

TITLE International Migration of Health Workers: Can Spain Follow the British Steps?

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Abstract

The paper explores migrant workers careers in the health sector, comparing the Spanish case and the British case. International migration has become an important feature of globalized labour markets in health care. Recently, concerns over the need of ensuring staff and skill shortages in the health system are becoming a common issue in many European countries. Following this, the paper is focused on career uncertainty for migrant workers, qualification recognition processes, policy issues on the training of nurses and doctors in both countries selected as contrasting cases given the different length of immigration experience. We consider trends in migration, working conditions of migrants, migration policies and recruitment practices. By using a qualitative approach, the paper demonstrates that professional trajectories of migrant doctors and nurses are more uncertain, although there are important differences regarding the role of regulatory institutions, and union's action.

Introduction

In the 1990s and 2000s, concerns over growing shortages of health workers, and particularly doctors and nurses, have emerged in most European countries. These shortages are projected to increase in the near future due to ageing population and changing technologies, which contribute to an increase in the demand of health professionals, while reducing the share of population in employment age. One route to partially overcome these shortages is via international mobility of health workers, as it has been increasingly promoted by the European Union.

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 a large share of foreign health workers. By contrast, most continental European countries, for political, economic and linguistic reasons still have much lower numbers of foreign health workers. According to national census data (OECD 2007), in 2001 the UK was (after Luxembourg) the EU country with largest share of foreign-born nurses (15.2%) and

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doctors (33.7%). For a comparison, the shares of foreign nurses and doctors were 10.4% and 11.1% in Germany, 8.9% and 22.9% in Sweden, 5.5% and 16.9% in France, and 3.4% and 7.5% in Spain. If health professionals' migration were to keep increasing across the EU it would become, from an essentially Anglophone-world phenomenon, a continental or even global one, exacerbating the issues of social and political governance that have been long been raised (e.g. Meja 1978).

This paper compares the experiences of an 'old' and a 'new' health immigration country, UK and Spain. After reviewing the British experience since the 1950s, it will look more in depth at the current Spanish situation, asking to what extent Spanish institutions are ready to face the social issues stemming from the employment of foreign health professionals. Spain is chosen because, while starting from a very low level of foreign health workers, it has the potential for a particularly high increase: it has witnessed the largest overall immigration flow in Europe over the last decade, it has a particularly fast ageing society, and thanks to the global popularity of Spanish, it disposes of a particular large pool of prospective foreign professionals speaking the same language than any other continental EU country.

The specific focus of the paper is on issues relating to employment uncertainty. While the use of foreign workers can be seen as a policy to face recruitment uncertainty, it also often involves an over-proportional burden of uncertainty for the foreign workers themselves, in particular with regard to employment and work permit security, job content definition, and career prospects. In addition, even if immigration can solve the recruitment needs of the host country, it can result into a 'care drain' at the international level, producing shortages in other, poorer countries, and even result in insufficient provision of training if countries reduce, as a result, their investment in health-sector education. These issues have been exacerbated by the recent economic crisis (OECD 2010). This paper will look at how the UK has over time responded to these issues and look at whether Spain, as an example of the rest of the EU, is likely to follow the same path. After a general overview of both nurses and doctors, the paper focuses more on nurses, as the largest occupation group and largest single expenditure item in the health sector, and one potentially particularly vulnerable.

The paper is organised as follows. First, it will describe the issue of health professional migration and highlight the employment uncertainty issues related to it. Secondly, it will introduce the data and the comparative rationale of the UK and Spanish cases, which are then described in two separate sections. The conclusion will draw comparative conclusions on the role of different institutional settings in a global social phenomenon, as well as policy implications.

Social issues of international health professionals' migration

According to data from the OECD (2007), on average 11% of employed nurses and 18% of employed doctors were foreign-born in the OECD countries. There are, however, important

variations across countries, which partly reflect differences in the characteristics of the health workforce and its general patterns of migrations. It is remarkable that in long-term trends over the past 25 years show that the number and the percentage of foreign-trained doctors has significantly increased in most OECD countries. Moreover, over the past 5 years a radical upward shift in the immigration trends has occurred. This recent migration flow shows a trend towards a diversification of origin countries. Main countries of origin, such as India or Philippines, still play an important role, but this is accompanied by increased flows from African countries, Central and Eastern European countries, and Latin America. It is therefore less and less an Anglophone-only phenomenon.

The migration of health personnel across international borders is of growing concern worldwide because of its impact on health systems in developing countries and developed countries alike. When focusing on high-skilled migration, there used to be a strong debate concerning 'brain drain' from Third World countries to the Western world. Developed countries generally act as poles of attraction for medical professionals resulting in the risk of a 'brain drain' or loss of professional capital in less developed countries. In recent years global concern with this issue has increased, especially with the creation, in 2006 of a 'Global Health Workforce Alliance' by the World Health Organization (WHO), to focus on the needs of the 57 countries with the sharpest shortages of health workers. The Global Health Workforce Alliance combines professional organisations, NGOs and national governments of countries with major inflows or outflows of health professionals: the EU countries that are members of it are UK, Germany, France and Ireland.

On its side, the EU adopted in 2005 a 'Strategy for Action on the Crisis in Human Resources for Health in Developing Countries', and the European Commission produced in 2008 a Green Paper on the European Workforce for Health' (European Commission, 2008). The Green Paper is supportive of international mobility and the removal of barriers to intra-EU movement of healthcare workers, already liberalised by Regulation 1612 of 1968, but still hampered by regulatory barriers. But it also acknowledges the potential unbalance problems, stating that 'the response to tackling the effects of increased mobility is not to introduce legal restrictions to the free movement of students or workers, but rather to address these issues through appropriate policies and in a coordinated manner' (p. 9). Already internally, the EU has faced the issue of the risks of unregulated free movement of health professionals: in 2003, the European Parliament blocked the European Commission's proposal of removing nurses' obligation to register in foreign countries (Kingma 2006, 166). In 2008, the European Social Dialogue Committee of the hospital sector adopted a Code of Conduct and follow-up on Ethical Cross-Border Recruitment and Retention, which includes the promotion of circular migration.

Recruitment of foreign nurses and doctors originates in the incapacity or unwillingness, by host countries, to predict future needs of health professionals, then train them and attract them into the profession. In theory, proximity services like health are not affected by economic

volatility or seasonality, which are at the roots of migrant recruitments in some private sectors. For instance, in construction migrant workers provide, in both UK and Spain, a hyper-flexible buffer of employees, who accept unsecure and unsafe jobs without causing political problems (Meardi *et al.* 2012). In a high-skill sector like health care, instead, economic volatility and employment insecurity are less prominent issues. However, health care attracts large numbers of foreign workers as well, and is affected by uncertainty too.

Despite its apparent 'naturalness', health services demand is variable too. Some of the variability depends on natural factors, such unpredictable like epidemics (i.e. AIDS both increased the need of nurses, and caused premature deaths of nurses in Africa at a massive scale, estimated at around 13% of the total) and some only partially predictable like demographic change. But the demand for health services also varies depending on changing political priorities as well as cultural shifts. The increase in public health expenditure in the UK following the election of a Labour government in 1997, and the changes introduced by the Spanish law on Personal Autonomy of 2006 are examples of the former, while the medicalisation of pregnancy/birth, obesity and body aesthetics are examples of the latter.

In addition to changing overall demand of health services, workforce composition and conditions may also change in response to organisational restructuring. Changing boundaries between private and public health expenditure are the most visible example, but also within the public sector itself major organisational change can take place. In many European countries, there have been trends towards decentralisation and marketisation, with important implications for employment relations (e.g. Grimshaw *et al.* 2007; Weber, 2011; Galetto *et al.* 2011). For instance, re-organisation in the UK increased managerial prerogatives and thereby employees' uncertainty with regard to their pay, job definitions and career progression (Cox *et al.*, 2008).

In this paper we also address the subjective side: the uncertainties that migrant doctors and nurses experience in the process of being integrated in the receiving health systems. Due to increasing concerns in host countries about the safety and quality health provision by foreign physicians, we are facing the risk of creating barriers and, in some cases, discrimination against foreign physicians and nurses. There are already indications that foreign health professionals face more uncertainty than national ones in important regards: the recognition of foreign qualifications and professional experience; the content and definition of their tasks; career and further training information and opportunities. In addition, for non-EU employees the right itself to stay in the country may be uncertain. An important implication of such uncertainty is the tendency of foreign health professionals to be segregated horizontally and vertically, in the areas with less prestige and fewer career opportunities, such as geriatric care: given the shortage of information, the limited recognition of experience and the need for immediate employment due to visa requirements, they may be prone to accept any job, and then find it difficult to change.

The subjective and objective sides of uncertainty interact. The subjective side is affected by political and structural variables, but also, in turns, may affect the overall organisation of healthcare employment. In particular, migrant workers may play an important role in the 'deskilling' of professions. The tendency of a 'deskilling' of medicine, driven by cost considerations, is visible in the tendency to shift tasks from doctors to nurses and from nurses to health assistants. 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 of the workforce.

The 'circular migration' policy promoted by international organisations and in particular the EU to reduce brain drain and care drain risks, do not address these uncertainty issues of overseas health professionals. In fact, by creating a transient workforce, they may actually exacerbate them, as short-term immigrants may have particularly limited information and opportunities. This paper contributes to the debate through the combination of structural and subjective issues, in two relevant national cases.

A UK-Spain Comparison: Rationale and Methods

The key objective of this paper is to present a comprehensive picture of immigration in the health sector in the UK and Spain, in a comparative perspective, in order to better inform policy dialogue at national and European level.

The health care sector is relatively similar in the UK and Spain. The two countries spend a very similar amount of their GDP on health (in 2009, 9.8% in the UK, 9.5% in Spain – OECD data). Moreover, in both countries the large majority of the expenditure is public: 84% in the UK, 74% in Spain. Traditionally, the Spanish system has been more decentralised than the British National Health Service (NHS), but in recent times, the NHS has been affected by decentralisation too. There are, however, important differences in the workforce structure. The UK has a larger number of nurses, but a lower number of doctors than Spain: according to WHO data, in 2009, Spain had 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 also Table 1). It can be inferred that in the UK a larger amount of medical tasks are performed by nurses than by doctors, as a case of 'medicine deskilling', but also that there is a higher overall demand for professional health care: the total of the two groups is 13 in the UK and 8.9 in Spain.

This difference in employment composition combines with the major difference in overseas recruitment that we have identified in the introduction. The UK started recruiting foreign health workers in the 1950s, whereas until the 1980s Spain was, if anything, a supplier of nurses to foreign countries such as France (Kingma 2006, 29). A comparison between the two countries is interesting in order to predict, drawing on the British experience, the challenges that Spain, and foreign health professionals in Spain, may face, and to identify the roles that different institutional frameworks may have.

The migration of health workers is distinctive because it is strongly influenced by the regulatory frameworks of individual governments that control the training, recruitment and deployment of health professionals (Bach 2010a); such frameworks give rise to particular national patterns of migration. The centrality of government regulation in the health sector is a significant factor, and this provides greater scope for policy interventions. Health sector work is characterized by both a highly interdependent labour process and the proliferation of specialized professional roles with long lead times in terms of training. The labour-market factors influencing migration in the health sector are: the scope and nature of the involvement of the state in the labour market; the role of professional bodies and their accreditation regulations in monitoring entry and passage through the labour market; the nature of labour-market shortages; the role of migration regulations and the categories through which migrants enter; as well as, the channels used by migrants to entry. All of these factors vary among countries and justify a comparative approach.

In the UK the issue of health care migration has already attracted a large amount of interest and produced extensive literature. Given the wealth of secondary sources, no primary research was needed for this paper, but an interview was carried out in the specific, and important case of overseas nurses union organisation. In Spain, where the research issue is more recent and the secondary literature still scarce, we conducted twelve interviews with key personnel: employers' representatives, trade unions' associations, public administration's representatives, immigrants' associations, and actors themselves (doctors and nurses).

Table 1. Total number of doctors and nurses in the UK and Spain, 2007

	Doctors	Nurses	Total	Proportion of doctors (in relation to nurses)	Proportion of nurses (in relation to doctors)
United Kingdom	133 641	740 731	874 372	15.28%	84.72%
Spain	199 123	237 775	436 898	45.58%	54.42%
EU	1 621 903	3 965 327	5 587 230	29.03%	70.97%

Source: Consejo General de Enfermería, 2007

From the mentioned gap in number of nurses between UK and Spain and from Table 1 data, we can gather that there is a relative lack of nurses in Spain, not only in comparison to the UK, but also in comparison to EU average: only Greece and Portugal, of the EU countries before the 2004 enlargement, had a lower number of nurses per 1,000 inhabitants. Were Spain to follow the path of the 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 importance of prospective international recruitment.

Table 2. Total number of foreign nurses and doctor working in the UK and Spain, 2007

	Nurses	Doctors
United Kingdom	81 623	49 780
Spain	5 638	9 433

Source: OECD, 2007

Until now, foreign recruitment of health professional in Spain has lagged much behind the UK, and especially so for nurses (Table 2). 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 (OECD data). In the UK, health professionals' migration is mostly from Commonwealth countries like India, Pakistan, Australia, South Africa, Nigeria, Malaysia, Zimbabwe, as well as Ireland and the Philippines – which are not a post-British empire country, but are linked by a historical nurse provision relation with the USA. In Spain, by contrast, immigration is mostly from Latin America. In both cases, however, there is an increasing trend of attracting nurses from the European periphery: Central Eastern Europe in the case of the UK, and Morocco in the case of Spain.

The British experience

The use of overseas workers in the British health care has been driven by state policies, both in the area of health care and in the area of migration (Bach 2010a). The recruitment started already in the 1950s, following the cost containment by Conservative governments on the ambitious universal healthcare system (the National Health Service) created by the previous Labour government (Carpenter 1988). That recruitment was mostly from former colonies such as the Caribbean, South Africa and Australia. Over time, the Philippines also became a prominent origin country.

International recruitment went through a second wave in the early 2000s, following unprecedented government investment in the NHS by the Labour government of Tony Blair (Bach 2010b). In the 2002-2008 period the real-term expenditure in health care grew on average by 7.4 per cent per annum (*ibidem*), and a substantial proportion of this investment, naturally, went into staff growth. In 2002, the NHS planned to recruit 7,500 more consultants, 2,000 more GPs, 20,000 more nurses, and 7,500 Allied Health Professionals (therapists), and these targets were exceeded, often substantially, by 2006 (Wanless et al. 2007: p. xix). The total number of NHS nurses increased from 246,000 in 1997 to 307,000 in 2007 (Bach 2010b). 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 (NMC 2009). 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 (Bach 2010b).

The wave of international recruitment in the early 2000s has been considered a case of political short-termism and lack of planning (Bach 2010a). In their study of NHS managers' policies, Young et al. (2010) conclude that international recruitment was the result of short-term calculation based simply 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 also moved the emphasis on '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 since 2007, foreseen increasing demand (Wanless et al. 2007, Bach 2010b). The UK had also encountered the ethical issues of international recruitment, spectacularly raised by Nelson Mandela on an official visit to the UK in 1997, when it pleased not to recruit nurses from the AIDS-afflicted Southern Africa. The government responded by issuing 'Guidance on International Nursing Recruitment' in 1999, although these did not cover the private sector and, after the re-organisation of the NHS into autonomous Foundation Trusts in 2004, it does no longer cover the public sector either (Kingma 2006). In 2003, a Commonwealth Code of Practice was agreed, which includes compensations for origin countries and facilitations to return. 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 (Crisp 2007) 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 (Bach 2010a).

Among the most recent employment policies in the British health sector there are the extension of nurses' mandate (including performing medical activities) and the increase use of healthcare assistants, which do correspond to the 'deskilling of medicine' scenario defined in the previous section, and can be seen in relation to the employment experience of foreign health professionals.

A range of sources and research has pointed, following the most recent surge in health sector's international recruitment, issues of segregation and vulnerability. In the case of doctors, the most visible example is their concentration in geriatric care, considered as a less prestigious speciality (Hatzidimitriadou and Psoinos 2011). For nurses, the RCN (2007, cited in Bach 2010b) reported that internationally recruited nurses were much more likely to work

permanent nights. O'Brien (2007) highlights the issue of task definition, and that 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. 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 more professional activities.

These practices (worse shifts, professional hurdles) result into strong subjective feelings of being devalued, which have been noticed by a number of studies (e.g. RCN 2003; Smith et al. 2006; Aggergaard Larsen 2007; Winkelmann-Gleed 2006). 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.

An area of particular uncertainty leading to resentment is the distinction between caring and nursing. According to a study (Allan 2007), 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: in some countries of origin nursing and caring are more closely combined in everyday tasks, but in the UK they discover 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. Allen (2007: 2010) concludes that these policies have led 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'. 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 (Smith et al. 2006). The use of overseas workers, therefore, corresponds to a double rationale: cost reduction, and 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 a specific group 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 (Winkelmann-Gleed 2006).

Trade unions have become concerned with this process. They have conducted research on the issue and highlighted difficulties in the area of respect and promotion (Pike and Ball, 2006; Unison, 2009). Trade unions were not concerned with job and pay protection of UK nurses: in a period of public investment and in a tight labour market and with national pay determination, there was no threat to terms and conditions of native employees (Bach 2010a). In fact, during the 2000s pay of nurses increased more than average in comparison with low skill migrants

employed in unregulated sectors, and 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' (Bach 2010a). 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, both the official professional body of UK nurses, the Nursing and Midwifery Council, and the Royal College of Nurses are sceptical for what could be a threat to the occupational standing of British nurses, undermining, over time, their employment opportunities.

A specific focus of union concern has been temporary work agencies, due to evidence of unethical practices. The use of agency staff by hospitals corresponds less to cost considerations (agency employees are actually more expensive) but to flexibility and short-term consideration: 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.

The most high-profile case of overseas' nurses union organising in the UK occurred in Glasgow, on the initiative of Unison in response to bad practice in the use of foreign agency nurses by the Southern General Hospital. In 2003, a 'Scotland Overseas Nurses Network' was created, organising about 1,000 foreign nurses, especially from the Philippines but later also from Central Eastern Europe. It ran important information campaigns, obtaining in particular the condemnation of agencies that charged nurses abroad illegal fees just for the promise of a job in the UK. It also expressed concern with the over-proportional reporting of foreign nurses to the NMC for malpractice, especially for drug errors, which suggests a situation of institutional discrimination, whereby, in the same situation, a foreign nurse is more likely to be accused, especially by patients, than a British one. Over time, however, the network reduced its activity. This was due in part to the difficulty of organising employees who were particularly transient, changing place of employment frequently. However, it appears also to be due to the solution of the most urgent problems, allowing foreign nurses' issues to be dealt with by the ordinary structures of the trade union, without the need for a special organisation. At the time of our research, in February 2011, the Network's activity was limited to maintaining a contact list.

Recent trends in immigration of health professionals in Spain

Spain has started recruiting foreign nurses only recently, and the institutional obstacles which may undermine doctors' and nurses' careers have not yet been explored. In this section, we point out the effects of legal status, credential recognition, the national health system, and possible unions' action. In terms of employability, overseas health personnel encounter three main problems during their first period in the Spanish labour-market.

- a. Legal problems: long period for official credential recognition.
- b. Cultural problems in the relationship doctor-patient: patients could show reluctances due to language and/or cultural backgrounds; while this problem may decline over time, the UK case suggests that it might not disappear.
- c. Professional activity problems: ignorance of some common pathologies and treatments, non familiarity with equipment, team working and diagnosis procedures.

Findings points out the importance of personal networks. Doctors and nurses try to spend their efforts (including money) in developing employment-related networks: they study post-graduates courses to meet people, work as assistants in private clinics, enrol professional associations, etc. Nonetheless, native workforce is able to benefit more from personal networks.

In Spain the average profile among foreign nurses is a young, Latin-American woman (coming from post-colonial territories). They spend on average a year to complete official degree recognition, and they tend to obtain first the standardization of their level of studies so they can work in qualified jobs but not necessary linked to nursing, and later the specific degree. The average profile of doctors is a young man who normally comes to study a master, again from Latin America. In addition, there are a little group from China and the Nord of Africa in the area of Barcelona and Madrid, and also a community from Eastern European countries usually in hospitals.

In terms of mobility patters, we can distinguish between occupations. As far as doctors are concerned, there is a high degree of mobility between hospitals and regions among overseas doctors. This mobility between hospitals could be explained by specialist shortages. Among the native-born it occurs but not so often. In terms of sex distribution, among native workforce there is a remarkable tendency towards feminization. However, migrant doctors are mostly men, due to gender gaps in their home country. Conversely, the vast majority of nurses are women. In addition, there are higher employment opportunities among doctors who work in influential hospitals due to better chances for training. Concerning career advancement, differences are linked to recognition process. Migrants may wait for their credentials to be recognised, and during this period (2-4 years) social uncertainties are relatively high. Nonetheless, once they get the academic degree recognition, they rapidly catch up with native doctors. Compared to native-born, migrant doctors have a more uncertain labour-path,

characterised by legal obstacles: work permit, visas, and academic recognitions. Just after landing, they encounter the highest degree of uncertainty, many cannot work as a doctor, and must wait between 2 and 4 years while they are employed as assistants (in private clinics). After 10 years, differences between workforces have sharply reduced. To sum up, to understand foreign doctors' career in Spain, we need to focus legal status, credential recognition process, degree of cohesion of their personal networks, seniority, shortages and needs of the national labour-market.

When looking at nurses, at some point, their pathways are relatively more uncertain than doctor's. This is more obvious among migrants than native-born, as they tend to occupy those jobs that Spaniards do not want (such as in geriatric hospitals). Similar to doctor, while they wait for having legal status to work as nurses, they often work in non-qualified positions (elderly care). They experience a relatively high mobility between hospitals, but less than doctors. Moonlighting is quite often, especially among migrants. In addition, advancement opportunities are directly related to their educational level. Skill Level appears to be one of the cornerstones to understand foreign nurses' situations in the labour-market. Professional success occurs when they do an effort to raise their education level, after migrate. Those who studied a master after migration have better job offers. This has two explanations, firstly because future employers can better assess their experience, and secondly due to job-related networks they can scheme. For both workforces (natives and migrants) family responsibilities seem to play an important role in their career. Uncertainties (in terms of lack of job opportunities and career developments) are larger among those who combine family and work. There is a singular "self-conviction": *I don't want any job opportunity, I've chosen my kids*. It is particularly interesting that nurses' trajectories (both native-born and migrant) show a certain degree of "path dependency" related to the professional area that they are employed at the beginning. This is, nurses employed in geriatric area will remain there, and this plays an important role among foreign nurses. Summing up, to understand nurses' careers, some variables play an important role: legal status, credential recognition processes, education level and post-graduate degrees, problems in balancing work and life.

Finally, in this part we also want to consider Unions as a cornerstone of employment conditions improvement. According to the data from interviews, in Spain the level of unionization among skilled workers health is quite low. Indeed, it is lower among migrants. This implies that the union action on this group do not receive special treatment. According to the interviews, we confirm that migrants are taking those jobs more precarious in the health sector, and thus their attitudes towards union action are very cautious.

On the other hand, among native-born physicians unionised, they question the process of standardization of foreign degrees. The general attitude point to the fact that due to labour-market needs the quality of this process is questionable, giving that it is realised too fast.

Nonetheless, they are aware that migration is occupying those job positions more insecure and vulnerable.

As it also happens for UK doctors (Medical Manpower in Europe, 2001), a number of Spanish health professionals work abroad. The current problems of shortages seem to have their origin in an incorrect distribution of health personnel, but also in nurses and doctors' emigration to other European countries, which adds to the difficulty of workforce planning. One emerging issue is the possibility of foreign nurses to enter Spain as a relatively 'open door', thanks to liberal immigration regulations between 2004 and 2008, to the EU. But while interviews have mentioned interest of non-EU nurses in Spain to move on to other EU countries and especially the UK, this seems to be still a very marginal phenomenon. According to NMC register data, the phenomenon of non-EU nurses' international mobility through Spain towards other countries and in particular, among the top 25 countries of origin of nurses in the UK, there is no Latin American country, while non-EU nurses' immigration into Spain is largely from Latin America. The mobility of nurses from Spain to the UK is overall rather small: in 2008, only 38 nurses from Spain registered in the UK.

Conclusions

International mobility of health professional is of increasing importance across Europe, beyond the traditional limits of the Anglophone world. Spain is a country where the issue is emerging particularly strongly, due to demographic and linguistic reasons, but still it is, numerically, well behind the British experience. While in the UK foreign recruitment is an explicit employer choice, mostly based on short-term cost and flexibility consideration, in Spain it is largely an unintended phenomenon stemming from the attraction of foreign students in nursing and medical education.

Our exploratory evidence points that many of the problems traditionally encountered in the UK – segregation in worse jobs, barriers to professional development and career, cultural stereotypes – are emerging in Spain as well. In particular, uncertainty is a largely neglected social issue that affected foreign professionals.

The UK needed several decades to raise awareness of these issues. Important forms of response have been through union organising and the elaboration of more sophisticated diversity management. Both are still underdeveloped in Spain: unionisation is rather low and diversity awareness, let alone management, still patchy. Moreover, Spain is still not active, internationally, on the issue of the global care drain, while the UK was forced to face it during the last fifteen years. British solutions may not all be relevant or well-suited for Spain, due to the different characteristics of the immigrant populations and the different institutional settings. However, looking at the British experience may be useful, for Spanish policy makers and professional associations, in order to detect early, and possibly prevent, social problems that can affect professional standards and equality in the long run.

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