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Actors of Transnational Labour Mobility in Europe

A Case Study from the Swedish Healthcare Sector

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Abstract

In order to enhance free movement and mobility of individuals across borders, the European Commission has established several agencies and programmes aimed at informing and assisting individuals and organizations on mobility matters. The European Employment Service is one of these organisations at the center of an extensive network of diverse actors involved in labour mobility at the European and cross-border level. However, there is still little transnational mobility and Labour mobility in Europe has not only strongly declined since the 1970's, but it has at the same time considerably increased in complexity.

The aim of this Thesis is to offer a better understanding of transnational labour mobility, i.e. the migrations of European-national workers from/to another European country. It will focus on the actors of this mobility, who they are and how they interact and match each other.

The European healthcare sector provides a good case to investigate this issue. The sector is large and is one of the most affected by the European directives and measures to promote labour mobility. The Skaraborg Recruitment Project provides the case of a Swedish organisation considering the recruitment of healthcare personnel in another European country with the assistance of the EURES agency as an intermediary. The Project shows concretely the obstacles, complexity but also opportunities of labour mobility from the perspectives of its different actors: Individuals, employers and eventual intermediaries.

Key-words: Labour mobility, healthcare sector, healthcare professionals, organizational entry, matching model, intermediary, EURES, Skaraborg Recruitment Project, mobility obstacles.

Preface

While numerous students and workers are moving across borders each year in Europe, I still have the impression that most people have a rather vague understanding and knowledge of mobility matters. Having lived and studied in three successive European countries, I have myself felt increasingly interested in mobility matters at the educational level. Labour mobility was a natural step for me to become aware of. Once I was set on the desired area of research and study, I decided to tackle the labour mobility issue where it probably was the most active at the moment: in the healthcare sector. I am pleased with this decision and realise thereafter that I have opened my eyes and started to understand some processes and actors behind labour mobility.

I thank my Tutor Ola Bergström for his keen assistance and interest in my work. My gratitude also goes towards all the people I interviewed and who helped me in my research. I also thank the faculty of the Master of International Management for giving throughout the Programme a large autonomy to its students, which I greatly value.

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1. Introduction

1.1 Background: New Free Movement for Europeans

The relationship between economic integration, migration and welfare was one of the basic ideas behind the common market which the European Community began to strive for in the mid 1950's. The right of free movement of persons and goods has been successively extended from the Treaty of Rome in 1957 until the Schengen Agreements of 1985, ratified by almost all the EEA countries (EU & EFTA members).

The free movement of workers has actually not always been the case in Europe and obstacles to mobility existed under many aspects. Only recently was it made possible by some of the aforementioned treaties. The free movement of labour in the European treaties means the 'abolition of any discrimination based on nationality between workers of the Member States as regards to employment, remuneration and other conditions of work and employment.' (Cedefop, 2001)

Political, legal, and administrative measures have been taken to facilitate labour mobility within the union: from the recognition of qualifications to the assistance to individuals looking for a job in another EU/EEA country. The recognition work began by sectors in the 1960's and the strategy was to agree on common minimum requirements, especially in the regulated professions like in the healthcare sector. In February 1991, a directive came into force to cover many professions of the healthcare sector such as nurses, dentists, vets, pharmacists and doctors. These directives set a minimum standard for what is required of a professional practicing in an EU/EEA country. Thus, mutual recognition of education is in principle automatic although the host country can require further documentation on education and training background. In this case, it has legally four months to give its decision to any individual request.

All these directives, not so easily foreseeable half a century ago, have ensured that any individual is entitled to work and live across the EU/EEA zone. In order to enhance free movement and mobility of individuals across borders, the European Commission has established several agencies and programmes aimed at informing and assisting individuals and organizations on mobility matters. The European Employment Services (EURES) is one of these organisations at the center of an extensive network of diverse actors involved in labour mobility at the European and cross-border level. It acts as an embryo of a European employment agency, by notably diffusing some job vacancies available in each country.

However, if the legal barriers have been lifted, culture, languages, or simply lack of information are some of the remaining obstacles to labour mobility. Moreover, in spite of a legal and political environment which encourages the free movement of persons, and in spite of the European Commission programmes to promote mobility and eliminate any obstacles in its way, there is still little transnational mobility among EU countries, especially when one compares at a historical level when there is much less intra-European mobility than in the past, or at a geographical level, with less internal mobility than in the U.S.A for instance. It is estimated that only less than 0.5% of the population actually moves across EU borders (Cedefop, 2001).

1.2 Labour Mobility & the Swedish Healthcare Sector

Behind the promotion of European labour mobility at political level, there are economic arguments as well. Labour migrations, national or international, have often helped in readjusting the regular bottleneck situations. In other words, workers have tended to move from areas where unemployment was high into areas where there were labour shortages. Labour Mobility in the 1950's and 1960's has been particularly crucial for the European economy, when millions of unemployed workers fled from Southern Europe to the industrially and economically booming Northern Europe.

What could be seen as a simple matching of needs to an economic problem was probably the case in the 1950's and 1960's but the conditions have changed nowadays. Labour mobility in Europe has not only strongly declined since, but has also considerably increased in complexity. Most relevant sources of information observe that people are now moving in different shapes & colours within Europe. European Economies have converged and the differences in unemployment rates or wage levels have decreased. Most economic theories on mobility are arguing that the incentives of working away from home strongly diminish with an acceptable level of unemployment and wages in the home country (Werner, 1996).

Meanwhile, the economic environment has also evolved from a blue collar to a white collar and knowledge based economy. The factors of productivity are more based on knowledge and experience of workers. New groups of highly educated workers, with specific skills and competences are now characterising the labour force of the knowledge based economy. Therefore, labour mobility in Europe is more likely to concern these new groups than the low skilled workers thirty years ago. Taking into account the relatively small number of European people actually migrating, there seems to be substantial potential for further initiatives and support towards labour mobility.

The European healthcare sector provides a good case to investigate this issue. The sector is large (one of the largest labour market sectors, both in absolute and relative terms) and broad, covering a wide range of professions. It is one of the most affected by the European directives and measures to promote labour mobility, the healthcare sector being originally strongly regulated. Meanwhile, there are many factors indicating the increasing need for mobility among health professionals. Some countries educate far more than necessary while others are in desperate need of the same professions. (Skar, 2001)

The Skaraborg Recruitment project has offered me the opportunity to investigate this situation. It provides the case of a Swedish organization considering the recruitment of healthcare personnel in another European country with the

assistance of the EURES agency as an intermediary. It will allow the observation of labour mobility at a concrete level, to understand its reasons, happening and outcomes. Furthermore, the Skaraborg Project will enable some deeper understandings of the EURES agency and its role as an intermediary in the job matching process, which is at the core of labour mobility success or failure. For this analysis, I chose to use the theoretical framework of organizational entry, more particularly the Matching Model of individuals and organizations.

1.3 Purpose & Research questions

My aim in this Thesis is to offer a better understanding of European transnational labour mobility, i.e. the migrations of European-national workers from/to another European country. I will focus my attention on the actors of this mobility, who are they and how they interact and match each other? In this regard, I have also become interested in the work of the European Employment Services (EURES) in it support of labour mobility. What are its roles and activities, and how can it provide assistance to individuals and organisations?

Furthermore, I was interested in understanding how labour mobility takes effect concretely and in which case it is felt needed. For this I needed to investigate in a real situation when intra-European labour mobility was at the core of a problem solving process, namely the problem of labour shortages in the Swedish Healthcare sector. With this orientation in mind, I came across the Recruitment project of the Skaraborg County authorities, which sought solutions to the staffing challenges of their Primary Health Centers.

In addition to the better understanding of labour mobility processes, these research questions will also help me to analyse the obstacles of labour mobility: From the perspective of healthcare workers migration to Sweden to a more general one for Europe. This in return, will deepen my understanding on labour mobility issues, and eventually sow some potential seeds for successful job matchings.

1.4 Methodology

In order to understand the processes and actors of labour mobility at a concrete and real life level, I had to acquire first an overview of labour mobility and healthcare standards in Europe. As the Skaraborg Recruitment Project dealt mostly with Spanish healthcare professionals, I also decided to narrow down my investigations on presenting and comparing successively the Swedish and Spanish healthcare sectors and healthcare labour/education markets. For this, I used different sources from the European Commission, Eurostat or Health Organisations such as the World Health Organisation. However, traditional sources like Eurostat and the labour force survey do not categorise health professionals and statistics on mobility among health professionals are not easily available (Cedefop, 2001).

For the investigation of EURES, I based myself mainly on the sources from the European Directorate for Employment Affairs such as the EURES activity report, and an interview with Ms. Margaretha Holmer, head of EURES for the Western Sweden Region (Västra Götaland). To Investigate the Skaraborg Recruitment Project, I held an Interview with Mr. Kjell Pettersson, HR Manager for the Skaraborg County, and head of the recruitment project. I also inquired for further help to Mr. Tom Roffey, Manager of the Primary Health Care Center in Lidköping (part of the Skaraborg County).

To analyse the experience of incoming workers within the project frame, I based myself on the September 2002 report of the Swedish National Employment Agency, which conducted 16 interviews with doctors (eight Germans and eight Spaniards) after they were recruited in the project and came to work in Sweden. I also conducted interviews with Spanish and German doctors and health professionals in order to strengthen my analysis.

My choice of a theoretical framework for the analysis of EURES and the Skaraborg Recruitment Project has focused on organisational entry theories and

particularly a matching model of organisations with individuals. I chose the model of Wanous, which focuses on both the organizational and individual perspective for the success of the matching process (Wanous, 1992). Furthermore, I drew critics of the model, especially considering the international and unusual settings of international labour mobility. I also made adjustments to the model, considering the importance of the role of an intermediary level in some job matching processes. As we will observe later, that has been partly the case with EURES and the Skaraborg Recruitment Project.

Finally, this adjusted theoretical framework will enable me to analyse the different roles and perspectives of each actor of the project, and more generally with respect to labour mobility and the traditional job matching processes. Figure 1 below shows my course of action and structure model of the Thesis. I will use both empirical data and theory to conduct my analysis of the different roles and actors of labour mobility, which will be used later on the enunciation of labour mobility obstacles.

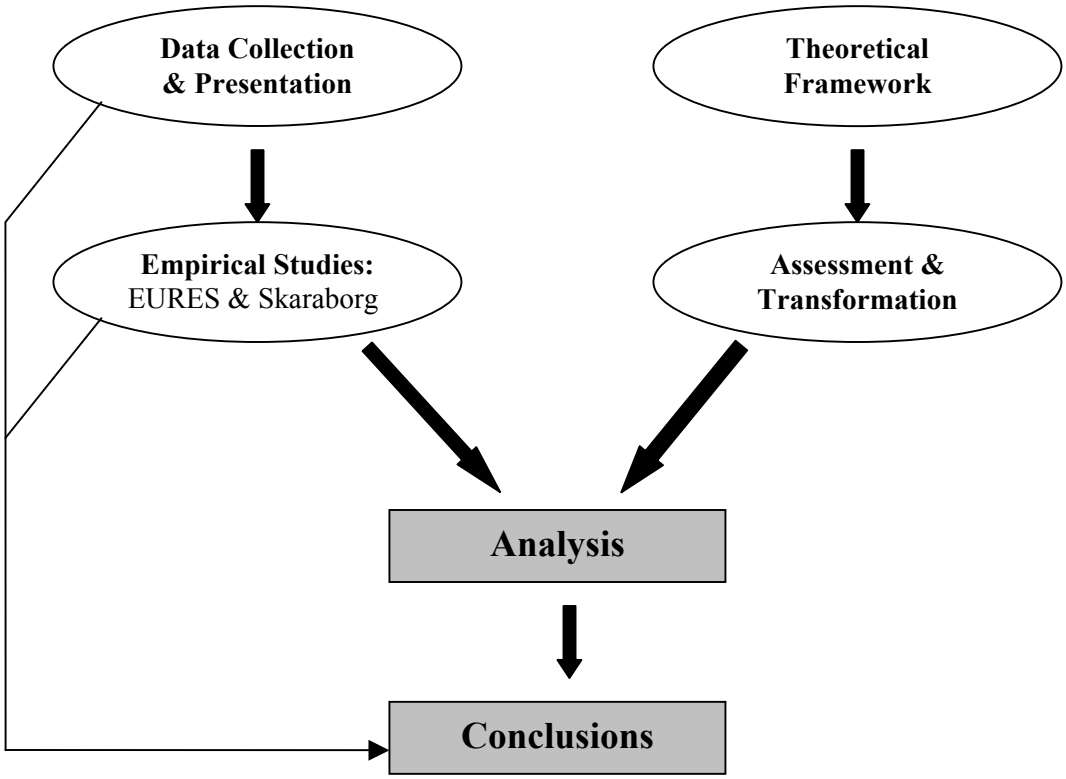


Figure 1: The mapping & structure model of the Thesis

2. Theoretical Framework: Organisational Entry & the Matching Model

Organisational entry includes the wide variety of events occurring when new members join organisations. By its very nature the entry process has often been considered from the perspective of both the individual and the organization. Individuals chose to apply, organizations select newcomers from among applicants, and job candidates choose from among offers (Wanous, 1992). In the framed study of this thesis, the organisation is represented by a Swedish employer (hospital or county council) and the individual by a EU/EEA-national worker from the healthcare sector (doctor, dentists, nurse, etc.).

The reasons why organisational entry is important lie in the consequences of mismatching. Turnover costs are very expensive for the organization, especially in the case of recruiting and working abroad. The recruiting and training of new employees is expensive and time consuming. Therefore, organizations want to keep their new employees, limit absenteeism and the lack of commitment, and avoid the exit of valued employees. It is also very important to find the candidates that best suit the skills and experience which are needed and sought after. Therefore it's important to create an appropriate model of job matching between the individual and organization.

Furthermore, the study of transnational labour mobility showed me that there were no impassable obstacles in Europe and that most obstacles were located upstream, before and during the moving took place. Therefore, I felt it more important to use theories describing the entry processes, such as the dual matching model and the four phases of organisational entry.

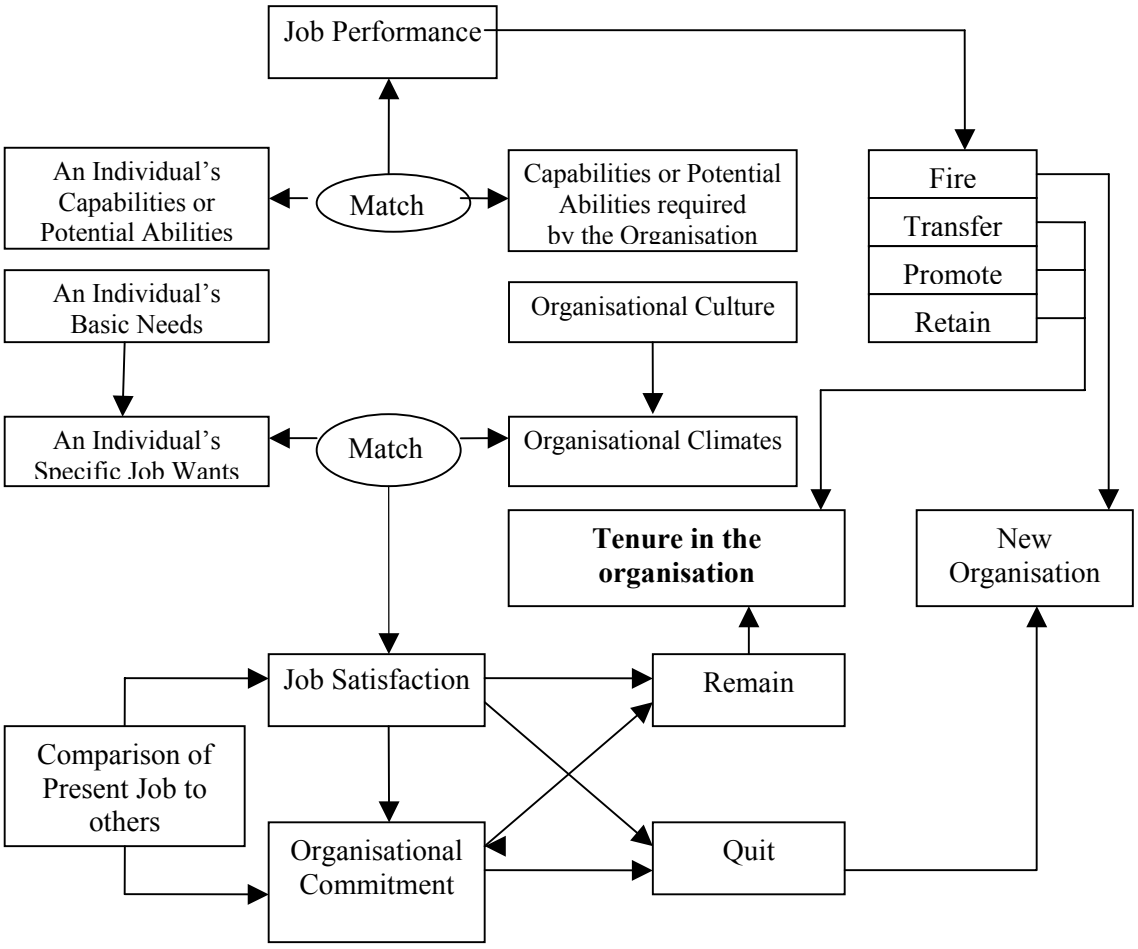
2.1 The Matching Model between the Individuals and the Organisations

A major theme in the examination of the entry process is the matching of individual and organisation. Matching models have been constructed upon empirical studies of real recruiting processes and after that individuals have joined organisations. One widely recognized matching model has been elaborated by Wanous. It was based on the Minnesota studies of vocational adjustment that has been changed to an organisational focus (Wanous, 1992).

It is a dual matching process in which individuals and organizations get matched to each other. One match is between the individual's capabilities, and potentials, and the requirements of a particular job. The other match is between the individual's specific wants and the capacity of the organizational climates to fulfill them. The direct consequence of this match is on job satisfaction, and, indirectly on organisational commitment and voluntary turnover or absenteeism. One essential factor for successful job matching on the long term is the level of commitment of Individuals to the organisation, which I will discuss in my analysis.

Even though Wanous made his model twenty years ago, the relations between individuals and organizations haven't much differed. If for instance, the individual needs have evolved with time (e.g. more free time, empowerment, etc.), the clashes of objectives and intentions between organisations and individuals remain, and the need of a common ground for matching still exists.

Figure 2: Matching Individuals and Organisations.



Source: *J.P. Wanous, 1978, Realistic job interviews: Can a procedure to reduce turnover also influence the relationship between abilities and performances? Personnel Psychology.*

The Matching Model prefigures two matches, which each hold their own challenge and perspective:

- Employers have difficulties to find the right people for the job available, that is to say the right competences. When looking abroad, outside their usual pools of recruitment they might be even more blurred (recognition of education, legal procedures, etc.) These job matching concerns are represented in the upper part of the matching model. Employers will consider the matching with the individual accordingly to his/her job performance.

- Individuals have difficulties to get realistic information about the job that they are best suited for and that they are motivated to do. In addition, they also often lack information on other countries they plan to work and live in (taxes, pension schemes, etc.). This situation is represented by the lower part of the matching model. Individuals will normally consider the matching with the organisation accordingly to their job satisfaction. The Model further details some considerations of the individual job satisfaction as regard to his/her previous experience with previous jobs and commitment to the new organisation he is entering.

2.2 The Matching Model in the frame of International Labour Mobility

Free movement in the EU with its new internationalisation of labour mobility has put a more complex dimension onto the traditional organisational entry theories and models. Most of these theories have considered the fact that individuals and organizations were, if not from the same country, culturally bound. Most studies in this field have been based on the analysis of companies (or their overseas branches) that recruit individuals living in the same country, even if the job position is for a placement abroad. Sometimes, as we will see in the Skaraborg

Recruitment Project, organisations and individuals have never set foot in each others' country before, and therefore enter a Matching process in some terra partly incognita.

Many Scholars have considered the Matching Model only from the organisation perspective, claiming that the employer had full control on the recruiting and hiring over the potential candidate. Therefore, the employer's point of view prevailed and only the upper part of Wanous model was relevant. This view of the matching process has been effectively the traditional view of organisational selection. However in recent years, there has been a revaluation of the concept of recruitment. Not only in terms of a greater concern for the well-being of employees but also an interest in trying to match the individual values and norms with corporate culture, in particular in corporate settings where knowledge resources are scarce and corporations face tough labour markets. Under these circumstances, the traditional concept of recruitment, based on a single choice from the organisational perspective, is inappropriate. Instead, some critics claim that recruitment should be regarded as a dual matching process of mutual negotiation (Bergström, 1998). This situation is even more relevant for the intra-European labour mobility, which is increasingly highly-skilled and knowledge based.

However, Wanous has been keen on including the employee's perspective and a second match in the matching process. In the case of the Skaraborg Recruitment Project that we will observe later, the employer made the (still) unusual effort to operate the recruiting in another non-bordering country. This new situation puts a new stronger argument on the employee side. While most potential candidates might not feel essential to a new organisation, here candidates realise that the employer has made the extra effort of coming to their country. By doing so, the employer has revealed some of its lacks and needs and therefore the employee may have probably more weight in the negotiations.

One critic to the adding of the individual perspective though, is that Wanous only considers the individual basic needs. As the Skaraborg Recruitment case will later demonstrate, the mobility of labour across borders greatly concerns the basic needs of the surrounding family. Therefore, the model should not only consider the individual's basic needs but also the basic needs of people who are moving with him/her, i.e. the nuclear family.

In his Matching Model, Wanous insists that the success of the job matching will depend greatly on the exchange of realistic information between the organization and the individual. For instance, if the employer gives as much realistic information as possible to the employee, he/she will have the most realistic knowledge if his/her competences should match or if the organization culture/climate will correspond to his/her expectations.

In the case of international labour mobility, some complications may arise in the exchange of realistic information. In general, both parties will be distorted by the new prospects of working/hiring abroad and both will try to obtain as much realistic information as possible. For a worker who has the opportunity to live in another country he never lived before, the demand for information about this new country (and the employer as well) will be very high. To him, it is an important step not to be compared with changing of job in his hometown or region. Therefore, a special relationship between the employer and candidate might often be needed in order to exchange an unusually great amount of realistic information.

Another issue concerns the exchange of realistic information in a multinational and multicultural setting. The employer and candidate will probably come from different cultures and will have therefore different perceptions of realities and what is realistic information. Hoftsede defines culture as those differences of basic assumptions requiring some cross-cultural awareness, especially for the employer if it wishes a good integration of foreign doctors in Skaraborg

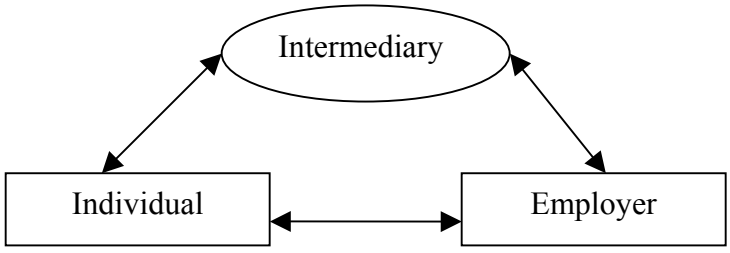
Another important criticism of the Matching Model is that it does not take into account the role of intermediaries. In other words it assumes direct contacts between the organization and individual without any interference or coordination from an intermediary in the recruitment process. While this might be true within one country, hiring and working across borders are more likely to use an intermediary, such as EURES, in order to deal with the increased uncertainties and lack of information/communication with the other party.

Therefore, I chose to add an intermediary ladder in the Matching Model, where the matches between the organisation and individuals are coordinated by the intermediary actor. The underlying question will be to know if that intermediary is just temporary, or likely to stick in every future relation between the same organisation and new individuals.

2.3 Adding an Intermediary Level to the Model: The EURES Agency

The introduction of intermediaries in the labour market means that the employment relationship takes the form of a three party relationship as it can be seen in the figure below. According to Bergström & Storrie, there is no common agreement on what to call this intermediate actor. Following the definition of dictionaries, an intermediary is a person or organization that initiates and coordinates the contact between two different persons, groups or organizations.

Figure 3: Model of the intermediary interaction with the Individual and Employer.



Source: Contingent Employment in Europe and the United States. Ola Bergström & Donald Storrie.

From this perspective, an intermediary can intervene by providing an information interchange to both the workers and employers. I will develop this idea of the Skaraborg Recruitment project, where the pertinence of an intermediary was aroused. Moreover, the transaction costs aforementioned can be lowered dramatically for both parties if an intermediary intervenes in the matching process.

A natural intermediary could be seen as a public Employment Service such as EURES. Public Employment Service (PES) has evolved in recent decades to become a key instrument in government employment policy. The Employment Service Convention of 1948 defines the role and scope of the PES. The main emphasis of this article is that the PES is central to the best possible organisation of the employment market, not just as a direct provider of placement services and labour market information, but also as partner in the achievement of full employment and the fulfillment of national or European employment policies (Thuy et al., 2002).

2.4 Four Phases of Organisational Entry

Wanous foresees four phases of organizational entry from simultaneously the individual and organisational perspectives. There are two pre-entry phases, recruitment and selection, which are followed by two post-entry phases: orientation and socialization. Once again, viewing organisational entry from both perspectives is a central theme. Wanous reckons himself that the reality of this process is much less tidy than the figure below might suggest. I found it however pertinent to use as a frame of analysis.

Figure 4: Individual and Organizational Issues at four Stages of Entry (Wanous, 1992).

Phase of Organisational Entry	**The Newcomer Individual Perspective**	**The Organisation being entered Perspective**
1. Recruitment: The Process of mutual attraction	• Finding Sources of information about job openings • Determining the accuracy of information about particular organisations	• Finding sources of effective job candidates • Attracting candidates with appropriate strategy ("selling" vs. "realism")
2. Selection: The process of mutual choice	• Coping with job interviews and other assessment methods • Deciding whether or not to apply • Choosing from among job offers	• Assessing candidates for future job performance and retention
3. Orientation: The process of initial adjustment	• Coping with the stress of entry	• Managing both emotional and information needs of newcomers
4. Socialisation: The process of mutual adjustment	• Moving through typical stages • Detecting one's success	• Influencing newcomers with various tactics • Using the psychology of persuasion

3. Labour Mobility & Healthcare in Europe

3.1 Transnational Labour Mobility in Europe

Before discussing the mobility of workers in the EU, it is important to distinguish and define two different forms of labour mobility: transnational and cross-border mobility. Transnational mobility means that EU citizens move away from their countries of origin, either permanently or for a limited period of time. These persons are also called "traditional migrant workers". Cross-border mobility of "frontier worker" means that a worker pursues his occupation in one country while he resides in the territory of another (likely to be neighbouring) country. The rule is that he returns to his home country daily or at least once a week.

Currently there is relatively little transnational mobility in the EU labour force. Although all EU citizens have the right to work and live in other Member States, less than 6 million citizens (1.5% of the population) have opted to settle in another country. Figure 5 below details the origin of these migrations as for 1995. A significant amount of these are mobile for reasons other than employment. There are a growing number of students who accomplish their studies partly or entirely in another Member State for instance. There are also a growing number of retired EU citizens moving away, generally from the northern 'frost-belt' to the southern 'sun-belt'. In 2000, the number of cross-border workers in the EU was estimated at around 300,000, which meant that cross-border mobility was even less developed than transnational mobility (MKW, 2000).

While free movement has been made possible on the legal, political and administrative level, the EU is yet composed of 15 (and probably 25 by May 1st, 2004) different countries with their different history, culture, traditions, languages and patterns of behaviour. Historically, there are very few examples of such high-degree levels of integration among so different and diverse constituents. Even very culturally and ethnically diverse markets like India, the USA or Brazil represent one country with a certain level of cohesion.

Figure 5: Repartition of the ca. 5.5 million EU citizens living in another EU country in 1995. Source: Eurostat (figures in thousands). For example, 3 000 Spaniards lived in Sweden, while 478, 400 lived in another EU country.

Living in:	Belgians	Danes	Germans	Greeks	Spaniards	French	Irish
Belgium	-	2.8	29.3	20	49.5	95.2	2.8
Denmark	0.4	-	8.9	0.6	1	2.2	1
Germany	22	18.3	-	345.9	133.8	90.9	13.8
Greece	1.7	1.6	14.1	-	1	8	0.7
Spain	7.2	4	30.5	0.5	-	22.6	2.1
France	56.1	3.5	52.7	6.1	216	-	3.5
Ireland	na	na	na	na	na	na	-
Italy	4.6	2.4	39.5	16.2	15.6	25.4	2.5
Luxembourg	na	na	na	na	na	na	na
Netherlands	24	1.9	49.3	5.6	16.8	10	4.4
Austria	0.5	0.4	57.3	1	0.7	2.2	0.2
Portugal	1.1	0.5	5.4	0.1	7.7	3.7	0.2
Finland	0.1	0.5	1.6	0.2	0.3	0.4	0.1
Sweden	0.4	27.2	12.9	5.7	3	3.1	0.7
UK	6	9	51	25	33	42	466
EU 15	124.1	72.1	352.5	426.9	478.4	305.7	498

Citizens	British	Swedes	Finns	Portuguese	Austrians	Dutch	Lux.	Italians
541.8	24.9	3.1	0.8	20.5	1.1	69.7	4.6	217.5
40.6	10.9	8.4	1.9	0.4	0.6	2.3	0	2
1719.3	107.1	14.4	12.2	98.9	185.3	113.6	5.4	557.7
64.7	20.7	2.3	1.2	0.4	1.9	3.7	0	7.4
181.8	53.4	5.3	1.9	28.6	1.5	10.5	0.1	13.6
1321.4	50.4	4.8	1.6	649.7	3.3	17.9	3	252.8
66.8	55.5	na	na	na	na	na	na	na
160.2	28.4	3.2	1.6	5.3	8.3	7	0.2	-
na	na	na	na	na	na	na	-	na
189.2	44.1	2	1.1	9.4	3	-	0.3	17.3
79.3	3.4	1.4	0.5	0.2	-	2.6	0.3	8.6
32.6	9.3	0.7	0.2	-	0.3	2	0	1.4
12.3	1.6	6.5	-	0.1	0.2	0.3	0	0.4
187	10.7	-	111.5	1.5	3.7	2.6	0	4
770	-	12	9	15	7	22	na	73
-	420.4	64.1	143.5	830	216.2	254.2	13.9	1155.7

Traditionally, labour force mobility has been seen as a consequence of economic push and pull factors (Werner, 1996) Unemployed people moved to a country or an area where there are jobs. A couple of decades ago, mobility in Europe was dominated by people moving from south to north. The complexity of the migrations has obviously increased. No longer are there clear movements in certain directions. Instead, mobility tends to be more temporary, cross-border based and limited to several sectors such as the healthcare. Moreover, an increasing trend towards the mobility of specialists, experts, multinational employees, individuals seeking education, etc. is apparent.

European workers are becoming less mobile than, for example, those in the second half of the 19th century. The reasons are diverse for this decline but observations made tend to agree that the traditional push and pull factors have shifted onto other parts of the world. Therefore, parallels with previous intra-European migrations can be made with recent migrations to Europe from developing countries.

Statistics for mobility among healthcare personnel are not easily available. Eurostat regularly publishes figures on foreign workers in EU States, but does not trace health professionals. The most accurate data are provided by the Directorate General Internal Market from the European Commission. It shows how many professionals in each member state have applied for recognition of qualifications. It shows that the number of health professionals who cross borders is low. The total amount of applications for recognition of qualifications between 1993 and 1996 was 43 809. While this figure is low, it represents 82% of all application for all sectors (53 182), showing that healthcare is one of the sectors most affected by labour mobility in Europe.

The number of doctors having obtained authorization to practice in a Member State other than where they obtained their basic qualification in 1997 was 80 in Sweden, 203 in Spain. The UK was from far the greatest host country with 1908 authorisations. (Skar, 2001)

3.2 Different Healthcare Approaches & Standards in Europe

European countries vary widely in their standards of facilities and professional staffing. These reasons generally reflect the amount of GDP spent on healthcare and the prosperity of the country itself. Most European countries have a state-run healthcare system with a different mixture of national and private health services, and dilution of responsibilities within the different levels of authorities (municipalities, regions and states). The number of private beds in hospitals for instance, varies between the United Kingdom by 5% and the Netherlands at 92%.

Figure 6: Employment in health and social work sector as percentage of working-age population.

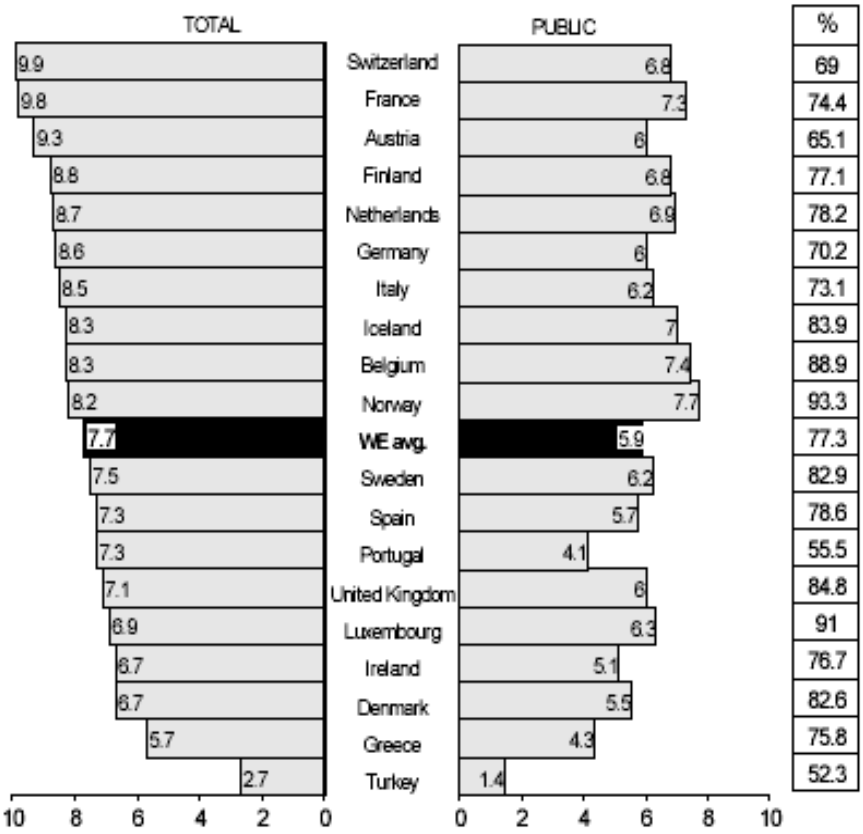
EU15	A	B	D	DK	E	F	FIN	GR	I	IRL	L	NL	P	S	UK
5.7	5.5	6.2	5.7	13.0	2.5	6.3	9.3	2.5	3.0	5.0	4.4	9.5	3.1	13.6	7.8

Source: Employment Rates Report, Community LFS, 1998.

Sweden has the highest Employment level in the health and social work sector as a percentage of working-age population. The difference between 13.6 % (Sweden) and the lowest 2.5% (Greece) is significant and implies a picture of two different health and social care services.

Healthcare, in the same way as education and training, is a national responsibility not subject to EU legislation and regulation. Each Health systems will also depend on how each country and culture views health and what is meant by being in good health. Moreover, healthcare education varies significantly in Europe even though the European Union has set some standard requirements and procedures. Figure 7 below, shows that the expenditures on health care are unequalled and also underline some differences of culture and priorities. The Sums spent do not however reveal the efficiency of any systems.

Figure 7: Total and public health care expenditure as a share of GDP (%) in Western Europe, 1993. Source: World Health Organisation.



3.3 The Swedish Healthcare Sector

The Swedish health care system is a regionally based, publicly operated national health service. It is organised on three levels: national, regional and local. The county councils, on the regional level, together with the central government, are the basis of the health care system. The principal responsibility of the central government of Sweden is to ensure that the health care system runs efficiently and according to its fundamental objectives. This is the responsibility of the Ministry of Health and Social Affairs. The National Board of Health and Welfare has a supervisory function over the county councils as it acts as the government's central advisory and supervisory agency for health and social services.

The 1982 Health Care Act was an important landmark for several reasons. It completed the successive process of transfer of responsibility for all health services provision from the national level to the county council level, it formalized the needs-based approach to health care planning; it made county councils responsible for preventive care and health promotion; and it constituted the framework for health planning and health activities The Health Care Act requires the county councils to promote the health of their residents and to offer equal access to health care. They are also required to plan the development and organisation of health care with reference to the needs of the population. The general authorities and responsibilities given to the county councils are stated in the Local Government Act. The most important special authorities and responsibilities given to the county councils are stated in the Health Care Act. The overall responsibility is stated in Paragraph 3: "Every county council shall offer good health and medical services to persons living within its boundaries. In other respects too, the county council shall endeavour to promote the health of all residents".

A county council is an independent regional government body, which, like a local municipality, has the right to levy a proportional income tax on its residents. The population in the county councils ranges from some 250 000 to 1.7 million. Within each county council there are usually several health care districts, each with the overall responsibility for the health of the population in its area. Some of the county councils' income is received from the state and national insurance system, but two-thirds of their income is generated through county council taxes. The county councils are in charge of the health care delivery system from primary care to hospital care, including public health and preventive care. The county councils have overall authority over the hospital structure and are responsible for all health care services, they are free to choose whatever structure they consider suitable, corresponding to their responsibilities.

The county councils are generally organised into geographical health care districts, each managed by their own political board. A district usually comprises one

hospital and several primary healthcare units. Within these districts the primary health care services are often subdivided further into geographic primary health care districts. A primary health care district is usually the same geographical area as the local municipality, although larger cities correspond to more than one health care district.

The county councils have the authority to negotiate the establishment of new private practices and the number of patients they can see during a year. Since the private provider must have an agreement with the county council in order to be reimbursed by social insurance, the county councils are able to regulate the private health care market. If the private provider does not have any agreement or if the private provider does not use the regulated fee schedule, a private patient will have to pay the full charge to the provider. Private health care is quite limited, with only about 8% of physicians working full time in private practice. It is mainly in the larger cities that private practices are common.

The Swedish system provides coverage for all persons who are resident in Sweden regardless of nationality. In addition, coverage for emergency attention is provided to all patients from EU/EEA countries and seven other countries with which Sweden has a special convention. The services available are highly subsidised and some services are provided free of charge. The maintenance of a high level of quality in the health care system and continuous efforts toward quality improvements have been issues of major interest in Sweden over a long period of time. At the present time, resources are limited and it is believed that it is important to demonstrate quality in the services provided.

Primary health care is mainly publicly provided. Primary care services deliver both first-level curative as well as preventive care through public primary care centres. As of today, Sweden has 950 health centres, each of which provides services to 20 000–50 000 inhabitants. The health centres are administered by the county councils. The aim of the primary care level is to improve

the general health of the people and to treat diseases and injuries which do not require hospitalisation. Patients attend physician consultations by appointment, but most health centres give the patient the opportunity to come during certain hours in the day without an appointment.

Swedish health care is predominantly publicly financed through taxation. In the most part this involves proportional county council income taxes levied by each of the 26 counties on their populations. These tax revenues are used mainly for financing health care, as well as other services. Some 77% of total county council expenditures are health care expenditures, while the remaining 23% are expenditures on other services, including activities within social welfare, culture and public transportation. Some 72% of total health care income of the county councils was in 1993 derived from tax revenues. Other income sources of significance are grants and payments for certain services received from the central government which amounted to 11.2%. Out-of-pocket contributions from consumers amounted to 3.5% of total county council income, and 6.2% were reimbursements from other county councils and/or municipalities for health services to their residents.

During the 1990's the Swedish healthcare system underwent a major deregulation and a move towards market orientation. This has provoked cost savings from public administrations. At the same time, Temporary Work Agencies were made legal in Sweden and the use of contingent employment has steadily increased. Meanwhile, the decentralization has accelerated the pace.

Figure 8: In-patient facilities utilization and performance, Sweden, 1970–1994. Source: OECD Health Data, 1995.

In-Patient	1970	1975	1980	1985	1990	1991	1992	1993	1994
Hospital beds per 1000 population	15.3	15.5	15.1	14.6	12.4	11.9	7.6	7.0	6.46.4
Admissions per 100 population	16.6	18.1	18.3	20.0	19.5	19.9	19.5	19.5	
Average Length of Stay in Days	27.2	25.8	24.4	21.3	18	16.8	10.1	9.4	
Occupancy Rate (%)		83.6	83	85.8	84.2	84.7	81.7	83	

Under Capacity of the Healthcare Education System

In the late 1970s and early 1980s debate over whether excessive numbers of physicians were being produced resulted in planned declines in the numbers of new medical students, thus giving rise to a substantial slow-down in the rate of increase of physician numbers during the 1980s. Between 1992 and 1993 growth leveled off, and from 1993 onward the number of healthcare personnel has declined every year. This has been partly due to financial pressures and changes in the work done by the personnel (WHO, 2001)

There was general upward trend for most categories of personnel until about 1985–90. The number of active physicians per 1000 population has increased steadily since the 1970s, leveled off in the period 1985–90, and began to decline after 1991. The number of certified nurses peaked a few years earlier than that in physicians (WHO, 1996)

In the case of physicians, the Swedish pattern tends to follow that of the Western European average of steady growth followed by decline since the early 1990s. The case of nurses is somewhat different in that as noted above the peak in numbers that occurred earlier, in 1980, after which there has been a steady decline. Concerning dentists, by March 2002 there was an estimated need of 237 general dentists and 79 specialist dentists for the Swedish public dentistry centers (Socialstyrelsen, 2002).

In the years to come, it is expected that recruitment of new health care personnel will grow, and the health sector is already experiencing some problems in recruiting skilled personnel. The average age of physicians is above 45 years and the number of retirements will increase substantially in the early part of the next century. However, the trend differs for different groups of personnel, reflecting a different balance between supply and demand.

Figure 9: Healthcare personnel, Sweden, 1970-1992. Source: OECD health data, 1995 & WHO.

Per 1000 population	1970	1975	1980	1985	1990	1991	1992
Active physicians	1.36	1.72	2.20	2.59	2.54	2.59	2.53
Active dentists	0.84	0.86	1.0	1.01	0.61	0.95	—
Certified nurses	5.08	7.31	8.81	7.72	—	7.13	9.55
Midwives	—	—	—	—	—	—	0.72
Physicians graduating *	0.009	0.1	0.12	0.13	0.09	0.1	—
Nurses graduating *	—	—	—	42.2	—	39.7	—

3.4 The Spanish Healthcare Sector

As in the Swedish healthcare sector and in other European countries there is a pressing need to manage health services with greater efficiency through transferring responsibilities and risks to local budget holders, increasing the autonomy of hospitals and health centres, particularly in terms of day-to-day organization and involving health care professionals in management.

The distribution of responsibilities and functions is established by the General Health Act (1986) that shares healthcare responsibilities between the State Administration and the Autonomous States. Thus, planning and management of the health system is based on the need for fundamental consensus between the different political powers, the region-based administrations and the central state.

The Spanish health care system has been set up as an integrated National Health Service which is publicly financed and provides universal health care free-of-charge at the point of use. It is decentralized, with local organization in each of the 17 autonomous communities which make up the Spanish state. The general principles of the National Health Service as defined by the General Health Act of 1986 are:

- Universal coverage with free access to health care for all citizens.
- Public financing mainly through general taxation.

- Integration of different health service networks under the National Health Service structure.
- Political devolution to the autonomous communities. Region-based organization of health services into health areas and basic health zones.
- Development of a new model of primary health care, emphasizing promotion and prevention activities.

The State Health Plan, approved in 1995, lays down the general framework of the system to operate across the different administrations. It fixes 14 priority areas for action (elderly people, AIDS, diseases of the cardiovascular, respiratory, digestive and locomotors systems, communicable diseases, cancer, tuberculosis, diabetes mellitus, pre- and postnatal care and infant health, mental health, dental health and accidents), in accordance with the regional health plans. The state also specifies a package of benefits which the National Health System must offer in all regions; and sets out minimum requirements which must be met as regards public health, health care and health facilities.

Coverage is almost universal and guarantees a fairly comprehensive package of benefits to all Spanish citizens regardless of personal wealth. Where individuals are omitted from the national scheme, this is on the grounds of membership of an alternative, employment-linked insurance program and not on the basis of inability to contribute. The possibility of purchasing additional, private insurance is also open to all citizens. Concerning the financing, 80% comes from the state budget (taxes) and 18% corresponds to social security contributions (employers and employees). The remaining 2% is generated by care provided for patients with other types of coverage.

According to Rodriguez and Gallo de Puelles, the financing and delivery of health care services in Spain has the particularity of maintaining high levels of health among the population while spending comparatively less on the health care system than most industrialised countries. (Rodriguez et al., 1999).

Primary health care in Spain is an integrated public system with its own centres and staff. Management is primarily through specific PHC management bodies at the level of the health area, but organization is based on the basic health zone, the smallest geographical unit of the health system. They are, in effect, the first contact the population has with the health system. General practitioners (GPs) screen patients and will provide both diagnosis and treatment if appropriate. They may also refer on to specialized services if necessary. Patients having received specialist care are expected to return to the primary care physician who then assumes responsibility for follow-up treatment, repeat prescriptions, etc (WHO, 1996).

Figure 10 below shows some figure assessing occupancy and quality standards at Spanish hospitals. This can be compared with the table 8 for the Swedish standards. Although there are no important differences, Swedish patients seem to benefit from more systematic and longer access to hospital care.

Figure 10: In-patient facilities utilisation and performance in Spain, 1975–1993. Source: WHO.

In-patient	1975	1980	1985	1990	1991	1992	1993
Hospital beds per 1000 population	–	5.4	4.6	4.15	4.2	–	–
Admissions per 100 population	8.1	9.3	9.3	9.7	9.9	10.0	10.4
Average length of stay in days	16.8	14.8	13.4	12.2	11.9	11.5	11.0
Occupancy rate (%)	69.0	70.0	75.2	76.2	76.7	77.0	77.8

Over Capacity of the Healthcare Education System and Employability Problems

In 1994 in Spain there were 4.1 physicians, 0.3 dentists, 1.0 pharmacist and 4.3 nurses per 1000 population. These figures indicate Spain meets the Western Europe Average, and has an adequate supply of qualified staff to meet current Health System needs, although geographical distribution is uneven due to the

attraction of the major cities. There is an overproduction of doctors with around 4000 students graduating from medical school annually. However, there have been significant reductions in the number of entrants to medical schools following the 1987 agreement of the University Council to restrict admissions. While it is hoped to reduce graduates per year to 3500 in the future, current levels already contrast markedly with those of 1973 when there were 22 000 students enrolled in the first year undergraduate course (WHO, 1996).

This production of excessive numbers of doctors in the past has left a legacy of difficulties, in particular in the entrance to specialties. The examination entry system for residents could not absorb the high numbers of graduates coming out of the universities and this has caused unemployment among physicians who have been unable to specialize. According to the news magazine L'Express, Spain did not set a quota to the education of nurses, and as a consequence, bears 15,000 nurses unemployed today.

The basic salary of all physicians is regulated by the State Government, although the Autonomous communities do have the capacity to vary some of the components which make up the total salary. The payment system for hospital professionals has been very controversial and failed to satisfy either the system's financiers or the physicians themselves. It is widely held that it largely fails to reward efficiency. The dissatisfaction of staff reached a peak in 1995 when there was widespread strike action amongst some hospital physicians and in several regional health services. Moreover, the wages in the healthcare sector are amongst the lowest in the European Union.

Apart from these dissatisfactions, there are also problems concerning Employability and flexibility of the sector. As opposed to other European countries, there is no presence of intermediary agencies when hiring in the Spanish healthcare system. Although Spain is one of the countries in the European Union that most uses the services of the temporary work agencies when hiring workers, this mechanism of flexibility in employment through private work

agencies, has still not being inserted in the public healthcare system, since hiring staff is an exclusive and direct competence of the Public Administration, through their corresponding administrative organs. Thus when compare to Sweden, Spain lacks some flexibility that brought contingent employment that developed steadily in Sweden since 1990.

The figure 11 below is to be compared with the table 9 from the Swedish health systems. While there are not huge differences, the Swedish health system tend to have a greater amount of some professions proportionally while Spain has more in other professions.

Figure 11: Health care personnel in Spain, 1970–1993. Source: OECD health data, 1995.

Number per 1000 population	1970	1975	1980	1985	1990	1991	1992	1993
Active physicians	1.3	1.5	2.3	3.3	3.8	3.9	4.0	4.1
Active dentists	0.1	0.1	0.1	0.1	0.3	0.3	0.3	0.3
Certified nurses	0.8	1.0	3.4	3.7	4.1	4.1	4.2	4.3
Midwives *	–	–	–	–	–	–	–	–
Active pharmacists	–	0.1	0.4	1.1	1.7	2.0	2.1	–
Physicians graduating *	–	0.11	0.21	0.20	0.13	0.13	–	–
Nurses graduating *	–	0.15	0.14	0.13	0.13	0.14	–	–

4. The European Employment Services (EURES)

This chapter will present an overview of EURES activities in Europe and a more detailed presentation of EURES activities in Sweden, mainly based on the information given by Ms. Holmer, EURES adviser and EURES Manager for the Western Sweden Region (Västra Götaland). In order to understand EURES, I also collected information from different sources, notably the European Commission and the Directorate General for Employment and Social Affairs.

4.1 History of EURES

When employers and employees think of hiring or working in their respective countries, they can naturally turn to intermediaries such as national employment agencies (e.g. the Arbetsförmedling in Sweden) or to other private companies such as temporary work agencies.

However, when the hiring or working is planned for another country, information and communication channels tend to become more opaque and reduced. This becomes quickly an important obstacle to labour mobility abroad. There are very few actors dealing with labour mobility in Europe indeed. As a result, it was very difficult for companies and workers to obtain relevant and comprehensive information about mobility in the EU. If the information existed, it was not compiled or made easily accessible for the intended user (Holmer, 2002).

It is precisely for these reasons that the European Employment Services came to life about 10 years ago. It is actually more of a network than a proper institution but nonetheless, it acts as an embryo of a European employment agency. EURES was set by decision of the European Commission in October of 1993. The charter mentioned EURES existence and objectives as “to offer job seekers and employers an information and advisory service in order to facilitate labor mobility and enhance the transparency of the European Union’s labor market.” In other

words, EURES was aimed at putting into place the principal of free movement of workers within the countries who signed the charter.

The 18 countries forming the European Economic Area (the 15 members of the European Union and three of the four members of the European Free Trade Association) have agreed to take part in the EURES scheme. These countries are as follows:
-Austria, Belgium, Denmark, Finland, France, Germany, Great Britain, Greece, Italy, Ireland, Luxembourg, The Netherlands, Portugal, Spain and Sweden from the EU and Iceland, Liechtenstein and Norway from the EFTA. Switzerland, the remaining EFTA country has recently entered into talks to fully join the EURES network.

EURES consists of a network of partnerships between the European Commission, the national public employment agencies of the above 18 countries and other bodies concerned with European workers mobility, in particular the local social partners and local and regional authorities of border regions.

The EURES network became operational towards the end of 1993 and the beginning of 1994 with the training and placing of EURES advisers and the exchange of general information, especially on living and working conditions in the various signing countries. Exchanges of Community job offers started at the beginning of 1994.

The network consists nowadays of more than 500 EURES advisers appointed by the various public employment services, other network partners (Trade union, Employer's organizations and others), and an offer of circa 12 000 vacancies throughout the participating countries. The EURES network is supervised by the European Coordination Office, an entity of the European Commission, in Brussels, which notably handles the EURES job and curriculum vitae databases.

The tasks given to EURES are aimed at facilitating the freedom of movement within the participating countries (EU+EFTA) and minimizing the obstacles to labour mobility. Here is a list of the officially recognized tasks of EURES:

- Inform, counsel and advise any individual on living and working in another participating country.
- Assist employers in recruiting workers from other participating countries.
- Provide particular advice and guidance in 20 border regions in the so called EURES cross-border or EURES-C.
- Offer a website with European-wide vacancies and CV databases: http://europa.eu.int/comm/employment_social/elm/eures

All services provided by EURES are free and any individual or organisation legally residing in the participating countries is entitled to access these services. Meanwhile, the costs of the network are divided between the different actors, mostly between the European Commission and each participating country in the budget they allocate to their respective public employment agencies.

The European Commission made several studies and assessments on the impact and activities of EURES. In 2000, it released a report naming three main criticisms of EURES:

- The results of EURES vary a lot between the different participating countries. Hence, some are more efficient in offering their services and providing information or job vacancies.
- The job vacancies offered by EURES are too concentrated on a few sectors like Tourism, IT or Healthcare, and are not representative of all the sectors on the labour market.
- Thirdly, EURES is little known by the main European public, both workers and employers. Marketing EURES to the public has not proved successful yet.

Lastly, another critic of EURES that comes from different literature is that the amount of job vacancies offered by EURES is ridiculously low compared to the total amount of job vacancies in Europe. To exemplify this, on their website EURES is currently proposing only 114 job vacancies for the whole of Sweden. To compare this figure, that amount represents fewer vacancies than the municipality of Stockholm offers.

4.2 EURES in Sweden

In Sweden, EURES is represented by the international division of the Swedish Employment Office (Arbetsförmedling or ams) and the LO (Landsorganisationen) Trade Union for the special cross-bordering EURES entities. Ms. Holmer gave further information on the EURES activities in Sweden.

There are 29 EURES advisers operating in Sweden, including four in the region of Western Sweden: Gothenburg, Trollhättan, Skövde, Borås. Each EURES office is located at the offices of the international department of the Swedish national employment agency and each EURES adviser is employed by this same public agency. The manager of the EURES network in Sweden, Ann-Christin Lennartsson-Ståhl, is located in Stockholm.

There is also one cross-border EURES office in Malmö, managed by Dieter Zippert. Yet, the Danish-Swedish organisation AF Öresund has taken over most of its functions as the main coordinator for cross-bordering working in the Öresund region between Denmark and Sweden.

According to Ms. Holmer, the Actions undertaken by the EURES network are diverse and often deal at a very practical level. Her office was among other tasks, involved in the Skaraborg Recruitment Project that I will present thereafter.

At the beginning of EURES activities in Sweden in 1993, reckons Ms. Holmer, there was no recruiting in Sweden from other countries due to high unemployment and the excess of skilled workers. Throughout the 1990's, the Swedish EURES advisers' main task was to "export" Swedish workers, especially to Norway, which had a great demand for nurses and construction workers.

However, since the end of the 1990's, Ms. Holmer says she deals less with Swedish workers but rather job-seekers from other countries who want to work in Sweden. When the flow reversed, Ms. Holmer had to work a lot with information gathering for the newcomers:

"*We had to produce a lot of information material about living and working in Sweden. No such things existed. On social security there was lots of information and there was info about taxes, schools, but nothing was compiled so you couldn't get an overall information about everything, you had to go to different kinds of authorities to get all kinds of information that you needed.*"

The kind of information she provides to job-seekers is wide, going from information on how to sign an employment contract to information on taxes, social security, etc.
Yet, Ms. Holmer has been also lately working with recruitment projects and the recruitment of medical doctors from Spain and Germany. She says that Sweden has currently a great demand for doctors, nurses, and also other categories within the healthcare sector. Therefore she has worked intensively with Swedish employers who want to recruit in other countries.

According to Ms. Holmer, this change of orientation is part of our work, to "adapt with the existing labour market situation." She further clarifies EURES new goals in Sweden:

"*We are very keen on our role to contribute to the national goals of the labour market policy. So for the moment, our goal is to contribute to the bottleneck situations and to reduce the bottlenecks in all the labour markets in Sweden.*"

Ms. Holmer admits she has frequent, if not daily, contacts with her colleagues of the international department, as well as other EURES advisers in or outside Sweden. For instance, she works "quite a lot with her German colleagues."

When I mentioned some of EURES critics, MS. Holmer explained what could be the underlying reasons.

- The reason why countries have different results comes from the fact that their respective governments have different views and resource allocations on EURES activities. Thus, she feels that Sweden is having good results due to the fact that EURES advisers work fulltime on their EURES tasks while in other countries, they also do national work. According to her, EURES advisers in Southern Europe are likely to spend less than half their working time on EURES related work.
- Her answer to the imbalance in job vacancies in specific sectors comes from the fact that these aforementioned sectors are traditionally international and have recruited foreign workforces before EURES even started.
- The poor notoriety of EURES could be improved if the European Commission was keen on injecting more money into the network for marketing purposes. In comparison, the European Commission spends much more money on Education programs like Socrates/Erasmus.

As for the limited offer of job vacancies, Ms. Holmer mentioned the natural way for employers, private or public, to see recruiting with nationals first. She also mentioned that one of the main obstacles to labour mobility was in the mind of Swedish employers in trusting the abilities of foreign workers.

"*It's no point in advertising vacancies where you can find people nationally. So why should you put those vacancies into a European vacancy database. So, normally the vacancies that are put in there are because you can't find people nationally*."

According to the European Commission and Ms. Holmer, one of EURES flaw is that few people know about its existence. Taking this fact into consideration I found it valuable, for the deepening of the knowledge of EURES, to add in the appendixes two self-made flow charts dedicated to the clarifying of EURES organisation and activities.

5. The Skaraborg Recruitment Project

The Swedish health system is mainly handled by the public sector and to a much lesser extent by private actors, most employers of healthcare personnel are therefore public hospitals and administrations collaborating with them, notably regional and local authorities like the county councils.

Under the Swedish Welfare Act, employers are striving for to maintain and improve high quality standards of healthcare services, with a better level of competence from the personnel. Yet, employers have to consider budgeting concerns, in line with any other public expenditures and the taxpayer's money, which is not unlimited.

Moreover, faced with a worsening shortage of health-care personnel, these employers have growing difficulties to maintain high-quality standards and cope with the problems mentioned earlier about the Swedish healthcare sector. According to a report on the Swedish healthcare made by Johan Hjertqvist, Swedish citizens and patients are generally facing longer waiting lists, along with a weaker choice of health services (Hjertqvist, 2001).

According to an e-post poll taken in November 2000, local authorities all over Sweden foresaw increasing recruiting difficulties during the coming three-year period. Eighty percent of 122 mayors feared complications, ranging from an inability to deliver services to worn-out personnel. Mr. Hjertqvist claims that the Recruitment of healthcare personnel is obviously at the heart of their concerns and has become a prime matter. Moreover, a study made on contingent employment in Swedish hospitals stated that the staffing of the hospitals was regarded as the most important issue by the regional human resources department of the Western Sweden region.

The aim of this thesis being to analyse healthcare labour mobility in a certain angle and not the solving of Swedish healthcare labour shortages itself, only two alternatives for employers have been considered. The first obvious concern was to focus on the hiring of foreign and EU workers in Swedish healthcare organisations. However, the need was felt to consider this alternative first with the other most common actions undertaken to cope with Sweden's healthcare labour shortages. That is the contracting of personnel and services, notably by the use of contingent workers employed on limited duration contracts. Other alternatives such as employees' retention methods have so far not proven to give consequent solutions to the crucial labour shortages issues.

5.1 Contracting Personnel & Services in Sweden

Labour shortage in the healthcare sector has been more strongly resented in the northern regions of Sweden. There, regional governments have shown signs of turning to contracted entrepreneurs as well as temporary work agencies to attract personnel more than any other regions in Sweden.

According to Mr. Hjertqvist, statistics have confirmed that local and regional authorities have rapidly increased competitive contracting. The volume of welfare services delivered by Private Companies on contract have tripled during the late 90's, albeit from a starting point of almost zero when temporary work agencies were illegal in Sweden prior to 1990 (Hjertqvist, 2001).

The NUEWO case study on contingent employment mentioned that medical divisions of county councils tried to analyse why an increasing number of employees were leaving their employment at the hospitals and often joining Temporary Agency Firms. They found out that they were too unsatisfied with their work environment (evoking an excessive workload), willing to try new experiences and more independent. In addition, they were attracted by higher

salaries which could become 50% higher than the one they had before (Mintjes et al., 2002).

Arguments against the excessive use of contingency employment in hospitals are numerous and varied. Mr. Hjertqvist claims for instance that in this context, the winners are not only nurses and doctors, but even more so private temporary work agencies. Increases in salary have been dramatic: fresh, for-hire, primary health care doctors make roughly 60,000 SEK a month, meaning that the least skilled of them easily make much more money than their senior managers, who are part of the ordinary staff.

Professor Anders Lidström, a Social democrat whose specialty is health care, recently said that the financial resources for health care are a given, and that large salary increases for workers should therefore be impossible. And according to Mr. Hjertqvist, in the long run, the deficit problem cannot be resolved by stealing doctors and nurses from other parts of Sweden. Instead, Swedish authorities are bound to look abroad.

Either if contingent employment is a viable solution to labour shortage or not is not clear. What can be observed on the other hand is that many persons concerned by the Swedish healthcare sector are rejecting it partly or completely. Moreover, they, with others, are looking for other alternatives such as the importation of foreign healthcare workers (Larsson, 2002).

5.2 Importing Healthcare Professionals

Since the decentralization laws of the Swedish Welfare system, regional governments and county councils are now a lot more involved in handling healthcare services within their area of authority. The main action carried out to analyse the point of view of these employers and how they proceed with the recruiting of foreign personnel was to interview Mr. Kjell Pettersson, head of the

HR department of the Skaraborg County. One of Mr. Pettersson's functions is to recruit doctors and dentists for the primary healthcare hospitals of the Skaraborg County, an administrative entity of circa 300, 000 inhabitants within the Western Sweden Region. I also cross-analysed some information with Mr. Tom Roffey, Manager of the Primary Healthcare Center in Lidköping. Mr. Roffey has also dealt with the recruiting and managing of foreign doctors.

According to a report co-published on September 2002 by the Västra Götaland Region (Western Sweden County Authorities) and the Arbetsförmedling (Swedish National Employment Agency), the hospitals of Skaraborg County were the first ones in the region to actually proceed in a large-scale recruiting of doctors and dentists from other EU countries. Also according to Mr. Pettersson, Skaraborg county administrators were among the first ones to take such an action within the whole country.

The first doctors to come to Skaraborg County arrived on February 2000 and came from Spain. From this date until autumn 2002, there have been more than a hundred doctors from other EU countries recruited in the Western Sweden region, from Germany and Spain for the most part.

5.3 Reasons to Recruit Foreign Personnel

Mr. Pettersson stressed the high quality standards required by the Swedish welfare system. The Swedish Government endeavours that the different regions and counties follow the same high standards across Sweden.

Mr. Pettersson mentions some concrete requirements from the Swedish Welfare Act:

"*Everybody has to meet a doctor within a week. We must have a health center in very small cities, and it must be open*."

Behind these declarations, one can realize that counties and hospitals do need a certain number of doctors, dentists, nurses and other personnel to fulfill their mission towards the population. The previous study of the Swedish healthcare sector has shown us that Sweden is in dire lack of such qualified personnel at the moment. Mr. Pettersson confirmed these situations by mentioning two cases.

Medical Schools in Sweden take about only 800 students a year, when he believes maybe 1 600 are needed. The access to Swedish medical schools is very difficult and one needs very high grades in high-school to enter these schools. For the Western Sweden region alone, 300 seats are available while 3000 persons are applying for a seat.

The problems of dentists differ a bit. Sweden had too many dentists in the mid 1990's, and as a result, unemployment was high for Swedish dentists. A lot of them moved to work in the United Kingdom (about 1 000) or Norway. However, the situation has reversed and now a county like Skaraborg has a shortage of available dentists.

Mr. Pettersson claims that everybody (i.e. employers of healthcare personnel) puts pressure on the Swedish government to change this situation and allow more doctors and dentists to be educated in Sweden. At the moment he has received no cues from higher authorities that steps will be taken in this direction.

Given the ubiquitous aforementioned required healthcare standards, along with the will to provide high quality standards to their patients, Mr. Pettersson affirms that if hospitals can't find doctors on the regional and national labour market, actions have to be taken considering the international labour market. Mr. Pettersson puts it more bluntly in expressing that concern:

"*So the only thing we can do now is to recruit doctors from other countries.*"

As I have mentioned in the early part of this thesis, I only examined the other alternative of contingency workers and stuck to his opinion considering that my work was on the mobility of EU workers and not the finding of solutions to Swedish Healthcare bottleneck problems.

Mr. Pettersson further clarified why they, at Skaraborg hospitals and county administration, thought that hiring EU doctors and dentists was a viable solution.

The measures taken by the EU member states that I briefly enunciated at the beginning have tremendously eased the hiring of other EU nationals. According to the Skaraborg Administrator, now it's easy to recruit in another EU country when before it was much more difficult because of masses of rulings and constraints. For instance, nowadays it's still very difficult to hire doctors outside the EU/EEA area for the previously mentioned reasons. In Kalmar, a Swedish town on the Baltic Sea, a recent project has led to the hiring of more than 50 polish doctors. However, the constraints are important, and authorities there obtained authorizations for limited contracting no longer than two or three years. Before the EU put in place the incentives for labour mobility, the only foreseeable alternative for Skaraborg hospitals was to hire other Nordic personnel in the frame of free movement agreements within the Nordic countries (Denmark, Finland, Iceland, Norway & Sweden) since 1956. A few Danes came to work in Skaraborg, but this low migration trend has been almost reduced to zero since other Nordic countries are now in a similar situation to Sweden.

On a socio-cultural perspective, Mr. Pettersson underlined some underlying problems in Sweden of trusting and accepting foreign personnel from non Germanic origin. Although he agreed on more global Western patterns ("*Spanish people are nearly the same as Swedish people in their way of living and thinking*"), he also later admitted that it was difficult for southern Europeans to find jobs in Sweden. Nevertheless, all the Swedish persons involved in this recruiting project felt beforehand that the recruiting of other EU doctors and

dentists was socially and culturally acceptable for them and the Skaraborg inhabitants.

Financial considerations, even for healthcare matters, were also very important in the decision process. As we will see in more detail later, the Skaraborg County intervenes a lot in the recruiting and moving costs of foreign personnel. According to Mr. Pettersson, each individual doctor or dentist, along with his/her family, costs Skaraborg between 200 000 and 300 000 SEK on average (i.e. 22 000 and 33 000 Euros). However, Mr. Pettersson still considers that it is a good deal for the community.

"*It's very cheap. You get fully educated doctors. A Swedish doctor has to go to the medical school five years in Gothenburg, hospital for three years…It's very expensive for the taxpayer.*"

After having assessed the feasibility of hiring EU nationals, Mr. Pettersson and his colleagues made more field work and research in order to proceed to recruiting campaigns. Although only partly involved in the recruiting process, Mr. Roffey also evoked some similar thoughts on the conditions and reasons why they undertook the option of hiring EU nationals.

5.4 Spain and Germany as Recruitment Targets

Spain was at the time, and is still today, one of the EU countries with the highest excess of unemployed healthcare personnel, notably nurses and family doctors (source: French newspaper). The reasons for this are diverse but are mainly based on the fact that Spain has educated too many healthcare people in certain areas, and the employability is much lower than say Sweden. (See charts) Mr. Pettersson recognized this situation as one push factor they needed to attract Spanish doctors, and a logical reason for further investigations in this country.

"*Spanish doctors were unemployed, so we thought of hiring some.*"

Doctors and administrators did some research about the Spanish health system and went directly there to evaluate how things were done. Their main conclusion was that the health system and competences were quite similar with to those in Skaraborg. The decision was then taken to go and try to hire Spanish doctors and dentists.

Germany has also a growing proportion of unemployed doctors and some healthcare professions. According to Mr. Hjertqvist, more than 10,000 doctors are apparently unemployed in Germany, and Stockholm officials staged a first, highly successful road show in Berlin to start importing German competence. Several sources from Mr. Pettersson to the EURES agency claim that German workers are very attracted by the prospect of living in Sweden.

Mr. Pettersson also said that their recruiting project has later turned on prospecting on the German labour market and he felt that Germany would be the next major contributor for healthcare personnel for Skaraborg and Sweden. The interview with the Ms. Holmer of EURES also led to the ascertainment that not only this was true, but that German workers accounted for a much bigger amount than Spanish workers in the whole of Sweden.

5.5 The Recruitment Method

Since the beginning of the recruitment project two years ago, the Skaraborg County has hired more than thirty foreign doctors. A few of them left to return home or to somewhere else, including two doctors who established themselves in Umeå, in northern Sweden.

Once Skaraborg authorities made the decision of hiring first Spanish doctors, they approached the international section of the Swedish employment agency (Arbetsförmedling/utland), which itself contacted its EURES branch, in order to

get information on the proceedings for recruitments. Contacts were made with the Spanish Employment Agency (Insituto Nacional de Empleo), which contacted unemployed doctors.

Basically this is what happens next. Mr. Pettersson and his project colleagues received answers from interested doctors. Meetings are arranged with the doctors in major Spanish cities (Madrid, Barcelona and Valencia). After evaluation, some doctors are chosen and offered free Swedish courses in Spain. If after multiple contacts and trips to Sweden, things go well, Spanish doctors move in to work in the hospitals scattered in the Skaraborg counties, usually on January or February of each year. During the latest recruiting campaign, 60 doctors have shown interest, 25 were interviewed in Madrid alone, and ten were finally chosen. But let's consider now, in a bit more detail, this process.

When Skaraborg officials present themselves in the first place and during interviews, they operate a virtual charm campaign, selling the merits and prospects of a new life in Sweden. Their arguments consist of green unspoiled nature, great spaces (Skaraborg County lies right between two of Europe's largest lakes) and a more relaxed and calmer living environment. Moreover, Mr. Pettersson is keen on presenting them also with a better working environment. There is for instance a video film decrypting a charming Life in Skaraborg that could look like a tourist movie.

"*In Sweden, we can provide them with more materials, machines…In Sweden, they can have 10 to 20 patients a day, while in Spain they can have 50 patients a day.*"

Spanish doctors are also offered to be paid to Swedish standards, at the same level of Swedish doctors. According to Mr. Pettersson, that is in most cases more money than they get in Spain. Although he admits higher taxes and a more expensive life in Sweden, he's also prompt on underlining some social advantages (longer pregnancy leaves, free kindergarten, etc.) that most Spaniards, who come, tend to appreciate. In addition, a house in Skaraborg County is also cheaper than

where most of these doctors come from. Mr. Pettersson estimated the median prices of 100 000 euros for a house in Skaraborg against 200 000 euros in Valencia.
Once the interests of some Spanish doctors have been raised, interviews are conducted in major cities. There are present the interested individual, two Swedish doctors (with now two other Spanish doctors already recruited by Skaraborg), Mr. Pettersson and one of his colleagues.

Once the candidates have been selected, constant communication is established with them. They must follow 700 hours of Swedish courses in Swedish, and are offered one or several trips to Sweden. According to Mr. Pettersson, this is a very crucial part of the recruiting process and will affect the living environment and job performances of these doctors or dentists once they arrive in Sweden. The teachers are professional Swedish teachers from the Gothenburg Folkuniveristet whose human qualities are praised by Mr. Pettersson.

"*It's important that the doctors do not feel constrained and get genuinely interested in learning Swedish and knowing Sweden.*"

The website of the Folkuniversitet gives a few more details on the development of these Swedish courses:

"At the request of the Primary Care Services in Skaraborg, we conduct intensive courses on site in Spain for three months, followed by a further two months in Sweden. The period in Sweden focuses on language related to the profession and on cultural aspects of Swedish society and the Swedish medical care services."

However, lessons from the first recruiting campaign have been drawn. Only doctors were given courses, but not their relatives who couldn't speak when they arrived in Sweden. Most spouses could not find a job and as a consequence three families went back home, although the three doctors did a good job according to their employers. It was then decided to teach both the candidates and their spouses

Swedish for 700 hours both. Most spouses have now found a job and the turnover is much lower.

5.6 Settling in Sweden

Once the courses and contacts have proven to be fruitful, the doctors are offered a two year contract at one of Skaraborg's medical facilities. As it was mentioned earlier, Skaraborg administrators consider that a two year period is the time necessary for their return on investment. After two years, if the doctor's performance is positively assessed, they are encouraged to stay but are free to choose either to stay or go somewhere else.

Mr. Pettersson also stresses the importance on assisting foreign doctors with their move to Skaraborg from A to Z. That includes very practical problems such as housing, schools for the children, taxes, etc. Apparently, no other intermediaries such as EURES or Arbetsförmedling are involved in this assistance process during the two year contract.

After the doctors have arrived in Sweden, they are followed and assisted by the actors of the project. Each doctor is given a Swedish doctor as a mentor and they get introduced to all kinds of departments and personnel (nurses, secretaries, etc.) during a six to eight week period. After that period, they start with four patients a day. Some doctors after 10 weeks have 10 patients and 20 after 20 weeks, at the same level as Swedish doctors, depending mostly on their level of Swedish. According to Mr. Pettersson, some of them speak fluent Swedish after three months in Sweden, while others after two years.

After two years in Sweden, the doctors normally get their Swedish specialization. Meanwhile, Swedish doctors must work five years to get a specialization. This is assuming of course that the foreign doctors have worked previously more than

three years. Only one Spanish doctor did not have enough medical knowledge to become specialized.

In their first recruiting campaign, Skaraborg authorities used the help of two intermediaries: the Swedish national employment agency and its EURES office, as well as the Spanish national employment agency. However, from their second campaign on, Skaraborg county was no longer using these intermediaries. They based themselves on two sources: the contacts from Spanish doctors who had been already hired (i.e. their colleagues back in Spain). The other source is the Spanish union for doctors (Consejo General de Colegios Oficiales de Médicos), who spread the information to its members. In other words, the recruiting of Spanish doctors is now almost entirely based on word of mouth.

5.7 Results and Assessments of the Project

Mr. Pettersson puts it clearly that he and his medical colleagues in Skaraborg have a very positive experience and evaluation of the project and are satisfied with the coming of foreign doctors to their county. His opinion on the hired Spanish doctors is that:

"*They are good educated, good workers, they are appreciated…colleagues and patients like them very much, they take good care of their patients…they are warmer than Swedish doctors.*"

According to him, after their second campaign, one woman doctor went back home for personal reasons (divorce) and only two doctors broke their contract and went to Umeå. To him, this was an acceptable situation since Umeå also badly needs doctors and it was "ok" since it was still in Sweden and serving the cause of the Swedish taxpayers. However, Mr. Pettersson and his colleagues strive to keep the recruited doctors in the Skaraborg county area as long as possible. According

to him, they enjoy living there, and most of them want to stay at least five to ten years before coming back to Spain, notably for their retirement.

When asked if there were any objections to this import of foreign doctors, Mr. Pettersson says that the higher authorities approve these actions and think they are a good solution.

"*The only one who doesn't like it is the doctor's union* (Sveriges Läkarförbund)…*If you have a lot of doctors, the salaries will not be so high.*"

One reason why the project has been successful so far, according to him, is that Skaraborg County is a small organization which has time and can take care of the family for all matters. They help them with everything (from housing to the important problem of finding jobs for the spouses). He further rejected the assistance of the EURES agency saying that it was a too big organisation that couldn't properly take care of the needs of individuals.

The Skaraborg project, Mr. Pettersson claims, is at the forefront in Sweden for hiring European doctors on a large-scale. Coming from Luleå, he has also advised his northern colleagues to follow in Skaraborg's steps. For the future, Mr. Pettersson foresees that the Import of European doctors will increase. The main migration flow according to him will come from Germany. The Skaraborg County also plans to recruit doctors in the Netherlands in the near future. Meanwhile, Skaraborg is also looking at the smaller pool of Swedish doctors and dentists living abroad. A recent article mentioned that 400 Swedish dentists living in England have received a letter and a video film from the Primary Health Services of Skaraborg. In this case, more than the Spanish one, arguments other than financial have to be found by Skaraborg to attract the professionals since wages are on average much higher in England than Sweden in this sector (Hofflander, 2002).

5.8 The Perspective of the Newcomers

I have based my observations from the report issued by the Västra Götaland region and Arbetsförmedling, which interviewed 16 doctors (eight Spaniards and eight Germans) to see how their integration in Sweden went after their coming to the Region. I also interviewed some foreign doctors involved in the Skaraborg project to cross-reference their opinions with those of the managers of the organisation.

The main result is that Skaraborg administrators seem to have a fair judgment on the opinions of foreign doctors. They came to Sweden for different reasons, many by being tipped by a colleague already settled in Sweden. Most are quite positive with their experience so far and most stress that their integration is at least as important as their job. For instance, the fact that the spouse could also find a job was very important to most of them. Therefore the help that Skaraborg administrators gave was essential.

One persistent criticism though is the lack of information. German doctors particularly stressed the lack of information on the working conditions before coming to Sweden. Some doctors also mentioned the importance of having clear and detailed information. Difficulties to make social relations outside work were also evoked.

Moreover, most doctors stressed that there should be more collaboration between Skaraborg/the Region and the Employment agency/EURES on the other side. One Spanish doctor revealed that EURES did not seem flexible enough to them and that more information was needed from them.

6. The Different Roles & Actors of the Skaraborg Recruitment Project in the Matching Model

The aim of the Thesis is to give a better understanding of intra-European labour mobility. One way to analyse it is to look at the mobility through the relations, interactions and roles of its different actors on one hand and the consequences of these new relations on the other hand. I chose to do so by analysing first the different actors of the Skaraborg Recruitment Project under the theoretical framework of the Matching Model, by observing the interactions between the three actors: Individual, organisation and intermediary. Furthermore, I chose to analyse the consequences and new implications of these relations under the model of the four phases of organisational entry. In each of the four phases, I will regroup both the individual and organisational perspective. These observations will lead me to the more general consequences and implications at the European level and the obstacles to mobility of the labour market.

6.1 Characterisation of the Matches and Interactions

The perspective of the organisation (the Skaraborg County and Primary Healthcare Services) in the Matching Model is represented by the upper part and the upper match. The organisation is assessing the new hired individual upon its satisfaction with his/her job performance. In other words, the organisation evaluates if there is a match between the capabilities and potential abilities required by the organisation and those provided by the individual. In this case, two managers of the organisation, Mr. Pettersson and Mr. Roffey, have expressed so far their entire satisfaction with the new doctors' job performance and the project itself. Their prerequisite was that the newcomers' job performance in the short or mid-term becomes as good as the established Swedish doctors. The vast majority of Spanish doctors who came to Skaraborg have proved to sustain the same level

of efficiency (10 to 20 patients a day) with similar standards of quality as the Swedish doctors.

Since, the organization prefigured some eventual difficulties for newcomers to adapt to the new organisation culture and climate, the new coming doctors have been assisted and chaperoned for an extensive period of time. Assessing their integration, Mr. Pettersson feels that they are well accepted at work and by their patients and therefore their matching with the organisation culture and climate has been successful. There have been continuous improvements in the matching of the newcomers' basic needs with the organisation culture and climate. One major step was to include not only the individual basic needs but also his/her family, by for instance teaching Swedish to the spouses and helping them finding a job in the County. The only opposition mentioned by Mr. Pettersson came from the Swedish Doctors Union, but that did not concern the organisation itself since it has different if not opposing objectives to the Union.

At least in its first recruiting campaign, authorities of Skaraborg asked for EURES to intervene and contact the interested parties in Spain. Whatever the results of this interaction with EURES, it shows that Skaraborg County and Primary Health Services did not have the proper contacts and relations in order to fulfill its objectives and launch the project. While this sounds like a very natural challenge for this organisation considering its position and a natural way of taking steps, it is interesting to note that Skaraborg did not directly turn to EURES itself, but rather to the nearest international branch of the Swedish employment agency, which happened to be also an office of EURES. This can be probably explained by the fact that the activities were either unknown or little known by the employers themselves back in 2000.

The employee's point of view is represented by the lower part of the Matching Model and the lower match. The job satisfaction is what will mainly influence their decision to remain or not in the organisation. As the Model claims, the job satisfaction will depend on three essential points:

- The expectations of the individual compared to the reality of the new job
- The comparison of present job to previous ones
- The commitment to the organisation

The interviews have shown that most doctors have been satisfied when comparing their work and life in Skaraborg with their expectations and previous experiences. These two conditions have from the individual perspective enabled a matching with the Skaraborg Primary Health Services during the last two years. However, one can question the long-term job satisfaction matching with the latest conditions described above: the organisational commitment.

From all the observations made, one can conclude that the continuing job satisfaction of the foreign doctors if not altered by other reasons will certainly depend on the level of commitment from each individual. While the matching model names only the organizational commitment, there are also different ladders of commitment for any individual. Apart from the organisation, the most important are profession, the patients and the country/region commitments. It is every individual's perception and experience that prioritize these commitments. Thus, if the commitment to the organisation is stronger for a doctor, it may be argued that he is likely to stay longer in this organisation than a doctor more committed to its patients or profession. Furthermore, Spanish people, like in many cultures, are known to be profoundly committed to their culture and country. This suggests that most Spanish doctors are likely to have Sweden as a temporary stay rather than an ultimate destination, and that they are committed to go back home sooner or later. The managers of Skaraborg County and Primary Health Care Centers seem to realise this situation, and both anticipate an average of five to ten years stay for each doctor recruited.

Concerning their matching with the required capabilities, nowhere in the interviews was it mentioned that foreign doctors had difficulty concerning their job performance. On the contrary, most were satisfied with practicing in

Skaraborg. One can therefore say that there has been a match for the job performance from an individual perspective (the upper match on the model).

Even in the first campaign, individuals seemed to have less contact with EURES than Skaraborg had. One reason for this was that Skaraborg wanted EURES to be more a contact person than a 'full' intermediary acting upon Skaraborg's will and interests.

In the case of the Skaraborg project, several intermediaries have played a role throughout the successive recruitment campaigns. After reading the recruitment methods, a non exhaustive list can be drawn to mention some of the intermediaries used in the process:

- The EURES agency via its representations at the international department of the Swedish national employment agency (Arbetsmarknadsstyrelsen/AMS, Utland Avdelning)
- The Spanish national employment agency (Instituto Nacional de l'Empleo)
- The Spanish doctors union (Consejo General de Colegios Oficiales de Médicos) and the newly recruited Spanish doctors themselves.

I chose to analyse the first intermediary mentioned as its activities are directly concerned with the mobility of European workers across Europe, notably in the healthcare sector. Other actors have participated with the project but more as assistants or contractors of the Skaraborg County than as intermediaries as it is defined. These actors were for instance, the Western Sweden Region or the teachers of Swedish at the Folkuniversitet in Gothenburg.

The first intermediary to be approached by Skaraborg County was the nearest international branch of the Swedish employment agency, which transmitted Skaraborg assistance request to its EURES office in the Western Sweden Region. For the project, administrators of the County researched and gathered some information with the help of EURES to come to the conclusion that the

recruitment of Spanish doctors seemed feasible. But EURES main assistance to Skaraborg was to arrange the contacts with the Spanish employment offices, by contacting their EURES colleagues in Spain, directly linked with the Spanish employment agency. The free assistance of EURES has certainly cut some transaction costs for Skaraborg, including the time spent in searching for the right information and contacts.

It is interesting to note however that EURES was only used in the first campaign and that later on it was dismissed by Skaraborg authorities. Mr. Pettersson felt that after its first campaign, Skaraborg County was better off handling the recruiting themselves. What happened is that they preferred to rely on the Spanish doctors they had hired before to make the new contacts. The Spanish doctors freshly installed in Skaraborg have created new communication channels between Skaraborg, its primary health centers, and the Spanish doctors and medical sector, which did not exist prior to the first recruiting campaign. EURES was at the time needed to fill in the existing gaps and open communication between these two distant actors. On the other side of the job matching process, Spanish doctors sending their candidature were provided with information from their colleagues already hired. Hence, not only they could now rely on familiar insights while their need of using the assistance of EURES also decreased dramatically.

This change of intermediary might be explained when Mr. Pettersson said that he viewed EURES as being “too big” an organisation. To him, they certainly could not deliver a tailored service to their specific needs. The underlying reason is probably that EURES is involved in a multitude of recruitment projects and could not spend the required time and effort on Skaraborg’s particular problems. As we have seen before, there are only four EURES advisers for the Western Sweden region, a rather large area with ca. two million inhabitants. Mr. Pettersson stresses this point when he claims that the success of their recruitment project originates from the fact that they have the time to take care of the foreign doctors. Skaraborg probably considered not to coordinate its efforts with EURES in the second recruiting campaign because it felt self sufficient and did not expect that EURES

could bring them more added value, thus making the role of the intermediary temporary for the initial phase.

6.2 Consequences of the Project on each Actor

By turning abroad to the European Labour Market, the organisation found new sources of effective job candidates. As according to the model of four phases of organizational entry, the organisation tried to attract these candidates with an appropriate strategy, different than the one they would normally use to recruit doctors from say Skåne in Southern Sweden. While the way of life, landscapes and working conditions in Skaraborg are rather similar to the ones in Skåne, they differ significantly with Spain to make it an attractive argument for the potential candidates. However, the case of Swedish dentists in England shows that the organisation will use similar attracting strategies with both Swedes and Spaniards as long as they are working abroad and have not practiced in Sweden for at least a certain amount of time.

Meanwhile, potential immigrants had to find other sources of information than the ones they were used to before. For instance, to obtain information on a vacancy at another hospital or city in Spain they relied on word of mouth, personal experience, and other familiar sources such as medical and other specialized publications. In order to move abroad, the individuals searched for non familiar sources of information including those provided by Skaraborg and EURES.

While the selection process probably bears more similarity with the one of Swedish doctors, the employers have to consider a wider range of issues when selecting foreign candidates. First, the employer has to assess an education and professional background it is not or much less used to assessing. For instance, if a doctor has studied medicine in Burgos and worked two years at the hospital of Almeria: how can that be assessed and compared with a Swedish doctor who studied in Malmö and worked for two years in Umeå? Both the latter school and

hospital are probably known to the employer in Skaraborg but it is probably not the case for the Spanish ones. Another issue for the employer is to assess whether the candidates are either committed to the new job and new organisation, but also to the new region/country. Finally, the employer has also to assess if the individual (and his/her family) is likely to fit the new organisation and country. Let's take another example: on the one hand there is a very competent Spanish doctor, highly esteemed in his/her country and committed to move to Skaraborg. On the other hand there is a young doctor with lesser experience who showed signs of his/her interest in also working in South Africa or Australia. While the selection choice would be clearer in Sweden, the organisation has also to consider the matter of adaptability. Maybe after all, the more experienced doctor knows only Spanish and will show difficulty to learn Swedish or adapt to Skaraborg working and living environment, while the younger one will be able to adapt well in record time. It is also part of the recruitment selection to assess which candidate is more likely to fit in with the work and life in Skaraborg.

For the potential candidates, even if the stakes are unusual, the selection process may have appeared to be rather similar than if they were applying for a national job. One could argue that they are in a stronger situation to bargain since the employer has come from far away to fulfill its need of staffing. On the other hand, the labour market situation not being satisfactory in Spain, the candidate is probably aware of the potential competition from other candidates. In addition, the offer to work abroad are not yet made widely available to Spanish doctors so the prospect of working abroad may require something similar than a national labour market that is tense with higher unemployment rates. Further study on the recruitment processes during the project would have to be made in order to understand the new power relationships of bargaining between the employer and candidate. It is probably still relevant to consider the traditional Principal and Agent theory, where both protagonists mutually need each other and bargain using the information they are each willing to provide.

The third and fourth phases of organisational entry do not demand much effort from the employer but they play a key role in the hiring process of foreign doctors. It is a mix of giving as much realistic information as possible while positively influencing the candidates. Some doctors interviewed described the prospect of working at Skaraborg as a presentation of an ideal job with better working conditions than at home, thus showing the success of Skaraborg to manage both emotional and information needs of newcomers. The reason why the persuasion work was not too difficult was that Skaraborg started in a practical and logical way by looking at the labour market most likely to respond positively to their offer: the Spanish Healthcare sector, and now Germany, where both have signs of push factors in their healthcare sector.

Seen from the individual perspective, each doctor has been rather closely assisted in his/her coming to Sweden. Therefore one can question if the cultural match has really occurred since individuals have experienced their move to Sweden through the bubble of the Recruitment Project. Thus, a Spanish doctor coming to Sweden on his own is likely to face much greater obstacles and 'impersonal' confrontations with the new host country. Yet, the doctors interviewed in the report have shown signs that information was still lacking before and after their move and that they encounter some difficulties to socialize with Swedish people.

Apart, from the phases of organizational entry, the recruitment of foreign professionals also means a lot for the organisation in acting "out of its way". By recruiting foreign professionals, it had the unusual task of taking care of the employee outside the organisation, like finding a job for the spouses or housing for the family. Hence, the incoming of new foreign personnel includes a lot of issues that Human Resources did not traditionally cover or consider. Therefore, in order to enable the success of international labour mobility and the tenure of foreign candidates into the organisation, the employer has to extend the tasks and concerns of not only its HR department but also managers and Administration department as well.

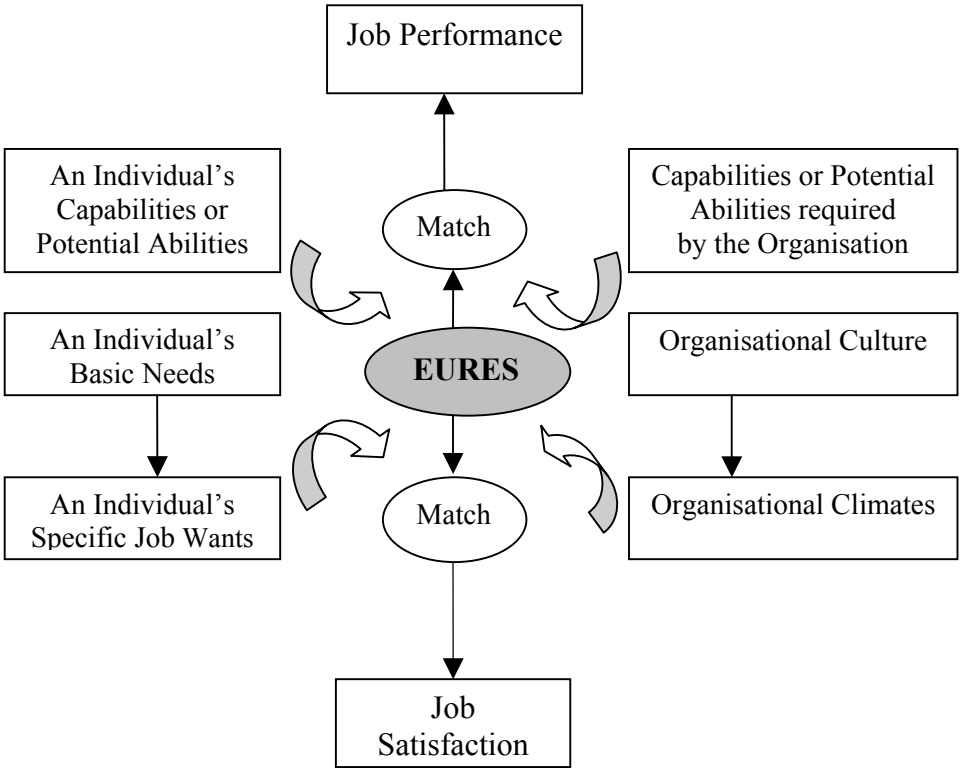
All these issues concern the organisation in short and long term, but what are the impacts of recruiting foreign workers in the long-term for the organisation? The first natural step is to say that the more Spanish and foreign doctors come, the more the organisation is likely to change, but how? The Skaraborg Recruitment Project only started three years ago, and the impacts on the organisation culture and climate can not be fully understood yet. One might need a ten year scale or more to analyse the impacts. The main question is to know whether the organisation will attempt to reproduce 'clones' of Swedish doctors, or will it adapt to the new way of working of Spanish doctors. While the Spanish Health system temporarily generates unemployment, it is also praised for its Western quality standards compared to its lower costs (efficiency issue) or its excellence in donation and transplantation of organs (Socialstyrelsen, 2002). Until time passes, one sound guess would be that the organisation culture and climate will remain mainly as it was before the recruitment project, naturally taking into account the evolution of time, but also the influence of foreign doctors. It could be interesting to analyse Skaraborg Primary Health Services with those of another county not recruiting foreign personnel on a large scale, both before and after the recruitments happened.

The role of EURES in the Skaraborg case has been temporary, limited to the time before Spanish doctors created the missing links and communication channels, and before the administrators of Skaraborg became acquainted with the recruiting in Spain. This does not mean that EURES was ineffective as an institution as it has proven useful on at least the first recruiting campaigns. An Intermediary is requested when it is felt needed or useful by at least one of the two protagonists. The role it can play in a job matching process will certainly depend on the degree of involvement it is willing or able to offer. EURES deals with many different projects concerning employers and individuals. However, each project has its own particularities. Each employer needs to recruit a certain type of employee for a certain reason and each employee wants to move abroad for his/her own reasons.

In order to be a perfectly neutral intermediary, EURES would have to know 'personally' each of these employers and candidates. While, this is feasible in the studied case, one can imagine the difficulties when several projects exist at the same time in addition to the other tasks of informing each individual on working in and out the country. The major criticism of EURES from the interviewed doctors was that it could not deliver them the appropriate information they needed. But then again, it is a difficult task for a EURES adviser (either in Spain or Sweden) to provide sudden detailed information on living and working in Skaraborg and recruiting adequate Spanish family doctors while dealing with Swedish construction workers moving to Norway for instance.

So where does EURES stand in the matching model? This intermediary acts temporarily in the job matching process and in this case responds first to the demand of the organisation. One can therefore draw a model where EURES is at the center of the individual and organisation and the two matchings and acts as a temporary match maker. However, both the individuals and organisation later orientate themselves towards each other, thus describing EURES role as the one of an initiator for the job matching process. Figure 6 below illustrates this situation. The consequences of the success or failure of the Skaraborg Recruitment Project over EURES will depend where its true interests and objectives lay. This will be discussed in the coming section at the European level.

Figure 12: EURES, an intermediary initiating the match making in the Matching Model.



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6.3 Consequences at the European Level

When analyzing the Skaraborg Recruitment Project at a national or European level (i.e. EURES level) one encounters a plethora of questions and contradictions. Maybe all the actors of the project will become very satisfied in the long run, but will this successful dual matching be compatible with its surroundings? In the Skaraborg case, there might be for instance a conflict of diverse interests:

- Vis-à-vis the Swedish national employment policy: the employment or education scheme strategy of the government may not be compatible with the actions undertaken by such projects. For instance, if the government schedules a steady increase of diploma delivered, the intake of foreign doctors can make some governmental actions weaker. In fact the interests of some counties might not serve the interests of others.

- Vis-à-vis the Spanish employment policy: this can be represented by the case of the Swedish doctors who left Sweden during the mid 1990's. Although it reduced the tensions on the healthcare labour market in the short term, these migrations may cause problems in the longer term. One could evoke the risk of an occasional brain drain and a leveling of the competences in the sector. Financial prospects traditionally reward highly-skilled workers so that the most competent professionals are more likely to leave the country. Another important aspect is the fact that Spain bears the expensive costs of education and training while Skaraborg County is mainly benefiting from these 'investments'. As Mr. Pettersson mentioned, it is cheaper to bring foreign doctors over to Skaraborg than to educate some for several years. On a large scale, it is difficult to conclude the presence of a win-win situation or not. However, most literature on labour mobility tends to assert that high-skills migrations positively affect the host country while they are negative for the economy and dynamism of the home country (Corry, 1996).

- Vis-à-vis the European Union: all member countries are supposed to operate on equal terms and European employment policies officially for the sake of all members. Hence, the EURES network is supposed to facilitate free movement and follow neutral principals. For the common interests of both parties, a neutral intermediary is supposed not to favour one or the other parties and not act in its own interest or the interest of a third party. However, the EURES activity report and the interview with Ms. Holmer

have indicated that the diverse EURES offices are acting first in the interest of the national employment policy where they are located, and not for the sake of European wide employment policy. Meanwhile, the Skaraborg project was initiated for the sake of the County health standards. Therefore, there might be conflicts between economic and social principals (e.g. the goodness of free movement) and the vested interests of each actor of labour mobility.

One doctor interviewed mentioned that since the labour situation in Spain wasn't good before she left, she thought of moving to another country that could offer better employment and work conditions. However, another country did not necessarily meant Sweden in her mind and she was entitled to work without many legal barriers at least in the 18 countries of the EEA area. By enforcing free movement throughout the EU area, European directives are also slowly installing the bases for competition between the national health labour markets and health systems. Most EU countries, for instance, have actually put conditions on the free movement of EU citizens: individuals can not officially move to another country if their ultimate goal is to take advantage of the host country health system and services. Healthcare professions are among the most regulated professions, each country usually carefully tries to follow the demand and supply of such professions and plans policies accordingly. The unplanned incoming or outgoing of health professionals may increase uncertainty of policies and create tensions on the national healthcare markets. The Skaraborg project is a tiny project on the scale of the Spanish health sector, but if multiplied in Sweden and other parts of Europe, it will certainly have an impact on the Iberian Peninsula.

Now, if one does admit for a moment that the free movement of goods and persons becomes complete and uncomplicated and the recognitions of qualifications systematic, there is still a major drawback to a single health labour market: there are in the EU, 15 different health systems that are paid by 15 different pools of tax-payers, not to mention the increasing presence of the private health services. In the case of the Skaraborg project, the Swedish Primary Health

Centers took advantage of the contributions of Spanish tax payers, which could be related economically to some free-riding. One could also argue that Skaraborg project also helps regulate the Spanish health sector, provide opportunities for new entrants and lighten the burden of unemployment allocations. It is therefore a complex task to understand all the implications, wins and losses on each side. This however is an important issue since it can answer the question of sustainability of such projects in the long term. If one considers that wealth and growth have followed Spain after many migrants left in the 1950's to 1970's, one could draw the conclusion that it has helped the economy. However, the pertinent question should also be if it has also helped the European economy in general and if Spain could have had even better results without these large migrations taking place.

6.4 Obstacles to the European Labour Market Mobility

The Skaraborg Recruitment Project has shown that labour mobility requires efforts for both the organisation and individuals but that there are no major obstacles for each actors. One of the key factors for its success was the good preparation and mutual willingness to make the project work from both sides.

A survey made by PricewaterhouseCoopers revealed that a lack of language skills is the major barrier to job mobility in Europe (Ambler, 2002). Yet this seems to be not the case in the recruitment project, where no doctors could speak Swedish prior to being approached by Skaraborg. While mastering the Swedish language was a necessity for foreign doctors to work, the learning process by courses or conversations with Swedes have proven to be efficient and sufficient.

The European Commission published a comprehensive report in 2000 entitled "Obstacles to cross-border mobility within the European union." The list of cross-border obstacles can often be related to those of transnational mobility. These findings were based on surveys made with all cross-borders EURES advisers. Their main list of obstacles was as follows:

- Cultural and Language barriers.
- Information shortcomings and lack of transparency.
- The problem of recognition of qualifications.
- Economic and financial obstacles: taxes, social security benefits, pensions, banking, etc.
- Legal and administrative problems: residence permits, etc.

When comparing these obstacles to the Skaraborg case, one sees the benefits for individuals to work abroad within the frame of such projects. Although naturally not pervasive, the actions undertaken by Skaraborg administrators have tackled each of these obstacles to make the coming and job matching of foreign doctors a success. However, relatively few organisations and sectors can afford the time, money and efforts that Skaraborg did when dealing with Labour Mobility. Furthermore, healthcare being one of the most regulated sectors in Europe, organisations and individuals looking for recruitment abroad in this sector are likely to face lower uncertainties concerning their future conditions after the move.

Transnational and cross-border mobility have also to be considered with internal labour mobility. Even on the national levels, most European countries do not demonstrate a level of geographical mobility comparable to the U.S.A. In Italy and Spain, migration rates average about 0.5 % of the regional population, while these figures are almost triple in the Netherlands and Germany. Yet, in the latter country there are still very significant bottlenecks problems: The two Southern States of Bavaria and Baden-Württemberg have unemployment rates around 6.5% while this is more than double in Eastern German Sates like Sachsen-Anhalt. Therefore, each Member State has natural reasons to worry in the promoting of internal mobility first rather than looking abroad.

7. Conclusion

Historically, barriers to foreign workers in Europe have been considerable, and developments of the European Union have involved progressive removal of restrictions for EU nationals to move across borders. While this has removed many obstacles, and not merely the easiest ones, there are still some remaining.

The Skaraborg Recruitment Project teaches that some organisations and individuals are actively taking advantage of these new facilities to pursue their goals. One of the facilities offered is the use of EURES as an intermediary at no cost (without considering the taxpayers' money of course). This intermediary has proven to be useful to many organisations and individuals but still carries many flaws. One main reason is its lack of financing and personnel to initiate very close relationships with employers and employees as the international labour mobility of highly-skilled workers requires.

It is interesting enough to observe that although EURES and organisations like the Sakaraborg Primary Health Services punctually intervene on the healthcare labour market of other countries, they do not seem to interfere on each labour cycle, thus the Spanish system reproduces its flaws and advantages with or without the moving of Spanish doctors abroad. Certainly, there are some lessons to be learned from this situation.

Labour Mobility is a complex issue much work and research is yet to be done on its development and deeper implications as literature often limits itself to practical issues.

8. References

8.1 Bibliography

Ambler, M. and Graham, H. (2002) *Managing mobility matters - A European perspective*. PricewaterhouseCoopers.

Bergström, O. and Storrie, D. *Contingent Employment in Europe and the United States*. To be published. Edward Edgar Ltd.

Bergström, O. (1998) *Cultural Match: Recruitment in a knowledge-intensive firm*. Gothenburg School of Economics and Commercial Law.

Corry, D. (1996) *Economics and European Union Migration Policy*. London: Institute for Public Policy Research.

European Center for the Development of Vocational Training (Cedefop) Publications. (2001) *Mobility and Migration of labour in the European Union and their specific implications for young people*.

Hjertqvist, J. (2001) *Swedish Healthcare in Transition*. Atlantic Institute for Market Studies.

Hofflander, F. (2002) *Skaraborg locker hem tandläckare från England*. Metro Sweden Article. Tuesday 3rd December 2002.

Lamiere, N. et al. (1999) *Healthcare systems: an international review, an overview*. In Nephrol Dial Transplant 14.

Larsson, P. and Aronescu, D. (2002) *Temporary Doctors: selfish capitalists or care-giving workaholics?* Gothenburg School of Economics and Commercial Law.

Mintjes, R. et al. (2002) Contingent *Employment in Hospitals: Case Study Report WPIII*. NUEWO Publications.

MKW Wirtschaftsforschung (2001). *Obstacles to mobility for workers in the digital culture in the European Union*. Report commissioned by the European Commission.

Oskarsson, A. (2002) *Rekryteringen från tyskland och Spanien : hur gick det?* Report from Västra Götalandsregionen and Arbetsförmedlingen.

Rodriguez, E., Gallo de Puelles, P. and Jovell, A. J. (1999) *Health Policy and Planning*. Vol. 14.

Skar, M. (2001) *Mobility in the European health sector: The role of transparency and recognition of vocational qualification*. Office for Official Publications of the European Communities, Luxembourg.

The European Commission Directorate General XXIII. (1996) Background Statistics Citizens.
The European Commission. EURES activity report 1998-1999 and 1999-2000.

The European Commission (1998) *EURES: the European network for information employment and worker mobility*.

The European Commission (2001) Second Report on Economic and Social Cohesion.

Thuy, P., Hansen, E. and Price, D. (2001) *The Public Employment service in a changing labour market*. International Labour Office Publications.

Wanous, J. P. (1992) *Organizational Entry: recruitment, Selection, Orientation and Socialization of Newcomers*. 2nd Edition. Addison Wesley, HRM Series.

Werner, H. (1996) *Mobility of workers in the European Union*. Nurnberg.

World Health Organisation Publications (1996) *Health Care Systems in Transition*. Reports on Spain and Sweden.

8.2 Internet Sources

http://www.aforesund.org

http://www.ams.se

http://www.estia.educ.goteborg.se

http://europa.eu.int/comm/employment_social/elm/eures

http://europa.eu.int/comm/eurostat

http://www.folkuniversitetet.se

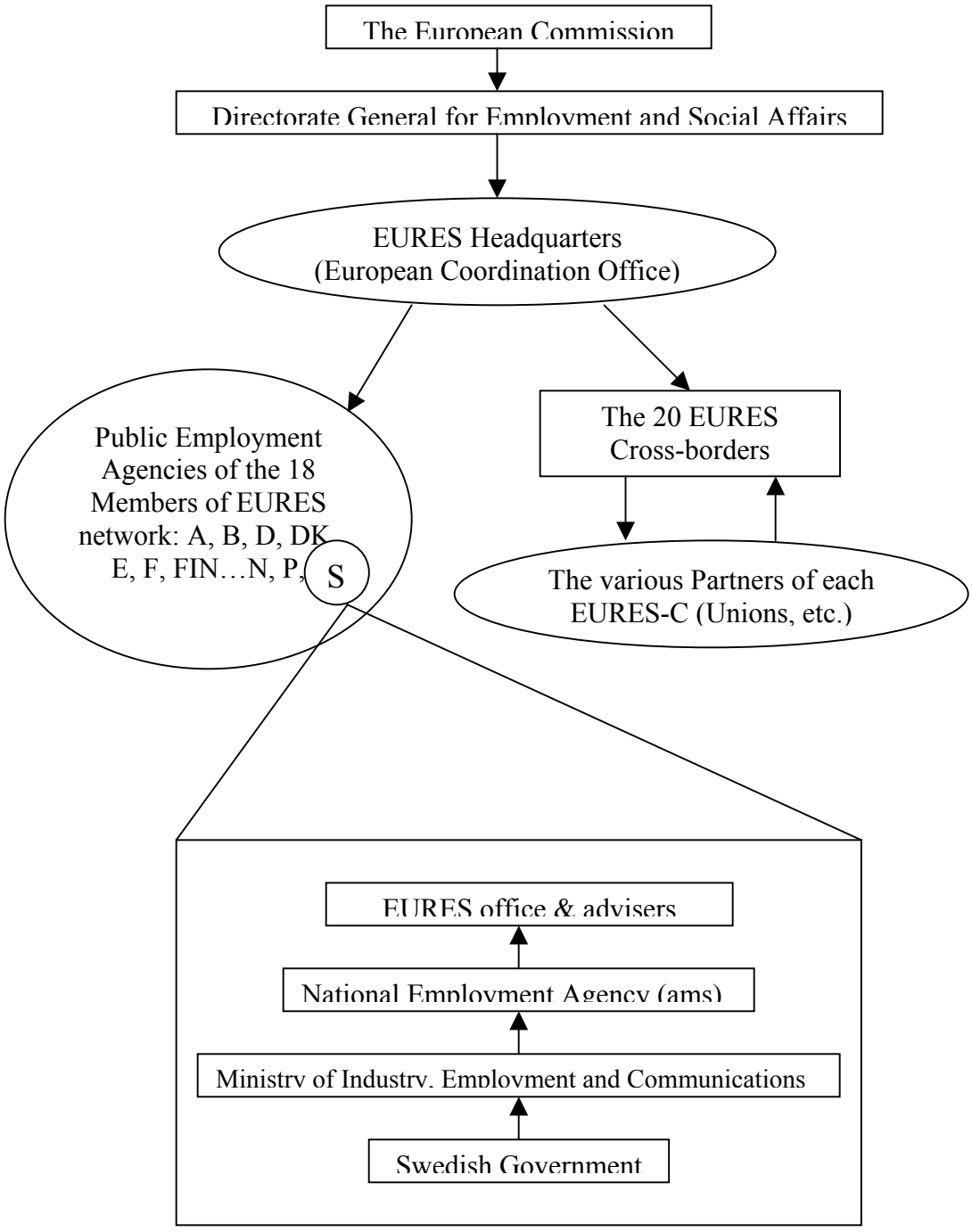
http://www.norden.org

http://www.sos.se

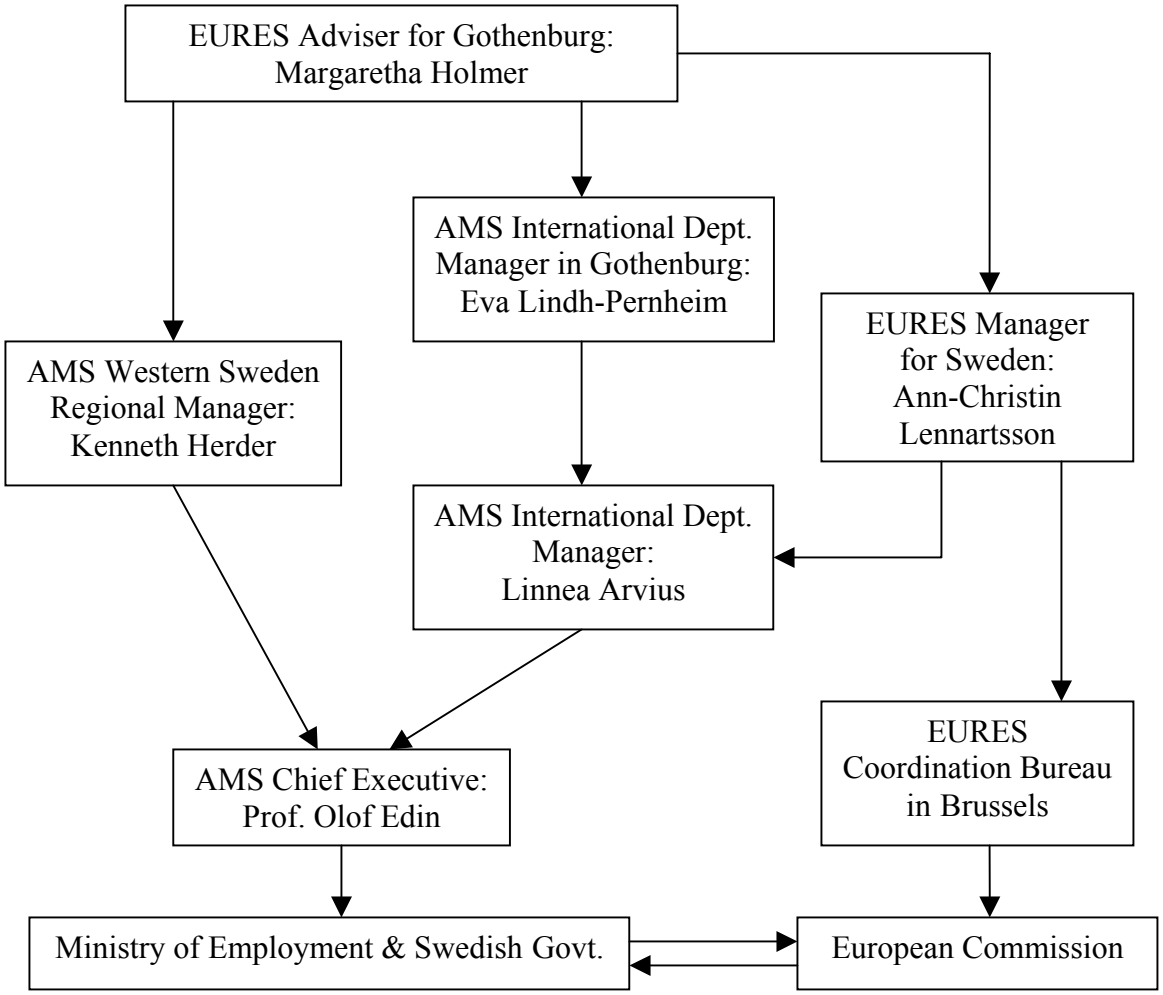
http://www.uemo.org

http://www.vgregion.se

Appendix I: Flow Chart of EURES activities in Europe



Appendix II:Flow Chart of EURES Activities inSweden



N.B: AMS=Arbetsförmedlingen, the Swedish National Employment Agency.