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**Experiences of hospitals with foreign health workers: how
current practices relate to European circular migration
policy.**

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Summary

Circular migration is the phenomenon of staff moving to another country and then returning to their home countries after some time. The European Union proposed a circular migration policy to solve predicted health worker shortages in 2020. Because there is lack of evidence about the applicability of the policy in healthcare organizations, this thesis studied the experiences of hospitals with foreign workers and examined how current practices relate to the European circular migration policy. Ten conducted interviews in Dutch and Belgium hospitals provided insight into current practices and experiences with foreign workers and topics related to circular migration. It showed that European migration is a relevant topic, although respondents perceived the need for staff in hospitals is not as urgent as presented in European reports. Employment of foreign workers was practice in most participating hospitals and European countries were most common as country of origin. Several forces of migration were distinguished: income, social capital, human capital and power. Regarding the employment of foreign workers, five barriers for hospitals were mentioned: communication, medical education, recognition of qualifications, cultural differences and medical-ethical issues. To overcome these barriers and enhance social embedding, organizational support is necessary. Regarding other elements of circular migration: it appeared that the temporary character and its European policy perspective did not fit into current practices of hospitals. Temporary labour is of common use, but not for foreign workers, and hospitals usually deal with national legislation instead of European regulations. Taking the barriers and healthcare characteristics into account, the European policy proposal is not likely to be successful in its current form. Several improvements could be made, for example to start on regional scale and cross-border networks. The European circular migration idea provides valuable insights, of which the good should be taken and the bad left aside.

Table of contents

SUMMARY	2
1. INTRODUCTION.....	5
2. PROFESSIONAL MIGRATION IN EUROPE	7
2.1. EUROPEANIZATION	7
2.2. EU POLICY ON CIRCULAR MIGRATION	8
2.3. UNDERLYING FRAMEWORKS: EU AND PROFESSIONAL MIGRATION	9
2.3.1. <i>Free movement of workers</i>	9
2.3.2. <i>Recognition of qualifications</i>	9
2.4. SUMMARIZING REMARKS.....	10
3. THEORIES OF MIGRATION	12
3.1. THEORETICAL DEBATE	12
3.2. THE NEO-CLASSICAL EQUILIBRIUM PERSPECTIVE	12
3.3. HISTORICAL-STRUCTURAL THEORY	13
3.4. INCOMPATIBILITY	13
3.5. HUMAN CAPITAL AND SOCIAL CAPITAL.....	14
3.6. CIRCULAR MIGRATION: RELATED THEORIES.....	15
3.7. SUMMARIZING REMARKS.....	17
4. TEMPORARY WORKERS IN HEALTHCARE.....	18
4.1. TYPES OF TEMPORARY WORKING.....	18
4.2. GROWING DEMAND	18
4.3. CONSEQUENCES FOR HEALTHCARE ORGANISATIONS	19
4.4. INTERNATIONAL TEMPORARY STAFFING	20
4.5. SUMMARIZING REMARKS.....	20
5. RESEARCH METHOD.....	21
5.1. THE RESEARCH PROBLEM.....	21
5.2. RESEARCH APPROACH	21
5.3. DESCRIPTION OF METHODOLOGY	22
5.4. VALIDITY AND RELIABILITY.....	24
6. RESULTS.....	26
6.1. THE NEED FOR FOREIGN WORKERS.....	27
6.2. EXPERIENCES WITH FOREIGN HEALTH WORKERS	28
6.2.1. RECRUITMENT AND SELECTION	28
6.2.2. ORIGIN OF THE CANDIDATES	30
6.2.3. BARRIERS.....	32
6.2.3.1. <i>Communication</i>	32
6.2.3.2. <i>Medical education</i>	33
6.2.3.3. <i>Recognition of qualifications</i>	33
6.2.3.4. <i>Culture</i>	34
6.2.3.5. <i>Medical-ethical issues</i>	35
6.2.4. SUMMARIZING REMARKS	36
6.3. CIRCULAR MIGRATION	37
6.3.1. ADVANTAGES	37
6.3.2. DISADVANTAGES	38

6.3.3.	WOULD IT SOLVE SHORTAGES?	38
6.3.4.	SUMMARIZING REMARKS	39
6.4.	TEMPORARY LABOUR.....	40
6.4.1.	COMMON PHENOMENON	40
6.4.2.	INTEGRATION OF TEMPORARY LABOUR.....	41
6.4.3.	QUALITY	41
6.4.4.	SUMMARIZING REMARKS	42
6.5.	EXPERIENCE WITH EUROPEAN POLICIES	43
6.5.1.	UNFAMILIARITY WITH EUROPE REGARDING HEALTH POLICY	43
6.5.2.	NATIONAL LEGISLATION	43
6.5.3.	UNDERLYING EUROPEAN FRAMEWORKS.....	44
6.5.4.	SUMMARIZING REMARKS	45
7.	CONCLUSION	46
8.	DISCUSSION	49
9.	LITERATURE	51
	APPENDIX.....	55

1. Introduction

This thesis is about a proposed strategy for sufficient staffing of healthcare organizations in Europe in the future. Demographical changes in the twenty-first century are said to change staffing levels within the healthcare sector. Three of these changes are relevant: ageing, decreasing birth rates and retirement. Firstly, ageing will increase the demand for healthcare in societies. Elderly people have different health needs and the growth of aging-associated diseases will increase the national health expenditure of EU member states (Wismar 2011). The second demographic trend is the low birth-rate: fertility rates are low in Europe since the 1960s, having negative impact on productivity and economic growth (Andreason 2011). The third issue is that, since the average age of health workers is increasing every year, more staff is approaching retirement age. This decreases the effective workforce for health. The combination of aging, low birth-rate averages and retirement of health workers is causing a (growing) shortage of health workers. There are insufficient younger recruits to replace the retired. In their calculation, the Directorate General SANCO (Health & Consumers) of the European Commission estimated that there will be an overall shortage of 1 million health workers in 2020. Expectations are that 13.5-14% of demanded care will not be covered (Sermeus 2010).

The shortages on the health workers labour market is not a problem only individual member states are struggling with, also on European level solutions are sought. The European Commission (EC) recognised the need for a comprehensive approach for this problem. In 2008 the EC published the green paper 'On the European Workforce for Health', aiming to 'promote a sustainable workforce for health in Europe' (EC 2008:3). A sustainable workforce means here: sufficient qualified workers to address the health needs of European citizens.

One of the problems to overcome before reaching that point is unequal migration within the EU, because the European Commission aims for an equal situation for all European citizens. Free movement of persons is one of the fundamental freedoms, and according to Regulation 1612/68 every EU citizen has the right to work in another EU member state as employee or civil servant (Wismar 2011:6). However, health worker salaries are higher and working conditions are better in West-Europe than in East-Europe, causing a flow of East-to-West migrating health professionals (Wismar 2011:45,75). Problems of unavailability and inaccessibility of healthcare in e.g. Romania caused by moving professionals to other EU countries are well reported (Wiskow 2006).

Another related problem is that increasing salaries in Europe will attract health workers from poor countries. Shortage of workers is most acute in Sub-Saharan Africa: there is worldwide agreement that employment of workers from this area in Europe will cause a brain drain in Africa (García-Perez 2007). For that reason the EU adopted the 'Strategy for Action on the Crisis in Human Resources for Health in Developing Countries', aiming to prevent brain drain from third countries by promoting circular migration (COM(2005) 642, COM(2008) 359).

Taking these problems into account, the European Union stated that the main route for a sustainable workforce for health in Europe is to achieve self-sufficiency at EU level, reasoning that self-sufficiency on national level is not achievable for all EU countries. Since some countries are having surpluses of health workers (Buchan 2007), the EC proposed a policy to take advantage of these surpluses on European level by filling the deficits by these workers: circular migration.

Circular migration is the phenomenon of staff moving to another country and then returning to their home countries after some time (EC 2008). It should enhance labour mobility, thereby enabling the market mechanism of supply and demand on European level. Proponents of circular migration also

argue that circular migration will improve the overall level of knowledge and skills. Circular migration intrinsically fits into the ideology of the European Union to create a shared market (further explained in chapter 2). Free movement of persons, one of the fundamental rights in the Union, ensures the possibility of circular migration. The recognition of professional qualification is also part of European policy. Supporters of circular migration policy (also in a worldwide context) argue that circular migration is a triple win (Vertovec 2007). The migrant gains extra knowledge, skills and more income. Sending countries benefit from remittances and the return of better-skilled health workers. And for receiving countries because their deficits are filled, a condition for a sustainable healthcare sector. Whether the benefits of circular migration are as mutual as argued will be discussed in chapter 3.

A remarkable issue is that there is little empirical evidence about the existence of circular migration projects and their successfulness. Evidence from studies about the experiences of foreign workers in healthcare is available, as there is literature about the impact of migration on national healthcare (for example in the United Kingdom) (Wismar 2011). Remarkably, one important issue has not received attention yet. There is neither information about the attitude of healthcare organisations towards (circular) migration, nor are current experiences of healthcare organizations with foreign personnel well reported. This thesis tries to fill that gap of knowledge. The aim of this study is to gain insight into current practices related to (circular) migration of health workers in healthcare organisations and to compare this to the European circular migration proposal.

The main question of this thesis is:

“What are the experiences of hospitals with migration of health workers and how do current practices relate to European circular migration policies?”

This thesis is structured in eight chapters. Following this introduction, the second chapter will review Europeanization of healthcare policy, and give a description of current EU policies relevant to this thesis. The third chapter will then give an overview of theories of migration, and will explore the characteristics of circular migration. The fourth chapter will present the implications of temporary staffing in healthcare, one of the important aspects of the proposal. In the fifth chapter an overview of the used methods to address the research question will be given. The sixth chapter will then give the results of the interviews performed in Belgium and Dutch hospitals. Drawing on these results, the seventh chapter will review the barriers and opportunities of circular migration in healthcare and draw a conclusion. Finally, the eighth chapter discusses the results, the limitations of this research, policy implications and suggestions for further research.

2. Professional migration in Europe

This chapter is about the migration of health workers in the European Union. Originally, health policy was not within the responsibility of the European Union. The influence of European policy on healthcare seems to be evident, however. This is described as so called 'Europeanization' of policy, which is discussed in the first paragraph. The second part of this chapter will describe the proposal of the European Commission on circular migration. Then follows background information about two European legal frameworks of already existing policies: free movement of workers and recognition of professional qualifications, because they are related to (circular) migration of health workers.

2.1. Europeanization

The European Union has no formal competence to regulate national healthcare, according to article 152 of the Treaty Establishing the European Community. Health policy formally falls within the national competence of member states. Strong national public policy traditions imply no significant influence of Europe (Martinsen 2008). The impact of European policy on health care is broadly recognized, however (Beaten 2010, Martinsen 2008, Duncan 2002, Knill 2002). Radealli (2003) called it 'Europeanization': a process through which formal and informal rules are first defined and consolidated at the EU level and then incorporated in the domestic discourse.

The issue of having no formal competence and influencing health policy at the same time is discussed by several authors. They identify three ways of making health policy by the European Union, as summarized by Duncan (2002). The first way is making direct health policy. The European Union then identifies a health problem and develops policy in cooperation with member states. This form of policy making is criticized by academia and politicians, by arguing that the EU does not have the formal competence to make healthcare policy (Martinsen 2008). The second possibility is making indirect health policy: the EU is pursuing another objective, but health considerations can play an important role. An example is strengthening the internal market, which also has impact on, for example, pharmaceutical policy. A third type is unintentional policy making. From that perspective healthcare is affected by European policy in an unplanned manner with unforeseen effects. A clear example of this is patient mobility in the EU. In the Kohll and Decker cases, the European Court of Justice judged that, based on the right of free movement of goods and services, healthcare provided outside the country should be reimbursed by national health insurers (Rosenmöller 2006). Since the right of free movement was implemented without considering these consequences for healthcare, it shows that Europe's influence can be unintentional. The influence of the European Union varies per policy area and is sometime mixed. These policies are usually made and adapted over a longer period of time, which makes it sometimes hard to distinguish between indirect- and unintentional health policy making.

The impact of the European Union on healthcare policies seems hard to measure, because it takes place as a result of multiple influences (Martinsen 2008). The afore mentioned difficulty to distinguish between forms of policy making is one example of this. The relation to national institutions and national traditions makes research complicated, because of slight adaptations in the translation of European policy. Literature on European social policy shows, however, that national welfare states are 'semi-sovereign' (Kendall 2005). In the case of patient mobility, for example, the European Court of Justice used its jurisdiction to be active in policy domains that were previously

ignored. Particularly in the case of quasi-market systems the European Court of Justice has potential competences (Liebfried 1995). Another issue that encourages the influence of the European Union in health policy is that third sector organisations are significant economic actors (Martinsen 2008). Therefore they are affected by the EU labour market and fiscal policy. This is also the angle from which the EC proposed the idea of circular migration of health workers in Europe.

2.2. EU policy on circular migration

At European level, the Task Force on Temporary and Circular Migration of the European Policy Centre introduced the idea of temporary and circular migration – not specifically for healthcare, but in general. According to the taskforce, “in spite of high levels of unemployment across Europe, labour market shortages persist in a number of sectors and are likely to become more acute in the coming years as Europe’s workforce shrinks as a consequence of demographic change. The Task Force on Temporary and Circular Migration investigated whether temporary and circular migration policies are part of the solution to sustaining Europe’s economic and social models in the future.” (McLoughlin 2011:64) In their report ‘Temporary and circular migration: opportunities and challenges’, it is written that “the short-term insertion of migrant workers into the workforce would not suit all sectors of the labour market. Temporary and circular migrants could instead fill low- and medium-skilled job vacancies in defined sectors that experience difficulties in finding workers to meet cyclical demand, be it the seasonal sector or non-seasonal sectors that make use of temporary work agencies.” (McLoughlin 2011:8). The healthcare sector is not incorporated in this report. In a mentioned Dutch project for circular migration, healthcare was excluded from the pilot – a limitation of the donor, the Dutch government (HIT foundation 2011). The Taskforce concluded that circular migration fits best to young people with medium-to-low qualifications. The healthcare sector, however, is a sector that sets high requirements for qualification (Dumont 2007, see also 2.3.2).

However, in December 2009 the European Commission published a Green Paper about the European workforce in healthcare (EC 2008). The Green Paper gives a broad range of policy options to be implemented in member states in order to create a sustainable workforce for health. One of the ideas is the circular movement of health workers. According to the Commission, it refers to “staff moving to another country for training and/or to gain experience, and then returning to their home countries with additional knowledge and skills” (EC 2008:10). The idea is seen as a possible area for action to increase the mobility in the European Union, ‘to ensure that health professionals go where they are most needed’ (ibid, p9). According to the EC, staff is not motivated solely by their rates of pay, but employees are increasingly aware of educational opportunities and employment options (Kidd 2010). Attractive incentives could take the form of an agreed career pathway, so that the person returning comes back to a post and receives a salary which recognises the experience gained.’ (EC 2008:11) Member states “will gain from collaborating with other Member States rather than being in competition with each other. Cross-border agreements on training and staff exchanges may help to manage the outward flow of health workers” (Kidd 2010:22). The importance of the topic is also recognised by a large share of the 197 European stakeholders (including health professionals, academia, politicians and regulators from all EU member states) that were asked to respond to the green paper (EC 2009).

The subject of circular migration in Europe refers to two important underlying regulations of the European Union: free movement of workers and recognition of professional qualifications. These will be addressed in the following paragraphs. These are necessary to understand the European ideology of European mobility, as well as the already existing provisions enhancing the possibility of professional mobility. When already familiar with these regulations, the reader could continue with the next chapter about theories of migration.

2.3. Underlying frameworks: EU and professional migration

2.3.1. Free movement of workers

The free movement of workers is one of the fundamental civil rights of in the European Union. The origin of the right dates back to 18 April 1951. After the Second World War, six countries felt the need for better economic cooperation and founded the European Coal and Steel Community (ECSC). In 1951 Belgium, France, Italy, Luxembourg, The Netherlands and West Germany signed the Treaty of Paris. One of the aims of the ECSC was to revitalise the European economy, starting with the coal and steel industry and free movement of workers was one of the important regulations (article 69). The right of free movement of workers was expanded to all workers in article 48 of the Treaty of Rome, establishing the European Economic Community (EEC). The EEC led to the establishment of the European Community (Maastricht Treaty) and the European Union (Lisbon Treaty). Now the right is enshrined in article 45 of the 'Treaty on the Functioning of the European Union'. According to this article, "freedom of movement for workers shall be secured within the Union". The provisions of this right are 1) the abolition of any discrimination, 2) to accept offers of employment, 3) move freely in the territory of Member States for this purpose, 4) to stay in the Member State and 5) to remain in the Member State after being employed. The right has been amended several times, and in the interest of clarity and rationally on 5 April 2011 the European Union published Regulation (EU) No 492/2011. In this regulation the freedom of movement for workers within the European Union is further expanded. According to the introductory statements, movement of workers is one of the means for workers "to improve their living and working conditions and promoting their social advancements, while helping to satisfy the requirements of the economies of the Member states." (EU no 492/2011). Workers should enjoy the same social and tax advantages as national workers, should have access to training provided by vocational schools and training centres and shall enjoy the same rights as national workers in matters of housing.

2.3.2. Recognition of qualifications

For healthcare the recognition of professional qualifications is of the same importance as the above mentioned right of free movement for workers. Jobs in healthcare are heavily regulated by health bodies in all member states of the European Union. Because of the differences between educational practices and qualification systems, recognition of professional qualification is necessary to enable migration of health workers. At EU level, the recognition of professional qualifications is codified in Directive 2005/36/EC on the recognition of professional qualifications which came into force in 2007.

The purpose of the directive is to allow holders of qualifications of regulated professions to pursue the profession in another Member state of the European Union. A regulated profession is an activity or group of activities subject to legislative, regulatory or administrative provisions. The recognition of qualification means that a professional can gain access to the same profession as he is qualified in the Member States. After 2007 the European Union consists of 27 Member States, all with their own educational systems and qualifications. For the reason of comparability, the Directive sets the minimum requirements for recognition of qualifications by professionals.

European Commission and the green paper

In March 2010 the Commission published a green paper about recognition of professional qualifications (COM(2011)367). The first new idea is the 'European professional card'. This would be a personal card that should be built around fast communication technologies of the 21st century. Fast communication will lead to a fast-track recognition process. According to this idea, the competent authority from the home country would be responsible for verification of professional qualifications that will be linked to the personal card. The IMI (Internal Market Information System) could be used to store official documents of professionals, which would be accessible by competent authorities of the receiving countries. The only thing professionals should do is providing the professional card number to the authorities. In order to achieve this identification system it is necessary to expand the IMI-system. IMI is developed by the European Commission to make administrative cooperation across borders easier by using a common IT-based network. Using IMI is not mandatory for health authorities yet, while a European identification system requires a common system. Another idea from the green paper is to make a National Contact Point (NCP) in every country. These NCP's should provide clear information to professionals about the procedures they have to follow.

The third important notion from the green paper is an update of the system of automatic recognition for doctors, nurses, dentists and midwives (COM(2011)367). Language requirements are not enough embedded in the current directive, while insufficient language skills may in some cases be life threatening for patients. The EC therefore suggests special requirements for professionals that have direct contact with patients.

The European Parliament agreed on the need for an update of previous Directives. An issue that is not covered in the green paper but is important to the Parliament is the regulation of professional qualifications. In case of dysfunctional professionals, it is possible that the competent health authority in a country voids the qualification of professional. In some cases, this is not reported to authorities in other member states, giving dysfunctional professionals the opportunity to practice in other member states by using their revoked diploma.

2.4. Summarizing remarks

Although the European Union lacks formal competence to make healthcare policy, Europeanization also affects healthcare. This is relevant to understand, because the circular migration policy requires cooperation with national healthcare systems. Two underlying frameworks are partially enabling such a system. The condition of free movement of labour encourages worker mobility, taking away an important formal barrier. The recognition of professional qualification is crucial for foreign health workers, because a recognized diploma is a requirement to work with patients. The system of

(automatic) recognition is used, but could be further improved. European policy is seen as a possible area for action to increase the mobility in the European Union and to ensure that health professionals go where they are most needed, by circular migration in Europe. When this policy would be implemented, it is likely to change healthcare practices and regulations to facilitate the migration and migrant workers.

3. Theories of migration

This chapter contains an overview of the theoretical debate about international migration to get a better understanding of relevant topics for this study. Two fundamental economic theories are reviewed which focus on economic factors to explain international migration. But economic factors alone cannot explain migration; therefore also the social capital theory and human capital theory are introduced and discussed. Finally, these theories will be applied to circular migration.

3.1. Theoretical debate

In the past and current decade international mobility has increased substantially. Modern technologies are providing the opportunity to travel large distances. According to many people the world has become a global village. Parallel to this trend of globalization, the interest in issues of migration has grown rapidly (Vertovec 2007).

According to an analysis of De Haas (2008), the theoretical debate in the post World War II period has shifted radical from pessimistic to optimistic views on migration. The research on migration is relative small and young (Bodvarsson 2009). Until the 1970s, the research community worked from development and migration optimism. It dates back to an economic analysis of Adam Smith's 'An inquiry into the Nature and Causes of the Wealth of Nations' in 1776, where he suggested that migration is a response on dis-equilibrium in labour markets. The capital and knowledge transfers by migrants would encourage development. Between 1973 and 1990, scepticism grew. Scholars and policymakers were concerned about brain drain and dependency and its negative consequences on poor countries. At that time it was reported that poor countries were suffering from an outflow of skilled workers, thereby worsening the situation in the home countries. At the same time, countries were facing difficulties with the integration of migrants in western societies, for example the German *Gastarbeiter* system where large groups of (mainly Turkish) migrant workers moved to West Germany in the 1960s and 70s (Vertovec 2007). Between 1990-2001 more subtle views were developed, because of increasing empirical work, giving more insight into the complex practice of migration. After 2001 the number of scholarly publications on migration boomed, generally with a nuanced view, because of a general shift to pluralist- and structuralist approaches to integrate structure and actor perspectives (instead of regarding those as opposites) (De Haas 2008).

Because the first authors on migration asserted that the major factors explaining migration are economic, this perspective has been important for the debate on migration. Two fundamental theories are important: the neoclassical equilibrium perspective and the historical structural perspective. These perspectives are radically different, the first rooted in neo-classical economics, the other in Marxist political economics (De Haas 2008).

3.2. The neo-classical equilibrium perspective

The neo-classical equilibrium perspective is based on the economic thought of demand and supply. According to this theory, migration on macro level can be explained by differentials in wages and labour scarcity (De Haas 2008). Workers from an area with low-wage and oversupply of labour will migrate to areas with labour scarcity and high-wage. In a perfect situation, there will be equilibrium,

removing the incentives for migration. The leading factor explaining migration is a binational wage gap (Massey 1997).

On micro level, migrants are expected to be individual and rational actors (De Haas 2008). Assumptions in the theory are free choice, full access to information, expected to go where they can be most productive and earn most money. Migrants make a cost-benefit analysis in deciding whether or not to migrate internationally (Todaro 1987).

This migration theory largely ignores market imperfections and social constraints. Although empirical evidence shows that a wage gap is an important predictor of migration (Wismar 2011, Buchan 2006), according to critics this assumption is hardly realistic. According to De Haas (2008:6): "Migration does not take place in a social, cultural, political, and institutional void. Neo-classical migration theory is also not able to deal with constraining factors such as government restrictions on migration."

3.3. Historical-structural theory

A theory that is the opposite of the neo-classical equilibrium theory is the historical-structural theory, having its roots in a Marxists political economy (Wood 1982). This theory was dominant in the 70s and 80s, postulating that economic and political power is unequally distributed in the world, where powerful countries will strengthen their own positions and countries with less power are trapped in their underdevelopment (De Haas 2008). Instead of focussing on market mechanisms, this theory focuses on the power position of countries. According to this perspective, migration 'ruins stable peasant societies, undermines their economies and uproots populations'. It focuses on the problems related to brain drain and the problems for countries trapped in their underdevelopment.

In contradiction to the neo-classical equilibrium theory, historical structuralists stated that individuals have neither free choice, nor full information. Instead, migrants do not move because of own initiative of choice, but are forced by macro-forces, such as bad living conditions or economical downturn (De Haas 2008). Instead of actively acting on financial incentives, these people are victims, for example because they become increasingly deprived of their traditional livelihoods. These macro-forces are caused by undermining of the economic structures in 'trapped countries'.

The historical-structural theory has been criticized by scholars for being too deterministic. According to this theory, migrants are victims of a system, thereby passively adapting to macro-forces. Empirical evidence shows that economic weak countries, such as the Philippines, have sustained economic growth while exporting labour capital, showing that asymmetric power does not necessarily lead to (trapping into) underdevelopment (Dumont 2007).

3.4. Incompatibility

A theoretical problem that applies to both theories is that they could not be used to develop a general migration theory. On micro level, some actors may be rational and act according to neoclassical economic rules, for example income as an important incentive for people to migrate. At the same time, macro forces play a role, for example poverty, wars or underdevelopment (De Haas 2008).

Some researchers denied that it would be possible to develop an overall theory of migration. According to this school, migration is such a complex practice and the different areas that composite the field are so disparate, that a theory can only be developed on a highly abstract level (Portes 1997). Others point out the difficulty to separate migration from socio-economic and political processes (De Haas 2008). What is common in all critics is the difficulty to integrate the micro structural and macro structural theories. Micro structural theories focus on the individual decision to migration, while macro structural issues include the onset of migration flow and the power of the state system to regulate such movements (Portes 1997). Some scholars conclude that the incompatibility of these theories make a general theory of migration impossible (Salt 1987, Van Amersfoort 1998).

Others argued that theories on micro structural and macro structural level are not mutual exclusive (Massey 1993). Portes (1997) states that “we cannot explain everything, but we can explain some things with a reasonable margin of certainty. (...) drawing on the wealth of historical and contemporary research on immigration seems the strategy most worth pursuing” (p812). Two concepts that draw on contemporary research are human capital and social capital. These theories look from a different angle to migration and are an addition to the previous presented theories, while they take other factors into account.

3.5. Human capital and social capital

The previous theories focus on the economic force behind migration. But economic forces alone cannot explain the migration patterns of the past decades (Salt 1987; De Haas 2008). Others have therefore argued that it is important to broaden the scope to other factors: institutions, social networks and cultural and historical roles in creating new migration patterns.

The social capital theory explains the role of social networks in migration (De Haas 2008). Social networks embed migrants in a social environment, which is important for migration and settlement (Massey 2011). Social capital is “the sum of the resources, actual or virtual, that accrue to an individual or a group by virtue of possessing durable network of more or less institutionalized relationships of mutual acquaintance and recognition” (Bourdieu 1992:119). Networks are sets of interpersonal ties that connect migrants, former migrants, and non-migrants in origin and destination areas through bonds of kinship, friendship, and shared community origin (Massey 1993). Bourdieu interprets social capital as an instrument for migration, because networks facilitate the transfer of information and support. In case of migration such networks can include both similar migrants and non-migrants that are open for cooperation. The role of networks for migration makes it difficult for governments to control migration and explain the perpetuation of migration (De Haas 2008). When a critical mass of social capital is achieved, this will attract more migrants, who in turn further strengthen the interpersonal ties, and it is difficult for governments to control or establish a minimum of social capital. Reasons to migrate related to social capital are family reunification, seeking refuge of political asylum, a more attractive culture or religious beliefs (Bodvarsson 2009). The social capital theory is valuable for the consideration of migration theories, because it adds an important concept for understanding current migration patterns.

Another theory that is important is the human capital theory. Becker defined human capital as “the knowledge, information, ideas, skills, and health of individuals” (Becker 2002:1). In the literature this

concept can be approached from different perspectives. Economists tend to focus on the value of education and working experience, and how individuals make choices to invest in their human capital (Wright 2011). Psychologists on the other hand have studied the individual development of human capital by examining characteristics about job performance and focusing on individual differences. Both perspectives can be used to illustrate that economic forces alone cannot explain migration patterns. Migrants can use migration as a method to substitute educational attainment for the lack of job experience. For example, graduated medical students are relatively 'overeducated', but lack job experience. While it is difficult to gain a position in a hospital, they can choose to work as a volunteer in developing countries for some years. In this example the binational wage gap from the neo-classical model cannot explain why people migrate to places where their income is lower. The human capital theory tries to explain this by regarding migration as an individual investment in one's human capital.

What the theories of social capital and human capital illustrate, is that migration cannot only be explained by economic factors. They also bridge the gap between the micro- and macro level. Especially the social capital theory shows the value of networks on meso level, connecting both forces on macro level and interaction on micro level. But also the human capital theory can explain why, for example, organizations try to attract migrants: because of their knowledge and skills.

3.6. Circular migration: related theories

A form of migration that also incorporates the idea of networks and human capital is circular migration. Circular migration is staff moving to another country and returning to their home countries. It is related to the idea of border-crossing networks, which is also related to the social capital theory (Vertovec 2007). The idea of circular migration incorporates temporary moving, thereby creating an international network. Already existing social contacts on micro- or meso level could be a condition for effective circular migration, and already existing social networks could at the same time enhance migration. For example, international networks of hospitals can benefit the exchange of health workers between those hospitals, but also individual contacts with e.g. family can be a reason to migrate. From the perspective of human capital, circular migration could be an investment to gain additional skills and knowledge, both for individuals and organizations.

Increasing human capital is also one of the reasons for policy makers to call for circular migration. The main reason why they are calling for circular migration now, is that they believe it could bring win-win-win results: for receiving countries reduced labour shortages, for sending countries remittances and more experienced workers and for migrants themselves better education, more skills and more knowledge. Castles (2006) draw four important reasons why policymakers are calling for circular migration:

- (1) Recognition of the prevalence and importance of transnational practices among migrants (...): remittances and the developmental potential of organized migrant labour schemes.
- (2) The 'win-win-win' mantra is being taken seriously, again especially around migration and development. Circular migration appears to be a readily available option to provide immediate three-way benefits.

(3) Circular and other temporary forms of migration are considered by policy-makers to be more amenable to public opinion (...).

(4) Many policy-makers believe they now have the technical know-how (...) that would potentially enable them to keep track of migrants as they come and go between homelands and foreign places of work.

Whether these reasons are really beneficial as stated is questionable. From a macro-point-of-view, the benefits of migration are listed in table 3.1 (Stewart 2007). In a situation of free movement of workers and permanent migration, the benefits for receiving countries are higher than for sending countries. The only benefit for sending countries is the eventual increased national income by remittances to the home country. For receiving countries the relative costs for recruitment and reduction in tax receipts are not in proportion compared to the benefits when the country is facing supply shortages. Circular migration, on temporary basis, could enhance a better balance between the benefits for both sending and receiving countries, compared to non-temporary migration. The extra benefit for sending countries is the improved skills of returnees, contributing to better quality in healthcare.

A level that seems to be forgotten is the meso- or organizational level. From this point-of-view, the insights from the social capital theory are not taken into account. According to this theory, it is important that organizations are able to enhance social capital, while most interaction with migrants will take place within organizations. The 'technical know-how' might not be as effective as imagined without social integration. Therefore, when no social networks are available, circular migration might not be successful. The question remains therefore, whether the win-win-win mantra is a magic bullet for European health policy. The 'wins' of the win-win-win scenario may not be as mutual as imagined (Vertovec 2007).

Table 3.1 – Costs and benefits of worker migration for sending and receiving countries

	Sending countries	Receiving countries
Costs	<ul style="list-style-type: none"> - Reduction in domestic health care delivery capacity - Loss of training investments in emigrating professionals - Loss of consumption and tax receipts - Decline in morale and commitment among remaining workers 	<ul style="list-style-type: none"> - Recruitment costs - Resettlement costs - Decline in compensation and working conditions of domestic workers - Decline in morale and commitment among domestic workers - Reduction in tax receipts from domestic workers
Benefits	<ul style="list-style-type: none"> - Remittances received from expatriates - Improvements in skills of returnees 	<ul style="list-style-type: none"> - Relief of supply shortages - Improved quality of health care - Tax receipts from foreign workers - Enhanced local competitiveness

Source: Stewart, Clarck & Clarck. 2007. Migration and recruitment of healthcare professionals. Causes, consequences and policy responses. Page 4.

3.7. Summarizing remarks

Several theories of migration provide insight into the relevant factors for (circular) migration of health workers. Economic forces, power, social capital and human capital are such factors. Some argued that those theories are exclusive and incompatible, while others distinguished different levels for analysis. On micro level, the motivation and choices of individual migrants are analysed, for example the role of income. On macro-level, forces as poverty and underdevelopment can lead to inequality. In order to have successful and eligible policy, it may be important that the meso level, in this case healthcare organizations, is able to enhance social and human capital. Most interaction with migrants will take place within organizations, and they can therefore play an important role for realising the potential benefits of circular migration.

4. Temporary workers in healthcare

This chapter is about temporary workforce, which is next to migration the other important aspect of circular migration. A growing demand for temporary workers in healthcare is reported. The consequences in term of costs and benefits for healthcare organizations are analysed, because this is the locus of this thesis. Finally, examples of international temporary workers mobility are given, showing that this is not a new idea.

4.1. Types of temporary working

One of the key elements of circular migration is the temporary nature of the employment contracts, something that fits into a trend in many European healthcare systems. The demand for temporary (agency) workers has expanded rapidly over the recent years (Kirkpatrick 2009). The profession where temporary staffing is most common is nursing (Mercer 2010). There are three forms of temporary health workers: those employed by external agencies, internal hospital per diem pools, and permanently employed workers “floated” from their permanent units (Aiken 2007). Agency workers are employed and supplied by private agencies. Usually they are used to cover individual shifts (Mercer 2010). Health workers in internal per diem pools are also known as bank nurses or bank workers. They often have a permanent contract with the organisation they are working for and have worked as a permanent nurse for several years, but want to work on occasional basis (Mercer 2010). These nurses indicate the hours or days available to work in the pool, and if there is a sudden staff shortage, they will be deployed to work. Permanently employed workers “floated” from their permanent units are those who work in another unit if their own unit has a (temporary) surplus of manpower, while in other parts of the organisation there is a shortage.

Two questions arise. The first question is: why is there growing demand for temporary workers in healthcare? The second question is: what are the consequences of temporary workers for healthcare organisations (e.g. costs, quality etc). These questions give insights how the temporary character of circular migration fits into current temporary labour practices, and how it would influence healthcare organizations.

4.2. Growing demand

There are two basic reasons why the demand for temporary staffing has grown recently: staffing difficulties and tighter budgets in healthcare (Kirkpatrick 2009, Goodman-Bacon 2007). When a healthcare organisation is not able to fulfil vacancies, they are often forced to hire staff from private parties. Staff absence, e.g. sickness absence or pregnancy leave may cause a temporary or acute demand (Hurst 2010). Those vacancies are more and more filled with temporary workers. Employers also may have little choice because of hard-to-fill vacancies (Kirkpatrick 2009). Tighter budgets are changing the staffing strategies of healthcare organisations. They desire greater numerical flexibility (Conley 2002). Where hospitals previously adjusted the basic staffing to peak times, now hospitals have a minimum staffing and a flexible pool of workers to respond to peaks. Temporary staffing may also be the most cost-efficient strategy of adjusting to tight labour markets, because it is not necessary to increase the permanent workforce (Houseman 2003). Besides these most common

reasons, temporary staffing can also be used as a source of knowledge. Because of evidence based medicine, specific expertise might be a reason for employers to hire staff on a temporary basis to get knowledge into the organisation (De Ruyter 2004).

4.3. Consequences for healthcare organisations

Critics of temporary staffing have said that temporary staff will worsen the quality of care, that it is an assault on the continuity of care and argue that it is costlier than having permanent staff. Research indeed showed that healthcare organisations sometimes lack a clear strategy for using temporary staffing and that they have contradictory reasons (Kirkpatrick 2009). Regarding the quality of care, there is no consensus about the consequences of temporary staffing. Kirkpatrick (2009) argues that agency workers often lack continuing professional development and have less experience and training. Another problem is the lack of organisation-specific knowledge, potentially causing medical errors (Mercer 2010). Case studies showed that managers ran through compressed health and safety regulation introduction, usually lasting only 15 to 30 minutes (Kirkpatrick 2009). On the other hand, in case of hard-to-fill vacancies, appropriate nurse staffing is necessary for quality of care (Goodman-Bacon 2007). Others argue that the use of temporary staffing 'will benefit the organisational learning and acquiring new knowledge from highly qualified and experienced (...) nurses' (Mercer 2010 p17). To let temporary staffing be successful and beneficial to the quality of care, good management and guidance seems to be a necessary condition. It will further depend on organisational characteristics, such as the number of hard-to-fill vacancies, level of specialization and organisational culture.

Literature on the impact of temporary staffing on continuity suggests that it is difficult to achieve a stable skill mix. The use of temporary workers also seems to have a negative impact on the morale of permanent staff (Mercer 2010). Because flexible staff usually only performs easy tasks, the workload for permanent staff can increase substantially, thereby increasing the turnover of staff in the organisation (Hurst 2010). When a relative large share of staff is working on temporary basis, continuity seems to be a serious issue, threatening the organisation.

The costs of using a temporary resource in healthcare are studied as well. Most studies showed that agency nurses are more expensive than permanent staff (National Audit Office 2006, Kirkpatrick 2009). This means that reducing the number of agency workers, and replacing them by bank workers, is a benefit for organizations. Temporary workers also involve hidden or indirect costs. In the first place, temporary staff is usually less experienced and has less routine. This reduces the efficiency when using temporary staff on day to day basis. Training and education are also more expensive per worked hour for temporary staff compared to permanent staff, assuming that temporary workers work less hours and for a shorter period in the organization organisation (Kirkpatrick 2009).

Kirkpatrick (2009) has summarized the benefits and costs in table 4.1. The consequences of temporary workers for healthcare organizations depend on the situation. In case of understaffing or lack of knowledge, temporary workers benefit the organization by assuring workforce and expertise. In case of normal staffing, the costs and losses might be higher for organizations.

Table 4.1 - Professional Agency working in tight labour markets: some consequences for employers (adapted from Kirkpatrick 2009)

Benefits	Costs
Maintaining services by covering vacancies and staff absence	Higher employment costs than permanent staff due to high agency fees
Numerical flexibility (responding to changes in activity levels)	High costs of training and support for agency workers lacking generic competencies and organisation specific knowledge
A cheap source of adjustment to labour market shortages of key staff	Possible conflict with permanent staff and declining morale
A source on new knowledge and organisational learning	Risks associated with the lack of continuity in service provision

4.4. International temporary staffing

Of specific interest for this thesis is the already existing experience with international temporary staffing. Temporary staffing in healthcare organisations is a European issue (Hurst 2010). In the book ‘Cross-country analysis of health professional mobility in Europe: the results’ (Wismar 2011), evidence is reported that short-term mobility in the European Union has expanded. Examples contain weekend work, short-term contracts of several weeks/months and increasing mobility to the home-care and long-term care sectors (Wismar 2011). Estonians are known for providing care in Finland, Sweden and Norway, while returning to their homes in Estonia in the weekends. In the UK the ‘Easyjet phenomena’ emerged: ‘dentists and general practitioners supplement their main incomes in their home countries by using budget airlines to fly to the UK in order to provide services for a few weeks, months or just weekends’ (Wismar 2011:44). It has been observed that Romanians work in Belgium on temporary basis and the overall short-term contracts of Polish, Romanian and Slovakian nurses are also present in many countries. These examples are not widespread yet, but they show that mobility of health workers in the European Union is not new. The benefits and costs of temporary labour for health workers have not received much attention yet.

4.5. Summarizing remarks

This review shows that the demand for temporary workers has grown over the recent years, because of more cost-efficiency and the desire for greater numerical flexibility. Several factors influence the outcomes of temporary labour, such as integration in the organization and a clear strategy for using temporary staffing. It is otherwise a threat to the continuity of healthcare organizations and the quality of care. For international temporary staffing, it is likely that the same issues apply, although no research has been reported yet. Therefore, it is important to study the practice and consequences of (international) temporary labour, to gain better insight in the impact of circular migration policy for healthcare organizations.

5. Research method

This chapter contains a description of the methodology of this thesis. It describes the research problem and approach. It is followed by an explanation of the used methods related to the literature review and conducted interviews. Finally, this chapter provides insight into the validity and reliability of the used methods.

5.1. The research problem

The topic of this thesis is circular migration of health workers in Europe. The aim of this research is to gain insight into experiences with migration of health workers. While orienting on this subject, a telephone interview was conducted with an expert of the European Observatory on Health and Health Systems, who recently published a report about health professional mobility in the European Union. Following his up-to-date analysis, it was suggested that the organizational- or meso-level is missing in current (circular) migration research within the European Union. After further orientation, this suggestion seemed to be justified. The general question that followed from this conclusion was what the experiences of healthcare organizations are with migration of health workers and the consequences for circular migration policies. The operationalization of this problem will be explained in the following sections.

5.2. Research approach

The first step towards the operationalization of the research question is through theoretical research defining the key topics related to the subject. Three basic topics were identified: European policy related to healthcare, theories of migration and the impact of temporary workers in healthcare. Because this is a relatively new field of research, this thesis uses explorative, qualitative research methods. Interviews will be used to gain understanding of the current procedures and practices in health organisations related to these three topics.

Two advantages of qualitative methods in exploratory research make it very suitable for this research topic. The first is that ‘use of open-ended questions and probing gives participants the opportunity to respond in their own words, rather than forcing them to choose from fixed responses, as quantitative methods do’ (Mack 2005:14). In this case, there is no framework to use for designing fixed responses. “Open-ended questions have the ability to evoke responses that are:

- meaningful and culturally salient to the participant
- unanticipated by the researcher
- rich and explanatory in nature” (ibid)

The second advantage is that open questions allow flexibility to probe initial participant responses – that is, to ask why or how. By engaging and carefully listening to what participants say, the researcher encourages them to elaborate on their answers. To study hospitals’ experiences with migration, it is important to have the possibility to ask for clarification or more details. The combination of open-ended questions and follow-up questions give rich and explanatory data that can be used to answer the research question what the experiences of hospitals are with migration of health workers and how practices relate to European circular migration.

5.3. Description of methodology

1. Literature review

This thesis starts with a theoretical description of the three key topics. An extensive review of the literature was conducted to use already available theories and gain insight in related topics, such as migration and temporary working in healthcare. It also provided an overview of already known and discussed theories and findings. Main academic search engines were used to identify relevant articles, such as PubMed, Google Scholar, ScienceDirect, Springerlink and Elsevier.

2. Selecting healthcare organizations

The research question focuses on 'healthcare organizations'. The methodological choice was made to narrow this down to hospitals. Hospitals need, relative to the care sector, substantial numbers of staff and therefore are more experienced with recruitment and selection. Although some healthcare organizations in the care sector also need a large number of staff, the staffing of hospitals is more complex, because hospital care is very diverse and it has more training requirements (Dumont 2007, Boot 2005). Hospitals are also more experienced with patient mobility. Another advantage of taking hospitals as healthcare organizations is that they can compare between different professionalisms: doctors, specialist nurses, general nurses and staff working in supporting services. Experience of hospitals with doctors may be different from the experience with nurses. By involving more professions in the study, more factors can be found that are important for (circular) migration.

Hospitals were selected based on their characteristics. In the first place the size of the hospital, for which the number of hospital beds was taken as a proxy. The size of a hospital determines the demand for health staff. In this research small hospitals (<300 hospital beds), medium sized hospitals (301-550) and large hospitals (>550) were included. The second characteristic is the location of the hospital. The Netherlands and Belgium were taken as case countries. These countries share the same language and there are existing patterns of migration between these two countries. This provides not only the opportunity to compare experiences with staff from e.g. east-European countries, but also to compare the successfulness of Dutch personnel in Belgium and vice versa. The third characteristic is the type of hospital: city hospital/academic hospital/regional hospital. This determines the type of operations in a hospital and its patient population. All these types were included.

A total of 22 hospitals were asked to participate in the interviews, 15 Dutch hospitals and 7 Belgium hospitals (with Flemish as the spoken language).

3. Participants: selection

The selection of participant was through self-selection in the hospitals. The management structure differed substantially per hospital. In one hospital the Human Resource Manager is

responsible for relevant decisions, while an academic hospital has a separate International Office for supporting foreign workers.

The 22 hospitals were asked to participate in interviews. Five Dutch hospitals rejected the request, two did not respond to e-mail and phone calls. The reasons that were given are (some mentioned more than one):

- We don't have the expertise (3x)
- We don't have time (2x)
- It is not in our interest (1x)
- It is not on priority list (1x)

Five Belgium hospitals rejected the request, three of which did not give a reason; the other two did not have experience with the subject. According to participating interviewees from Belgium, Belgian hospitals are usually not willing to be open about internal issues. The denial to participate in the research, because hospitals lacked experience, was also included into the results.

The participants that did respond positively are listed in the table below. The position of the participants is diverse. Qua location, the Randstad is an area in The Netherlands with high density of the major cities (Rotterdam, The Hague, Leiden, and Amsterdam). The periphery means in a smaller city outside the Randstad, in the west and south.

Table 5.1 – Overview of the participants- and hospitals characteristics

Date	Respondent number	Position	Size hospital (hospital beds)	Location	Type
4-1-12	1	Personnel adviser	Large (613)	The Netherlands, Randstad	City hospital
4-1-12	2	Head HR department	Medium (321)	The Netherlands, periphery	Regional hospital
5-1-12	3	Head P&O	Medium (450)	The Netherlands, Randstad	Regional hospital
10-1-12	4	Head International Office	Large (1100)	The Netherlands, Randstad	Academic hospital
10-1-12	5	Staff member paramedical department	Medium (550)	Belgium, periphery	City hospital
11-1-12	6	Head P&O	Large (1050)	Belgium, large city	Academic hospital
13-1-12	7	Personnel advisor	Small (228)	The Netherlands, Randstad	Regional hospital
17-1-12	8	Head recruitment and selection	Medium (500)	The Netherlands, periphery	Regional hospital
19-1-12	9	Personnel advisor	Large (882)	The Netherlands, Randstad	Academic hospital
19-1-12	10	Personnel advisor	Medium (366)	The Netherlands, Randstad	Regional hospital

4. Open interview questions

The interview technique used can be characterized as a semi-structured interview. Topics were used to formulate the open questions. The interview contained four major questions:

- Could you describe how a vacancy is filled in your hospital?
- What are your experiences with hospital staff on a temporary contract / temporary workers?
- What experiences has your hospital with foreign workers?
- How is your hospital affected by European (staffing) policy?

The formulation of the questions is based on the theoretical insights from the previous chapters about the European Union, migration and temporary workers. The order of the question is from meso- to macro level: from core activities (filling a vacancy) to influences from the environment (the European policy).

5. Interview procedure

A week before the interview would take place, a reminder with an accompanying letter was sent to the participants. In the letter, participants were asked 'for providing supportive information, such as protocols related to recruitment and selection, figures on number of employees with short-term contacts, etc.'

In the accompanying letter, participants were also asked consent for recording the interviews.

During the interview, first one open question was asked, followed by follow-up questions based on the answer. The structure of the interview provided the option to deviate from the order when necessary. After the four main questions, interviewees were asked to give their opinion about the proposed policy of European circular migration. If necessary, more information was provided about European policymaking, qualification of professional qualifications and free movement of workers.

6. Data coding and integration

All recorder interviews were transcribed by using a text editor. A total of 7:23 hours were transferred into written text. Data coding was used to set the data in analyzable units. First, results were coded into four general categories: 'Experiences with foreign workers', 'Europe', 'Circular migration' and 'Temporary working'. For each of these categories, the data was again analyzed and coded in more specific categories. These categories are the (sub)headings of the following results-chapter.

5.4. Validity and reliability

Validity and reliability are both qualities of measurement and used as a qualifying test for research (Golofshani 2003). Validity in qualitative research has many definitions, but the main issue is whether the results of the method are valid for the studied sample (and results are not the result of research artefacts). "In other words: does the research instrument allow hitting 'the bulls' eye' of the research object?" (Golofshani 2000:599). Validity is divided into internal- and external validity. Internal validity

expresses the degree to which it is justified to use the results to answer the research question. External validity expresses the extent to which data can be used for generalization. Reliability in qualitative methods is “the extent to which results are consistent over time and an accurate representation of the total population under study” (Golafshani 2003:598). It assures that the results are trustworthy.

This method maximized the validity of the research in both the selection of the participants and the interview questions. To give a valid answer to the research question it is necessary to interview the people in the right positions in the hospitals. The selected participants were all responsible for, or involved in, the recruitment practices in the hospital, having key positions related to recruitment and selection and HR-policies. Regarding the interview questions, a topic list was compiled based on scientific literature. Using literature to explore the relevant topics is a form of triangulation. Triangulation is a powerful tool to facilitate validation by using cross-verification from several sources (Golafshani 2003)

The reliability of this research is ensured as much as possible by asking open questions to the participants, thereby minimizing the influence of the researcher on the results. The same questions are asked to all participants, and the same information is provided. This research is limited in its external reliability, because experiences of the participating hospitals might differ from other hospitals. The purpose of this research is to gain insight into former and current experiences with foreign health workers, not to have representative outcomes in terms of the extent to which experiences are prevalent – quantitative research should be used to answer that question.

6. Results

This chapter contains the results of the interviews that were performed to answer the question what experiences hospitals have with foreign health workers and how this fits into current European policy proposals. For all quotes in this chapter, the number between brackets makes it possible to trace them to a specific respondent (characteristics of participants and hospitals are provided in table 5.1).

The order of this chapter follows the order of the research question: five paragraphs which can be divided into three parts: paragraph 1 (necessity of the issue), paragraph 2 (experiences with foreign workers) and paragraph 3-5 (practices related to circular migration).

The first paragraph is about the need for foreign health workers. One of the main arguments for circular migration is the predicted shortage of health workers in Europe. This paragraph answers the question whether hospitals do recognise the shortages and if they take this prediction into account.

The second paragraph reports the experiences of the participating hospitals with foreign workers. It will address information about recruitment and selection, and the origin of the candidates. It also contains an analysis of the mentioned barriers for hospitals regarding foreign health workers.

The third paragraph concerns the attitude of hospitals towards circular migration. The main question of the chapter is: do hospitals think that circular migration would solve shortages? Besides that, the paragraph includes sections about the advantages and disadvantages of such a policy according to the respondents for the hospitals.

The fourth paragraph explores the experience with temporary labour. The employment of workers on temporary basis is a common phenomenon. Interviewees were asked about the optimal length of temporary contract, the integration of temporary workers in permanent departments and the consequences for the quality of care.

The fifth paragraph is about the experiences of hospitals with European policies. The interviews indicated unfamiliarity of hospitals with European health policy. The participants pointed to national legislation as through which European policy is translated into national policy. Two other relevant policy areas were mentioned as well: free movement of labour and the recognition of professional qualifications.

These results will be merged to conclusions in chapter 7.

6.1. The need for foreign workers

One of the main reasons for circular migration in Europe is the prediction of the European Commission that there will be extensive health worker shortages by 2020. During the interviews, several respondents denied the reasoning that they would be facing shortages in the future. Their focus was on improving current Human Resource Management (HRM) to prevent future shortages in their hospitals and did not recognize the need for foreign workers. One strategy was the use of 'above formative training': more students were trained than demanded at the time. One of the Belgium respondents said:

"We are intensively working on that. We have actions for second- and third year nursing students and we provide internships for orientation. The relations with schools are very good." (Respondent 5)

Another strategy used to solve shortages with the already available workforce is the 'annual hours system'. CLA's (collective labour agreements) give hospitals the opportunity to employ permanent workers extra hours in a certain period. This should be compensated in quiet times, so that the total of worked hours on annual basis is as agreed in the contract. In that way, temporary vacancies can be absorbed.

But not all hospitals were convinced that these strategies are sufficient to prevent shortages in the future, and several hospitals admitted that they were already facing shortages. They recognized the need for extra workers, especially specialised nurses for the operating rooms, emergency rooms and intensive care units were scarce. These interviewees agreed that collective action is necessary to solve this problem. Most of the current initiatives were focussed on local areas, however. Hospitals in the area of Rotterdam are united in a foundation that encourages corporate HRM. Another hospital initiated a digital database with three other hospitals, to create a small staffing database.

But even when hospitals acknowledged that they were already facing shortages, it did not mean they were all able to do something about it. Other constraints also have their influence on HRM-strategies. One hospital had a (selective) vacancy stop because of a weak financial position. Others faced restrictions due to the size of the hospital or knowledge. A small peripheral hospital is not likely to fulfil a vacancy for a gastroenterologist, for example, because even larger hospitals are facing difficulties to attract them. According to the respondents, a small hospital does not have enough patients to offer a challenging environment for these professionals.

The need for foreign health workers to solve shortages was not as urgent to hospitals as expected based on EU rapports. This should be taken into account, because it (potentially) decreases the willingness of hospitals to participate in projects such as European circular migration. But as is shown in the following paragraph, this does not mean that hospitals do not have experiences with foreign workers.

6.2. Experiences with foreign health workers

The first finding about experiences with foreign health workers is that all participants had experiences with foreign workers in their healthcare organizations, or in other (healthcare) settings. This might be a selection bias, while some hospitals refused to participate because they lacked experience (as will be discussed in the discussion chapter). But based on the conducted interviews, several results can be presented. The experiences were very diverse. Some hospitals only had experiences with European workers; others were employing nationalities from all over the world. Some hospitals organized the recruitment of foreign staff themselves, while others made use of third parties. Some hospitals only employed domestic nurses, while in others also foreign doctors and supporting staff were hired. One academic hospital employed 75 nationalities, while some hospitals in the periphery had only three or four. In some hospitals the selection of foreign staff was successful, but in most it was not a success. Despite these differences, important lessons can be drawn, as will be shown in relation to recruitment and selection, origin of the candidates and barriers (divided in communication, education, recognition of qualifications, culture and medical-ethical issues).

6.2.1. Recruitment and selection

The recruitment and selection of foreign workers in the participating hospitals differed considerably. Four groups can be distinguished here. The *first group of hospitals* were passive towards international recruitment, and only when confronted with a foreign application, they considered hiring foreign staff. A manager in another hospital showed a policy document that was based on a (bad) case with a foreign physician assistant, to instruct managers in the hospital in case of foreign candidates. He said:

“Here you see that we do not have much experience. We are confronted with a case, after which we figure out: what does this mean and how should we deal with it?” (Respondent 2)

The initiative to apply should come from the candidates. Due to modern communication technologies, it is possible for health professionals all over the world to apply on a vacancy in Europe. As one respondent said:

“This woman has responded on this vacancy via our website, which is also easily accessible in Suriname.” (Respondent 10)

In these hospitals, experiences with foreign health professionals who applied for a job in a hospital were mostly positive, especially when they originated from European countries. The intrinsic motivation of the migrant was reported as an important driver of successful migration and integration.

The *second group of hospitals* consisted of hospitals that expect worker shortages in the future. To be prepared, they experimented with foreign recruitment as a possible area for action. Only a small part of the reported experiments was successful in terms of sustainable employment. It should be noted that for these hospitals successful employment was not the primary goal. Their motivation was to get experience with foreign recruitment in terms of ‘knowing what to look for’. This second group

is of special interest for this thesis, because it can function as a case for studying the research questions. Two clear cases related to recruitment were reported in a Belgium academic hospital.

“The Polish project started in 2009. We have recruited five Polish surgery nurses. They were recruited in Poland, in Polish, with a translator. Those people came to job interviews, in Polish with a translator, were selected and started with Dutch lessons in Poland. Then they came to our hospitals. (...) So they were recruited at a moment they were, also mentally, at the beginning of the process of working abroad.” (Respondent 6)

“The Romanian project was different from setting. (...) We have recruited three nurses with interviews in Dutch. They were prepared and had Dutch lessons in advance. The drop-out of those who failed for Dutch lessons were not for our costs. We have interviewed 7 or 8 people who passed the Dutch exams, of whom we have selected three nurses.” (Respondent 6)

These two cases both involved an external bureau, who organized the recruitment in first instance. The experiences with this external bureau were largely negative. The Polish project failed, because of communication problems (which will be discussed later) and bad organization. Because the migrants lacked social embedding, they all returned to Poland within a period of two years. According to the respondent, the Romanian project succeeded because the communication problems were overcome by a better preparation. Another aspect was, however, that the hospital took over the organization of housing and social integration. Besides, the hospital organized internal counselling. The (social) integration seemed to be an important aspect of successful professional migration, something that not only in this hospital was well-organized. A participant from a Dutch academic hospital also told about a large amount of social and technical services available for migrants. And a third respondent said:

“At the moment you bring people from a foreign country here, that includes additional care outside office hours. They should certainly not languish in loneliness in their room in the first week” (Respondent 8)

The importance of social integration confirms the role of social capital as an instrument for migration. For hospitals that lack experience with migration of foreign workers, the organization of social integration often seems to receive insufficient attention or needs a lot of effort.

The *third group of hospitals* needed foreign workers to satisfy the need for highly qualified staff. The expertise those hospitals needed was only found in foreign countries. This applied mostly to academic hospitals, for positions in highly complex and specialized departments. A personnel advisor said:

“We do not attract foreign staff because we prefer it, but it is because the expertise – in this case haematology – was only found in Germany”. (Respondent 9)

In the field related to scientific research, which tends to be internationally focussed, people have a larger willingness to travel, according to respondents from academic hospitals. Many times professional networks were used for recruitment, because professionals tend to know each other. Scientific platforms, such as magazines and organizations, were also used to advertise in case of vacancies. These professional networks again related to the role of social capital in migration of workers. At the same time, hospitals need human capital, because of specific knowledge and skills.

The *fourth group of hospitals* were forced to hire foreign staff because they could not attract enough personnel within the home county. In contrast with the previous group, this had mainly to do with HR-problems, because there was insufficient supply of professionals in general. It was mainly reported in The Netherlands regarding specialized nurses, because there was a scarcity in the labour market.

A simple classification of hospitals based on the four groups is not possible, because it is necessary to differentiate between professionalisms. A hospital can be forced to hire foreign specialized nurses at one hand, while being passive towards recruitment of foreign doctors. In general, however, nursing was the most commonly reported profession for foreign recruitment. International recruitment of scientists was also widespread in academic hospitals, with may again relate to the afore mentioned characteristics of scientists in terms of willingness to travel and attitude. Many participants also indicated that the level of education is an important factor for the migration of health professionals.

The extent to which the hospital facilitates the migration process seemed to be a relevant factor for recruitment and selection procedures and successful employment afterwards. At first sight, the lower the degree of organization, the more successful the recruitment and selection was, since the hospitals were passive had mainly positive experiences with European candidates. In that case the intrinsic motivation of the candidates was very high, being the main driver. But when the hospital took the role of initiator, coordination and organization by hospitals seemed to be a critical factor for (social) integration.

6.2.2. Origin of the candidates

During the interviews, many examples of candidates from foreign countries were provided. In a large Dutch academic hospital, the top four countries from which foreign workers originated were Germany, Great-Britain, Belgium and France. A Dutch general hospital had contracts with a Belgium genealogy faculty for the exchange of medical students (participant 10), and an academic hospital (participant 9) recruited in Germany for specialized positions. According to the respondents, the reason that the top four existed of these countries is that in case of European candidates “you only have to organize the facilities, without cumbersome procedures”. Besides the advantage for hospitals to employ European migrants – less procedures, migration to neighbouring (European) countries was also attractive to the migrants:

“...these countries are our [Dutch] neighbours, which makes it is very easy for migrants to work in a country like The Netherlands. (...) It is just nearby, (...) and an attractive country to work in (...) You are quickly established and back home soon in the own country”.
(Respondent 4)

In Belgium, also workers from neighbouring countries are most common as foreign staff, mostly Germany, The Netherlands, Luxembourg and France. Especially Dutch professionals were reported, and “that worked very good”. Another area of origin that appeared frequently in the interviews were East-European countries, mainly Poland and Romania. As the cases from Polish and Romanian projects showed, the migration of workers from East-European countries is usually organized. According to the interviewees, the motivation of East-European professionals to work in The Netherlands and Belgium is “to begin a better life”:

“To own a house in the periphery of Romania, the male nurse had to have a second job. Moreover, it is not easy to find a work environment and there are mafia practices. They say: you have to pay your first annual salary as a ransom to buy your place”. (Respondent 6)

Foreign health workers from outside Europe came from a large range of countries. Countries that stand out regarding organized migration are South-Africa, Suriname, Indonesia and the Philippines. But also projects with Iran (in a Dutch academic hospital) and Cuba (Dutch general hospital) were reported. The experiences with these workers were largely the same as European workers. One difference, making migration more complicated, were the required heavy procedures, such as work permits and residence permits.

These findings relate to theories of migration, on different levels. On micro level, experiences suggest that social capital plays a role for migration. People want to easily return to their families and friends in home countries. For them, the difference in income seems not to be very important, while respondents told that the income differences between those neighbouring countries do not differ very much. On the other hand, according to the respondents, for East-European workers income and better living conditions are a driver for migration. The income differences between e.g. Romania and Belgium are substantial; causing that the selected candidates migrated with their whole family from Romania to Belgium.

On macro level, other issues were relevant. The arguments from the historical-structural theory were recognized by participants, namely that attracting workers from (financially) weak countries damages (healthcare) systems, thereby worsening the position of those countries. As a participant said:

“It is unethical to ask them to migrate, because the healthcare in their countries is already weak and we have the advantage that we can pay higher loans”. (Respondent 5)

The results from the interviews clearly showed two things. First of all, although migrants came from non-European countries as well, European professional migration is a relevant issue in hospitals. It is already happening, although on a small scale. Lowering of procedural barriers on a macro level seems to be important. The second finding confirms that it is difficult to apply a general theory of migration. On micro level, both income and social capital play a role, while on macro level, arguments of the historical structural theory were recognized by the respondents. What is relevant for this study is that in case of social integration and housing, the organizational level can play a crucial role. The way of organizing recruitment, selection and employment can enhance better migration practices. In order to get a better understanding of elements that are important for such organization, it is necessary to analyse reported barriers.

6.2.3. Barriers

Besides empirical information about the recruitment and selection and the origin of the candidates, barriers for the migration of foreign health workers were appointed. The fact that they were appointed as barriers does not mean that they cannot be seen as an opportunity as well. What is relevant in this case, however, is that the respondents classified them as barriers.

6.2.3.1. Communication

According to the respondents, the most important and foremost barrier for migration of health workers is communication. With communication is meant: the reading of doctor's orders and talking to patients and colleagues. All hospitals stated that good knowledge of the (Dutch) language is a requirement for good care. The insufficient knowledge of spoken Dutch appeared to lead to many misunderstandings and even many medical errors were reported. A reported medical error was the provision of wrong materials at a crucial moment by a foreign nurse, due to poor understanding of the Dutch language. Especially in hospital departments dealing with very complex or acute situations, communication was essential for delivering good care. Tight responding to commands is crucial for lifesaving care in such circumstances. But also the communication with patients is an essential part of the medical practice.

To overcome the communication problems, some hospitals provided language courses to their foreign staff, which was not entirely successful. Several participants expressed the importance of mastering the finesse of the language, especially in Flanders, because of the dialects. Mastering these finesses often was a pitfall, as one respondent said:

“These entrance courses were probably sufficient for shopping, but not for medical-technical communication.” (Respondent 1)

Language courses provided by professional institutes were considered as well, but appeared to be very expensive. One P&O manager indicated that a course would cost around 10.000 euro's per candidate, and according to him the investment was not worth it. A complicating organizational factor regarding doctors in general hospitals was that they usually are not employed by the hospital, but work in a partnership with other medical specialists. In a participating hospital a respondent told the following:

“The problem is: they are not your employees. You cannot say: ‘I will send you to a language course’. You can try it, but it simply does not work that way”. (Respondent 7)

A participant concluded:

“To learn a Romanian or a Polish the Dutch language is not easy. As it is not evident for us to learn Romanian. Dutch is certainly not an easy language”. (Respondent 6)

Communication is an important barrier because it is difficult to overcome, and it involves several organizational problems. Learning the Dutch language is difficult for migrants, especially when they speak a language from another linguistic family. Providing language courses is usually expensive for hospitals and because of uncertain outcomes, often not worth the investment. Several Dutch hospitals indicated that they considered an operation room with English as spoken language,

because English is a more common language in higher education. A hospital performed an orientating project, and concluded that they were able to facilitate a team that communicates in English. But it appeared that the English skills of East-European workers were even below basic level, causing the project to fail. A solution for the communication problems with foreign workers was not reported in one of the participating hospitals, expect high entry requirements.

6.2.3.2. Medical education

The second barrier was the medical training of foreign workers. The respondents were divided about the comparability and quality of the training of foreign staff. Their judgments were dependent on their experiences and their view on personal development of staff.

A Dutch participant said about Romanian nurses:

“Their training was not the problem, it was sufficient, comparable in terms of reserved procedures (Dutch: *voorbehouden handelingen*) and knowledge. They probably knew a different infusion pump, but that was not problematic”. (Respondent 1)

In a Belgium academic hospital, they had equal experiences with Polish nurses:

“In Poland the nurse training is excellent. I should perhaps not say this, but it is probably even better than ours. It is a four years academic training there”. (Respondent 6)

But other participants criticized these experiences:

“In The Netherlands, nurses are trained in looking through a clinical eye at the patient. They arrange a dietician if necessary, or pull the doctor on his jacket if something is not going well. We noticed that foreign staff lacks this attitude, for example the Irish.” (Respondent 3)

“They [Romanian nurses] were not used to the same instruments as we do. If you take wound care as an example: we have sterile packaging, they worked with recovered materials (...) They acted like: ‘oops, we don’t know how to use all that equipment!’” (Respondent 5)

The judgment about the sufficiency of medical training of foreign staff is also depending on the definition of it. When interpreted as technical knowledge and performing procedural steps, respondents said that some were highly-qualified. When interpreted as professional attitude and experience, they were more critical. It seems to be in line with literature stating that migrants are sometimes ‘overeducated’. They have a good education, but lack job experience. The attitude of hospitals towards foreign medical education may be related to the extent in which they are able to supervise foreign staff and to the content of the job.

6.2.3.3. Recognition of qualifications

A related topic is the recognition of professional qualifications. Both Dutch and Belgium interviewees acknowledged that the current situation regarding recognition of qualifications is not optimal. A respondent from an academic hospital pointed towards the difference in requirements between foreign and national standards:

“These people are well educated, but they need to get a lot of additional qualifications, because the requirements are slightly different. There are very strict rules to pass before you get started with a patient” (Respondent 4)

Another participant from an academic hospital also recognized the gap between degrees in different countries:

“We have to compare diplomas. For the Polish it is a bit easier now, because they [the government] know that their training is an academic degree in Poland. But it is equated to what is a bachelor degree here. The Romanian degree, which is a bachelor degree there, is recognized as a ‘higher secondary education degree’ here in Belgium” (Respondent 6)

According to the interviews, the recognition rules are not reflecting the real training levels and are also not unambiguous:

“Those candidates ask for recognition of qualifications in the French-spoken part of Belgium, (...) because Flanders is stricter. But with the recognition obtained there, they start working here. Those are Kafkaesque situations” (Respondent 6)

The recognition of professional qualifications is sometimes mentioned as “slow, bureaucratic and ambiguous”. The participants recognized that easier procedures will probably lower the barrier for professionals to migrate, but the results show that this is not the most important barrier for employing foreign health workers.

6.2.3.4. Culture

The culture of the country also plays a role in the use of foreign workers. Several hospitals experienced that the larger the distance to the country of origin, the more problematic the cultural problems of migrants are. The personnel advisor from the academic hospital employing 75 nationalities said:

“Medical specialists can be very dominant. Filipinos are submissive, that is difficult, because they should counteract. Indians are used to castes, and then you get the situation that a researcher can command his professor, because the professor is from a lower caste. Japanese always say yes, while they can be very unhappy.” (Respondent 4)

These cultural differences affect the functioning of health personnel in teams. The Polish project in an academic hospital failed because of homesickness of the migrants, as did a pilot in a Dutch hospital with African health workers. Homesickness may be a sign that there is not sufficient social capital for the (cultural) integration of workers, because participants indicated the degree of estrangement is a cultural issue, for example regarding food and behaviour.

The difficulties of cultural differences were not exclusively dependent on nationalities. A manager said:

“It is true that cultures differ, but we see the same with regions. Someone from Amsterdam opens his mouth earlier than someone from the countryside.” (Respondent 4)

This does not mean that cultural differences are not a problem, but the problem occurred with domestic workers as well. According to other respondents, the differences between foreign workers are larger, so that the problem becomes more apparent.

The cultural attitude toward labour also played a role for the satisfaction of hospitals with workers. Several hospitals experienced that the work ethic of Africans lead to dissatisfaction.

“What you observe is that European workers usually have a work ethic that is close to ours. We had cases of people who were an hour late. In case of scientists, this is not a big problem, because they can manage their own time. But in case of a full continue schedule in which one has to show up at half past seven, this is not appreciated. We had cases of South-Africans who showed up at half past nine, who drily said: here I am, I am going to take over your shift”. (Respondent 9)

The opposite was the case with German nurses:

“The real German Punctlichkeit. When we were drinking coffee at half past ten, they said: ‘Why? I had coffee at half past 7 already, I will continue’”. (Respondent 3)

These results show that cultural differences can cause serious obstacles, but some hospitals also had an eye for the advantages of cultural differences:

“In a team, multiple cultures have a clear added value. We have patients with multiple cultures as well and we learn to have an understanding of each other, which makes it variegated. That is the added value in a team: that you do not have identical types only.” (Respondent 1)

The interviewees from both Belgium and The Netherlands thought that the respective cultures are attractive for people to work, because of openness and freedom.

These results show that culture is a potential barrier for employment of foreign workers. When hospitals had consecutive disappointing experiences with foreign health workers, because of a culturally determined work ethic, they were less willing to employ foreign workers in general. But on the other hand, when hospitals were open to cultural differences – which might also be caused by a diverse patient population, multiple cultures in a team were regarded as enriching. This shows that the role of culture towards the successfulness of foreign health workers is to a large extent dependent on organization specific characteristics. Issues such as a different work ethic, however, remain a barrier.

6.2.3.5. Medical-ethical issues

A barrier that was not found in the literature were medical-ethical issues. For an academic hospital, it was the most important reason not to work with health workers from East-European countries. The personnel advisor told:

“The gap between culture and religion, related to the Dutch attitude towards medical-ethical issues, has been very difficult in the past. (...) We have requests for euthanasia, which is something other countries do not have experiences with. When you, as a medical, have to

perform euthanasia, and it is against your personal belief, it causes an unpleasant situation. (...) If you take Poland for example, there they are strict Catholic, and close-minded, which can be very colliding [with our practices in the hospital].” (Respondent 9)

On the other hand, several hospitals indicated that they let their staff free to refuse such requests, and that such issues never caused problems, neither with domestic employees, nor with foreign workers. One Dutch hospital acknowledged that medical-ethical beliefs are relevant, but that health professionals should be able to deal with other beliefs.

“That is the key: you should remain respectful as a person has very different ideas”.
(Respondent 7)

Although medical-ethical beliefs were not reported very often to be a problem, they are particularly relevant because they are not easy to change. They can be a complicated factor for employment of foreign workers, and were not reported in literature on migration of health workers.

6.2.4. Summarizing remarks

These results show that the interviews provided a wide variety of experiences of hospitals with foreign and European migration of health workers. For recruitment and selection of foreign candidates both the motivation and attitude of the migrant (micro level), the degree of organization of e.g. social integration and housing by hospitals (organizational level) and national- and European policy (macro level) play a role. A general theory of migration is difficult to apply to the results. On micro level, both income and social capital are important criteria for migrants. On macro level, respondents recognise the increase in inequality when West-European countries employ a lot of East-European workers. What is relevant for this study is that the organizational level can play a crucial role. The way of organizing recruitment, selection and employment can enhance better migration practices.

The participating hospitals were confronted with five barriers. First of all, communication was a problem because sufficient mastering of a language is a requirement in healthcare, and for migrants this is often a problem. Secondly, medical education and training were not always equal to national standards, which decreased the quality of care and led to medical errors. Thirdly, the recognition of professional qualifications of foreign workers leads to bureaucracy and did not always reflect the real level of skills and knowledge. In the fourth place, cultural problems on the one hand disrupted the organization, but otherwise strengthened teams through cultural diverseness. Finally, medical-ethical beliefs of foreign candidates were also a barrier to employ workers from national with other ethical traditions.

These results give an answer to the first part of the research question. How current practices relate to European circular migration proposals is described in the following paragraphs.

6.3. Circular migration

In order to answer the second part of the research question and to understand how current practices in hospitals relate to the idea of circular migration, respondents were asked to react on the idea of European circular migration from their perspective. Several advantages and disadvantages were mentioned, as the first two sections show. The idea of European circular migration involves the migration of European health workers from areas with a surplus to areas with a deficit. A question almost all respondents answered was: would an implementation of this policy solve shortages, and is therefore also incorporated in this paragraph.

6.3.1. Advantages

When asked for the advantages of the idea of circular migration, several respondents pointed at other branches. In shipping, aviation and petrochemical industry an international focus is common. According to the interviewees, such focus could potentially benefit the healthcare sector, since it becomes more and more evidence based and specialized. It could make healthcare organizations more flexible also to operate in other countries. An academic hospital, for example, wants to open a clinic in a foreign country, but would need employees from all levels in the organization for the establishment. In that organization, the willingness to participate was low. For that reason, additional provisions in contracts of new employees provide the possibility to an employer to ask employees to work in a foreign country for a certain period.

Another advantage of circular migration is an increase in the labour mobility. It could enhance a better skill mix in organizations and regions. One participant stated that circular migration would enhance the improvement of human capital within organizations. He said:

“We then share in the knowledge, which we can use. I notice that in health care, we are often locked into certain patterns of thought. Implementing another way of working is difficult. I think this could help to change.” (Respondent 2)

Both advantages, an international focus and increased labour mobility, may make the healthcare sector more attractive to employees from outside the healthcare sector.

According to the participants, an organizational advantage of circular migration policy is that it potentially reduces the bureaucracy. Less procedures and better (digital) infrastructure would reduce the cumbersome procedures for organizations and migrants. It might also reduce the recruitment costs, because of centralized systems which enhance a better matching of demand and supply.

The last argument is that ‘necessity knows no law’. According to these respondents, circular migration is in principle not a good idea, but in case of extreme scarcity in the future, it is better to have foreign workers than no workers. In that case it is better to have a system that enhances such practice.

These advantages show that they should mainly be sought in the increase and mobility of human capital and decrease of formal and bureaucratic obstacles.

6.3.2. Disadvantages

The mentioned disadvantages firstly related to the barriers that were described in paragraph 6.2.3. The respondents believed that these barriers limit the applicability of the idea to a large extent. The fact that hospitals already had negative experiences with foreign workers and that experiments with solutions to overcome the barriers failed to a large extent, caused a negative attitude towards the idea.

Respondents also mentioned the many layers between them and European policy makers. It caused scepticism about the applicability of the European ideology. This attitude can be explained by relating to many layers that divide Europe away from the usual practice of hospitals. Especially in situations in which European policy is conflicting with own traditions; there is no willingness to participate in European initiatives. Only when offering a clear benefit for the organizational level, Europe can take its role. When taking into account barriers from previous chapters, which required the involvement of hospitals to make circular migration successful, a division of the levels would discourage fruitful policy.

When asked for other disadvantages, many participants pointed at conflicting issues with national healthcare systems. In The Netherlands, the government designed a system to stimulate the training of specialized nurses by invoking a financial incentive. When the number of trainees is below a certain norm, hospitals have to pay other hospitals who trained more nurses than the norm. This makes recruitment of foreign specialized nurses less attractive, because it could induce additional costs. Another conflicting issue would be the model with partnerships of medical specialists in some (peripheral) hospitals. This limits the market entry of foreign doctors. A doctor has to invest capital into the partnership to be able to participate, and participants indicated that acquiring capital is more difficult for foreign doctors. It is also questionable whether established partnerships are open to cooperation with partnerships of foreign medical specialists.

The idea that foreign workers would be cheaper than local workers does not hold according to the respondents. On the contrary, many legal restraints make it impossible to pay lower salaries to foreign workers, such as non-discriminatory rules and Collective Labour Agreements. When corrected for additional costs, such as training, support and language courses, the cost price for foreign workers will be above national workers.

6.3.3. Would it solve shortages?

The answers to this question varied largely, all with their respective argumentation. Participants in favour of the idea thought it would solve labour shortages, because it would enlarge the labour market – with the hidden promise that a larger market means a better matching of demand and supply. Critics pointed at the many barriers for employment of foreign workers that were mentioned as answer to the question about experiences with foreign health workers. Communication, medical-ethical beliefs, cultural differences, bureaucracy; all were used as arguments against the idea. They pointed at empirical evidence:

“There have been many pilots. Nine out of ten proved that it is not a success” (Respondent 9)

The idea of a larger market was also criticized:

“There have been so many thoughts about and experiments with labour marketplaces, in and outside The Netherlands. It has never worked.” (Respondent 3)

Another argument against European circular migration is the low mobility of health workers. Three characteristics should be taken into account:

“Many are women, many are working part time, many have a family besides” (Respondent 7)

Overall, the respondents who were against the idea were in the majority, and their arguments were based on many empirical experiences. The idea of a larger market leading to more efficiency by a better matching of demand and supply was not favoured by the respondents, although some gave examples of (national) projects to create larger markets. What this might show, is that the neo-classical assumption of matching demand and supply ignores market imperfections and social constraints. On the labour market not only supply and demand of workers matter, but also social constraints. These constraints, such as family, may even be more important for respondents than income or a job. This negative attitude of the participants did not mean that they did not see any opportunities at all. Some plead for vision for the future:

“We should start once. Shortages of health workers are a national problem, but also a European problem. We are not the only country in which baby boomers retire and we have to work to our eightieth year.” (Respondent 4)

“Necessity knows no law. If it is: or no nurse at a hospital bed, or an English-speaking nurse, the choice is easy. If you want to keep sufficient staffing levels, then you must be creative.” (Respondent 8)

Still, the idea of organized European circular migration could not count on the appreciation of the hospitals, because according to the respondents the advantages do not outweigh the disadvantages.

6.3.4. Summarizing remarks

Circular migration within Europe was proposed to enhance a sustainable workforce for health in all EU member states. Increased labour mobility by creating a shared market would encourage better matching of supply and demand. When hospitals were confronted with this reasoning, they largely disagreed. The characteristics of health workforce are different to other sectors and many pilots that are similar on a smaller scale were not successful. The advantages of the system for hospital would be an increase of labour mobility, allowing for more flexibility, also in the international context. It could also increase human capital and decrease bureaucratic barriers. But according to the respondents, the advantages do not outweigh the disadvantages. Conflicts with national legislation, higher costs and the difficulty to overcome barriers as communication, medical education and culture make it not beneficial for hospitals at this moment.

6.4. Temporary labour

An element of circular migration is its temporary character: participating workers do not settle permanently. For that reason, hospitals were asked about their experiences and attitude towards temporary workers in general. Temporary labour was common use in almost all hospitals, as will be presented in next section. For the assessment of European policy proposals, it is necessary to gain insight into practices regarding contract periods. Integration of temporary workers in permanent departments and the consequences for the quality of care.

6.4.1. Common phenomenon

The use of temporary labour was common use in most participating hospitals. All hospitals had so called 'flex agencies', providing workers for sudden vacancies. The size of these flex agencies varied, but was not related to the size of the hospital. There was also a difference between Belgium and The Netherlands. In Belgium, flex agencies were filled with staff that was working part-time in the hospital, but had the possibility to work additional hours. In The Netherlands this is known under the term 'annual hours system', but not widely used. Here, flex agencies had specially selected staff that do not have a permanent department. As a respondent explained:

"They are employed on individual services: absenteeism, other vacancies or anywhere else in the hospital. Tonight at the surgery, tomorrow on the internal department, for example."
(respondent 1)

According to the participants, staff usually starts working in flex agencies or external agencies because they do not want to work in irregular shifts, while this is required for a permanent appointment. The family situation of (mainly) women also plays an important role, according to the participants. All hospitals expressed their wish to minimise the use of external staffing agencies, mainly because of the costs of hired workers. This does not mean that all of them achieve this. Especially for scarce specialist nurses many hospitals are dependent on external agencies. Several Dutch hospitals designed their staffing system with a solid core of permanent staff, a flexible layer of temporary staff and an external layer with third-party agencies (sometimes with dedicated contracts).

The contract period of temporary workers varied per hospital. Asked for a minimum length of the contract, Dutch participants ended somewhere between six months and a year. Belgium interviewees clearly had a different approach and focused on retention policy:

"It causes a lot of change, when someone leaves a department. (...) When people choose for us, they should feel pleasant and stay". (Respondent 4)

"Before, one chose an employer, and except when it was heavily disappointing, that was for the rest of your life. That changed ever since, but when we see a CV filled with 6-months experiences, instantly the question is asked: 'what is the matter with you? Why should you stay only six months?'" (Respondent 6)

In The Netherlands, temporary staff usually has a 'zero-hours contractual arrangement'. That means that staff has a permanent contract with an employer, but that the number of hours per week is not

fixed. Some hospitals have arrangements with permanent contracts of 16 or more hours per week, but this was more the exception than the rule.

These results about temporary labour are in accordance with literature, also describing these forms of temporary staffing and its growing use. From that perspective, the temporary character of circular migration might fit in current staffing practices. Something noticeable is the different perception of temporary labour between The Netherlands and Belgium. In the Netherlands, temporary work usually refers to staff in a separate internal agency, whilst in Belgium it refers to staff that work in addition to their regular contract.

The consequences of these results for this thesis are that they seem to imply that temporary workers should stay for at least six months in a hospital, but preferably longer. It also shows that temporary labour fits better in the Dutch system, than in the system in Belgium, because the Dutch are more focussed on numerical flexibility.

6.4.2. Integration of temporary labour

The integration of temporary workers into the organization is important, because of continuity and organization specific knowledge. This integration of temporary workers is, according to several respondents, difficult. Flex workers have their basic training, but do not have the organization-specific knowledge necessary for efficient working. In a hospital in Belgium, for example:

New employees “must work at least three months fulltime to get to know the organization. For radiology, three months introductions, but for the Intensive Care Unit you need one year to be fully integrated.” (Respondent 5)

The integration of flex workers is labour intensive. Some hospitals required one permanent worker per flex worker, because a flex worker cannot perform the same tasks as a routined worker on a permanent department. For that reasons, hospitals try to overcome this problem by making pools of flex workers. They preferably work on one department or on comparable departments, so that the changes in environment are limited. The integration of flex workers in departments stays labour intensive, however, something that is problematic, especially with already existing shortages:

“They have a shortage, and they have to train others. That causes noise and quarrel. (...) Thus you get into a circle: we have a shortage of workers, we should train new people, but we are already too busy; ‘I am overworked’. It is very complicated to deal with.” (Respondent 4)

These results correspond with literature (see chapter 4.3) stating that temporary workers can lead to a conflict with permanent staff and cause a declining morale. Difficulties with integration of temporary workers limit the applicability of large numbers of temporary workers in hospitals.

6.4.3. Quality

Another important topic regarding temporary labour is the impact on the quality of care. Many respondents stated that temporary labour decreases the quality of care. Especially in Belgium there was scepticism about the quality.

“The quality is deteriorating, when working with temporary workers. Those lack hospital-specific knowledge, are not motivated and their motivation is to stamp the paychecks. It worsens the quality of care significantly”. (Respondent 5)

A P&O advisor in a peripheral hospital assured that although the use of temporary workers decreases the quality, it never happened that the hospital supplied poor quality. Other managers and personnel advisers acknowledged the problems regarding quality as well:

“I have heard that there is a bottleneck in the care they can provide and the answering of questions of the patients. It is unpleasant when patients’ questions cannot be answered because the nurse works there only for one shift. They [temporary workers] can provide less service than permanent workers.” (Respondent 10)

Another Dutch P&O-staff was more optimistic about temporary workers, although she recognized the problem. She said:

“Those people have seen many locations, experienced more employers and therefore can frame in a better way. When you work here for a long time, you probably are disappointed about some practices, but a temporary worker can say: ‘That is really well organized here!’ But: it can also work the other way around”. (Respondent 7)

She replied to Belgium critics:

“I really disagree! This is a different conception of what quality is. (...) We believe that we occasionally need someone with fresh ideas. To new employees we say: ‘do not hesitate to ask questions, wonder about the processes.’” (Respondent 7)

The implications for the quality of care might be one of the most important issues when employing temporary workers in hospitals or other healthcare organizations. The respondents disagreed with each other about these implications, and in the literature there is also no consensus about the impact on quality of care. The results indicate that temporary labour is possible on small scale, but that large numbers of temporary workers in hospitals distort the continuity of care and skill mix. This is also in accordance with more optimistic respondents, who said that they believed to need temporary workers occasionally.

6.4.4. Summarizing remarks

Temporary labour is a common phenomenon in most hospitals. This does not mean, however, that the idea of circular migration is in line with current practices. Most HR policies in hospitals are primarily focused on the own workforce, especially in Belgium. Since integration of temporary workers in a hospital takes a lot of effort, potentially causing conflicts with permanent workers. According to the respondents, temporary workers should therefore not be employed on large scale without organizational support. It may otherwise have bad influence on the quality of care and the continuity of care.

6.5. Experience with European policies

Another element of interest in relation to circular migration was the experience of hospitals with European policies. This is relevant to compare the applicability of European policies in the field of healthcare. The first section will show the (un)familiarity with European health policy, to study already existing followed by the relation to national legislation. Experiences with two other policies, the free movement of workers and the recognition of professional qualifications, are also briefly described. These policies are important because they are related to labour migration of health workers, and therefore known by hospitals.

6.5.1. Unfamiliarity with Europe regarding health policy

The interviews showed that many personnel departments are not familiar with European health policy. When asked about the experiences with European policy, almost all replied that they never had any experience. One manager even said that he was very surprised when he got the request for an interview that related to European health workers policy. So in general, hospitals do not seem to have experience with European policy and it has low priority for them. On the other hand, this unfamiliarity does not mean that (academic) hospitals do not have influence on European policy. One respondent in an academic hospital said:

“We do not have a chair at a table with European policy makers about migration policy. (...) But there are many different levels. (...) Participation goes via a dean that speaks a minister; that is the network, the power structure. So as an academic hospital we have influence, but always indirectly.” (Respondent 4)

This confirms what was found in literature about European health policy making, that there is not a direct relationship between the European Union and healthcare organization. The European Union does not have formal competence to have direct influence; therefore hospitals are not directly subject of policies or regulations. It also illustrates that European healthcare policies are a result of multiple influences, because of the many different levels and networks (see paragraph 2.1).

6.5.2. National legislation

Several participants indicated that “European policy is translated into national legislation”. According to them, national legislation is very important for hospitals, also for staffing policy. In The Netherlands, most interviewees thought that some of national policies came from European level, but only few examples were given. A manager reminded a ruling of the European Court about vacation days in case of illness, but:

“That is jurisdiction, having consequences for our policies, but there are many layers in between” (Respondent 10).

In The Netherlands, an important layer is agreements of social partners, who conclude Collective Labour Agreements. This makes it also difficult for hospitals to distinguish between national and European legislation:

“I do not know whether Collective Labour Agreements relate to European laws and regulations, or not.” (Respondent 2)

In Belgium, the case is different because the national legislation is different. European policies are also translated into Belgium legislation, but the interviewees had several examples in which these policies contradicted each other. Most clear is the example about ‘workers’ and ‘clerks’.

“We have two statuses for staff: workers (Dutch: arbeiders) and clerks (Dutch: bedienden). Workers were traditionally the craftsmen who worked with their hands. Clerks did the office work. When a worker was dismissed, they had five weeks’ severance pay, as a clerk had six months. European non-discrimination then rules: that was true enough a historical difference, but it should be abolished.” (Respondent 6)

In this case, European policy about an issue not directly related to healthcare (non-discrimination) had unforeseen consequences for healthcare. This was also the case regarding European labour provisions about working hours. This was conflicting with views in Belgium hospitals:

“We are obliged to have a maximum of 50 working hours per week, with 11 hours between two shifts. We are a full-continue organization, so that conflicts” (Respondent 5)

European influence in national legislation seems to be evident, although the situation in The Netherlands and Belgium differs. In The Netherlands less conflicting situations are reported, while the Belgium legislation sometimes differs from European provisions. Nevertheless, hospitals in both countries are affected by EU policy and legal rulings via national legislation.

Hospitals are informed about those relevant legal frameworks via national information channels. Most hospitals are subscribed to the Government Gazette, HRM magazines and websites related to personnel and organization. For legal issues, they make use of the employers’ organization for hospitals, which provide legal assistance and expertise.

6.5.3. Underlying European frameworks

One subject that was perceived different from the above mentioned policies was the free movement of professionals. All respondents that employed European health workers pointed at it as explicit European policy. Several interviewees were positive about the European free movement policy. Compared to foreign workers from non-EU countries, European policy simplified the procedures related to work- and residence permits. As one of the interviewees said:

“You only have to organize the facilities, without cumbersome procedures” (Respondent 4)

That has several positive consequences for hospitals. It speeds the process, solves bureaucracy to a certain extent and benefits the migrant. This can implicate that European agreements reduced the barrier for professional migration.

The respondents did acknowledge the importance of professional qualification recognition, although they did not primary related it to European policies. This can be explained, because – especially in The Netherlands – the recognition process is primarily the responsibility of the migrant and takes

place between them and the institute responsible for recognition of professional qualifications. In both countries, migrants usually arrange the equivalence of diplomas before they apply.

The participants recognized that the rules for recognition do not always reflect the real level of expertise of migrants. An update of the system of automatic recognition for doctors, nurses, dentists and midwives can therefore count on the support of most hospitals.

One of the proposals of the European Commission was to use the Internal Market Information System (IMI) of the EU to facilitate easier recognition throughout Europe. This would stimulate a fast-track recognition process in all EU-member states. One manager responded very specifically on this proposal:

“I think this is partly an ideological approach: ‘we need to unify Europe’. But when we look at costs and benefits, I think that central registration of qualifications will require a very expensive administration. It should be regularly updated as well, so it will include serious development and maintenance costs” (Respondent 6)

It is interesting to point that this manager spoke about an ideological approach. He recognised the European thought of integration, but the question is whether the ideological perspective clashes with practice. In other words: the respondents were not convinced that the European ideas would not be attractive. In the case of a European recognition system of professional qualifications, the participants acknowledged the importance for a European approach, but expected that the operating costs would be too high to make it attractive for hospitals to participate.

6.5.4. Summarizing remarks

These results show that hospitals are not familiar with much of European health policy, which is not surprising because the European Union lacks formal competence. In Belgium, however, European policies sometimes conflicted with national health policy. Applied to the idea of circular migration, a question that rises then is whether it will not lead to different practices in different countries, since it might conflict with national traditions. This could limit the comparability and compatibility of the systems. The free movement policy shows that there are possibilities that could benefit both European and national parties. Since recognition of professional qualifications is an important feature of European professional migration, a European approach seems necessary.

7. Conclusion

This thesis sets out to investigate the experiences of hospitals with the migration of health workers and explores the relation between European circular migration policy proposals and current practices. European circular migration implies that foreign migrants work on temporary basis, while this would solve health worker shortages, prevent European inequality in accessibility of healthcare and improve health labour mobility in the EU (Kidd 2010). Through results from ten conducted semi-structured interviews in hospitals in The Netherlands and Belgium, insight has been revealed into experiences of hospitals with foreign health workers. It showed that European health worker migration is a relevant topic, although the respondents received the need for hospitals to solve shortages not as urgent as expected from EU reports. In this concluding chapter, first the key findings of hospitals' experiences with foreign workers will be considered. The second part contains an analysis of the relation between European circular migration policy proposals and current practices, with sub-sections about temporary staffing and hospitals' experiences with Europe. Finally, recommendations to improve (circular) migration in Europe are provided to hospitals and (European) policy makers.

The interviews showed that employment of migrated foreign health workers is practiced in most participating hospitals. For recruitment and selection of foreign candidates it appeared that both the motivation and attitude of the migrant (micro level) and forces on national- and European policy (macro level) play a role. This corresponds to several theories of migration, describing forces on micro- and macro level. According to the neo-classical equilibrium perspective, the leading factor for migration is a binational wage gap (Massey 1997). In the participating hospitals, the mentioned motivation for East-European health workers was the higher salary in West-European countries. On the other hand, for migrants from neighbouring countries, the possibility to stay connected with their social networks appeared to be important, relating to the theory of social capital (De Haas 2008). On macro level, respondents recognised the increasing inequality when West-European countries employ a lot of East-European workers. This relates to the historical-structural theory, stating that underdeveloped countries can be trapped in their underdevelopment, because migration strengthen the position of strong countries, and weakens the (financial) position of weak countries (De Haas 2008). What these results show is that several forces are stimulating or inhibiting migration. The mentioned theories (e.g. neo-classical equilibrium theory and social capital theory) are not compatible with each other, because they have a different focus on migration (resp. economic force and social networks), but explain both another aspect on a different level. In that sense, the micro-structural and macro-structural levels are not mutual exclusive and can be used to explain practices with a reasonable margin of certainty (Portes 1997).

For the employment of foreign workers, five barriers were identified by the respondents. First of all, migrants should be able to communicate with patients and professionals in the national language. It appeared that most migrants had troubles with learning and mastering the language. Secondly, medical education and training need to be equal to national standards, because it is a formal requirement for (good) job performance. Due to different training traditions, the professional attitude tended to differ, causing problems for employability. Thirdly, the recognition of professional qualifications of foreign workers leads to bureaucracy and did not always reflect the real level of skills and knowledge, which caused inefficiency. Fourthly, cultural differences can be valuable to reflect a cultural diverse patient population, but can also disrupt the organization in case of another

work ethic. Fifthly, medical-ethical beliefs of foreign candidates should fit the organizational and national rules regarding medical-ethical issues such as euthanasia and abortion, which was not always the case.

From a theoretical point of view, it appeared that the need for support from the organizational level was not found in the literature. However, the findings support the idea that the organizational level is very important to enhance migration. For recruitment and selection, respondents indicated that the involvement of hospitals was necessary for both procedural issues as well as the social integration of migrants. The extent to which the hospital facilitates the migration process seemed to be a relevant factor for recruitment and selection procedures and successful employment afterwards. Regarding employment of foreign workers, four of the five mentioned barriers were on organizational level and need to be addressed there. For communicational and cultural problems, organizations could facilitate training – although the results showed that this made employment less attractive for hospitals. But also in the way of dealing with differences in medical education and medical-ethical issues, the attitude of the hospital played an important role. Compared to regular employment of foreign workers, this seems to be even more important for circular migration. It is not a self-supporting system that simply equates supply and demand, and in the case of circular migration the motivation of workers might be less than regular foreign workers. The organization of social capital in the form of networks and social support is very important as catalyst of the process.

The second part of this concluding chapter is an analysis of European circular migration policy proposals and current practices. The hospitals recognized several advantages of the idea, such as an international focus, increased labour mobility and reduced bureaucracy. But also disadvantages were mentioned. These are firstly related to the barriers for employment of foreign workers; especially communication and medical education were often named obstacles. Besides that, the many layers between European policy makers and hospitals caused scepticism. The results showed that hospitals are not familiar with European health policy, which is not surprising, because the European Union lacks formal competence (Duncan 2002). It does not mean that the European Union does not have influence, but European policy does not focus directly on the organizational level, but works through national legislation (so called Europeanization (Radealli 2003)). This brings the next disadvantage: the policy idea may in some situations conflict with national legislation. Foreign workers would also not be cheaper to employ than domestic workers. Another important characteristic of circular migration is temporary labour. It appeared to be a common phenomenon in most hospitals. An analysis of current practices indicated that the integration of temporary workers in a hospital takes a lot of effort, potentially causing conflicts with permanent workers, which corresponds to literature (Kirkpatrick 2009). For that reason, temporary workers should not be employed on large scale without organizational support. Its possible bad influence on the quality of care calls for caution with employment of temporary labour within circular migration proposals.

Based on these results, it can be concluded that implementation of the European circular migration policy in its current form would most likely not be successful. Two elements are explanatory in this context. In the first place: the characteristics of health workforce are different to other sectors. First of all, in healthcare communication is one of the most important skills; not only for consultation with colleagues and professionals, but also for talking with patients. Mastering the domestic language (sometimes even with its dialects) is therefore required, while in other sectors professionals can communicate in a shared language, e.g. English. Secondly, the fact that healthcare has protected

professions, for which very specific qualification are required, limits the labour mobility. Although the European Union did attempts to tear down this barrier, the results show that the current system should be improved to increase the comparability of qualifications. In the second place: the organizational level is not enough incorporated into current systems and proposals. Healthcare organizations play a crucial role in encouraging social capital and organizing the integration of new staff in their organizations. In the case of foreign workers, both issues are more difficult and take more effort than with domestic workers. Four of the five barriers with foreign workers are on organizational level and need to be addressed there: communication, medical education, culture and medical-ethical issues. It is therefore not surprising that hospitals do not see potential in the current proposal, while they recognized that staffing shortages are a European problem and need to be addressed.

Several improvements could be made to increase the potential of European circular migration. First of all, some respondents asked for vision for the future, both in hospitals as on EU level. They expressed their willingness to participate in experiments. A requirement for successful projects is the focus on the enhancement of social capital by healthcare organizations. The embedding of a migrant worker in the organization and social environment is important for successful employment. With that assured, a first step towards successful circular migration is to connect already existing labour exchange networks on regional scale, for example to connect Belgium and Dutch networks of hospitals close to the border. This would take away the most important barriers: communication, culture and recognition of qualifications and provide the option to extend those connected networks. A next step would be to set up European language course requirements for health workers. In that way, hospitals could be sure that the level of applying workers would match their expectations. Complementary to an improvement of the system of professional qualifications recognition, several important barriers could be lowered. On the other hand, it should be acknowledged that the healthcare sector is different from other sectors. Care is provided and received on a very small scale, between an individual patient and an individual professional. Thinking of healthcare as a new European market would not reflect the nature of healthcare. The idea of circular migration provides valuable insights, of which the good should be taken, and the bad left aside.

8. Discussion

This thesis about circular migration on European scale at the organizational level explored a new area of research. The participants indicated the unfamiliarity with the topic several times, and little literature was found during reviewing. While exploring the concepts related to circular migration, not enough evidence was found to formulate a 'theory of circular migration'. For that reason, the methodology used had an explorative nature, which inevitably has methodological restrictions.

First of all, because of a limited research period this research used a relative small sample, 10 hospitals of which eight were located in The Netherlands and two in Belgium. In total there are approximately 140 hospitals in The Netherlands and 35 hospitals in Flanders. Especially the very small sample in Belgium limited the extent to which conclusions could be drawn about Belgium. Because of the small sample, the results are not representative for The Netherlands or Belgium. On the other hand, smaller samples are inherent to the used qualitative research method. The focus was on meaningful and culturally salient answers, and exploring related topics, not to get a representative sample. However, the similarities between the results indicated that some experiences were not individual to these hospitals. Insights from literature about specific subjects, such as temporary working, confirmed more general conclusions.

The second methodological issue is the selection of hospitals and participants. Both were dependent on the cooperation of the hospitals. The reasons to refuse participation showed that selection bias could occur. However, by asking refusing hospitals for a motivation, this could be taken into account for the results. Regarding the participants: those were self-reported experts within the organization. During the interviews no large problems occurred, but it might be possible – especially in the large hospitals – that other employees in the organization would have given different answers.

The third methodological restriction was the semi-structured interviews. In case of interviews, it is hard to repeat the results, because the structure of the interview depends on the follow-up questions by the researcher. Although participants were assured that their information would be made anonymous, it is possible that they did not share all their knowledge and experiences.

In the case of European policy, one restriction was that there were no entries to internal information of the European Union. It is possible that the openness about their strategy is limited, because their formal competence towards health policy is limited. It may therefore be possible that European policy makers already knew that the implementation of this policy in its current form should be improved. This would fit in the idea of a green paper, which is an initial step towards new regulations.

Based on the findings in this thesis, several areas for further research can be identified. As presented in the previous chapter, more research should be done on border-crossing networks. An experiment with the connection of already existing networks at the Dutch and Belgium border can be set up. Another area for additional research is to gain more empirical evidence about temporary foreign workers. In their report, Wismar et al (2011) mentioned two examples of professionals who worked only during the weekends in a foreign country (the Easyjet phenomenon). Up to date, no research is performed on what scale these practices take place and with what background, while this would

strengthen the analysis and theory development about European circular migration. Also relevant is an analysis of the impact of temporary staffing on the quality and continuity of healthcare (organizations). The lack of consensus urges to perform better research with a large sample and comparable health outcomes, to determine the effects.

9. Literature

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Appendix

Table A – Overview of minimum training conditions for professional qualifications in Directive 2005/36/EC

Profession	Article	Part of training	Requirements
Doctor of medicine	24	Basic medical training	<ul style="list-style-type: none"> - 6 years study - 5500h theoretical and practical training - Academic level
	25	Specialist training	<ul style="list-style-type: none"> - Basic medical training - Duration of specialist training according to Annex 5 of directive (e.g. General surgery 5 yrs, Obstetrics and Gynaecology 4 yrs, Neurology 4 yrs, Anaesthetics 3 yrs)
Nurses (general care)	31-33		<ul style="list-style-type: none"> - 3 years study - 4600h theoretical and clinical training, at least 1/3rd theoretical, ½ practical. - Clinical training: work in and lead a team
Dental practitioners	34	Basic dental training	<ul style="list-style-type: none"> - Five years study - Academic level
		Specialist training	<ul style="list-style-type: none"> - Basic dental training - Three years study
Midwives	40		<ul style="list-style-type: none"> - Three years theoretical study - 18 months fulltime training
Pharmacist	44		<ul style="list-style-type: none"> - Five years study, of which 4 years theoretical training and 6 months traineeship - Academic level