International recruitment of health workers: British lessons for Europe? Emerging concerns and future research recommendations

Abstract

Immigration as a solution to staff and skill shortages in the health system is increasingly on the agenda in the EU. The paper highlights the related social and policy dilemmas by comparing a new with an old destination country: Spain and the United Kingdom. After describing the challenges met by the UK, the article asks how far Spain is prepared to face the same issues. In particular, attention is paid to the occupational mobility of health workers after entry and to how immigration as a staffing solution poses new political and social challenges. Through the review of the background information regarding the immigration of health workers in the two countries, and the preliminary analysis of 15 exploratory interviews, this paper aims to identify the main trends and the key concerns for future analysis. Although our interviews only allow us to draw tentative conclusions, they do highlight emerging issues to be explored in the near future.

Our conclusions show that many of the problems traditionally encountered in the UK are now emerging in Spain, suggesting scope for further collaboration between government, employers and other stakeholders across the EU.

Keywords: Health workers, immigration, recruitment, occupational mobility, future research.

Introduction

In the 1990s and 2000s concerns over growing shortages of health workers (doctors and nurses) have emerged in most European countries. These shortages are projected to increase in the near future due to the needs of an ageing population. One route to partially overcome these shortages is via international mobility of health workers, as it has been increasingly promoted by the European Union (1). However, European countries differ strongly in their use of overseas health

workers. In particular, English-speaking countries (UK and Ireland) have long followed the US example of importing health workers. According to national census data (2), in 2001 the UK was (after Luxemburg) the EU country with the largest share of foreign-born nurses (15.2%) and physicians (33.7%). For a comparison, the share of foreign nurses and doctors were 1.04% and 11.1% in Germany, 8.9% and 22.9% in Sweden, 5.5% and 16.9% in France, 6.6% and 11.8% in Belgium, and 3.4% and 7.5% in Spain.

This paper aims to question how far, and with what implications, continental Europe can follow the path of Anglophone countries in attracting foreign health professionals. It will do so by comparing an old immigration country, the UK, with one continental country particularly inclined to follow its example: Spain. This country was chosen because, while starting from a very low incidence of foreign health workers, it has the potential for a high increase, has witnessed the largest immigration inflow in Europe over the 2000s, it has a fast ageing society (3), and it disposes of a larger pool of prospective foreign professionals speaking the same language than any other continental EU country. It must be noted that this paper does not aim to be an exhaustive analysis of the immigration of health professionals in both countries, but rather to identify emerging issues and key concerns through a review of secondary information and exploratory interviews from key informants. Relatedly, the paper highlights important knowledge gaps concerning the international recruitment of health workers in Europe.

The paper is organized as follows: in Section 1 we review the policy implications of international mobility of health workers, and in Section 2 we summarize the main features of immigration history in the UK and Spain. Sections 3 and 4 describe immigrant health workers experiences in both countries, and section 5 discusses similarities and dissimilarities to conclude with policy recommendations and future research goals.

1. Policy implications: health workers migration in Europe

Recruitment of foreign nurses and doctors originates in the incapacity by host countries to predict future needs of health professionals, train them and attract them into profession. In theory, proximity services like healthcare are not affected by economic volatility or seasonality, which are the roots of migrant recruitment in other industries (i.e. construction); however, health care attracts large number of foreign workers as well, and it is also affected by uncertainty. This uncertainty depends on natural factors (i.e. epidemics), but also changing political priorities and organizational restructuring. Changing boundaries between private and public health expenditure are the most visible example. In many European countries, there have been trends towards decentralization and marketization, with important implications for employment relations (4,5). For instance, re-organization in the UK increased managerial prerogatives and thereby employees' uncertainty with regard to their pay, job definitions and career progression (6).

The migration of health workers is distinctive because it is strongly influenced by the regulatory framework of individual governments that control the training, recruitment and deployment of health professionals (7). These frameworks give rise to particular national patterns of migration. The centrality of government regulation in the health sector is a significant issue, and this provides greater scope for policy interventions. Among the labour-market factors influencing migration in the health sector are the scope and nature of state involvement, the role of professional bodies, the nature of labour-market shortages, the role of migration regulations and migration entry categories, and the channels used by migrants to enter into the country. All of these factors vary among countries and justify a comparative approach.

The health care sectors in the UK and Spain are relatively similar. These two countries spend a very similar amount of their Gross Domestic Product (GDP) on health: in 2009, 9.8% in the UK

and 9.5% in Spain (8). Moreover, in both countries the large majority of the expenditure is public: 84% in the UK, 74% in Spain. The UK has a larger number of nurses, but a lower number of doctors than Spain: according to WHO data, in 2009, Spain had a 3.7 doctors and 5.2 nurses per 1,000 inhabitants, while the respective figures for the UK were 2.7 and 10.3 (see Table 1). In the UK, not only is the total number of the two groups higher than in Spain, but a larger amount of medical tasks are performed by nurses than by doctors, which suggests a case of 'medicine deskilling': according to labour process theory (9), deskilling is the downgrading of previously specialised skilled operations to less skilled ones. The lower number of nurses in Spain is also related to the Mediterranean type of welfare state (10), where more care activities are provided by the family (nuclear and extended). Of all Mediterranean countries, Spain is however the one that has recently made most steps to surpass that model, especially during the Socialist government of 2004-11 (11), which may result in an increase in the demand for health professionals.

The number of foreign-born nurses in Spain is very low in comparison to the UK (see Table 2). In addition, countries of origin are different between the UK and Spain, but in both cases they are characterised by a strong distinctive post-colonial and linguistic link (12). In the UK, health professionals' migration is mostly form the Commonwealth, while in Spain immigration is mostly from Latin-America. In both cases, there is an increasing trend of attracting nurses form the European periphery: Central Eastern Europe in the case of the UK, and Morocco in the case of Spain.

Were Spain to follow the path of other western European countries, it would require a major increase in nurse recruitment, which is unlikely to be met by only Spanish workforces. Hence, the prospective importance of international recruitment.

2. General trends in international migration in the UK and Spain

In Spain, migration is a relatively new phenomenon, being particular intense since the late 1990s. In just a decade, Spain's foreign-born population increased from less than 4 percent of the total population to almost 14 percent (13). Thus, Spain appears to be a new immigration-receiving country. During the first decade of the 2000s, foreign workforces have been employed in unskilled economic sectors characterised by precarious employment conditions, such as informality, low wages, insecurity and uncertainty (14).

Spain's experience with immigration has attracted international attention in the past few years, not only because of the rapid increase in inflows, but also because of the way this country has dealt with incoming populations. Surprisingly, while other EU countries have developed anti-immigrant attitudes and restrictive policies, Spain appears to be an outlier compared to other immigrant-receiver countries in Europe (15). Groups in favor of immigration are large, active, and vocal in their opposition to any sentiments that could be seen as racist, xenophobic, or simply hostile to immigration, and there is a widespread belief that immigrants are entitled to the same rights as other members of society (15). However, after the economic crisis that hit the country in 2008, there is evidence that this could be changing. The conservative government elected in 2011 introduced changes in Spain's immigration policy, eroding the strong commitment to immigrants' integration that had prevailed in the previous decade. Nonetheless, since the onset of the current economic crisis, no major social disruptions have been reported and the politicization of immigration has not significantly increased, despite the rise of unemployment in Spain to around 25% (16).

Regarding the health sector, in just two decades Spain has turned from being an international supplier of nurses (17,18) to being a receiver of health workers. Since the 2000s, shortages of

health professionals have been filled through immigration, but not without cultural and social tensions (19).

The UK has a long history of immigration (20). New Commonwealth immigration began in the 1950s, and until the 1960s commonwealth citizens were guaranteed the right to entry. As in the rest of Western Europe, immigration policy became more restrictive since the 1970s, while the share of refugees increased especially in the 1990s. When the Labour Party came to power in 1997, immigration policy shifted towards a "selective openness to immigration", with a focus on economic needs, security and control over inflows. The change in economic immigration was initially accepted across the political divide, but started to be openly contested by the Conservative Party from the mid-2000s. In 2008, the Labour government introduced more restrictive rules governing the acceptance of labour migration, and from the 2010 the new Conservative-led government has aimed to reduce immigration inflows sharply.

The use of overseas workers in the British health care has been driven by state policies, both in the area of health and care in in the area of migration (7). The recruitment started already in the 1950s, following the cost containment by Conservative governments on the ambitious universal healthcare system (the National Health Service, NHS) created by the previous Labour government (21). That recruitment of nurses was mostly from former colonies such as the Caribbean, South Africa and Australia. Over time, the Philippines also became a prominent source country. International recruitment has gone through a second wave in the early 2000s, following unprecedented government investment in the NHS by the Labour government of Tony Blair (22).

3. The British experience

In the UK, the recruitment of foreign health workers was actively sought by the government in the early 2000s. The total number of NHS nurses increased from 246,000 in 1997 to 307,000 in 2007 (22), and in the same period the recruitment of doctors increased by 47% (23). Such increase in staffing over a short period could be met only through international recruitment. Registrations of foreign-trained nurses to the Nursing and Midwifery Council (which are compulsory for practicing in the UK as registered nurses) increased massively between 1998 (5,000) and a peak in 2002 (16,000), although some of these newly registered may not have actually taken up employment in the UK (24). According to the Labour Force Survey (LFS), in 2007 22% of employed nurses were born abroad, and specifically 19% were born in non-European Economic Area (EEA) countries, and 3% in other EU/EEA countries (22). By 2013, 14% of all professionally qualified clinical staff and 26% of doctors were not British (data from the Health and Social Care Information Centre, HSCIC). While India was the first country of origin for foreign doctors, for nurses it was the Philippines, as a result of the shift from traditional Commonwealth migration to pro-active recruitment from countries with a specialisation in nurses' education. This pro-active international recruitment in the early 2000s has been considered a case of political short-termism and lack of planning (7). A study of NHS managers' policies (25) concludes that international recruitment was the result of short-term calculation based simply on the recruitment costs, without considering the long-term comparative costs of training and managing foreign staff, nor any long-term planning.

Since 2003, the UK government has however moved the emphasis to 'self-sufficiency', increasing internal training. Realising that among the causes of these up- and downswings in international recruitment is poor workforce planning, the British government has made increased efforts in this direction, foreseeing increasing demand (26, 6). The UK had also encountered the ethical issues

of international recruitment when it plead not to recruit nurses from AIDS-afflicted Southern African countries. The government issued the 'Guidance on International Nursing Recruitment' in 1999, but this did not cover the private sector and, after the re-organisation of the NHS into autonomous Foundation Trusts in 2004, it does no longer bind the public sector either (17). After the 2004 EU enlargement, the UK government became confident that unpredicted shortfalls in nurse staffing could be addressed through recruitment from the new EU member states (27) and recruitment from outside the EU declined. In 2006 nurses were removed from the shortage occupation list, and in 2008 a Point-Based System was introduced, which does not favour nurses' immigration. Following the economic and public deficit crisis, and then a change of government in 2010, new investment in the NHS came to a halt, and thereby recruitment of new staff was stopped (7).

Among the most recent employment policies in the British health sector there are the extension of the nurses' mandate to include more medical tasks and the increased use of healthcare assistants, which correspond to the 'deskilling of medicine' scenario. Foreign workers, due to their own uncertain position, may be the most prone to accept positions below their qualifications, initiating a deskilling process that in turn can affect the whole workforce.

The international recruitment of doctors and nurses in the UK has raised a number of issues with regard to equality. A large scale survey (23) has shown that in the UK, as in the US, the doctors' labour market is a two-tier one, and that foreign doctors, while not visibly disadvantaged in terms of wages, tend to work longer and more flexible hours (23). Segregation and vulnerability of foreign professionals became soon apparent. In the case of doctors, the most visible example is their concentration in geriatric care, considered as a less prestigious speciality (28). For nurses, the Royal College of Nurses (29) reported that internationally recruited nurses were much more likely

to work permanent nights. The issue of task definition has also been highlighted in cases in which non-EEA nurses were expected to undertake less technical direct-care duties, while artificial barriers were raised to exclude them from the most professionalised ones (30). For instance, a UK training requirement was introduced for Intravenous Therapy, regardless of previous training overseas, but this training was then offered very rarely, keeping foreign nurses excluded from that professional activity.

These practices (worse shifts, professional hurdles) result into strong subjective feelings of being devalued, which have been noticed by a number of studies: foreign nurses are reported to feel that their competence as a nurse is being questioned, and to develop a sense of injustice for the tasks allocated and the pay received (31, 32).

An area of particular uncertainty leading to resentment is the distinction between caring and nursing. According to a study (32), overseas nurses complain about being allocated caring, as opposed to nursing, tasks, in a process that marginalizes them and devalues their skills. It appears that some overseas nurses recruited through agencies arrive to the UK not fully aware of the kind of job they are offered: they expect a professional nursing job but end up in care jobs such as in nursing homes for the elderly. A cultural factor seems at play too: nurses from countries where nursing and caring are more closely combined in everyday tasks discover, once in the UK, a process of task demarcation whereby some nurses are allocated to basic care only. As a result, they experience UK nursing practice as less autonomous and of a lower standard than they expected. International recruitment has contributed to a 'care gap where UK nurses and managers acknowledge the contribution overseas nurses can make in delivering and maintaining standards of care because of the lack of skills and poor attitude to bedside nursing of UK nurses' (33, p. 2010). These attitudes reflect an 'uncoupling of caring from nursing' and reproduce a stereotype

of caring as more suited to foreign nurses, who in turn are also graded at below their competence level (34). The use of overseas workers, therefore, corresponds to a double rationale: cost reduction and division of labour. The latter consists in limiting the task uncertainty inherent in the nursing profession – whereby the needs of the patient vary – through the segregation of certain tasks and their allocation to specific groups of workers. According to extensive research on the NHS, only more sophisticated diversity management policies can counteract these trends and allow a positive valorisation of foreign professionals' skills as a resource (32).

Trade unions have become concerned with this process. They have conducted research on the issue and highlighted difficulties in the area of promotion (35, 36). The unions' concern was not with protecting the jobs and pay of British nurses: in a period of increasing public investment, tight labour market and national pay determination, there was no threat to terms and conditions of native employees (7). In fact, during the 2000s the pay of nurses increased more than average, while it stagnated in less regulated sectors affected by large immigration in private services and manufacturing (data: ONS); moreover, given the previous staff shortages, the arrival of overseas staff helps reducing workload pressures for existing employees. Nonetheless, both unions representing nurses (the professional union Royal College of Nurses and the general public sector union Unison) stood up in defence of foreign nurses' rights. In particular Unison, also in reflection of its recent focus on diversity issue, expressed 'reservations about international recruitment being used as a short-term response to reductions in nurse training and unattractive working conditions' (7). Interestingly, the two trade unions appear to diverge on the issue of foreign nurses' occupational standing. Unison, in response to the problem of many foreign qualified nurses who are employed as carer, is in favour of the creation of an additional occupational level, intermediary between nurse and healthcare assistant (interview with Unison representative, Glasgow, February

2011). This would respond to the emerging focus on 'skill mix' between caring and nursing, and allow at least partial recognition and promotion for currently under-employed foreign nurses. However, the official professional body of UK nurses, the Nursery and Midwifery Council, the nurses' trade union, and the Royal College of Nurses, are sceptical about what could be a threat to the occupational standing of British nurses and, over time, their employment opportunities.

A specific focus of union concern has been temporary work agencies, due to evidence of unethical practices, in particular misinformation. The use of agency staff by hospitals corresponds less to cost considerations (agency employees are actually more expensive) than to flexibility and short-term considerations: it is a typical response to uncertainty. However, agency work results in particularly vulnerable positions for the employees, especially if from overseas given the limited information on the prospective jobs and the risk of their work permit expiring in case of unemployment.

4. An exploration of the emerging Spanish trends

In contrast to that on the UK, the literature on the Spanish case is somewhat scarce, reflecting the shorter immigration history of the country. Some rare studies have, however, investigated the occupational mobility of health workers after landing in Spain. Garcia and Amaya (37) pointed out that Spain would experience an important shortage of doctors and other health workers in the near future. Although there are no official data to quantify the amount of international health workers that have been employed in the Spanish health system, the authors estimate that in 2006 about a 10% of the total number of new graduates registered in Barcelona were foreign-born, and that between 2004 and 2006 a total of 8,228 foreign health accreditations were officially

recognised by the Spanish government, mostly to individuals coming from Argentina, Peru, Colombia, Venezuela and Cuba.

Barber and Gonzalez (38) conclude that immigrant health workers have been used in the Spanish health system as a regulator mechanism to fill shortages in the medical profession. In Spain, it is necessary to obtain an equivalence accreditation for foreign academic credentials to be recognised. This process may take up to four years for specialised practitioners, but it can be shorter for nurses. This means that, on arrival, foreign health workers must wait before being allowed to work as certified doctors or nurses. They may therefore start their occupational trajectories in non-qualified sectors. Compared to native colleagues, migrant doctors have a more uncertain career path, characterised by legal obstacles: work permit, visas, and academic recognitions. Nonetheless, after a period of 10 years, differences between workforces tend to disappear (39).

Due to the lack of previous literature exploring the occupational mobility of foreign doctors and nurses in Spain, we conducted 15 exploratory interviews. These interviews do not provide an exhaustive picture of the reality of migrant health workers in Spain, but suggest some trends that deserve further research. We selected seven key stakeholders involved in the process of recruiting and training foreign health workers in public hospitals, and eight migrant workers currently employed in the national health system (see Figure 1).

Five main trends have been identified. First, mobility patterns for nurses and doctors are different. While doctors are often motivated by professional incentives, for nurses the main motivation tends to be financial, specifically to sustain a family back home. This explains why nurses may be more likely to be very mobile for short-term considerations, including seeking temporary, sometimes illegal, working conditions. Secondly, networks and family factors play a substantial role in decisions about mobility, with an apparent strong gendered dimension. Thirdly, de-skilling

processes appear among foreign health workers, mostly in relation to qualification recognition obstacles, leading to foreigners filling undesired vacancies. The cost in terms of time, money and self-esteem for the workers involved are described as substantial, especially in the case of work as unregulated health assistants. Fourthly, barriers to inclusion include language, social and human capital, inflexible labour market (i.e. firm's low-level ability to make changes to their workforce), and legal restrictions for foreign citizens. These barriers to fuller inclusion of foreign health workers have been also found by Kahanec et al. (40).Fifthly, while the entry of international health workers in Spain has alleviated the shortages in the short-term, the occupational segregation and career uncertainty of migrant workers may turn into long-term problems for the Spanish health system.

5. Discussion and Conclusion

The international mobility of health workers is of increasing importance across Europe beyond the traditional boundaries of the Anglophone and Francophone countries, and in particular, due to demographic, political and linguistic reasons, in Spain. In the 2000s this country faced the emerging shortage of health workers through foreign professionals. The financial crisis that started in 2008 may stop recruitment in the short-term, but may also encourage the search for lower cost options in the medium term.

Our exploratory evidence points that many of the problems traditionally encountered in the UK – segregation in worse jobs, barriers to professional development and career– are emerging in Spain as well. In particular, our investigation shows that career uncertainty is an important issue regarding the occupational mobility of foreign health workers in Spain, which also appeared in the British case (deskilling, segregation). We also identified additional problems with regard to

institutional barriers and academic qualifications recognition. Qualification recognition is more liberal in the UK, where only recently (2013) stricter rules on language competence were introduced. In part, this is possible thanks to stronger connections with training institutions in the countries of origin, especially within the Commonwealth and with the Philippines.

The comparison suggests that looking at the British experience may be useful for Spanish policy makers and professional associations, in order to detect, and possibly prevent, social problems that may affect professional standards and equality in the long run. The European Union has an important role in this regard, as its promotion of professional mobility could be combined with a stronger co-ordination effort, in particular on ethical codes, skill definition, and the role of employment agencies. Some British good practices, especially in the public sector, might be transferable to other systems: 1. Compulsory registration of foreign-trained health works; 2. Increased training; 3. Government guidance on ethical international recruitment; 4. Recording data of inflows and final medical positions of overseas health workers.

There are several new lines of research that our initial exploration have highlighted. Firstly, on the social consequences of foreign health workers' occupational segregation and deskilling experiences. Secondly, on the institutional barriers to mobility, such as the costs of credential recognition processes. Thirdly, on the existing institutional barriers to upward mobility in the labour-market. Our exploratory analysis provides multiple indications that improved collaboration between government, employers and other stakeholders would help to reduce the negative effects that migration would have on the healthcare system**.** Further research, especially if comparative, could produce more specific analytical insights and policy recommendations.

References

(1) European Commission. Green Paper on the European Workforce for Health. COM (2008) 725 final, Brussels, 2008. http://ec.europa.eu/health/ph_systems/docs/workforce_gp_en.pdf (June 2012)

(2) OECD. Immigrant Health Workers in OECD Countries in the Broader Context of Highly Skilled Migration. International Migration Outlook, 2007. www.oecd.org/dataoecd/22/32/41515701.pdf (June 2012).

(3) Comas-Herrera, A., Wittenberg, R., Costa-Font, J., Gori, C., Di Maio., A., Patxot, A., Pickard, L., Pozzi, A. & Rothgang, K. Future long-term care expenditures in Germany, Spain, Italy, and the United Kingdom. *Ageing and Society* 26(2):285-302, 2006.

(4) Grimshaw, D., Jaehrilng, J., van der Meer, M., Méhaut, P & Shimron, N. Convergent and divergent country trends in coordinated wage setting and collective bargaining in the public hospitals sector. *Industrial Relations Journal* 38:591-613, 2007.

(5) Galetto, M., Marginson, P., & Spieser, C. Collective bargaining and reforms to hospital healthcare provision: A comparison of the UK, Italy and France. *European Journal of Industrial Relations* 20(2): 131-147, 2014.

(6) Cox, A., Grimshaw, D., Carroll, M & McBride, A. Reshaping internal labour markets in the National Health Service: New prospects for pay and training for lower skilled service workers? *Human Resource Management Journal* 18: 347-364, 2008.

(7) Bach, S. Managed migration? Nurse recruitment and the consequences of state policy. *Industrial Relations Journal* 41: 249-266, 2010.

(8) OECD. OECD Health Data 2011. Paris, 2011. http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT (June 2012).

(9) Braverman, H. *Labor and Monopoly Capital*. New York, Monthly Review Press, 1974.

(10) Naldini, M. *The Family in the Mediterranean Welfare State*. London, Frank Cass, 2003.

(11) Naldini, M. & Jurado, T. Families, Markets and Welfare States: The Southern European Model. Paper for the 7th ESP Anet Conference, Urbino, September, 17th-19th, 2011.

(12) OECD. International Migration of Health Workers. Policy Brief, Paris, 2010.

(13) Bover, O., Velilla, P. Migration is Spain. Historical Background and Current Trends. In *European Migration. What do we know?* Ed. K.F Zimermann. Oxford, Oxford University Press, 2005.

(14) Arango, J. Becoming a country of immigration at the end of the twentieth century: The case of Spain. In *Eldorado or Fortress? Migration in Southern Europe*. Ed. King, R., Lazaridis, G., and Tsardanidis, C. New York: St. Martin's Press: 253-276, 2000.

(15) Arango, J. *Exceptional in Europe? Spain's Experience with Immigration and Integration*. Washington, DC, Migration Policy Institute, 2013.

(16) Centro de Investigaciones Sociológicas, CIS. Actitudes hacia la inmigración. Research report No. 2918, 2011. Retrieved from [http://www.cis.es/cis/export/sites/default/-Archivos/Marginales/2900_2919/2918/Es2918_Muestra1.pdf]

(17) Kingma, M. *Nurses on the Move. Migration and the Global Health Care Economy*. Ithaca (NY), IRL Press, 2003

(18) Buchan, J. Migration of health workers in Europe: policy problems or policy solutions? In *Human resources for health in Europe*. Eds. C-A. Duboy, M. McKee, E. Nolte. New York, McGraw-Hill Education, 2006.

(19) Calavita, K. *Immigrants at the Margins. Law, Race and Exclusion in Southern Europe*. Cambridge (UK), Cambridge University Press, 2005.

(20) Greenhalgh, K & Rosenblatt, Z. Job insecurity: Towards conceptual clarity. *Academy of Management Review* 3:438-448, 1984.

(21) Carpenter, M. *Working for Health: The history of COHSE.* London, Lawrence & Wishart, 1988.

(22) Bach, S. Achieving a self-sufficient workforce? The utilization of migrant labour in healthcare. In *Who Needs Migrant Workers? Labour Shortages, Immigration and Public Policy*. Eds. M. Ruhs & B. Anderson. Oxford, Oxford University Press, 2010.

(23) Healy, G. *Diversity, Ethnicity, Migration and Work. International Perspectives*. Basingstoke, Palgrave, 2011.

(24) Nursing and Midwifery Council. Statistical Analysis of the Register 1 April 2007 to 31 March 2008. London: NCM, 2009.

(25) Young, R., Noble, J., Mahon, A., Maxted, M., Grant, J. & Sibbald, B. Evaluation of international recruitment of health professionals in England. *Journal of Health Services Research and Policy* 15:195-203, 2010.

(26) Wanless, D., Appleby, J., Harrison, A. & Pattel, D. *Our Future Health Secured? A Review of NHS Funding and Performance.* London, King's Fund, 2007.

(27) Crisp, N. *Global Health Partnerships: The UK Contribution to Health in Developing Countries.* London: HD, 2007.

(28) Raghuram, P., Bornat, J. & Henry, L. Ethnic clustering among South Asian geriatricians in the UK: an oral history study. *Diversity in Health and Care* 6(4): 287-296, 2009.

(29) Royal College of Nursing (RNC). Memorandum by the Royal College of Nursing. Evidence of the House of Lords Select Committee on Economic Affairs. London: House of Lords, 2007.

(30) O'Brien, T. Overseas nurses in the National Health Service: A process of deskilling. *J. Clin. Nurs*. 16: 2229-2236, 2007.

(31) Allan, H. & Aggergaard Larsen, J. "We Need Respect": Experiences of Internationally Recruited Nurses in the UK. Presented to the Royal College of Nursing. European Institute of Health and Medical Science, University of Surrey, 2003. www.rcn.org.uk/__data/assets/pdf_file/0008/78587/002061.pdf (June 2012).

(32) Winkelmann-Gleed, A. *Migrant Nurses. Motivation, Integration and Contribution.* Oxford, Radcliffe, 2006.

(33) Allan, H. Rhetoric of Caring and Recruitment of Overseas Nurses: The Social Production of a Care Gap. *J. Clin. Nurs.* 16; 2204-2212, 2007.

(34) Smith, P., Allan H., Henry, L., Larsen, J. & McKintosk, M. Valuing and Recognising the Talents of a Diverse Healthcare Workforce. Report from the REOH Study: Researching Equal Opportunities for Overseas-trained Nurses and Other Healthcare Professionals, 2006. . http://portal.surrey.ac.uk/reoh (June 2012).

(35) Pike, G. & Ball, J. Black and Minority Ethnic and Internationally Recruited Nurses: Results from Employment/Working Well Surveys 2005 and 2002. London: RCN, 2006.

(36) Unison. Unison Migrant Workers Participation Project: Evaluation Report. London: Unison, 2009.

(37) Garcia, M.A., Amaya, C. ¿Faltan médicos en España? *Ars Medica. Revista de Humanidades* 2: 152-170, 2007.

(38) Barber, P., González, B. ¿Hacen falta más médicos? ¿Tan sutiles son las señales? *Revista de Administración Sanitaria* 6(3): 393-401, 2008.

(39) Research Centre of Everyday Life and Work (QUIT). *Trayectorias Laborales de los Inmigrantes en* España. Barcelona: Obra Social La Caixa, 2011.

(40) Kahanec, M., Myunghee Kim, A., Zimmermann, K. Pitfalls of immigrant inclusion into the European Welfare State. Bonn: IZA, discussion paper No. 6260, 2011. Retrieved from [http://www.iza.org/en/webcontent/publications/papers/viewAbstract?dp_id=6260]

Table 1 Doctors and nurses in the UK and Spain, 2007 (Source: WHO)

	Doctors	Nurses	Total	Doctors per 1,000 inhabitants	Nurses per 1,000 inhabitants
UK	165,317	621,755	787,072	2.7	10.3
Spain	162,600	226,300	388,900	3.7	5.2
EU	1,563,000	3,154,000	4,717,000	3.1	6.3

Table 2 Foreign doctors and nurses in the UK and Spain, 2007 (data: OECD)

	Foreign doctors	% of total	Foreign nurses	% of total
UK	49,780	30.1	81,623	13.1
Spain	9,433	5.8	5,638	1.4

Figure 1. Sampling Chart for the Spanish case. Initial exploratory interviews

<table>
<tr><td colspan="10">DIMENSION 1 RESPONDENT RELEVANCE</td></tr>
<tr><td colspan="5">Key Respondents</td><td colspan="5">Target Subjects</td></tr>
<tr><td colspan="5">DIMENSION 2 INSTITUTION***</td><td colspan="5">DIMENSION 3 PROFESSION</td></tr>
<tr><td rowspan="2">Employer's Ass.</td><td rowspan="2">Trade Unions</td><td rowspan="2">Public Admin.</td><td rowspan="2">Public Hospital Human resources</td><td rowspan="2">Med. Faculty Dean</td><td colspan="3">Doctors</td><td colspan="2">Nurses</td></tr>
<tr><td colspan="5">DIMENSION 4 SEX*</td></tr>
<tr><td rowspan="4">R1, R2</td><td rowspan="4">R3, R4</td><td rowspan="4">R5</td><td rowspan="4">R6</td><td rowspan="4">R7</td><td colspan="3">Male</td><td colspan="2">Female</td></tr>
<tr><td colspan="5">DIMENSION 5 COUNTRIES OF ORIGIN**</td></tr>
<tr><td colspan="2"></td><td>Latin America</td><td>North Africa</td><td>Latin America</td><td>North Africa</td></tr>
<tr><td rowspan="2">DIMENSION 6: Occupational Trajectory</td><td>Upwards</td><td>R8</td><td>R10</td><td>R12</td><td>R14</td></tr>
<tr><td>No change</td><td>R9</td><td>R11</td><td>R13</td><td>R15</td></tr>
</table>

***** Sex distribution is typically male foreign doctors and female nurses according to data from COMB and COIB.

** Regions with higher percentages in Spain, which appears to be associated with occupational trajectory.

*** An exploratory map of stakeholders was designed to arrange respondent sampling. Available upon request.