area (EEA) countries. Nevertheless, the

[7] Naturalized migrants are not included in these data, so that the number of migrants in the sector is assumed to be higher.

proportions of doctors and nurses originating in countries outside the EEA still exceed those from within the EEA (Sumption and Young 2014). Currently around a fifth of nurses and a third of medical practitioners in the UK are born abroad (Sumption and Young 2014; Jayaweera, 2015).

In **Ireland** a prevalence of foreigners in medical occupations over those employed as nurses or nursing assistants is registered. The Irish healthcare system relies on international healthcare workers from a wide range of countries, in particular from India, Pakistan, the Philippines and African English-speaking countries (South Africa, Sudan, Egypt). In terms of occupational distribution of nationality, Sudanese (48.5%), Egyptian (18.6%) and Pakistani (17.9%) nationals recorded a higher than average number in the 'higher professional' category. Indians and Filipinos had the highest percentages in the 'lower professional' category (which includes nurses and midwives) with 53.2 per cent and 44.3 per cent, respectively (CSO, 2012). In this country passive recruitment strategies of foreign medical doctors prevail, with the facilitation of immigration and recruitment of foreign health workers already settled in Ireland, while active recruitment focused mainly on nurses. Also in Ireland is favouring immigration and recruitment of non-EEA (Devitt, Bobek and Kingston, 2015).

In **Spain** the overwhelming majority of MHWs is from Latin America (Uruguay, Argentina, Mexico, Peru, Colombia) and predominantly physicians. They were either admitted as specialists, through registering in the Hard-to-Find Occupations Catalogue, without having to pass a labour market check beforehand, or, since 2005, as temporary labour force in the form of internal resident doctors doing their specialty training in Spain. Until 2010 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. Since the end of the 2000s, the budgetary cuts in the health sector and new legal requirements for the access of foreign professionals to employment in the health sector, have considerably affected the employment possibilities of non-EU specialists, who often decided to emigrate to other EU Member States in search of better employment opportunities (Finotelli and Mateos, 2015; Finotelli Mateos and De Montbel, 2015).

### 3. Hospitals as increasing diverse workplaces

While a focus exclusively centred upon the structural dimension of integration would lead us to conclude that migrant health workers are poorly integrated in the labour market and in specific workplaces, a closer look at the relational and individual dimensions of integration, better apprehended at the workplace level, lets emerge a quite different picture. Indeed, MHWs, and especially non-EU workers among them, face strong barriers in getting access to occupations in line with their qualifications and struggle to see their credentials recognised. They are over-represented in lower-grade occupations within the health sector, such as nursing and nursing assistant positions. They often hold unstable and more vulnerable jobs, especially concentrated in the private sector. Nevertheless such disadvantaged position does not necessarily translate in a problematic and

unsatisfying integration within concrete workplaces. Based on what emerged by the fieldwork research in the five target cities, MHWs express a quite high degree of satisfaction with their jobs and the relationships they developed with co-workers and the broader community in their hosting contexts. However it should pointed out that in our research we collected data on self-assessed discrimination, rather than observable and measurable indicators, which may entail some methodological bias. Under-reporting of discriminatory episodes and attitudes can be linked with the difficulty associated in attribution of an experience to racism (Kaiser and Miller, 2001) and the personal pain involved (Bobo and Suh, 2000; Schmitt, 2002) as well as potential negative social repercussions which could be involved in labelling experiences as racism (Kaiser and Major, 2006). Migrant workers are highly and positively valued by their native colleagues, as well as by managers and supervisors, who view them as a strategic asset in business performance, while not neglecting the existence of important challenges related to the management of a highly diverse workforce. Quite interestingly, such overall positive picture at the workplace level is not always the result of ad hoc firms' policies and strategies aimed at enhancing the potential of diversity or tackling specific challenges related to diverse cultural background. Rather, the specific nature of the workplace and of the jobs performing there, namely the strong ethical dimension of health care work, the highly codified professional ethics and the high level of skills required act as strong equalizing factors and downplay the relevance of cultural diversity.

### 3.1 Challenges and opportunities of employing a diverse workforce: the perspective of managers and employers

In general terms, **MHWs are perceived predominantly as workers *per se*,** i.e. **as professionals** holding the required qualifications, whereas cultural and social aspects tend to be mentioned as secondary aspects, especially in Germany, Spain and Italy. Professional commitment to the health care deontology is considered to be more important than nationality or foreign origin. However, beside this common rhetorical level, specificities related to migrant staff emerge, both in terms of opportunities and challenges related to their integration and of contribution to the overall performance of the surveyed hospitals.

All the managers interviewed were quite keen in underlining **that the presence of a culturally and ethnically diverse staff is increasingly a strategic asset for the businesses they run**. At a first level, the reasons behind such positive view were rather pragmatic: most managers acknowledged that foreign-trained staff was an essential resource to face shortages of domestic workforce. Furthermore, the co-existence of different educational, professional and cultural background was seen as an enrichment also for native staff and a factor that could improve the working atmosphere and the quality of services delivered. Many consider that foreign trained nurses and doctors, with their past working experience in their countries of origin and different educational backgrounds, bring into the workplaces **additional technical competences, practical experience or relational skills** and contribute to raise quality standards of the services. In many cases, they are even seen as better trained than national workers.

*And interestingly once they are adapted in a way and feel comfortable, they bring up the standards. In*

*terms of the technical side of things, for instance their clinical skills, nurses from Portugal are able to cannulate, put in needles for drips and things, they're able to do venopuncture to take blood, they could do what's called arterial stabs which our nurses never, which means you stab into to get down to an artery to take blood. That's quite difficult to do missing all the other bits and pieces. And that's routine, that's what they're taught in their graduate programme.* (See Jayaweera and McCarthy, 2015, p. 48)

Doctors and nurses interviewed in **Spain** affirm that Latin American MHWs have **more (and often better) practical experience** than Spanish resident doctors in their first year of specialty training. The professional education and experience of Latin American nursing assistants is also valued very highly (Finotelli, Mateos and De Montbel, 2015).

Furthermore employers in **Spain** and in **Italy** were reported to particularly value foreign workers because they are usually seen as hard workers, they are perceived to create less conflicts and to complain less in comparison with natives, to be helpful and flexible, to adapt quickly and get along well with the rest of their colleagues (Finotelli, Mateos and De Montbel, 2015; Salis and Castagnone, 2015b). In **Italy** the perception is that **foreign workers are often more available to do extra-hours and make less use of paid leave**, or they rather prefer to concentrate their days off in a single period of the year, in order to be able to travel back to their countries for a longer period of time, instead of scattering their days off over the year. They are presented as less opportunist, compared to native Italian workers, in making use of the statutory benefits such as the possibility to get paid sickness leave or part-time working arrangements. However various managers pointed out that such greater commitment, flexibility and availability to work over-time is gradually reduced through a process of assimilation to attitudes of Italian workers after some time in the workplace, especially among those employed in the public sector (Salis and Castagnone, 2015b). In other previous studies based on interviews with employers of migrants (Allasino, Bertolini, 2006; Matthews, Ruhs, 2007; Castagnone, 2012; Sciarrone, Santi, 2000; Dench et al., 2006), employers' preference over migrant workers relies on a "**motivational capital**" that migrants would own to a greater extent than the majority of the nationals. A perceived greater spirit of sacrifice, a superior work ethic, tenacity, a strong adaptability and flexibility, are all soft skills making foreign workers more "attractive" to destination countries' firms, compared to local workers.

Besides, the positive aspects of having a multicultural workforce was put into relation with the increasingly multicultural user base: having foreign professionals in the firm staff was considered a strategic asset to meet the specific needs of a raising share of patients with foreign origin.

*It can be really nice if you have a patient you know, and maybe their English is not that great, and we have a list of the nurses with the different languages. That can be a real asset. The fact that I can't communicate or something but they can, that can be really nice.* (See Jayaweera and McCarthy, 2015, p. 50)

*The number of patients with a migration background is increasing significantly over the years. Therefore a foreign nurse can become a real asset. Hospitals have not yet elaborated explicit*

*policies to enhance such potential but in the practice it is largely exploited. For instance, if you have a foreign patients who barely speaks Italian, a co-national nurse can be very helpful in treating him. (See Salis and Castagnone, 2015b, p. 30)*

These findings indicate that the greater health professionals' diversity, mirroring the increasing patients' diversity, will likely lead to improved public health by enhancing access to healthcare for foreign populations, and by increasing opportunities for minority patients to see practitioners with whom they share a common race, ethnicity or language (Health Resources and Services Administration, 2006). Furthermore, in **Germany** it was mentioned that migrants could not only provide health care to persons with migration background already in Germany but also attract private patients from abroad for treatment at the hospital (Kovacheva and Grewe 2015b).

However, this overall positive picture does also include specific challenges and problematic issues which emerge especially in the early phases of workplace inclusion. In fact, from the perspective of employers, the increasing inflows of foreign workers, and the gradual superposition of different layers of international migration, with the "*super-diversity*" (Vertovec, 2007) this entails, produced major modifications in health workforce within the specific workplaces, thereby challenging **employers' ability to manage a much more diversified workforce**. Foreign-trained workers who are recruited abroad or hold foreign educational titles – and in some cases previous working experience – in the origin country, often encounter higher obstacles in speaking the destination language, are often bearers of different professional experiences and need longer adaptation time into the new workplace.

Main **challenges** mentioned in all surveyed countries derive from **language and communication problems,** that can be brought back to **cultural forms of communicating**; **knowledge of dialects, idiomatic expressions**, **and technical or general vocabulary**; and **accent.** In **Germany** and in **Italy** migrants were reported to face problems in writing in the national languages, particularly for the preparation of documentation. In **Germany** medical jargon was identified as country-specific and as even more challenging than everyday language. In **Ireland**, the **UK** and **Spain**, the main communication problems are instead related to foreign workers speaking the national languages with stronger accents. This phenomenon concerns in particular migrants coming from English or Spanish-speaking areas. Interestingly, in some cases, being a proficient speaker of the national language (or even a native speaker as in the case of Latin Americans in Spain) proved to be even more challenging than speaking a different language. In **Ireland** the main issue reported by most of the nurses who went through this process was the language difficulty, mainly related to understanding different Irish accents. While most of those coming from Asian countries completed their nursing education in English, understanding the natives in the host countries was often very challenging for the newcomers. The majority of Filipino nurses reported problems with certain idioms used in Ireland, which they were not previously familiar with.

Next to the main "**super-diversity**" axes of differentiation, such as *country of origin* (comprising a variety of possible subset traits such as ethnicity, language[s], religious tradition, regional and local identities, cultural

values and practices), *migration channel* (often related to highly gendered flows, specific social networks and particular labour market niches), and *legal status* (including a myriad of categories determining a hierarchy of entitlements and restrictions) (Vertovec, 2007: 3), other dimensions of differentiation related to the *educational and professional background* contribute to raise the level of heterogeneity of workers and the complexity of their integration in the healthcare facilities.

While generally valued in a very positive way, educational and working backgrounds obtained abroad may also have an adverse impact on the working environment. Professional socialization, intended as the process of acquiring technical skills, but also learning health system norms, values, behaviours and attitudes, the content and definition of tasks necessary to assume a professional role, may sensibly differ across countries. Different health systems entail different legal and ethical contexts, and divergent cultural and communication styles – even when migrant health workers are fluent in the receiving country's language. Different technologies and professional roles as well as patient characteristics or patient load can make professional life a challenge, (Slowther et al., 2009, in Schultz, Rijks, 2014: 23). Such differences may constitute a relevant **gap in healthcare working and professional cultures**, between the origin and the destination country, with possible skills deficit or surplus compared to their equivalent native colleagues, and require time and efforts in order to adjust to the working and professional culture of the receiving contexts.

For instance, these aspects came out as highly relevant, and sometimes problematic, in **Italy**: here the massive inflows of nurses from abroad were generated by, and occurred in a transitory phase when, deep changes in the role and position of nursing professionals were introduced. This means that foreign nurses, brought into Italian hospitals their different skills levels, and different notions about their professional roles (e.g. in the relation with doctors) in a moment when these aspects were undergoing radical transformations in the destination country. Some managers and stakeholders interviewed reported that while nurses from some Latin American countries were closer to the new "Italian way of nursing", hence better trained and more autonomous with respect to doctors, those from some Eastern EU countries were rather seen as more dependent from doctors and thus closer to the old model. This apparently created some tensions, especially in the early phases.

> *Foreign-trained nurses have more difficulties and sometimes they may create some problems that bring back our professional category to a situation that is no longer accepted here: they are less prone to project work and to innovation, and less autonomous with respect to doctors. (Salis and Castagnone, 2015b, p. 36)*

Similar issues related to the different configuration of the skill mix between different health professionals (i.e. doctors, nurses, nursing assistants or other auxiliary roles) across countries of origin and destination emerged in **Ireland** and in the **UK**. Such consideration is backed by interviewed migrant workers who confirmed that the day-to-day tasks of nurses in Ireland differ to those 'back home': some claimed that they were allowed to work more independently in their countries of origin. There were also issues related to personal care provided to patients: in countries such as the Philippines, such duties are usually the responsibility of other family

members. It was reported by a number of our interviewees that they did not expect to have to provide this care in Ireland (Bobek and devitt, 2015).

Unsurprisingly, the **initial period** of workplace inclusion is the most difficult in the integration process, when the migrant is required to adapt to a new context with its different formal and informal rules, strongly relying on the support of the peer group in adjusting to the new situation. In **Germany** besides language skills, migrant interviewees further referred to adjustment to the new workplace with its working processes and culture as a challenge at the beginning of employment. They show high acceptance of the necessity to catch up and to adapt to German and workplace-related customs, but call for more acceptance on the side of the employer and the team for the time it needs (Kovacheva and Grewe, 2015b).

However, in the Spanish report it was highlighted how integrating in a new workplace, such as an hospital, with its own protocols and idiosyncrasies, needs an adaptation and integration period for all new workers at the beginning are “outsiders”, where “coming from outside” can mean coming from another hospital or another service, or having trained in another speciality, or in another country (Finotelli, Mateos and De Montbel, 2015).

**Stereotypical representations towards specific nationalities** were also reported in **Italy**, with Peruvians (or Latinas in general) considered as more talented for care work, more lovely, careful and patient with elderly patients, and Romanians being more similar to Italians, at the same time harsher and more detached, or Africans sometimes depicted as rude (Salis and Castagnone, 2015b). In **Spain** interviewees in both hospitals mentioned the existence of social prejudices concerning work habits in countries other than Spain (e.g. German and Chinese people are hard-working, Latin people are slow, etc.) (Finotelli, Mateos and De Montbel, 2015). Such "**collectivized images**" of migrants (Ambrosini, 2005) – i.e. the positive or negative appreciation of national groups employed in certain occupations or sectors – are generated and act through the sharing of information between employers and workers, they are demonstrated to attribute certain virtues or weaknesses to some groups, thus influencing the processes of recruitment of co-nationals within firms in the same sector (Zanfrini, 2004; Castagnone, 2012) but probably also in shaping their integration into the workplaces.

Current evidence supports the notion that developing intercultural competence in health care settings is increasingly seen as a successful mean of responding effectively to the huge ethnic and racial demographic shifts and changes that are confronting our countries healthcare system and to provide care to patients with diverse values, beliefs and behaviours (Salisbury, Byrd, 2006). However, in order to achieve systemic intercultural competence in the structures of the health care system, developing mechanisms of management and training of both foreign and native health staff is needed in order to fully take advantage of the potential of such an approach.

### 3.2 Working in multicultural teams: the perspective of native and foreign colleagues

Similarly to what emerging from the employers’ and managers’ perspective, **MHWs** themselves, as well as their native colleagues, **express a quite positive assessment of their degree of integration** in the specific

workplaces. The circumstances in which the fieldwork was conducted and the interviews were carried out may have generated a bias in preventing the disclosure of more critical opinions. However, the remarkable coherence of opinions throughout all studied cases seem to prove the reliability of the overall judgement expressed in the interviews.

Though with some small distinctions linked to the specific contexts, in all countries both native and foreign health workers evaluate overall positively their experiences into highly diverse workplaces, acknowledge the potential benefits of a multicultural workforce, both for the quality of the services and their personal professional growth, and found it relatively easy to interact with each other at work.

**Multicultural teams** are considered **as an asset** for the working atmosphere and working process also in the workers' perspective. They are associated with "openness, different perspectives" and therefore greater opportunities for personal and professional advancement: native workers highly appreciate the professional competences of their migrant co-workers, often acknowledge that the latter hold higher training and professional standards and welcome the enrichment that different cultural and professional backgrounds can bring about.

> *[For] some nurses, the standards in their countries are higher than here. (...) They come with their own values and they show you things. You learn different ways of doing things. (...)* (Jayaweera and McCarthy, 2015, p. 36)

> *Personally I like having people from different cultures around and I like experiencing different people's view points, and I think that can add... to the patients overall care. And different perspectives can be good.* (Bobek and devitt, 2015, p. 35)

The presence of other foreigners in a team is perceived by MHWs as supportive for integration of newcomers at the new workplace and as a positive contribution to good working atmosphere. In general, conflicts that may occasionally arise in the workplace are attributed to individual characteristics or professional disagreements rather than to different cultural background. Several interviewees in the German study stated that they had conflicts with colleagues at different times, but the source of conflict was individual and professional and unrelated with national culture or origin (Kovacheva and Grewe, 2015b).

Again, relevant **specificities of the healthcare as a sector and of hospitals as workplaces** are evoked by health professionals interviewed as key factors explaining such overall positive outcomes and dominant optimistic rhetoric on multicultural working teams across all countries. Healthcare sector entails a **strong ethical apparatus**. It was often mentioned by both foreign and native workers how personal relationships and individual characteristics are secondary to the efficient overall functioning of the hospital as an organisation, while "*the important thing is that [patients] are well cared for, no matter who takes care of them*" (Finotelli, Mateos and De Montbel, 2015, p. 30). Furthermore hospitals are **based on highly codified procedures**, **interactions and tasks** and on **structured hierarchical relationships** within the internal staff. As effectively stated in the Spanish report, the use of coloured uniforms and/or badges according to different professional

categories dissolves the ethnic category in favour of professional ones (Finotelli, Mateos and De Montbel, 2015), while the level of competence, the disposition to collaborate with colleagues and the professional performance *per se* are considered as a priority.

The need to "get along well with everyone" is also determined by the existence of two hospital organisation levels: a formal one (that of hierarchy, protocols, formal supervision by HR, medical management and supervisors in general); and an informal one (that of daily practice, teamwork, informal supervision between colleagues, etc.), which becomes very relevant during the adjustment period, but also in the management of shifts, guards and vacations (Finotelli, Mateos and De Montbel, 2015).

While the general picture is one of positive and unproblematic interaction in every day work some **challenges to personal and professional relationships** and **sources of tension or conflict** at the workplace level were also mentioned.

One of the main challenges identified in the staff relationships was, again, around **communication**. In **Spain**, Latin American MHWs' different ways of speaking and writing Spanish do to not always generate sympathy. Yet none of the EU MHWs felt discriminated due to difficulties with the Spanish language. Instead, the opposite was the case: their colleagues see their faults as something "funny", they help them to learn Spanish and respect their work even if some patients are unable to understand them. In turn, Latin American MHWs' are often urged to change how they speak and to use proper vocabulary. This approach leads to the establishment of a kind of hierarchy between different ways of speaking Spanish ("*it is like speaking inferior Spanish*") (Finotelli, Mateos and De Montbel, 2015). In **Italy** some mention was made of minor problems with language and communication, which may 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. However, both in **Italy** and the **UK**, some problematic issues related to the **use of foreign language** in the workplace was reported, especially where the presence of foreign staff is larger and concentrated in some specific national groups, for instance Romanians and Peruvians in the Italian case. There it could happen occasionally that colleagues of the same nationality communicate among themselves in their native tongue not only during lunch and coffee breaks but also during work hours in the hospital wards. These practices seem to affect quite negatively the every-day interaction in the workplace and are usually disapproved by most interviewees, as a sort of disrespectful attitudes towards other colleagues (Salis and Castagnone, 2015b).

Building team dynamic at work can also happen outside of the workplace. No relevant differences between native colleagues and migrant health workers were reported in the frequency and **forms of socialising outside the workplace**. The majority of our interviewees do socialise with their colleagues occasionally, such as Christmas parties or birthday celebrations, or when there are work related events, such as farewell parties. Busy work schedules as well as family constraints are the main reasons that prevented them from socialising more with colleagues. In some cases differences were reported in cultural habits preventing migrant workers to engage socially with their colleagues, such as going to the pub after work. Different cultures and habits of separating or harmonising work and social life represented also a challenge in some cases.

No major episodes of racist behaviour, attitudes or opinions by colleagues towards **foreign workers were**

**reported, with the exception of isolated episodes.** However behaviours ranging from mistrust and ethnic stereotyping to open discrimination and xenophobic attitudes were reported in all countries on the part of patients and their families, with reported refusals to be treated by foreign staff and conflict situations. In **Germany** many interviewees encountered mistrust towards their professional or language skills by patients that asked for treatment by German colleagues. In **Italy** episodes of open racism were reported only in regards to black workers, especially within nursing homes for the elderly, where patients are usually very old people, typically affected by mental impairments, who are usually not accustomed to dealing with black people. The reaction of professionals with foreign backgrounds was to underplay such episodes, while native colleagues were much more assertive in deploring such attitudes and incidents and declared to have often actively intervened. Evidences from Italy reported that a certain degree of tolerance towards racist attitudes or forms of hostility towards migrant workers was shown by the health facilities' managers. The responsibility of dealing with these kind of situations was usually put on workers themselves, who were asked to bear and not react to any racist behaviour adopted by patients. Patience and tolerance, even of aggressive behaviours related to racism or hostility towards foreigners, were indicated as key skills pertaining to care work. While the need to adopt ad hoc measure to address these situations was usually neglected (Salis and Castagnone, 2015b).

### 3.3 How diversity is managed: Equality policies, diversity management, measures targeting workplace integration of migrant health workers

There is some controversy in the literature as to the consequences – beneficial or detrimental – of a diversified workforce for firm performance. The existing literature recognises the value of workforce diversity, showing that equality and diversity strategies have a significant effect in increasing productivity and innovation, in reducing employee turnover and generating marketing advantages. Other experts, however, highlight that diversity may induces negative effects on firm productivity mainly due to communication problems and that integration costs connected to a more culturally diverse workforce, seem to outweigh the positive outcomes coming from creativity and knowledge spill over (Parrotta, Pozzoli, Pytlikova, 2011). However, scholars suggest that the potential benefits will not come into being simply because of greater workplace diversity, but through creating an atmosphere of inclusion and making a commitment to valuing and managing diversity, by implementing ad hoc measures.

In response to the growing diversity in the workforce, customer base, market structure and overall business environment, the adoption of **diversity management** as "*a set of voluntary organizational actions that are designed to create greater inclusion of employees from various backgrounds into the formal and informal organizational structures through deliberate policies and programs*" (Mor-Barak, 2011: 218) is increasingly advocated by public institutions and implemented as part of strategic business agendas throughout the world.

As explained by Mor-Barak (2011) a **continuum** can be ideally drawn ranging from **equal employment opportunity legislation** (prohibiting discrimination), to **affirmative action programs** (positive affirmation

measures to ensure equal opportunities), and to **diversity management measures** (proactive policies aimed at promoting a diverse and heterogeneous workforce). While antidiscrimination legislation and affirmative action policies require the removal of barriers and the implementation of measures that encourage full employment of groups defined by personal characteristics (such as gender, race, physical ability, ethnic heritage, and family responsibilities, see Kramar, 1998), diversity management concentrates more on the firm level (being it private or public) and puts a particular emphasis on business advantage that such an approach can provide to organizations.

Diversity management approach has a double focus. On one side it is oriented at contrasting discriminatory practices and at overcoming the challenges that diversity itself can pose, including accommodating the differing values and expectations of a varied staff, as well as building trust and overcoming communication barriers. On the other side, it is aimed at improving organisational competitiveness and efficiency, driven by business purpose and market advantage. In relation to this, it emphasises the necessity of recognising cultural differences between groups of employees and making practical allowances for such differences in organisational policies. The idea is that encouraging an environment of cultural diversity where people's differences are valued enables people to work to their full potential in a richer, more creative and more productive work environment' (e.g., Cox, 2001; Ozbilgin and Tatli, 2008).

The EU as a whole has developed an increasing commitment to policies for diversity management and inclusion, by **encouraging employers to put diversity management more firmly on their strategic business agendas,** while also supporting their activities across the EU through numerous actions over the last few years. From 2004 to date, 13 national Diversity Charters have been adopted across Europe aiming at encouraging companies to implement and develop diversity policies. The charter is a short document voluntarily signed by companies which outlines the commitment of the undersigning organization to promote diversity and equal opportunities in the workplace, regardless of, for example, age, disability, gender, race or ethnic origin, religion or sexual orientation.

Different countries within the EU, however, have implemented varying levels of protection and initiatives, and some have adopted affirmative or positive action programs. Accordingly, companies in different countries may or may not design, or even aspire to implement, diversity management policies and programs, and those that have been developed will vary in scope and organizational commitment.

In **Spain** and **Italy**, although some isolated experiences of diversity management have been implemented in the last few years and there is a growing debate over this approach both in the private and public sector[8] the diversity issue and the implementation of related measures and policies is still of limited relevance. **No explicit**

[8] In Italy see, for instance, the project DyMove promoting the culture of diversity management in the public sector and in the transport sector (project website: http://www.unar.it/unar/portal/?page_id=4894) and Monaci, Zanfrini, 2014, for a review of practices of diversity management in Italy; and see Gualda, 2014 for a review of experiences on Diversity Management in different organizations in the Andalusian Region, in Spain.

**or implicit diversity management practice** has been observed in the surveyed health facilities in these countries. The need to envisage ad hoc measures to address the cultural diversity of staff was generally underscored and the fact that workers should be treated equally, regardless of their nationality or cultural origin was generally stressed in the first place. In the view of the interviewed managers, MHWs do not present specific problems or specific needs with respect to their Italian colleagues. As a result, specific integration initiatives or diversity management measures for migrants do not represent an institutional priority and are not objet of *ad hoc* policies within both public and private surveyed hospitals (Salis and Castagnone, 2015b; Finotelli, Mateos, De Montbel, 2015).

While **equal opportunity and anti-discrimination policies of workers are provided** at a state level in all European countries, in **Italy** and in Spain they are largely limited to gender and disabilities as areas of intervention, whereas **Germany**, **Ireland** and the **UK** show a more advanced level of implementation, covering a broader variety of groups and categories, among which ethnicity.

According to Mor-Barak (2011), equal rights legislation and affirmative/positive action policies can be considered as prerequisites for the development of diversity management, because they create the social, legal, and organizational environment on which diversity management initiatives can be based. However, the UK emerges as the only country with a proper set of diversity management policies and measures.

While surveyed hospitals in **Germany** joined the Corporate Charter of Diversity for Germany in 2008 (private hospital) and 2013 (university hospital) and are committed to creating working environments free of prejudice, managers from the health facilities report that migrants are not perceived as special target group for integration within their workplace and that no structured diversity management measures have been implemented for this purpose. They benefit from general measures for new employees such as orientation days and mentors assigned to them in the first months of employment. However, the surveyed German hospitals do have **support measures targeting special groups of migrants** such as guest doctors and participants in pilot projects for recruitment of trainees in nursing. In particular measures target incoming foreign staff at the initial stage of employment and include induction, language courses and tutoring and assistance with handling administrative formalities inside and outside the workplace, providing information about administrative formalities, such as obtainment of a work and residence permit and recognition of qualification, or general support related to opportunities for family reunification and labour market participation of family members (Kovacheva and Grewe, 2015b).

In **Ireland,** according to the public hospital managers multiculturalism in the hospital is an 'everyday norm' rather than an issue that needs to be emphasised. However, the public hospital in Dublin has a Cultural Diversity Officer until 2008 and used to organise a cultural diversity day every year as well as to provide cultural diversity modules as part of the induction for new staff. Furthermore it was recently adopted a Dignity at Work policy specific to this structure, framed in the **state-level equality policy**. The **Dignity at Work Policy** developed by the hospital states that staff members must be treated equally based on the nine grounds featuring in Irish equality legislation, among which marital status, family status, race, religion, age, disability,

sexual orientation, gender and membership of the Traveller Community (i.e. Gypsy, Roma and Travellers of Irish Heritage) (HSEA, 2004; Bobek and devitt, 2015). The focus of Ireland's most recent diversity measures focus of diversity management is on patients, rather than on staff. Similarly in **Spain**, where no major concern for diversity of staff is registered, measures were implemented to improve the relationship between doctors and patients belonging to the Gypsy minority (Finotelli, Mateos and De Montbel, 2015).

Similarly to Germany and Ireland, the **UK** has a strong equality legislation, which prohibits discrimination in the workplace and thereby should ensure equal treatment of migrant workers. Since 2010, a number of disparate pieces of anti-discrimination legislation have been brought together in a single **Equality Act**. As required by legislation, **each public hospital, as well as private health provider, has a comprehensive Equality and Diversity policy** in place, which makes an explicit and specific link between equality and diversity in the workforce and positive outcomes for patients.. This is the only case among the ones studied by the project, where a policy targeting migrant workers specifically makes mention of the fact that the diversity of backgrounds, skills, learning and thinking styles 'will add value to the business'. The policy also makes specific reference to nationality, and to work status (part time or fixed term status). Another important difference is the fact that the private hospital's policy explicitly applies to temporary and agency workers as well as to permanent staff (Jayaweera and McCarthy, 2015). In the **UK**, where hospitals (public and private) have done a large scale international recruitment, a strong emphasis is placed on support in the initial period, with targeted induction packages, meetings, training events and related tools. Also in **Germany** particular attention is placed on measures of mentoring and training of newly recruited foreign professionals.

## 4. Conclusions

The paper has illustrated how, due to the raising and structural shortages emerged in the health sector across Europe since the beginning of the 2000s, European countries have increasingly relied on the contribution of migrant health workers to fill such gaps. While the health systems have shown different needs in terms of professionals and various approaches in recruiting and providing access to foreign health professionals to the national labour markets, some common trends can be traced.

In the first half of the 2000s the main hiring strategy of MHWs implied active international recruitment campaigns, though with some national specificities in terms of role of private or public actors managing such processes and of source countries, based on historical colonial links, language and culture proximity, or bilateral local or governmental agreements. The report observed that in this period immigration policies, such as preferential entry channels for this category of workers or policies for the conversion of the permit of stay from study to work reasons, sustained such process.

With the economic downturn, since the late 2000s, the international recruitment polices as a main strategy for reducing staff shortages, has undergone a sharp decline. At the same time most EU countries have introduced tightening entry and stay requirements for non-EU health professionals. Labour shortages however have not lessened, while outflows of native workers seeking better professional opportunities and higher salaries abroad have arisen or increased their intensity.

The international recruitment practices, considered costly and inefficient and sometimes characterized by deceitful practices in some contexts, were thus replaced by other strategies. Policies aimed at raising the participation to health labour market of native and settled immigrant workers were thus implemented in all countries, by expanding medical schools and nurse training opportunities or implementing retention measures for resident workers. However, the most evident change consisted in a significant rebalancing of the magnitude of EU and non-EU health professional flows into some countries in the region, with a relative increase in EU flows, which, on one side, could not be controlled to the same extent at national level (Buchan, Wismar, Glinos, Bremner, 2014) and presented some advantages compared to non EU workers, on the other side.

The set of regulation mechanisms and institutional factors, such as the recruitment strategies, the recognition of professional titles, the labour market policies (as the access to professional practice, to the public sector, etc.), have shaped the characteristics of the migrant labor force, by determining their profile, in terms of nationality (i.e. their linguistic, cultural, social and cultural background), of working and professional cultures and of structural integration into the labor market (i.e. determining a prevalence in doctors/nurses/nursing assistants, their presence in the public or private sector, and concentration in the different levels of the health industry, etc.).

Such institutional choices, and the related dominant profiles they have produced in each country, imply different challenges at the workplace level and have a direct impact on the integration obstacles and opportunities at the workplace level, at least in the fist period of entry into the sector and of adjustment in the

health facilities. In this sense, the emerging option to hire EU workers instead of third country nationals since the last years has implied a positive impact in the practices of entry and of stay of foreign professionals in the destination country, since the automatic recognition of the educational titles for the first group was also eased by European directives.

However, in the surveyed countries a concentration of foreign workers in the lowest layers of the health labour market has been observed. Furthermore there is evidence that migrant health workers are more subject to unfavourable working conditions than nationals. They work longer hours and have a higher incidence of temporary contracts, non-standard working schedule and shift work than their native colleagues (See Villosio, 2015). They are disadvantaged in accessing upward mobility careers. Doctors from non-EEA countries are more likely to get stuck in short-term positions and slow career progression.

Despite the role migrant health workers have been increasingly assuming in the European health systems and their specificities both in terms of opportunities and challenges they bring to receiving health facilities, few targeted integration measures are in place in Europe. In the countries involved by the WORK-INT project we found that a variety of approaches has been adopted. The latters range from the neglect of the workforce diversity by employers and managers, who tend to leave foreign workers and colleagues to handle daily problems, such as discrimination by patients, to an approach oriented at reducing the structural forms of discrimination and at facilitating MHWs first entry into the workplace, through measures of adjustment, as in Ireland and Germany; up to the case of the UK, which appears to be the only country surveyed with a national level discussion of and set of policy responses to diversity within the health sector. However the implementation and effectiveness of such policies still varies depending on local employers.

However, despite the unfavourable structural integration of MHWs in the lowest segments of the health sector and their critical working conditions compared to their national counterparts, we found an overall good level of interaction and integration in the surveyed health facilities. This is particularly true in the medium-long term, whereas the entry of MHWs into the health care industry and the initial adjustment in the workplaces at destination are the most critical points of their career in this sector.

As discussed in the paper, such positive outcomes at a micro level can be explained by the specificities of the health industry itself, as a highly structured and regulated sector; of the health professions, based on a strong ethical apparatus; of specific health facilities, as hierarchical structures based on highly codified interactions, but also strongly relying on cooperative collaboration among its different human resources segments.

Such results confirm the necessity to study the integration paths and outcomes of migrants in destination countries looking at the specificities of the economic sector where they are employed. As discussed, the health sector in European countries has undergone important changes in the last decade and a half, in terms of structural restructuring, of highlighted staff shortages and related filling strategies. Furthermore, workplaces demonstrated to be crucial contexts where integration of migrant workers takes place and should be observed and analysed, by looking at their peculiarities, in terms of public or private nature, dimension, prevalence of specific professionals, national composition of health force and integration policies targeting migrant workers.

**References**


Allasino E. e S. Bertolini (2006) "Il lavoro operaio degli immigrati nelle interviste alle imprese", In: IRES Piemonte, *Immigranti in Fabbrica*, IRES quaderni 109.

Ambrosini, M. (2005) *Sociologia delle migrazioni*, il Mulino, Bologna.

Bach, S. (2008) *Staff shortages and immigration in the health sector*. Migration Advisory Committee.

Bijwaard, G.E. (2010) "Immigrant migration dynamics model for The Netherlands", *Journal of Population Economics*, 23 (4): 1213-1247

Bobek, A. and Devitt, C. (2015) *Workplace Integration of Migrant Health Workers in Ireland*. WORK→INT National Research Report, FIERI, Turin.

Bobeva D, Garson J-P (2004) Overview of bilateral agreements and other forms of labour recruitment. In OECD, *Migration for employment: bilateral agreements at a crossroads*. Paris, Organisation for Economic Co-operation and Development.

Bobo, L.D., Suh, S.A. (2000), "Surveying Racial Discrimination: Analysis from a Multiethnic Labour Market", in Bobo, L.D. et al. (ed.) *Prismatic Metropolis: Inequality in Los Angeles*, Russell Sage Foundation, New York, 523-560.

Bolzman, C. and R. Fibbi (1991) Collective assertion strategies of immigrants in Switzerland. *International sociology*, 6(3): 321-341

Bommes, M. (2004) 'Zur Bildung von Verteilungsordnungen in der funktional differenzierten Gesellschaft. Erläutert am Beispiel "ethnischer Ungleichheit" von Arbeitsmigranten', In: T. Schwinn (ed.), Differenzierung und soziale Ungleichheit: Die zwei Soziologien und ihre Verknüpfung, 399-428. Frankfurt am Main: Humanities Online.

Boswell, C. and D'Amato, G. (2012) *Immigration and Social Systems. Collected Essays of Michael Bommes*. Amsterdam University Press, Amsterdam.

Castagnone E., (2012) *Il lavoro immigrato: la prospettiva delle imprese*, In: FIERI-CCIAA, "Non Solo Braccia. Un'indagine sull'impiego di lavoro immigrato nelle imprese del torinese", CCIAA Torino.

Castagnone E., Mezger C., Schoumaker B., Nazio T., Rakotonarivo N. (2013) *Understanding Afro-European labour trajectories: integration of migrants into the European labour market, transnational economic participation and economic reintegration into the country of origin. A Comparative Study*, MAFE working paper

Castagnone E, Nazio, T., Bartolini, L. and Schoumaker, B. (2014) Understanding Transnational Labour Market Trajectories of African-European Migrants: Evidence from the MAFE Survey. *International Migration Review* 49(1): 200–231.

Chaloff, J. (2008) Mismatches in the Formal Sector, Expansion of the Informal Sector: Immigration of Health Professionals to Italy, *OECD Health Working Papers*, No. 34, OECD Publishing. http://dx.doi.org/10.1787/236168115106

Council of Europe (2000) Diversité et cohésion: des nouveaux défies pour l'intégration des immigrés et des

minorités, Strasbourg: Council of Europe Publishing.

Council of Europe (2005) Guide méthodologique. Elaboration concertée des indicateurs de la cohésion sociale, Strasbourg: Council of Europe Publishing.

Cox T. (2001) *Creating the Multicultural Organization. A Strategy for Capturing the Power of Diversity*, Jossey-Bass, San Francisco, CA.

Dench S, Hurstfield J, Hill D, Akroyd K. (2006) Employers, Use of Migrant Labour. RDS Online Report 04/06, Home Office

Devitt, C. (2014) Government Responses to Foreign Worker Demand During Economic Crises. The Cases of Britain and France 2008-2013, Comparative Migration Studies, 2(4), pp. 445-467.

Devitt, C. Bobek, A. and Kingston, G. (2015) *Migrant Workers In The Irish Healthcare Sector*. WORK→INT National Background Report, FIERI, Turin.

Entzinger, H. (2000) *The Dynamics of Integration Policies: A Multidimensional Model*, in R. Koopmans and P. Statham (eds), *Challenging Immigration and Ethnic Relations Politics: Comparative European Perspectives*, Oxford: Oxford University Press, pp. 97-118.

Erdogan-Ertorer (2014) *Cultural diversity and competency in the settlement sector*, Paper presented at the 11th IMISCOE Annual Conference, 27-28-29th August 2014, Madrid.

Esser H. (2004) *Welche Alternativen zur "Assimilation" gibt es eigentlich?,* In K. J. Bade and M. Bommes (eds.) *Migration - Integration - Bildung. Grundfragen und Problembereiche*, , Osnabrück: Eigenverlag IMIS, pp. 41-59.

European Commission (2014) *European Vacancy and Recruitment Report 2014*. Luxembourg: Publications Office of the European Union.

European Commission (2014) Analytical Highlight, Focus on Health Sector, EU Skills Panorama - May 2014 http://euskillspanorama.cedefop.europa.eu/App_Controls/Documents/ShowDocument.aspx?documentid=83&

Finotelli, C. and Mateos, E. (2015) *Migrant Workers In The Spanish Healthcare Sector*. WORK→INT National Background Report, FIERI, Turin.

Finotelli, C. Mateos, E. and De Montbel, F. (2015) Workplace Integration of Migrant Health Workers in Spain. WORK→INT National Research Report, FIERI, Turin.

Flückiger, I. and J. Ramirez (2001) Positions hiérarchiques et ségrégation par origine en Suisse, In H.-R. Wicker, R. Fibbi and W. Haug (ed.), *La migration et la Suisse: Resultats du Programme nationale "Migrations et relations interculturelles*, Zürich: Seismo, pp. 302-319.

German Medical Association (2014) Ärztestatistik. Bei den Ärztekammern registrierte ausländische Ärztinnen und Ärzte. Available online at http://www.gbe-bund.de, checked on 2/12/2014.

Buchan, J., Wismar, M., Glinos, I.A., Bremner, J. (eds.) (2014) *Health Professional Mobility in a Changing Europe: New Dynamics, Mobile Individuals, and Diverse Responses* (Observatory Studies Series) European Observatory on Health Systems and Policies: World Health Organization.

Hawthorne, L. (2008) The Growing Global Demand for Students as Skilled Migrants, MPI – Migration Policy Institute.

Heckmann, F. (2006) *Integration and integration policies. IMISCOE network feasibility study*. Bamberg: European Forum for Migration Studies

Ho, E.L.E. (2011) Migration trajectories of "highly skilled" middling transnationals: Singaporean transmigrants in London, *Population, Space and Place*, 17(1), 116-129

HSE MET (2012) *Implementation of the reform of the intern year. Second interim report*. Dublin, Health Services Executive Medical and Training Unit.

Humphries, N., Brugha, R. and McGee, H. (2009) *Career progression of migrant nurses in Ireland: Nurse Migration Project Policy Brief 5*, Dublin: Royal College of Surgeons.

Jayaweera, H. (2015) *Migrant Workers In The UK Healthcare Sector*. WORK→INT National Background Report, FIERI, Turin.

Jayaweera, H. and McCarthy, H. (2015) *Workplace Integration of Migrant Health Workers in the UK*. WORK→INT National Research Report, FIERI, Turin.

Kaiser, C.R., Major, B. (2006), "A Social Psychological Perspective on Perceiving and Reporting Discrimination", Law & Social Inquiry, 31(4), 801-830.

Kaiser, C.R. and Miller, C.T. (2001), "Stop Complaining! The Social Costs of Making Attributions to Discrimination", *Personality and Social Psychology Bulletin*, 27, 254-263.

Killias, M. (2005) Immigrazione e criminalità, Paper presented at the conference "Problemi e Ragioni della devianza tra i giovani immigrati" Torino, Fondazione Giovanni Agnelli, October 10th

King, R., Findlay, A., Ruiz-Gelices, E. and Stam, A. (2004) International student mobility *HEFCE Issues Papers* 30, HEFCE: London.

Kovacheva, V. and Grewe, M. (2015a) *Migrant Workers In The German Healthcare Sector*. WORK→INT National Background Report, FIERI, Turin.

Kovacheva, V. and Grewe, M. (2015b) *Workplace Integration of Migrant Health Workers in Germany*. WORK→INT National Research Report, FIERI, Turin.

Kramar, R. (1998) Flexibility in Australia: Implications for Employees and Managers, *Employee Relations*, 20(5): 453–460.

Lorenzo, F.M.E., et al. (2007) Nurse migration from a source country perspective: Philippine country case study, *Health Services Research*, Vol. 42(3), Part II, pp 1406-1418.

Luhmann, N. (1989) 'Individuum, Individualität, Individualismus', in idem, Gesell-schaftsstruktur und Semantik. Studien zur Wissenssoziologie der modernen Gesellschaft 3. Frankfurt am Main: Suhrkamp, pp. 149-258.

Matthews, G. and M. Ruhs (2007) *The micro-foundations of labour shortages: Deconstructing employer demand for migrant labour in the UK's hospitality sector*. Working Paper available at www.compas.ox.ac.uk/changingstatus

M. Monaci and L. Zanfrini (eds) (2014) *Creare valore con la diversità*, Franco Angeli, Milano

Mor-Barak, M. E. (2011) *Managing Diversity: Toward a Globally Inclusive Workplace*. Thousand Oaks, California: SAGE Publications, Inc.

Özbilgin M., Tatli A. (2008) *Global diversity management: an evidence-based approach*. Palgrave Macmillan.

Parrotta P., Pozzoli D., Pytlikova M. (2011) Does Labor Diversity affect Firm Productivity? Norface Migration Discussion Paper No. 2011-22

Pastore, F. (2014) The Governance of Migrant Labour Supply in Europe, Before and During the Crisis. An Introduction. *Comparative Migration Studies* 2(4): 385-415.

Plotnikova E.V. (2014) Bilateral agreements in regulation of health worker migration. In J. Buchan (ed.), *Health Professional Mobility in a Changing Europe - New dynamics, mobile individuals and diverse responses*, PROMeTHEUS, Volume II. Observatory Studies Series (32). Copenhagen, Denmark: World Health Organisation.

Rechel B, Dubois C, McKee M (eds) (2006) *The Health Care Workforce in Europe. Learning From Experience*, World Health Organization Regional Office for Europe, Copenhagen.

Salis, E. and Castagnone, E. (2015a) *Migrant Workers In The Italian Healthcare Sector*. WORK→INT National Background Report, FIERI, Turin.

Salis, E. and Castagnone, E. (2015b) *Workplace Integration of Migrant Health Workers in Italy*. WORK→INT National Research Report, FIERI, Turin.

Salisbury, J. & Byrd, S. (2006) Why diversity matters in health care. *California Society of Anesthesiologists (CSA) Bulletin*, 90-93.

Schultz, C. and Rijks B. (2014) *Mobility of Health Professionals to, from and within the European Union*, IOM Migration Research Series No. 48, IOM.

Sciarrone, R. e Santi, R. (2000) *Immigrazione e lavoro: i punti di vista delle Associazioni territoriali degli industriali*, Fondazione Giovanni Agnelli, Torino (Contributi di ricerca).

Simoens, S. Villeneuve, M. and Hurst J. (2005) *Tackling Nurse Shortages in OECD Countries*, OECD, Paris.

Slowther, A. et al. (2009) *Non UK qualified doctors and good medical practice: The experience of working within a different professional framework*. Report for the General Medical Council, University of Warwick–Warwick Medical School, Warwick.

Sumption, M., Young, R. (2014) Immigration and the health-care workforce in the United Kingdom since the global economic crisis. In: Siyam, A., and Dal Poz, M. (eds) *Migration of health workers: WHO code of practice and the global economic crisis*. WHO

Talbot, C. (2013) *Highly Skilled Indian migrants in Ireland*, CARIM-India RR 2013/36, Robert Schuman Centre for Advanced Studies, San Domenico di Fiesole (FI): European University Institute.

Thomson, S. Figueras, J. et al. (2014) *Economic crisis, health systems and health in Europe: impact and implications for policy*, European Observatory for Health Systems and Policies, WHO Regional Office for Europe, Copenhagen.

Tjadens F., Weilandt C., Eckert J. (eds) (2013) *Health Systems, Work Conditions, Patterns of Health Workers' Mobility and Implications for Policy Makers*, Springer, Verlag Berlin Heidelberg.

Vertovec, S. (2007) Super-diversity and its implications. *Ethnic and Racial Studies* 30(6): 1024-1054.

Villosio, C. (2015) *Migrant Workers in the Healthcare Sector in 5 European Countries: A Quantitative Overview from EU-LFS*, WORK→INT Research Report, Turin, FIERI.

Wismar, M. Maier, C.B. Glinos, I.A. Dussault, G. Figueras, J. (2011) *Health Professional Mobility and Health Systems. Evidence from 17 European countries*. European Observatory on Health Systems and Policies

Zanfrini, L. (2004) *Sociologia delle migrazioni*, Laterza, Roma-Bari.

Zincone, G. (2009) *Immigrazione: Segnali di Integrazione*, Il Mulino, Bologna.