DOCUMENT RESUME

ED 455 378 CE 081 990

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TITLE Mobility in the European Health Sector: The Role of Transparency and Recognition of Vocational Qualifications. CEDEFOP Panorama Series.
INSTITUTION European Centre for the Development of Vocational Training, Thessaloniki (Greece).
REPORT NO TI-37-01-089-EN-C
ISBN ISBN-92-896-0051-9
ISSN ISSN-1562-6180
PUB DATE 2001-00-00
NOTE 73p.; For related documents from the CEDEFOP Panorama Series, see CE 081 975 and CE 081 989.
AVAILABLE FROM CEDEFOP, PO Box 22427, Thessaloniki, GR-55102 Greece. Tel: 30 31 49 01 11; Fax: 30 31 49 00 20, e-mail: info@cedefop.eu.int; Web site: http://www.trainingvillage.gr/ (#5113 EN). For full text: http://www2.trainingvillage.gr/download/publication/panorama/5113/5113en.pdf.
PUB TYPE Information Analyses (070) -- Reports - Research (143)
EDRS PRICE MF01/PC03 Plus Postage.
DESCRIPTORS Administrator Attitudes; Certification; Credentials; Developed Nations; Employee Attitudes; *Employer Attitudes; Employment Patterns; *Employment Practices; *Employment Qualifications; Foreign Countries; *Health Occupations; Information Sources; *Occupational Mobility; Policy Formation; *Public Policy; Transfer Programs
IDENTIFIERS *European Union

ABSTRACT

Research was conducted in Europe to determine the current situation in the health industry with regard to transparency, recognition, and transfer of qualifications. The study identified current and needed patterns of mobility, European policy assisting mobility, and attitudes and practices of institutions and businesses. Data were gathered through a literature search; an investigation of statistical evidence on cross-border mobility; interviews with key people in the industry; written requests for information to designated country liaisons; and Internet research. The study found a small amount of movement of health professionals among member states of the European Union (EU). The main political and legal instruments seem to work and health sector professionals are the main users of these instruments. However, since the number of people actually transferring their qualifications from one country to another is small, there seems to be substantial potential for further initiatives and support. Basic information on the availability of jobs can be improved. Although there are official support systems to promote transfer of qualifications, attitudes seem to impede use of the systems. The study concluded that while some positive steps have been taken at legal and political levels, the full effect of these advancements relies on the availability of information and support structures aimed at the individual migrant, not at bureaucracies or politicians. (Contains 47 references.) (KC)

CEDEFOP

PANORAMA

Mobility in the European health sector

The role of transparency and recognition of vocational qualifations

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The role of transparency and recognition of vocational qualifications

Mariann Skar

Cedefop Panorama series

Luxembourg: Office for Official Publications of the European Communities, 2001

A great deal of additional information on the European Union is available on the Internet.
It can be accessed through the Europa server (http://europa.eu.int).

Cataloguing data can be found at the end of this publication.

Luxembourg: Office for Official Publications of the European Communities, 2001

ISBN 92-896-0051-9

Printed in Belgium

The **European Centre for the Development of Vocational Training** (Cedefop) established in 1975, provides information and analyses of vocational education and training systems, policies and research.

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Foreword

This report forms part of the Cedefop project on 'transparency of vocational qualifications' initiated in 1998. 'Transparency' in the project title is a key concept and reflects the main aim of the work which is to support the Member States and the European Commission in creating mechanisms for promoting transparency of qualifications. Transparency of qualifications can be defined as 'the degree of visibility necessary to identify and compare the value and content of qualifications at sector as well as regional, national and international levels ([1]) and expresses the need to make vocational qualifications more visible throughout Europe. The concept represents a shift in focus from central regulations towards the needs of individuals to provide information on the training they have received and their skills and competences when applying for jobs outside their country of origin.

The right of European citizens to live and work in other Member States is fundamental and a basic assumption is that real freedom of movement gives citizens greater opportunities to develop their skills and experiences and avoid unemployment. According to European policy, free movement is also a prerequisite for full economic and social integration and efforts to remove obstacles due to lack of information and understanding of 'foreign' vocational qualifications have been on the agenda since the Treaty of Rome in 1957. The transparency approach is one of the latest introduced. It covers measures to improve information on existing national arrangements and measures to increase the visibility of foreign qualifications. Its initial legal base can be found in the Council resolutions of 1992 and 1996, respectively.

Although issues of mobility and qualifications are regarded as important, there is little published research. Therefore very little is known about the real impact of measures at Community level and the relation between mobility and transparency of vocational qualifications.

In brief, this is the background to the initiative to launch three studies focusing on the transparency issue and its relation to mobility in three different sectors of the economy. One of these sectors, the health sector, is covered in this report. Two other reports cover both the chemical industry and the tourism sector and a separate synthesis report will summarise all three sectors.

Irrespective of national context, a doctor or nurse should be expected to face some of the same challenges in terms of diagnosis, treatment and care. If language problems and other obstacles are overcome, mobility may be relatively easy for individuals working in the healthcare sector. This is one reason for the choice of the health sector. Another is the fact that the sector has

([1]) Cedefop - European Centre for the Development of Vocational Training. Glossary, proposed by Cedefop, January 1999, p.17.

been covered by most political measures aimed at transparency and recognition of qualifications in the European Union.

Four main areas are covered by the research:

(a) the current situation on mobility;
(b) polices in the area of transparency and recognition of qualifications;
(c) the link between mobility and transparency of qualifications, systems for the recognition of qualifications;
(d) European standards.

The report gives a comprehensive picture of these four areas and is, as far as we know, the first study done of this kind. We hope the results will be used in different contexts and taken as a point of departure for further and deeper study of the relation between mobility and prerequisites for mobility. As this study shows, there is still a lack of crucial information and data necessary for further development of discussions and measures to be taken in the field.

Thessaloniki, September 2000

Stavros Stavrou
Deputy Director

Sten Pettersson
Project Manager

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Executive summary

This report focuses on labour mobility in the health sector of the European Union and European Economic Area (EU/EEA). The focus is specifically put on the aspect of transparency and recognition of qualifications and how this influences mobility of professionals within the sector. The European health sector is large and broad covering a wide range of professions. These professions incorporate a large variety of education and training backgrounds, from assistants with a few weeks' training to highly sophisticated specialists with more than a decade of systematic training. While differing somewhat due to cultural and national traditions, many core activities can be identified across national and cultural borders. This is not least due to the fact that the sector is highly formalised and strongly regulated. The health sector is therefore potentially well suited to mobility. However, at the same time, it is also a sector where mobility is easily affected by policies aimed at protecting national qualifications.

Healthcare was not included in the Treaty of Rome and neither was the educational system. There are big differences between European countries in the supply of healthcare facilities and personnel, while in effect, the treatment of illness and disease remains the same. The sectoral directives for healthcare (covering the professions of: doctor, dentist, pharmacist, midwife, nurse responsible for general care and veterinarians), set a minimum standard for professionals practising in an EU/EEA country. Recognition is, in principle, automatic, but the host country can require further documentation on educational and training backgrounds. Mostly, profiles of professional activities correspond but it is important to note that while healthcare employees may hold the same professional title, this does not imply that they have the same educational background or scope to practise. This issue is particularly important to those professions supplementary to medicine. For those groups of health professionals who are not covered by the sectoral directives, there is a general system for the recognition of higher education diplomas (Council Directives 89/48/EEC and 92/51/EEC). The great diversity within the health profession itself combined with differences between countries in terms of professional as well as education and training traditions, complicates the issue of transfer of professional qualifications.

Statistics for mobility among health professionals are not readily available. Traditional sources like Eurostat and the labour force survey do not categorise in terms of health professionals. However, the European Commission gathers statistics from Member States. Statistics from the sectoral directives have been compiled since the 1970s and they are collated annually. Data on the general system are collated every second year. Within the healthcare sector there is most likely a higher rate of mobility than statistics show. For example, short-term movers, going in and out of the labour market or vacation workers do not count. Nor do health professionals moving for educational reasons. Likewise, some migrants may have achieved academic recognition of their papers but they do not appear in the statistics either.

Generally speaking, the right of free movement has so far not led to large-scale exchange of workers between Member States. In spite of considerable differences between countries and regions with regard to income and unemployment rates, labour migration has still remained at a lower level than expected. The number of EU national residents in another Member State is only 5.5 million out of 370 million, approximately 1.5 % of the population. A series of concrete measures to ensure that more people can take advantage of their right to free movement within the EU have been implemented. Apart from a few exceptions, the legislative framework to ensure free movement of people is in place. The main political and legal instruments (the sectoral and general directives) seem to work, and health sector professionals are the main users of these instruments. According to statistics from the European Commission (DG Internal Market), between 1993 and 1998, a total of 55 331 health professionals asked to have their qualifications recognised in another Member State. While the numbers are low, it is still important for each individual to have his or her qualifications recognised as conveniently as possible. Between 1993 and 1996, about 15 % of applications were subject to compensation measures of which 63 % required adaptation periods and 37 % needed aptitude tests. Around 12 % received a negative decision. Physiotherapist seems to be the one profession which moves most under the general system as a whole. There is also evidence that the use of compensation requirements is declining, indicating that competent authorities are becoming increasingly familiar with qualifications awarded elsewhere and therefore see less need for them.

All Member States have established a contact point responsible for providing information. The role played by national coordinators is an important one; their formal task is to ensure the uniform application of the directive to all professions concerned, but in practice they also act as a conduit for information between the Commission and national competent authorities. The Member States are required to reply to requests for recognition by granting a decision within four months of presentation of all necessary documents. In reality, however, it is far more difficult than expected to contact the coordinators.

Basic information on the availability of jobs can be improved. The EURES system is a good instrument in this context but our experience indicates that only a small percentage of the jobs (in the health sector) announced nationally are announced by EURES. From a user's point of view it is difficult to get in contact with the support system established as a result of the directives. While the system is logical and well constructed from a 'systems' point of view, it tends (in part) to be impossible to access from a user's point of view.

Moving from one country to another requires a lot of practical information. Language, too, is a barrier to migration, especially within the health sector where dialogue with the patient is of ultimate importance. It is interesting to note that there seems to be a connection between language and border regarding which diplomas different countries are willing to recognise.

There are many factors indicating the increasing need for mobility among health professionals. Some countries educate far more than necessary while others are in desperate

need of the same professions. Taking into account the relatively small number of people actually transferring their qualifications from one country to another, there seems to be substantial potential for further initiatives and support.

The attitude to migrants in general and to the transfer of qualifications in particular, tends in some cases to counteract the intentions expressed by the legal and political initiatives at Community level. This problem is faced by the individual, and there appear to be no measures in place to help. Despite the number of positive steps taken at legal and political levels, the full effect of these positive steps relies on the availability of information and support structures aimed at helping the individual migrant, not the bureaucracies or politicians.

1. Introduction

This report focuses on labour mobility in the health sector of the European Union and European Economic Area (EU/EEA). The focus is specifically on the aspect of transparency and recognition of qualifications and how this influences mobility of professionals within the sector. This question reflects the following paradox: on the one hand, free movement of labour is a formal right established by the Treaty of Rome in 1957. This is one of the founding principles of the European Union. Yet, on the other hand, education and training matters are national responsibilities. If acceptance and/or non-acceptance of a migrant's qualifications is to be decided by the appropriate Member State authorities, then a worst case scenario is that EU citizens are free to move but they are not necessarily free to utilise their professional qualifications. If this is the case, then the right to free movement is an illusion.

The European health sector provides us with a good 'case' to investigate this paradox. The sector is large (one of the largest labour market sectors, both in absolute and relative terms) and broad, covering a wide range of professions. These professions consist of a high variety of education and training backgrounds spanning from assistants with a few weeks' training to highly sophisticated specialists with more than a decade of systematic training. Although differing somewhat due to cultural and national traditions, many core activities can be identified across national and cultural borders. This is not least due to the fact that the sector is highly formalised and strongly regulated. The health sector is therefore well suited for mobility but simultaneously, it is also a sector where mobility is easily affected by policies aimed at the protection of national qualifications.

It would seem that there is a need for mobility within the sector. While one country may have high demand for a specific profession, another may experience a surplus within that same profession. With physiotherapists, for example, the Netherlands educates far too many to be absorbed by the national labour market, whereas, the United Kingdom is in desperate need of them. Likewise, as Norwegian counties desperately seek doctors and dentists, members of the same professions are unemployed in Germany. Mobility in the health sector is thus something more than abstract political objectives. Rather, it should be viewed as something potentially influencing the welfare of European citizens. It certainly affects the use of resources; labour market imbalances like those indicated above are, to be modest, costly.

Chapter 2 of the report will outline the methodological approach applied during the study. The difficulties in collecting reliable data (statistical and other) has made it necessary to combine a number of approaches, which will be described in this chapter.

Chapter 3 of the report will give a short presentation of the health sector. While sharing many characteristics, European healthcare systems differ from each other in some important respects. These differences are of course relevant in a mobility context and we will try to emphasise the most important. These differences are not only related to the institutional and

organisational set-up of healthcare systems, but also to the way professions are defined and regulated; a psychotherapist does not have the same education, neither theoretical nor practical, in the UK and Norway.

Chapter 4 will present the tools and instruments established to promote mobility among health professionals. Mutual recognition of qualifications was not part of the original Treaty of Rome and it has therefore been necessary, through political and administrative initiatives, to try to remedy this shortcoming. As a result, a number of EU directives currently address this issue, partly supplemented by various administrative services in the Member States.

Chapter 5 will provide a picture of the current situation on mobility within the health sector of EU/EEA. This will be done through statistics mainly provided by the European Commission (DG Internal Market).

Chapter 6 discusses the efficiency of various Community initiatives related to recognition of qualifications. This will partly be shown through a presentation of experiences from the implementation of the general directives and the Member States' own comments in reports given to the Commission. The issue will be further addressed through an investigation into the availability and accessibility of national and Community-based information resources - is it possible for a migrant to find his or her way through the system?

Chapter 7 concludes the report.

Before entering the more specific discussion, it is important to underline that languages are an essential issue within healthcare. It is almost impossible to perform without being able to communicate in an advanced way. Very often it is necessary not only to understand the words, but also the different ways these are used in a specific context. Understanding the language more or less fluently is therefore a prerequisite for mobility. The importance of language does not, however, change the fact that legal, administrative and political ('protectionist') barriers to mobility need to be removed if an open 'health' labour market is to be realised.

2. Approach and data

A research orientation gaining international strength especially in the European context (Werner, 1996-98, Sørensen, 1997, Fisher and Straubhaar, 1992-96) has shown that current mobility and migration within the EU/EEA has a knowledge 'bias.' The traditional labour market mobility of the 1950s and 1960s has been dramatically reduced because of the reduction of economic/industrial imbalances and high unemployment in almost all EU/EEA countries, ruling out traditional push-pull mechanisms. Instead, an increasing trend towards the mobility of specialists, experts, multinational employees, individuals seeking education, etc. is apparent. Whether mobility within the health sector reflects this knowledge bias is an open question. If this is the case, policies towards recognition of qualifications will be of particular importance.

This study is partly based on studies of existing literature, documents and statistics, and partly on independent empirical research. Our investigation is based on the following sources:

(a) *general, research-based literature*: a wide variety of studies have been presented during the past decade but most of them have been of a general theoretical character and to a limited degree relevant to the health sector. There is a lack of 'real' knowledge on how people experience mobility. What is complicated, what is not? What is experienced as difficult? How easy is it to move and work in different countries? It is our general impression that empirical research on European mobility still has a long way to go. While theoretical studies abound, actual knowledge of the movement and the reasons for moving/not moving is hard to discover.

The European Commission (DG Internal Market) has produced a number of documents and reports covering the topic of mobility, and to a certain degree, mobility of health professionals. Studies have been conducted both at European and national levels and at national level, the United Kingdom has provided us with valuable information;

(b) *statistics:* figures on foreign workers in EU Member States are regularly published by Eurostat. These statistics are based on various sources - administrative data, social security records and sample surveys. Although not always directly comparable, they provide a picture of long-term developments. Unfortunately, Eurostat does not categorise their samples into health personnel. Neither does the Community labour force survey, which has been carried out annually since 1983 and is based on a representative sample of households in all EU countries and covers the whole population and labour force. When contacted directly, Eurostat confirmed the unavailability of statistics in this specific area. We were also in contact with the national health authorities in some of the different EU/EEA countries and asked for statistics on mobility among health professionals. Few had statistics or were willing to pass them on. Several asked us to contact the European Commission, DG Internal Market, who luckily had good statistics over the last years and

were willing to give them to us. Statistics from the sectoral directives have been compiled since the 1970s and they are collated annually. Data from the general system are collated every second year.

These statistics should, however, be treated with care. First of all, they tend to underestimate the rate of mobility. This is partly due to the fact that a number of professional groups are not included in the statistics and partly due to the fact that short-term migrants are not registered. A lot of health professionals move or change country for a short period of time, either filling a vacancy or while waiting for a job at home. These individuals will normally not appear in statistics. There is also a great amount of exchange within the educational system, for example related to doctorates or specialist training. These exchanges are normally under one year's duration and will not be counted under mobility. Furthermore, employers are not always obliged to have foreign papers recognised. If an employer is satisfied with the foreign papers presented, a *de facto* recognition may take place. If a health professional goes directly to a university or to the professional health education institution in the city where he or she wants to work and gets academic recognition, the employer will hold the same papers as the host country. In both these situations the health professional who moves will not appear in our statistics;

(c) *interviews*: a number of people in various positions have been interviewed. They have given their time and provided important information for this study. Contacts have basically been made at both the European Commission (DG Internal Market) and Member State levels.

On the national level, we have been in touch with several of the contact points set up by the European Commission and Member States (national coordinators of the general directives). Some were met in person in both London and Brussels while others were approached by telephone or fax. Some were easy to reach and gave valuable information (like the London office) whereas the Greek office, for instance, was impossible to get in contact with (nobody answered the telephone and faxes ended up in a taverna in Athens).

At national level, different kinds of organisations or bodies provided information. The UK Council for Professions Supplementary to Medicine (CPSM) whose offices are in London should in particular be mentioned. CPSM is an independent, self-regulating, statutary body. Among the duties carried out by the professional boards at CPSM is the offer of 'State registration' to members of those health professions approved by parliament as falling within the terms of the Professions Supplementary to Medicine Act of 1960. These were: arts therapies; chiropody; dietetics; medical laboratory science (biomedical science); occupational therapy; orthopedics; physiotherapy; prosthetics and orthotics; and radiography, at the time of conducting our research. Since then the professions of clinical scientists, paramedics and speech and language therapists have joined CPSM, but they are not part of this study. The boards at CPSM are 'designated authorities' for the purpose of

the operation of Directives 89/48/EEC and 92/51/EEC. They have sent us a lot of valuable information.

We also had a meeting with one of the coordinators of a Leonardo da Vinci programme on change of work organisation and improvement of key qualifications in the hospital sector;

(d) *written requests/queries*: in order to get updated information from Member States, faxes requesting information on experiences as well as updated statistical data were sent to all contact points/coordinators of the general directives. A specific question regarding the procedures to be followed by nurses, doctors and veterinarians wishing to have their qualifications recognised was also included. Six countries never responded to this request. This result is troubling since an individual seeking information about moving would clearly have been less successful than we were (substantial pressure was applied on the national contact points to receive an answer. Rarely would the same effort be made by private individuals not operating through the medium of a Community-financed project). While the system of contact points and national coordinators is a logical and well-intended administrative construction, resources and attitudes tend partly to work in contradiction;

(e) *Internet:* in order to test how easy it is to get access to information on transparency and recognition of qualifications, we approached the Internet. This turned out to be a long and arduous task. Key words turned out to be not so key and seemed to be based on internal administrative language. It was extremely difficult to find any useful information. We spent hours and weeks searching the Internet. The amount of information available is substantial but the problem is that there is no single entry point where an ordinary citizen, not trained in this particular field, could enter. It cannot be taken for granted that individuals know the structure of European or national administrations or that they know the exact directives or legal acts covering this area. The important lesson to be learned from our experience with the Internet (and other information sources) is that they have to be made user-friendly. How this is going to be achieved deserves (and requires) far more attention in the future. One single entry point, linking together the main information on labour market issues (EURES), mobility issues (the various DGs of the Commission, Cedefop, etc.) and transparency/recognition issues should be seriously considered. This entry point should then be given a 'label' making it possible for individuals to orient themselves.

The data collected are characterised by both strengths and weaknesses. First of all, statistical data are to a certain extent weakened by the lack of a single definition of *migrant*: when does a person actually move from one country to another? Individuals staying abroad for less than a year will often be missed by statistics. The same is likely to happen to persons migrating for educational purposes and in post-graduate cases. These weaknesses are mitigated however as the majority of health professionals have to register in order to be allowed to perform their occupation. Registration is thus a general entry requirement guaranteeing reliability to a

certain degree. Taking account of the weaknesses, we nevertheless think that the figures on mobility among European healthcare workers are reasonably accurate.

Before we begin to discuss mobility of European health professionals, including the obstacles they face and the efforts made to remove these, we will try to outline some of the main characteristics of the sector in which they work.

3. The health sector

Healthcare, in the same way as education and training, is a national responsibility not subject to EU legislation and regulation. In many ways this is a natural and logical reflection of the fact that the EU/EEA consists of countries with different languages, history, cultures and political systems. What is 'good health' for a person in a village in southern Italy may be interpreted differently by an individual living in the middle of London. Different societies tend to (and partly need to) organise their healthcare in different ways. Both geographical (distance) and social factors (how families are organised, how 'close' and integrated societies are) determine this. Different countries have defined and developed various kinds of health professionals and seek their professionalism for very different reasons. These differences are necessary to understand in order to discuss mobility among health professionals. Yet, at the same time, given that there are differences, it is important to stress all the similarities; people are people and the cure for illness and disease in the north and south of Europe is the same.

It is possible that the right to free movement may counteract this 'national' model. The increased demand for cross-border care may very well support such a trend. The discussion of mobility among health professionals should not be reduced to a question of labour market movements but should be interpreted as intrinsically interwoven into the tension between a national (specific) and a European (harmonised) model.

3.1. To be in 'good health'

Does the term 'good health' have the same meaning for a Lap in northern Finland as it does for a gypsy in Greece or a teacher in Spain? Most certainly they will have a lot in common. The flu or a heart attack will need the same medical attention. A stroke however, might require different attention and care according to culture and setting. Several studies have been conducted to see when people feel in good health and the findings show that definitions vary according to age, occupation and geography. Good health is thus a highly relative concept. Often the elderly score highest in view of their own health, while professional athletes score the lowest. This illustrates that your own expectations influence what it is to be in good health. Consequently, measuring health is a very complicated task. The economic strength of the country is of course another factor influencing this picture. A severely handicapped person will face very different future prospects depending on location; the service provided by the public healthcare sector in Sweden for example, will differ considerably from that provided in Greece.

Another example of these differences is in the treatment of mentally ill patients. What kind of behaviour is acceptable for the particular surroundings? When does the surrounding society demand that a mentally ill patient is to be involuntarily institutionalised? Studying these questions even within the relatively homogeneous culture of Scandinavia, major differences

between Norway, Sweden and Denmark can be detected. These three countries have a common history, a language that can be both read and understood by each other and the labour market has been open since 1954. Nevertheless, Sweden has the highest rate of involuntary hospitalisation while Denmark has the lowest and Norway is in the middle. Psychiatric institutions were built in most of Europe like 'French castles,' isolated from the rest of the world. Patients who were admitted were often kept inside for years. In the 1970s, the Italians reformed their psychiatric treatment, tore down their institutions and sent the patients 'out into the world.' This new treatment was copied by many countries across Europe but the success or otherwise of such reforms is still being discussed. Success in this instance has a lot to do with the view people have of others who behave differently, or, how far the limits for acceptable behaviour go.

Our expectations of good health service thus vary from country to country, from culture to culture and childbirth is another example of these variations. In Scandinavia, giving birth is looked upon as 'natural' and there is an ongoing process for getting the births out of the hospitals and back to the home. It is primarily midwives who are responsible for looking after the pregnant woman and the birth itself. In southern Europe, however, it seems to be mainly doctors who are responsible. Birth takes place in a hospital, often on a chosen day. The woman is either induced or has a Caesarean operation. These two different attitudes towards giving birth call for different health personnel with different educational backgrounds and a different health organisation.

How often does anyone approach the health service? The first port of call for patients in France is the pharmacist, whereas, in the United Kingdom it is the family doctor. France has 261 doctors per 100 000 people while the United Kingdom has 164 doctors per 100 000. In Spain and Portugal people simply turn up at the hospital. Spain has 409 doctors per 100 000 (OECD health data 1998). The figures show national differences and we know there are big local differences as well making it difficult to compare health services in a fair and correct way. Still, it is interesting to note what indicates a good support system for people's own feeling of being in good health.

3.2. Cross-border care

Patients are beginning to cross borders in search of better treatment. Patients have the option of obtaining treatment abroad under Community Regulation No 1408/71. This has presented a problem for EU countries.

Two landmark rulings by the European Court of Justice in May 1998 may change the healthcare system. A man called Nicolas Decker from Luxembourg broke his glasses while in Belgium and bought a new pair, which he claimed from his own insurer. They refused to pay, but the court backed Decker's claim that this obstructed the free movement of goods and

services. The court decided that healthcare is a service and that the refusal to cover this service contravenes the Treaty of Rome (and the free flow of goods and services). In a second ruling, a Mr Raymond Kohll, another Luxembourg resident, took his private healthcare fund to court for refusing to pay the cost of dental treatment performed on his daughter by a specialist based in Germany. These cases open the way for any EU citizen to claim treatment in another Member State.

These cases show that the clear distinction between national and EU responsibilities in the health sector are not easy to uphold. The EU is active in the healthcare field when exercising its competences in public health and in data comparison as well as when acting in its very broad domain of the internal market. So even if the healthcare service is not a part of the EU Treaty, a certain trend towards harmonisation may be identified. Denmark is in the process of changing its laws in order to make it possible for Danish patients to obtain treatment abroad while using their social security.

3.3. Organisation of the healthcare system

Europe supports a diverse mix of healthcare services mainly based on historical anomalies. Most European countries have adopted either a Bismarckian system of compulsory healthcare insurance or a national healthcare system funded by taxation. For both systems, a basic level of healthcare is free for all citizens. Access is nearly 100% in countries with a public provider system, while in most of the 'mixed' countries, the difference is made up by supplementary private insurance. No difference is seen between public and mixed provider systems in terms of quality of care, despite the fact that countries with the former model spend, in general, less of their gross national product on healthcare (Lamiere N, Joffe P, Wiedemann M, 1999). The private insurance model of the US produces the highest costs, but is lowest in access and is close to lowest ranking in quality parameters. Healthcare has been undergoing reforms in most countries. European countries vary widely in their standards of facilities and professional staffing and these generally reflect the prosperity of the country.

The World Health Organisation (WHO) has for the first time ranked the health systems of its 191 member countries. In its *World health report 2000,* the healthcare systems are ranked according to how well they perform on five measures. Among them is overall population health as in life expectancy and the number of years of good health an average newborn baby in a given country can expect in his or her lifetime. The study also rates how promptly they provide medical attention, how much choice they offer and how well they respect the confidentiality and autonomy of patients and other 'consumer-oriented' criteria. Both the quality of the national healthcare systems and their fairness in providing service to both poor and rich is of WHO's interest. Every healthcare system was also judged on the basis of its input and output, including both per capita spending and the average number of years its citizens spend in school. Education, along with other factors such as housing are known to

influence health. Measuring efficiency which has attracted most press attention, France and Italy were judged to have the world's most efficient healthcare systems, while Japan and Switzerland were ranked best in terms of attainment. The architects of the WHO assessment, Chris Murray and Julio Frenk, say their report breaks new ground and highlights some significant trends, such as the superior performance of State-run healthcare systems that stress health insurance for all. But they are also quick to point out its limitations, with insufficient data chief among them. The uncertainty surrounding much of the data means that the system rankings have substantial margins of error. But the league tables do at least allow countries to compare themselves with one another and question why their performance falls behind.

Healthcare is expensive, spending relative to GNP varies between the United Kingdom 6.6 % and Germany 10.8 %. Spending relative to GNP has been growing tremendously over past years. In Norway, for example, spending grew in 1962 from 3.7 % to 7.7% in 1990. According to *The European* (1998), Germany has the most generous healthcare system in Europe, spending an average of EUR 2 518 a year per person. Spain spent at least EUR 1 257 per person last year. The European countries have a different mixture of national and private health services. The number of private beds in hospitals varies between the United Kingdom with 5 % and the Netherlands with 92 %. In a Eurobarometer poll, Sweden's satisfaction with its health system was one of the highest in Europe (22 % private beds). The Swedish national health service is primarily funded through taxation though it has introduced more user fees for hospital stays and doctor referrals. Swedes pay between EUR 17 and 36 to see a doctor, up to a maximum of EUR 282 per year per patient. Employment is another indicator that illustrates attitudes towards the health sector.

Table 1. Employment in health and social work sector by NACE 2-digit sector as % of working-age population in EU

EU 15	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	S	UK
5.7	6.2	13.0	5.7	2.5	2.7	6.3	5.0	3.0	4.4	9.5	5.5	3.1	9.3	13.6	7.8

Source: Employment rates report 1998 based on Community LFS (data converted to a benchmark employment basis).

As we can see, Sweden and Denmark have the highest employment in the health and social work sector as a percentage of working-age population. The difference between 13.6 % (Sweden) and the lowest, 2.5 % (Greece) is significant and implies a picture of two totally different health and social care services. The Greeks focus on the low number of employees in the health sector, *Kathimerini* (20 March 2000) points out that at IKA, social security foundation, there is one nurse for every four doctors, *a situation without parallel elsewhere in Europe.* Sweden and Greece are two completely different societies with different family values. Although the rate of divorce is growing in Greece it is still low compared to many other countries and up to now Greeks have depended on the extended family for support and care of family members who need help.

Oral healthcare is mainly financed by government-regulated or compulsory social insurance. In southern Europe, Norway, Ireland and Iceland oral healthcare is largely financed directly by the patient, with occasional support through private insurance. Some publicly-funded and organised services exist in these countries but generally only for specific population groups (e.g. children, unemployed) or in particular regions. Today there are about 222 090 practising dentists in the EU and 12 853 other clinical workers, of whom 11 493 are dental hygienists (Eaton, Widstroem, Renson 1998). Since 1970, the number of dentists (proportionally) in Spain and Portugal have increased considerably with the increase in other countries less marked. In Austria there has even been a small reduction.

The public health systems have different restrictive practices. In the Netherlands, simple anaesthesia is administered at low cost by specialist nurses. In the United Kingdom, consultant anaesthetists vigorously defend their monopoly claiming that anything less would put the public at risk. Yet outcome statistics show that Dutch patients wake up as successfully and as often as their British counterparts.

The European (27 July 1998) compares the European healthcare service with an airline. It would be as if it were controlled by pilots who turned up when they wished, picked their favourite plane then took off for the destination of their choice. This would be a recipe for chaos. Europe's healthcare system is different in structure, finance and service. Still, at the same time, there is not much difference between a child with a cold and runny nose in Greece or Finland, or a man with a heart attack in Spain or Denmark - the medical treatment is more or less the same. What you can see as a visitor to a hospital in Norway or Greece, is the difference in family involvement. In Greece, the family provides much of the caring, giving food and looking after the patient, while in Norway the nurses would take care of this. There is a difference in standard and equipment, but not necessarily in treatment. Our own experience in visiting some local health institutions in the countryside in Greece is that they can give a poor impression but the service provided by the health professionals can be better and faster than many other places in far more impressive surroundings.

3.4. Health education, similarities and differences

The medical and pharmaceutical professions are among the oldest professions in Europe. Their educational system can be followed through several hundred years. The monasteries /hospitals were the basis for education of health professionals. Doctors were responsible for medical treatment with uneducated women and later nurses to help. Soon nurses had their own hierarchy, with a big group of uneducated women as helpers. As the treatment of illness and diseases has become more advanced, so too has the educational system. Today, European societies offer a great variety of treatment, reflected in the ongoing trend towards more and more specialised education and training.

The educational system seems to be divided into three main categories:

(a) professionals with a university degree (five to seven years of higher education) doctors, pharmacists, psychologists. This is mainly a theoretically-based education ('science-based'), with a relatively limited amount of 'practical' work-based training;
(b) professionals with a mixture of theoretically and practically-based education and training (two to four years of higher education). Nurses, physiotherapists and occupational therapists are examples within this group. In most countries, this is the biggest group of employees in the sector;
(c) professionals with practically-based training (normally of short duration, often at the level of upper secondary school). Nurses' assistants, dental assistants, etc. are examples. In many countries, formal training of this group is a relatively recent phenomenon. Traditionally, this is a group dominated by uneducated women gaining competence through learning by doing.

Table 2 illustrates how these three main groups are located at the three main levels of formal education and training.

Table 2 Education and training in healthcare; main categories

University, 5-7 years	General doctors	Orthopaedics	Psychologist	Dietician	Dentist
Professional education, 2-4 years	General nurses	Orthopaedic engineers	Social worker	Nutrition adviser	Dental nurse
½-1 year	Assistant nurses	Pedicure	'Set patients to work'	Cook	Dental surgery assistant

The shortcoming of this is that these categories/specialisations are not necessarily shared in detail between different countries and will differ according to the needs of each country ([2]). The UK Council for Professions Supplementary to Medicine (CPSM) provides us with an example. UK physiotherapists all have to undergo a three-year plus higher education degree course, while the German *Krankengymnasts* obtain what in the UK would be defined as a two-year further education diploma. But we can still say that most occupations are to a certain

([2]) In this context it is interesting to note the experiences of the European Union during the period 1985-94 when an effort was made to put in place a harmonised system of qualification levels. This five-level structure (often referred to as the Cedefop levels) was used as a starting point for comparing vocational qualifications in Member States to each other. A total of 219 occupations in 19 sectors were compared, the results being made public in the *Official Journal of the European Communities*. This exercise, although very time and resource consuming, never gained much attention among employers or educational authorities, and was given up in 1994. There is reason to believe that a certain fear for some sort of hidden 'harmonisation of qualifications' contributed to the end of this effort.

extent basically linked to the same educational level and the same amount of time for studying.

The difference between countries when we look at the educational system is already visible within elementary/upper secondary school. Within Europe, children start going to school at between four and seven years of age. Most countries have 12 years of basic education, the student is finished at the age of 18. Some countries have 13 years of basic education, where they finish at the age of 19. Higher, professional education seems to be mainly between two and three years, while university studies are between five and six years.

Healthcare professionals are today characterised by specialisation. You start out as a doctor and end up with more than 20 different specialities such as, neurologist, cardiologist, anaesthetist, orthopaedic surgeon, oncologist and so on. Nurses follow the same specialities to a large extent. Physiotherapists and occupational therapists have in the same way their specialisation. In 1946, in Norway, there were about 30 specialities within the healthcare sector, by 1979 there were 98 (Hofoss, 1980). The number is increasing. These specialisations are based on education. But the different specialities have their background in the workplace. As the treatment of patients becomes more advanced it is obvious that one person can no longer hold the full extent of knowledge available. Knowledge has 'modularised' and tends to live its own life dividing into new specialities. The European Union (DG Internal Market) has tried to find out how many professionals are regulated within the Community and they have found approximately 90 health professions. The same DG has, through a survey in all Member States, tried to investigate the structure of a limited number of health professions ([3]). Relevant authorities were presented with a questionnaire on psychologists and psychotherapists (and related professions) ([4]), focusing on their regulation, the interface with psychiatry and the structure of education and training. What can be read from the answers is that working as a psychologist in the public sector is regulated in most countries. Years of education vary between four and seven; for eight countries it is five years of higher education at university level. Differences are even bigger for psychotherapists; in some countries such as Greece, you have to be a psychiatrist, or in Luxembourg, you have to have a medical background before you can work as a psychotherapist. In the UK, a course in psychotherapy can be attended by a nurse or social worker. So, while the title of psychotherapist remains the same, it does not mean the same thing and does not involve the same education and training. This is the main problem within the whole health sector. Several of the main cores are similar, but the amount of training and organisation of studies varies greatly and is linked to the organisation of the health system as a whole.

([3]) European Commission (DG Internal Market). *Child care professions. Member States' replies to Commission questionnaire.* XV/D4/8476/98/-EN, Brussels: 1998. *Psychologists, psychotherapists and related professions. Member States' replies to Commission questionnaire.* XV/E/9926/3/95-EN, Brussels: 1998. *Social workers. Member States' replies to Commission questionnaire.* XV/E/6846-96, updated 19 April 1999.

([4]) Two countries did not respond, two others only informed on which laws regulate the profession and the other 11 countries answered more or less in detail.

More or less the same questions were drawn up for social workers, childcare professionals and the latest is a questionnaire for radiographers and physiotherapists. Social workers (1999) are one of the health titles that seemingly have a different educational background. Many countries mention upper secondary school and specific training, others professional, higher education, or university studies. The years of study or training vary between two and five years at different levels. Unfortunately, we have no special data on how easy or difficult it is for a person to have their papers recognised in another EU/EEA country. It seems to be even more difficult when it comes to a title within childcare professions (1998). Eight countries did not answer the questionnaire. The answers from the remaining countries show different educational systems for childcare professions. Many are connected to teacher or nursing education.

Franco (1999) focused on occupational physicians' education and training across EU countries. The framework directive on improvements in the safety and health of workers is being implemented in national legislation of EU countries and occupational physicians are requested to play a key role in undertaking preventive measures. There is no common specific requirement for the training and education of these health professions. Each curriculum provides theoretical knowledge and practical experience, but major differences exist between different countries.

At any rate, language is an essential element in the healthcare sector. This is a major difficulty for healthcare professionals crossing borders and performing their occupation. According to European law, you are not allowed to stop a professional from performing his/her profession because of language. But if you cannot communicate with a patient, there are few healthcare professionals who can perform. This is a practical difficulty stopping people from moving from one country to another, which is of course most noticeable in small countries. Language can also be perceived as an artificial barrier to free movement. The most recent leading case, however, upheld the Irish Government's right to insist on migrant school teachers demonstrating proficiency in Gaelic, the Irish language (as opposed to just English).

3.5. Conclusion

Healthcare was not included in the Treaty of Rome and neither were educational systems. National governments want to keep their part of social organisation of society in their own hands. This is getting more difficult because patients have started to cross borders in search of better treatment.

When you feel ill, how often and whom do you approach for help? This depends on where you have grown up, where you live and how the rest of society around you react towards illness and disease. 'In healthcare, geography is destiny,' or so many researchers maintain in their studies. It is hard to disagree even though life expectancy varies little across Europe. There are large differences both among and within European countries in the supply of

healthcare facilities and personnel. Educational systems have a lot in common, but differ on important matters. The same title for a professional healthcare employee does not imply the same educational background or scope of practice as illustrated by psychotherapists.

The big diversity of the health professions and the difference between countries in terms of professional as well as education and training traditions, complicates the issue of transfer of professional qualifications. Even when listing the basic professions (medicine, hygiene and public health, physiotherapy and occupational therapy; nursing, midwifery, dentistry, pharmacy) it becomes clear that the task is complicated.

In the following chapters we will see what has been done by the EU and Member States to solve this problem.

4. Instruments to promote mobility

Free movement of labour, the opportunity to look for employment in another EU country and to hold it just as any national of that country, has been a reality for the six founding members since 1968. Free movement of labour in the EEC Treaty means the 'abolition of any discrimination based on nationality between workers of the Member States as regards employment, remuneration and other conditions of work and employment.' It now applies to the 15 Member States and the three EEA States.

The relationship between economic integration, migration and welfare was one of the basic ideas behind the common market which the European Community began to strive for in the mid-1950s. The right of free movement has been successively extended from the Treaty of Rome in 1957 up to the Treaty of Maastricht in 1992. As the original treaty did not deal with the problem of transfer of qualifications between Member States, a number of political and administrative initiatives have been taken during the successive four decades. These efforts, aimed at mutual recognition of qualifications and increased transparency ([5]) of qualifications, have to a large extent also been implemented in the health sector.

The following sections will outline the main instruments of political, legal and administrative character put into place to support the transfer of qualifications and thus support mobility.

4.1. Political and legal measures

An individual qualified within one of the regulated health professions will be covered by two different political/legal mechanisms, normally referred to as sectoral directives ([6]) and general directives ([7]) (Council Directives 89/48/EEC and 92/51/EEC). Other political initiatives focusing on the transparency of qualifications will also be discussed. Only the main principles

([5]) The distinction between recognition and transparency of qualifications should be noted. While recognition implies a *de facto* agreement between the different countries involved to accept each other's qualifications, transparency is a more modest approach whereby the content of a certain qualification is made as visible and transparent as possible, thus making it easier to decide on acceptance or not.

([6]) Council Directive 77/452/EEC of 27 June 1977 general nurses; Council Directive 78/686/EEC of 25 July 1978 dentist; Council Directive n80/154/EEC of 21 January 1980 midwifery; Council Directive 85/433/EEC of 16 September 1985 pharmacy; Council Directive 89/594/EEC of 30 October 1989 -- doctors, nurses responsible for general care, dental practitioners, veterinary surgeons and midwives; Council Directive 93/16/EEC of 5 April 1993 doctors includes 75/362, 75/363,86/457.

([7]) Directive 92/51/EEC, implemented on 18 June 1994, has been transposed in all Member States. In some it was transposed later than the two-year deadline laid down in Article 16, which reduces the experience gained in applying it. Spain was approximately one year late, Ireland two years, Portugal and the United Kingdom two and a half years, Belgium three years and Greece four years late. The Commission therefore initiated and pursued infringement procedures.

behind the various instruments will be presented in this section, experiences and impact will be discussed in later chapters.

The sectoral directives

Work on sectoral directives began in the 1960s and the strategy was to agree on common, minimum requirements which should be adopted and applied by all Member States to arrive at a qualification recognised by all. The following health professions are covered by this system: doctor, dentist, pharmacist, midwife, nurse responsible for general care and veterinarians. The first directives came into force in 1975 and covered doctors (updated in 1993). These directives provide for the automatic recognition of diplomas, certificates and other qualifications related to the aforementioned professions insofar as they fulfil the minimum training conditions laid down by Community legislation.

These directives set a minimum standard for what is required of a professional practising in an EU/EEA country. Recognition is in principle automatic, but the host country can require further documentation on education and training background. The sectoral directives have been important in defining a common standard for what we may call the basic health professions but, as indicated earlier, the number of professions not covered by the sectoral directives is substantial. According to the tentative figures of the Commission (see Chapter 3) this amounts to more than 80. Another problem faced by the sectoral directives is the rather cumbersome and slow procedures followed. Some directives have taken more than 10 years to become established. Add to this the constant need for updating minimum requirements (professions are constantly changing) and the inflexibility of the approach becomes evident. This does not, however, mean that the sectoral directives have been wasted energy. Although we have not been able to find systematic research on their impact, it seems clear that mobility in the health sector would be far more difficult without them.

The slow progress seen through the sectoral directives led to a search for more flexible instruments. This search was to a certain extent influenced by a degree of scepticism towards the harmonisation of standards implied in the sectoral approach. This led eventually to Council Directive 89/48/EEC outlining a general system for the recognition of higher education diplomas (awarded on completion of professional education and training of at least three years duration). The general directives cover all higher academic and professional qualifications, not only those in the health sector.

The general directives

Introduction of the two general directives on recognition of higher education (academic and professional) marked a change in the political and legal approaches towards this policy field. The new system had to resolve the conflict between the strong political wish to protect national education and professional systems and at the same time allow European citizens to exercise their right to move and work throughout the Union. Regulated professions can be

looked upon as monopolies defined and controlled through national education and qualification systems. These types of national monopolies conflict with the entire idea behind a free internal labour market Purely national criteria for the definition and control of qualifications would seem to be insufficient in this new economic and political context.

The general system is founded on a single simple idea; the presumption that if one is qualified in one Member State to exercise a given profession, one should be entitled to exercise that same profession throughout the EU/EEA. The system is based on the principle of *mutual confidence and trust* on the actual comparability and transferability of qualifications. This does not mean, however, that qualifications covered by these directives are automatically recognised by the host country. If the host country is of the opinion that the qualifications in question display major weaknesses and deficits, additional documentation, testing or training can be required.

Every application for recognition will be treated individually by a competent authority in the host Member State. In principle, a fully qualified professional in the home Member State who applies for recognition of qualifications to practise that same profession in the host Member State could receive full recognition leading to immediate entry into the regulated profession in the host State. However, before reaching a decision, the competent authority will compare the professional education and training received in the home Member State with that required in the host Member State. If this authority finds that there actually are significant differences between the two, it may, subject to certain conditions, grant recognition conditional on the fulfilment of additional requirements. These additional requirements can consist of providing proof of experience, completion of an adaptation period or passing an aptitude test in the host Member State. Only one of these three requirements may be imposed and normally the applicant will be free to choose which. Member States are required to respond to requests for recognition by way of a decision within four months of presentation of all necessary documents.

During the 1990s; a number of political statements were made concerning the need for increased transparency of qualifications. Two Council resolutions of 1992 and 1996 respectively, recommend a number of specific initiatives to make it easier for employers to decide on the content of foreign qualifications ([8]). This approach assumes that the multitude of qualifications that exist in Europe is a positive situation which should be supported, not threatened by top-down harmonisation efforts. This diversity should, however, be presented in a standardised way. National diplomas and certificates should be translated automatically, certificate and diploma supplements should seek to present the competence held by an individual in as concise a way as possible, and a visible and well defined European system of information and guidance points should offer additional information support. While gaining political support, little actual progress has taken place along these lines. Somewhat delayed during 1999/2000, initiatives were taken to push forward these ideas in a more systematic

([8]) A resolution is legally weaker than a directive; recommending a certain action, Member States are not obliged to follow it.

manner. This will be discussed below in Section 4.2. In the same way as the general directives, the transparency initiatives have not been specifically oriented towards the health sector. There is reason to believe that several of the elements referred to above could also play a potentially positive role for health professionals.

As a concluding comment to this section it should be emphasised that 'regulation' makes a difference to the question of transfer of qualifications. Those professions protected by national law (as the majority of health professions are), seem to be best covered by the political and legal instruments introduced at EU level. The situation will be different for a non-regulated profession where the rules and behaviour of the labour market will normally be more important than legal rulings at national or EU levels. However, even if this is the case, a migrant will still have certain general rights. The authorities of the host country are obliged, under the articles on freedom of movement of the Treaty of Rome of 1957, to take into account the professional diplomas and qualifications acquired in another Member State, even if the profession is unregulated. There is also reason to believe that the transparency approach indicated above will be of relevance to these groups as well.

4.2. Administrative measures to support transfer of qualifications

This section will give a short presentation of what we will term administrative measures to promote transfer of qualifications. In some cases, these are closely related to and defined by the political and legal instruments described above. In other cases, they relate to the internal market, labour market policies and general educational policies.

All Member States have appointed a national contact point (where applications are received and distributed) and a national coordinator responsible for overseeing the implementation of the general directives. An important role fulfilled by national coordinators is to ensure uniform application of the directives to all professions concerned. In practice, they also act as a link between the national competent authorities and the Commission.

All Member States have appointed centres responsible for supporting recognition of academic qualifications. These centres for national academic recognition (NARIC) have been operational for almost a decade and are probably the most firmly established service in the area. However, they are not normally independent, as for example the UK NARIC. A network has been established at European level, aimed at a coordinated approach to the work and sharing of information on recognition issues. NARIC will, probably only to a limited degree, cover health sector professionals.

The European Employment Service (EURES) was established in 1994 following a Commission initiative. The aim is to link together the national employment services in the EU/EEA, thus providing an overall picture of available jobs within the internal market.

Partners in the network include public employment services, trade unions and employer organisations (coordinated by the European Commission). EURES was set up to inform, counsel and provide advice to potential mobile workers on job opportunities and living and working conditions in the EU/EEA. They assist employers in recruiting workers from other countries. There are some 500 EURES advisers in Europe. They are supported in their work by an IT system which allows job vacancies to be exchanged between public employment services.

The emphasis on guidance, illustrated by EURES , has been further strengthened through the setting up of national resource centres for vocational guidance (NRCVG) within the EU/EEA. The guidance centres aim at a concerted approach towards guidance, underlining that transfer of qualifications and competences is more a question of having access to information than of legal rulings. Like NARIC, the guidance centres are linked together through a European network, exchanging experiences and seeking common approaches. The guidance centres have received relatively low funding and have thus only been able to fulfil their role to a limited degree. The Commission is currently planning to strengthen this structure and beginning to appreciate the importance of guidance for transfer of qualifications.

Reflecting the poor implementation of transparency-related initiatives introduced by the Council resolutions of 1992 and 1996, Cedefop and the European Commission initiated a 'European forum on transparency of vocational qualifications' in 1998. The purpose of this forum, consisting of representatives of national ministries and social partners, was to work out a practically oriented action plan for transparency of vocational qualifications. This plan was presented to the Commission and the Member States in early 2000 and is currently being integrated into Community policies (basically a new council decision on mobility to be presented during Autumn 2000/Spring 2001). The actions presented are primarily those listed in the 1992 and 1996 resolutions but the difference being that measures to secure actual implementation have been taken.

In addition to these specific measures, a series of initiatives to facilitate the free movement of people within the EU and to strengthen citizens' rights have been announced. Following the debate on the possible synergies between academic and professional recognition initiated in 1994, the Council of Ministers invited the Commission, in their conclusions of 6 May 1996 'to examine in cooperation with the Member States, possibilities for the introduction on a voluntary basis, of a European administrative annex to the diploma, the aim being to facilitate transparency and recognition in States other than those in which they were dispensed.' A diploma supplement working group was established in December 1996 as a joint initiative by the European Commission, the Council of Europe and Unesco/CEPES. Their mandate was to develop a model for a diploma supplement to ease the problems of recognition and promote transparency and the international recognition of qualifications for academic and professional purposes. Their work has been met with scepticism, mainly because educational systems have very different ways of counting hours of study, giving credit points for a course and so on.

In 1996, the Commission established a 'high level panel' to examine the practical difficulties encountered by people when trying to exercise their right to enter, reside and work in another Member State. The high level panel on free movement of persons was chaired by Mrs Simone Veil, and their report of 18 March 1997 contains a series of concrete measures to ensure that more people can take advantage of their right to free movement within the EU. The main conclusion is that apart from a few exceptions, the legislative framework to ensure free movement of people is in place, and that the majority of individual problems can be solved without changes to legislation. Particular emphasis is put on the need for Member States to improve cooperation amongst themselves.

The green paper on education, training and research eliminating obstacles to transnational mobility is another example that looks at some of the problems and puts forward some ideas for solutions. Barriers linked to taxation and social security have been mentioned by everybody working with mobility and remain unresolved. An unemployed person who wishes to train or study in another Member State loses the right to unemployment benefit and social security if training exceeds three months.

Whether these more or less interlinked and coordinated efforts actually support those individuals trying to transfer their qualifications into a new country is of course another matter. We will discuss this in the following chapters.

5. The current situation on mobility

While product and capital markets have become increasingly integrated, this is less the case for labour markets. Even though tens of millions of people currently work outside their home countries, labour is less mobile than in, for example, the second half of the 19th Century. The European Union, which gives citizens of any Member State the right to work and live in any other, is a good example of this. Only a small proportion of workers venture across national borders. Language, cultural barriers and incompatible qualifications all combine to keep labour markets national.

It is difficult to say how much migration is going on. Official definitions of 'migrant' vary, resulting in somewhat different estimates. According to Peter Stalker (1995), roughly 80 million people (worldwide) live in countries they were not born in. Another 20 million live in foreign lands as refugees from natural disasters or political oppression. Each year another 1.5 million or so emigrate permanently and perhaps another million seek temporary asylum abroad. By historical standards, these numbers are large in absolute terms, but small in relation to the now much larger overall population.

5.1. Mobility in the health sector

Statistics for mobility among health personnel are not easily available. Figures on foreign workers in EU Member States are regularly published by Eurostat but unfortunately, health professionals are not possible to trace. The same lack of data is reflected in the Community labour force survey which covers the whole population and labour force in the EU, but health sector professionals do not occur as a separate category. This same lack of data was repeated by health authorities in different countries; few had statistics or were willing to pass them on. The only data available were finally provided by the European Commission (DG Internal Market), and our discussion will be based on these.

Table 3 shows how many health professionals in all Member States have applied for recognition of qualifications between 1993 and 1996 (these numbers are related to both the sectoral and general directives (see Section 4.1)).

Table 3 Total number of applications for recognition of qualifications; health sector personnel in all Member States, sectoral and general directives, 1993 and 1996

	1993-94	1995-96	TOTAL 1993-96
Dentists	425	921	1 346
EFTA nationals	25	7	32
Specialists		16	16
EFTA national specialists		0	0
Doctors	3 545	5 095	8 640
EFTA nationals	122	102	224
Specialists	476	1 633	2 109
EFTA national specialists	23	43	66
Services	283	309	592
Bilateral agreements	534	1 577	2 111
Third country national	7 217	7 307	14 524
Midwives	326	319	645
EFTA nationals	0	3	3
Nurses in general care	3 739	3 470	7 209
EFTA nationals	7	59	66
Paramedics (other health and scientific professions)			0
General cases			0
Chiropodists			25
Chiropractor			10
Occupational therapists			0
Orthopists			1
Physiotherapists			1 578
Preparateurs en pharmacia			0
Psychologists/psychotherapists			222
Radiographers/radiologists			73
Specialist nurse educators			153
Speech therapists			303
Dietician			44
Occupational therapists			188
Optometrists/Optician			163
Orthopaedic engineer			6
Registered dispenser of hearing aid			6
Chartered biologist			33
Chartered chemist			183
Laboratory technologist			82

Dental hygienist/Technician			32
Physical therapist			102
Masseur			30
Pharmacists	306	0	306
Third country national	572	0	572
EFTA	0	0	0
Pharmaceutical assistant			6
Social workers			120
Vets	472	0	472
Vets declaration	147	0	147
Bilateral agreements	814	0	814
Third country national	555	0	555
Total per Member State	19 588	20 861	43 809

Source: Directorate General Internal Market (internal document).

As we can see, the number of health professionals who cross borders is low. The total amount of applications for recognition (all qualifications, not only health) between 1993 and 1996 was 53 182. This means that more than 82 % (43 809) of all applications came from health sector professionals. Less than 18 % belong to other professional groups (9 373), these are mainly dominated by teachers. According to data for the period 1997-98 (all sectors in all Member States), a total of 13 522 applications were received. This means that an average of 11 117 applications have been received every year during the period 1993 to 1998. The UK, Germany and France are the countries that receive most foreign workers.

When we take away the sectoral directives (nurses, doctors, dentists, pharmacists, veterinarians, midwives and architects) from 1993 to 1998 the total number of recognition requests granted under both general system directives was 23 224. An analysis of the period 1993-96 shows that of the 12 595 requests granted ([9]), compensation measures were applied in 1 954 cases, or 15.5 %. Of this 15.5 %, 63 % were adaptation periods and 37 % aptitude tests. If we break down the 15.5 %, the relative percentages are as follows: aptitude tests were used in 5.6 % of all cases of recognition granted under the general system and adaptation periods in 9.8 % of such cases. On the other hand, some 1 781 negative decisions were also taken, which amounts to a 12 % failure rate, at least on first attempt. Some 7.13 % of those refused recognition had undergone compensation measures of which some 95 % were aptitude tests. In other words, 6.7 % of negative decisions happened after the migrant had undergone an aptitude test and 0.3 % after the adaptation period. Of all recognition decisions taken, positive and negative, 14.47 % were the result of the application of compensation measures (report on the application of Directive 92/51/EEC ([10]) to the Council and the European Parliament).

([9]) This is the most complete figure available.

([10]) OJ L 209, 24.7.1992, p. 25.

Table 4 gives an indication of which countries are most active in recognising qualifications and where migrants originate.

Table 4 Recognition of diplomas - according to country - 1995- 98 ([11])

Member States which recognise diplomas		Member States from which they originate
Norway	1 535	Sweden, UK, Greece
Germany	1 589	Netherlands, UK and Belgium
Luxembourg	283	France, Germany and Austria
Spain	229	Germany, UK and France
UK	279	Ireland, Netherlands and Finland
Austria	255	Germany
Denmark	137	Germany and Sweden
Italy	69	Germany
France	37	Belgium
Ireland	36	UK
Sweden	52	Finland, Denmark, Norway and Iceland
Netherlands	33	Germany and Belgium
Portugal	20	France and Spain
Finland	24	Sweden
Liechtenstein	18	Austria and Germany
Belgium	7	Netherlands

Source: Report on the application of Directive 92/51/EEC ([12]) to the Council and the European Parliament.

The States recognising foreign qualifications are not necessarily the same as those 'exporting' diplomas. This is illustrated in Table 5.

([11]) The figures come from 'Report on the application of Directive 92/51/EEC to the Council and the European Parliament' Markt/D4/8052/6/99. For the most part the given information for 1995-96 of the report has been obtained from the northern Member States (Denmark, Germany, Austria, the Netherlands, Sweden, Finland and the United Kingdom) and from Italy. Of the EEA States, only Liechtenstein provided statistics. For various reasons, the southern Member States did not supply information to the Commission (Portugal, Spain, Greece: few migrations; France: information not available; Ireland, Luxembourg: no applications. For 1997-98 complete data was received from all EU including EEA Member States except Greece.

([12]) OJ L 209, 24.7.1992, p. 25.

Table 5 Export of diplomas - according to country - 1997-98

Member States which export their diplomas		To :
Sweden	701	Norway (620), Denmark (30), Finland (15) and UK (13)
UK	580	Norway (460), Germany (54) and Spain (32) and Ireland (21)
Netherlands	574	Germany (504), UK (36) and Spain (12)
Germany	307	Spain (75) , Austria (68), Luxembourg (37), Italy (32), Norway (34) and Denmark (27)
France	277	Luxembourg (206), Spain (38) Germany (10)
Denmark	142	Norway (86), Germany (27) and Spain (18)
Spain	136	Norway (98), Germany (14), UK (11)
Austria	131	Norway (51), Germany (42) and Luxembourg (24)
Belgium	124	Germany (53), France (35), Luxembourg (11) and Spain (10)
Greece	111	Norway (93), Germany (7)
Finland	101	Norway (35), Sweden (22), UK (22)
Ireland	89	UK (77) Norway (18)
Iceland	52	Germany (35) Norway (16)
Italy	47	Spain (22) Germany (13)
Portugal	28	Germany (12) Norway (8)
Luxembourg	14	Germany (13)
Norway	7	Germany
Liechtenstein	4	Germany

Source: Report on the application of Directive 92/51/EEC ([13]) to the Council and the European Parliament.

For the above period, the main sectors where free movement occurs under this directive are health related professions and maritime transport (seafaring). Norway (EEA country) welcomed by far the highest number of EU migrants (mainly from northern Europe and most

([13]) OJ L 209, 24.7.1992, p. 25.

of the qualifications recognised were as marine engineering officers or deck officers). The Dutch and Finns have been called upon to grant fewer recognition requests than their neighbours, partly because they regulate fewer activities. The seafaring sector benefits from two-way cross-border traffic. Professionals move from the Netherlands, Sweden and the UK to Denmark, Sweden, the UK and Germany (report on the application of Directive 92/51/EEC to the Council and the European Parliament, pp. 6-10) ([14]). Returning to health professionals, the main movements are illustrated in Table 6.

Table 6 Main movements among health professionals

Main health professions for which free movement occurs under the directive
Physiotherapists (moving to Germany)
Specialist nurses (moving to Austria, Spain, Germany, France, Luxembourg and UK)
Opticians (moving to France)
Dental hygienists (moving to UK) and dental technicians (moving to Portugal)
Masseurs (moving to Italy)
Childcare workers (moving to Austria and Italy)

Source: Report on the application of Directive 92/51/EEC to the Council and the European Parliament.

The high number of specialist nurses moving between Austria, Spain, Germany, France, Luxembourg and the UK and childcare workers moving to Austria and Italy is explained by the fact that a lot of specialist nurses and childcare workers have been trained in these countries. The high migration of French opticians is somewhat difficult to explain, the same can be said of all the dental hygienists moving to the UK. Childcare professionals and specialist nurses tend to move in one direction: from Germany to Austria. So do physiotherapists, who move mainly from the Netherlands to Germany. Smaller numbers of masseurs and radiographers have moved to Italy. During the reporting period 1997-98, the impact of the second general directive is apparent. There is a threefold increase in the number of cases treated under Directive 92/51/EEC, a total of 4 603 cases. This indicates that there is a certain delay in putting these systems into practice; it takes time to make users aware of them.

Based on the picture provided by the statistics, some interesting facts can be deduced:

(a) countries that export the most diplomas tend to receive few back;
(b) countries that recognise many candidates export few.

([14]) OJ L 209, 24.7.1992, p. 25.

Migration is restricted to relatively homogeneous geographical and cultural areas (Germany/Austria, the Nordic region, Belgium/France, UK/Ireland, etc). There is more movement between countries physically close to each other.

The Council for Professions Supplementary to Medicine (CPSM) in the UK provided us with statistics (by profession) on registered members with addresses overseas, thus giving us an indication of the extent of migration into the UK. The addresses have been divided up into various countries, which we have divided into UK, EU/EEA, overseas (here EU/EEA is included) and total.

Table 7 The proportion of foreign professionals among UK professions supplementary to medicine, 1999

Profession	EU/EEA	UK	Overseas	TOTAL
Orthoptists	6	1 244	18	1 262
Arts therapists	31	1 390	57	1 447
Prosthetists/ orthotists	21	676	34	710
Physiotherapist	513	28 811	2325	31 138
Occupational therapists	119	19985	874	20859
Radiographers	198	19 314	523	19 837
Dieticians	134	4 512	338	4 850
MLT	56	20 903	280	21 183
Chiropodists	58	8 139	144	8 283

Even though the UK is one of the biggest receivers of health professionals (according to Commission figures) these figures show that only 1 136 out of a total of 109 569 health professionals supplementary to medicine come from other EU/EEA countries.

Until now we have covered professions subject to the general directives. Doctors, nurses and dentists are subject to the sectoral directives and we will have a closer look at their movements. We will start by looking at doctors (who have obtained their basic qualification and authorisation in a Member State other than that of their birth) ([15]).

([15]) It should be noted that the numbers related to the sectoral directives may actually underestimate the number of migrants. Some individuals may have gone directly to university and/or college and had their papers recognised through the academic system. The university/college will then have issued them with papers as if they were educated within the system of that country, making them disappear from statistics.

Table 8 Number of doctors having obtained authorisation to practise in a Member State other than where they obtained their basic qualification, 1981-97

	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	S	UK	Total
1981	13	5	478	129		52	57	17	12	93					546	1 402
1983	19	9	1 018	402		75	35	20	7	45					567	2 197
1984	36	7	989	346		62	34	23	5	54					302	1 858
1985	31			D	F	64	30	21	8	53					332	918
1986	67	6	749	332	49	114	32	23	7	76		15			445	1 915
1987	102	14		290	154	129	25	51	11	92		31			995	1 894
1988	129	16		311	54	157	19	52	11	73		64			1 309	2 195
1990	153	14		256	64	117	43	68	10	57		26			1 020	1 828
1991	182	10		205	51	136	40	79	3	64		26			956	1 752
1993	149	24						58	18	89					1 157	1 495
1995	126	48		101				59	48	60	107		20	71	1 796	2 436
1996		108				1881		40		76	75			57		2 237
1997	149	73		92	203		73	81		161	74		69	80	1 908	2 963

Source: Commission of the European Communities, Directorate General for Internal Market and Industrial Affairs; statistical tables relating to the migration of doctors: 1981, 1983-88, 1990-91, 1993, 1995-97.

The total figures are not reliable because of lack of data, Germany has not supplied data since 1986. There seems to be a slow growth in migration among doctors over the years but because of the low figures it is difficult to say. The figures for 1997 show that the Netherlands have a sudden increase in applications. Of the 161 applications, 95 are qualified in Belgium and 39 in Germany. In the same year, the UK had 1 908 applications, of which 569 are qualified in Germany, 281 in Greece, 239 in Italy and 167 are qualified in Spain. Of Ireland's 73 applications, 55 are qualified in the UK. Austria had 74 applications and of these 69 were from Germany. Finland shows a similar picture; of their 68 applications, 55 came from

Sweden. According to the 1996 report to the Commission, approximately 1.7 per 1 000 doctors obtain recognition in another EU/EEA country.

We have the same information regarding nurses responsible for general care, who are nationals of a Member State and obtained their basic qualification in another, whose authorisation to practise was issued in one of the States mentioned below.

Table 9 Nurses (general care) having obtained authorisation to practise in a Member State other than where they obtained their basic qualification, 1981-97

	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	S	UK	Total
1981	80	9	132	2		147	535	44	64	63					239	1315
1983	66	10	178	3		278		35	65	56					355	1046
1984	49	12	35	4		329	150	38	71	81					606	1375
1985	41	13	132	5		205		41	101	79					674	1291
1986	74	14	66	8	30	190		31	107	64		3			530	1117
1987	59	8		2	61	188	121	42	129	136		19			1002	1767
1988	48	12		4	54	182	202	51	134	52		64			586	1389
1990	50	18		7	45	293		66	193	92		23			761	1548
1991	61	8		10		1481	534	84	154	134		29			627	3122
1993	77	17		7		410		75	200	70		29			438	1323
1995	58	48		13			590	25		104	108	43	4	40	756	1789
1996		31						42		301	74	40		26	1041	1555
1997	55	30		11	81	186		37		200			5	44	1171	1820

Source: Commission of the European Communities, Directorate General for Internal Market and Industrial Affairs; statistical tables relating to nurses responsible for general care: 1981, 1983-88, 1990-91, 1993, 1995-97.

The movement among nurses seems to be relatively stable even if we see an increase in numbers, relative, no doubt, to the expansion of the EU. In 1991, France had a sudden increase of applications (1 481) of nationals who qualified in Belgium 520, while 298 came from the UK, and 264 from Germany. In 1996, the Netherlands had 301 applications, almost three times more than 'normal' (these were mainly from Belgium 196, from Germany 41 and from the UK 36. The UK received 1 171 applications in 1997 from nationals of: 329 from Finland, 253 from Ireland, 166 from Sweden and 127 from Germany. Of Sweden's 44 applications, 10 came from Denmark, 10 from Finland and 11 from Germany. What is said among the coordinators is that nurses mainly come to a new country because they have married and moved to the spouse's country. Another interesting comment is that it is mainly the husband who organises the paperwork to request recognition. This can of course be due to language barriers but one wonders whether it has to do with gender or with this specific group of professionals.

We will also look at the number of dentists who are nationals of one Member State and who obtained their basic qualification in another and whose authorisation to practise was issued in one of the States mentioned in the columns below.

Table 10 Number of dental practitioners having obtained authorisation to practise in a Member State other than where they obtained their basic qualification, 1981-97

	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	S	UK	Total
1981	6	2	80	1		20	1	0	5	28					103	246
1983	4	0	62	6		13	14		3	29					78	209
1984	10	0	52	5		3	6	0	4	8					67	155
1985	10	0		4		8	8	26	4	6					72	138
1986	15	1	170	9	3	12		107	7	9		0			82	415
1987	17	5		4	2	11	6	79	5	7		3			79	218
1988	19	0		2	2	29	13	74	2	7		8			95	251
1990	15	1		7		27	15	79	3	6		4			97	254
1991	17	0		1		27	17	88	4	8		15			93	270
1993	11	5		3				62	1	8					112	202
1995	15	15		10				52	6	6				4	229	337
1996		2						40		14	1			4	336	397
1997	18	19		7	98	37	29	28		43	0		2	7	356	644

Source: Commission of the European Communities, Directorate General for Internal Market and Industrial Affairs; statistical tables relating to dental practitioners in the Community: 1981, 1983-88, 1990-91, 1993, 1995-97.

There seems to be a rise in mobility among dentists within the EU/EEA and this is especially noticeable in the UK and Spain. The UK is one of the few countries that has provided the Commission with statistics every year. As we can see a lot of the other countries are difficult to discuss because of lack of data. Italy, the Netherlands, Belgium, Luxembourg, Denmark and Greece seem to have a relatively stable amount of applications every year. Sweden provided the UK with 212 and Ireland 63 of the 356 applications in 1997. Of the Netherlands' 43 applications, 26 were qualified in Belgium. There are supposed to be about 222 090 practising dentists in the EU. If we look at these figures not many are travelling abroad, only 644 in 1997.

Between January 1991 and the end of December 1994, at least 11 000 people obtained recognition of their diplomas in accordance with Directive 89/48/EEC. Of these, 1 450 were physiotherapists (an average of 310 per year or about 1.5 per 1 000 active physiotherapists). However, nearly 6 000 of the total number of diplomas were recognised by one Member State alone - the United Kingdom. The statistics also show that most applicants are successful in obtaining recognition. Negative decisions run at around 5 % of the total number of applications. Few appeals have been made against negative decisions.

Within the healthcare sector there is most likely a higher rate of mobility than our statistics show. Short-term movers, going in and out of the labour market for vacancies or for vacation work do not count. Likewise, health professionals moving for educational reasons for long or short periods do not count Neither is it known what happens to those who commute daily cross-border, maintaining a domestic address in the home country while working in the neighbouring country. How strictly employers follow the need for recognition of diplomas is difficult to say. If an employer has employed from a certain school previously, it is likely that the procedures are not followed so strictly. Procedures followed by public and private institutions may vary considerably.

5.2. Barriers to mobility

The figures above show differences in the rate of migration according to both profession and country. We also see that there is a certain imbalance between countries exporting and those importing qualified workers. These differences show that we speak of relatively small numbers, at least in proportion to the number of national professionals. We will therefore conclude this chapter with a more general discussion of factors influencing migration, and barriers preventing migration.

The proportion of EU citizens in each Member State with a foreign-born population varies considerably. Lately, there has been a general stagnation in migration of labour between EU countries. According to Werner (1996), economic theory provides two hypotheses why workers move. According to the integration theory, the creation of a single market generates additional welfare effects by enabling labour to move to where it is more productive. Prerequisites are, of course, that the labour market is mobile, that workers know about job opportunities in other countries, that no other constraints on migration exist either in the narrow sense - work permits, residence permits - nor in the broader sense - recognition of qualifications, cultural differences, living and housing conditions and language.

An economically-motivated potential for migration arises when varying levels of economic development exist between countries. More specifically, we can identify push factors in the emigration countries and pull factors in the immigration ones. Pull factors are the prospects of higher pay and the availability of jobs in the respective country. Push factors can be lack of employment prospects, unemployment or low income in the home country. There is a potential for migration if there are push factors in one country and pull factors in another.

All the investigations (Werner,1996) conducted so far on voluntary migration indicate that a major determinant is the differential in economic development and hence earning opportunities. But the emigration push does not solely depend on the absolute differences between income levels in the country of origin and the target country. The relative level of pay in the country of origin is important as well. When income is above the poverty line and

reaches a socially acceptable level, reasons to emigrate disappear. The absolute earnings differential must be considerable to cause labour to move, otherwise people tend to stay. Two decades ago in Europe the wage ratios between the richer countries in the north such as France and Germany and the poorer ones in the south such as Spain and Greece, were something like 6 to 1. Migrants arrived from the south to the north to take advantage of higher wages. Nowadays the wages ratio is something like 3 to 1 and relatively few people migrate, even though it is easy for EU nationals to work in other EU countries. If we compare the wages of a nurse or a doctor in Greece to that in Norway, the ratio is close to 4 (Norway) to 1 (Greece). The official wage is one matter but additions and benefits to wages are another. We definitely do not see a flow of doctors and nurses from Greece to Norway, so wages alone do not seem to attract labourers within the EU/EEA, yet at the same time, Greece exports the majority of its diplomas to Norway.

Before migration actually takes place a lot of conditions must be met. First of all a person has to want to move. Who moves and whether they move or not, is a question that is rarely asked by researchers. Barriers to mobility can be looked at on three different levels; the individual, national and supranational levels.

In late 1996, the European Commission published a green paper on obstacles to transnational mobility with an inventory of barriers that can be addressed at European level. On the national level, legal barriers such as work permits and residence permits have been more or less abolished within the EU. There are still administrative impediments such as differences in tax measures, social security systems and pension rights. There are examples of people who lose their right to unemployment benefits when moving from one country to another in search of work. These are important barriers which the Commission has to overcome if they want free movement of people within the EU/EEA.

Workers willing to move must be informed about conditions in the receiving country and that country must be accessible in terms of legal entry. In the EU context, work permits or residence permits no longer play a role, but cultural and language differences still exist and act as barriers to international mobility. On the individual level, a major problem is lack of information - where and how you get hold of the required information. For the majority of people, mobility is not something they want to tackle, they lack motivation and cannot see what they can gain in moving to another country. There exists a great amount of negative prejudice concerning the inhabitants, the culture or the landscape of countries other than our own. Distance is important, migrants are more likely to follow the routes previously taken by family or friends.

The economically motivated decision to migrate is dependent upon the expected transaction costs. Decisions concerning migration can only be made if all transaction costs are taken into account. Knowledge about transaction costs is a prerequisite for being able to distinguish between economic conditions of the home country and those of the host country. Examples of transaction costs are, for instance, the expected wage differentials, mobility costs, differentials

in the cost of living. Normally, if the transaction costs exceed individual gain, migration does not occur.

The decision to migrate will usually be affected by the following factors; unemployment, age, family circumstances, education and distance. Studies of migration repeatedly point to the central role of age. The older a person is, the less likely he or she is to migrate. There are various reasons for this; higher migration costs, size of family and the psychological cost which may rise with age. For youth, the requirement of two years' professional experience can work as a disadvantage. Article 3 (b) prevents young members of unregulated professions from moving to a Member State that regulates the profession until they have acquired the necessary professional experience. This in turn results in pressure being exerted on national authorities to regulate professions currently open to all.

As mentioned earlier, language is of course one of the biggest barriers especially within the health sector where the ability to communicate with a patient is of ultimate importance. This does not, however, mean that language barriers are impossible to overcome. A majority of examples to the contrary prove this. In fact, the possibility of learning a new language can also work as a positive factor in migration.

5.3. Conclusion

Statistics on mobility among health professionals are not readily available. Traditional sources like Eurostat and the labour force survey do not categorise health professionals. However, the European Commission gathers statistics from different countries every second year and distributes them. Within the healthcare sector there is most likely a higher rate of mobility than our statistics show. Neither short-term movers going in and out of the labour market nor vacation workers count. Moreover, health professionals moving for educational reasons do not count either. Some migrants may have received academic recognition of their papers but apparently these are not included.

Between 1993 and 1996, a total of 43 809 applicants within the health sector had their papers recognised. In 1997-98, a total of 13 522 applicants in all sectors had their qualifications recognised. Overall, the numbers are not high but it is extremely important for each individual to have his or her papers recognised in as simple and smooth a manner as possible. Between 1993 and 1996, about 15 % of applicants were subject to compensation measures of which 63 % required adaptation periods and 37 % aptitude tests. Approximately 12 % received a negative decision. The profession of physiotherapist seemed to be the one which moved most under the general system.

For the most part, people do not wish to move, yet the European Union has as one of its basic goals, the free movement of people. A series of concrete measures to ensure that more people can take advantage of their right to free movement within EU has been implemented. The main conclusion is, that apart from a few exceptions, the legislative framework to ensure free movement of people is in place. The question is, what effects these policies have had in the context of the different directives.

6. Effects and efficiency of policies on transparency and recognition of qualifications

Fisher and Staubhaar (1996) describe how the Nordic countries have had a common labour market, a passport union and agreement on non-discrimination and far-reaching social rights for people migrating from one Nordic country to another for more than 40 years. The culture, lifestyle and climate in the four Nordic countries are similar. Danes, Swedes and Norwegians can understand each other's languages. Finnish is different, but there is a Swedish-speaking minority in Finland. This has not lead to any mass migration. On the contrary, migration levels have fallen in both absolute and relative terms. Internal migration levels in the Finnish provinces between 1970 and 1989 were one to eight times greater than migration to the rest of the Nordic countries. Norwegians migrated one to seven times more frequently to another Norwegian province than to another Nordic country.

The organisation of the healthcare sector within the Nordic region is fairly similar, the welfare state is more or less the same, so the personal costs in moving when comparing tax and benefits, are not too great. Even so, people do not want to cross borders to live and work. While Norway has experienced a lack of nurses over recent years, Sweden and Finland have had unemployed nurses. The Ministry of Labour (*Arbeidsmarkedsetaten*) has campaigned in Sweden, Denmark and Finland over the past years and in 1995-96 quite a lot of nurses from Sweden went to work in Norway, but most of them stayed only a short time and went back to their home country as soon as they secured employment there. Despite a lot of effort in recruitment and offering language courses to Finnish nurses, most of them return to their home country within one year (Sykepleien, 1999).

Labour is more or less immobile in international terms unless forced to migrate. Young, well trained people are the most likely to move to another country, often in search of adventure or personal enrichment. European labour has not reacted much to the opportunity of free movement within a common labour market nor to the single market of the European Union. European labour prefers (and can afford) to stay unemployed in certain locations rather than considering international migration. The Nordic experience shows that the vast majority of people want to live, work and stay close to their roots (Fisher and Staubhaar, 1996:209).

Despite the small flow of immigrants it is still important for those individuals who want to move that their qualifications be recognised. A large portion of the professions in the health-related sector come under the existing directives. The figures collected by Member States, together with information obtained by the Commission, show that the directives have made it possible to recognise a large number of diplomas for various professions in the health sector.

6.1. Directives on mutual recognition and their effect on the health profession

It seems that the directives work satisfactorily in the health sector. However, as we can see from the table below, there are also a number of complaints. According to the 1996 report to the Commission these have been the result of individual circumstances and have not raised more general problems of interpretation. But at the same time it is interesting to note how many applications for recognition are denied. What we cannot see, unfortunately, is why the application was denied. There is no indication of the origin of those who were unsuccessful in their attempt to gain recognition of their qualifications.

Within the area covered by the sectoral directives, approximately 25 000 people obtained recognition of their diplomas in the period 1995-96.

Table 11 Mutual recognition in the area of qualification for regulated professions

Profession	Total number of applicants	Number of complaints 1994-96
Doctors 1995-96	18 336	30
Nurses 1995-96	3 598	18
Dentists 1995-96	952	29
Midwives 1995-96	324	
Veterinarians 1993-94	1 988	1
Pharmacists 1993-94	306	2
Physiotherapists 1995-96	1 015	
Paramedics		26

Source: Commission departments.

According to the latest statistics from the Commission, a total of 13 522 applications were received. Of these, 10 629 were granted a positive decision (8 498 immediate), 11 334 applications were completed and 705 resulted in a negative decision (606 immediate). The number of negative decisions appears to be falling. Over the years it has varied between 5 % and 12 %, currently it is approximately 5 % negative decisions.

Differences in education and training have led to compensation requirements usually involving adaptation periods. Migrants sometimes consider the compensatory measures required for obtaining recognition of their diplomas to be exaggerated. The existence of substantial differences in the content of courses is often a factual matter which the migrant can contest under national law. The Commission services have not yet heard of any cases in which a ruling has been given by a judicial authority on compensatory measures. An example is the

profession of physiotherapist, which comes under Directive 89/48 for most Member States but is covered by Annex C to Directive 92/51/EEC for Germany, since the level of training is different. Following discussions, an agreement was reached between Germany and Austria and these talks are continuing between the Netherlands and the United Kingdom with a view to facilitating the migration of physiotherapists.

There is evidence that the use of compensation requirements is declining since competent authorities are becoming increasingly familiar with qualifications awarded elsewhere in the Community and therefore see less need for implementing them. Perhaps this is also because migrants are being better advised by their universities and professional associations and are better prepared for the requirements of practice in another country.

According to the general system, the profile of professional activities must broadly correspond. It is not enough that the name of the profession is the same. This is particularly important in professions supplementary to medicine. In some countries, practitioners have patients who refer themselves directly and who are trained in diagnostic work and treatment planning, while in others, similar health professionals work with patients referred to them by a medical practitioner (Europe open for professions, 1997). When a Member State refuses recognition of a diploma on the grounds that the profession for which the migrant is qualified is not the 'same profession' as that which he/she is seeking to exercise, the question is principally one of fact and can only be determined adequately by a national court or tribunal with the assistance of experts (for example, *psychologue clinique*/clinical psychologist).

These problems mostly arise in the sector of non-traditional medicine. An activity such as that of chiropractor is a specific profession in certain Member States, while in others activities related to the 'art of healing' are strictly reserved for medical practitioners, in which case the professionals concerned cannot migrate. Migration is possible only to a Member State where non-medical practitioners are authorised to practise the profession. For certain activities there may be various levels of competence corresponding to different types of training. For example, alongside the training of physiotherapists there are shorter courses for the profession of assistant physiotherapist or exclusively for masseurs. CPSM provided us with an anecdote on what can happen when you cross a border and keep up the same working practice as at home. A UK-trained physiotherapist went to France and continued to work as a physiotherapist within the UK scope of practice. She was then sued by a French doctor for carrying out physiotherapy that he would normally have undertaken (and been paid for). It pays to be careful when you cross borders and ensure you are working according to national rules.

Recognition of professional qualifications is conditional on equivalence between professions and is not meant to make it possible to pursue an activity completely different from that for which one was trained. To put it another way, directives cannot be used to allow migrants to upgrade their professional status solely by crossing a border.

The Commission is also continuing its examination of the formalities surrounding the presentation of documents in support of a recognition request. In many cases, translations of diplomas are required and some Member States require the translation to be undertaken by certified or approved translators. This can be an unnecessary expense for the migrant and in an ideal world would not be necessary if the paperwork followed a certain pattern which was recognisable to all parties involved in the process.

Member States are required to reply to requests for recognition by way of a decision within four months of presentation of all necessary documents but there are indications that this is not the case. On several occasions, individual cases have been brought before the Commission services where the deadlines provided for in Article 12(2) of Directive 92/51/EEC for the taking of decisions have not been met. Many of these cases are related to late implementation of the second directive. In general, this situation has since improved. The most frequent cases relate to situations where migrants hold qualifications dating back in time and where qualifications have since changed. This makes it difficult for the competent authority to make a ruling.

Most countries have a strong belief in their own educational system and are sceptical towards others. Several coordinators contacted for this study have expressed concern about mutual trust and whether they are in possession of all necessary information.

The sectoral directives for the nursing profession (77/452/EEC and 77/453/EEC) regulate the question of recognition of diplomas but this recognition is restricted to general nursing. Many nurses have a basic education as a general nurse and in addition a specialisation (e.g. paediatrics or intensive-care). However, the directives on the general system exclude from their scope professions for which there is a specific directive. Consequently, if a Member State recognises only the profession of general nurse, migrants with specialist nursing diplomas cannot take advantage of the directives on the general system nor of the nursing directives. They can, however, invoke the provisions of the Treaty as interpreted by the court in the *Heylens* and *Vlassopoulou* judgements. The Commission proposed to solve the problem by making such cases subject to the general system; the provisions of the proposal for a 'third' directive were transferred by the Council into the proposal for a directive known as SLIM (simpler legislation in the internal market).

A major, general problem has concerned Greece, which by August 1998 had not yet implemented Directive 92/51/EEC because the competent authorities refused to apply it. In the Commission's opinion, the authorities are obliged to apply the directive even if it has not been formally implemented in national law. This issue affects a number of professions, including physiotherapists with diplomas awarded to Greek nationals in Germany. The information supplied by the Greek authorities states that national commissions began examining individual cases in January 1999. This follows on from the major delays in implementation of Directive 89/48/EEC in Greece, currently the subject of legal proceedings relating to fines and continuing evidence of non-application of implementation measures. This

No statistics were received from Italy for 1999.

(c) Germany:

According to the report there have been few migrants to Germany since the entry into force of the directive in 1991. In Germany, the *Länder* are responsible for data on health professionals and these data were not ready, but the trend is similar.

For 1999, they cannot supply any statistics on mobility among health professionals but enclose a list of addresses of competent bodies for the recognition of health qualifications. There are different authorities responsible for recognition of the different professions, as well as in the different *Länder* within Germany. We received 169 different names and addresses, which we did not contact.

(d) Ireland:

There is a low number of applicants and it is said that this reflects the employment situation in Ireland during the period, in which they received three opticians (automatic acceptance), The Ministry of Health did not receive any applications. However, certain professions like medical laboratory technician, optician, pharmacist, physiotherapist and social worker, require registration and the registration bodies would have information on the origin of those registered with them.

For 1999, we received no information on mobility.

(e) Greece:

For the same period in Greece there was only one applicant interested in working in Greece and that was a chartered accountant. We did not receive any statistics for 1999.

(f) Netherlands:

The figures show that a total of 56 applications were made under the directive and of these, 15 were within the healthcare profession: 9 physiotherapists (6 automatically accepted); 1 dietician (accepted); 2 chiropodists and 3 occupational therapists were under consideration.

We did not receive any statistics for 1999.

(g) Denmark:

There were 33 applicants. Of these, five were Danish nationals who had obtained their diploma in another Member State; 21 applications were automatically approved and four were

is not a problem concerning Greece alone, but also Belgium, France and Portugal (report on Directive 92/51/EEC, 1999).

6.2. Comments from Member States

Regarding Article 11 of the general directive which obliges Member States to furnish a report at the end of every two-year period, we will summarise the 1991-92 report. This is the first report to give a good indication of how the directive works. At the same time we wish to present new data with a view to finding possible interesting changes. The coordinators of Directives 89/48/EEC and 92/51/EU were asked to submit any statistics they had on mobility among health professionals, new or old. The following will outline what information was gathered and give a picture of the situation in different countries.

(a) France:

According to statistics from November 1992, of the 804 applications for authorisation to pursue an activity submitted under Directive 89/48/EEC, 75 % concern masseurs/physiotherapists, 12 % speech therapists and the remainder occupational therapists, laboratory assistants, manipulators of medical radiology, dispensing opticians, chiropodists/podiatrists and hearing-aid dispensers. The Belgian applicants, 44 % of whom are of French nationality, account for 82 % of total masseur/physiotherapists applications. French nationals take advantage of training opportunities in Belgium, which are less expensive and do not have the drawbacks of selection on admission. The pattern of migratory flow for speech therapists is similar, 97 % of total applications are Belgian, the others come from the Netherlands, UK and Ireland. The French are concerned and state:

> 'Occupational demographic policies are not harmonised in the Member States. Some countries endeavour to control flows of professionals while others, such as Belgium and Germany, train an overabundance of professionals that far exceed their own requirements. This lack of regulation produces an imbalance which, if not corrected, is liable to upset the balance of our system of professional training and practice.'

Exactly the same concerns were expressed by the French in their 1999 report.

(b) Italy:

In the summary for 1992, Italy had 96 applications and in the case of six applicants recognition was granted immediately. There were five applications as social workers and all had a positive decision. The Ministry of Health received 10 applications as physiotherapists, laboratory technicians, psychotherapists, medical radiology technicians, speech therapists and assistant director in nursing.

immediately rejected. Fourteen of the applicants belonged to the healthcare sector and of these 13 were automatically approved.

We did not receive any statistics for 1999.

(h) Spain:

Spain has seen a marked increase in the number of applications in the last quarter of 1992, when they received 234 diplomas; 201 were recognised immediately; in the remaining 33 cases the applicant had to take additional tests.

We did not receive any statistics for 1999.

(i) United Kingdom:

Since implementation of the directive there have been 2 711 full applications; 2 050 immediate acceptances; 136 rejections; 115 aptitude tests and 43 adaptation periods. There were five appeals to competent authorities in 1991. Regarding healthcare professionals, a total of 336 applications were registered while 310 were immediately accepted. The United Kingdom provided statistics on nurses, doctors and midwives for 1998, indicating the country from which they came and the one in which they were qualified.

In 1998, the UK recognised 1 660 doctors who were nationals of a Member State and who, by virtue of the directives for doctors, obtained authorisation to practise. During the period 1994 to 1998, a total of 43 doctors from Iceland and 51 from Norway had their qualifications recognised. In addition, there were 348 specialists, Community nationals, authorised by virtue of the directives for doctors to practise as specialists in 1998 (five from Norway). In this period, the majority of applicants originated from the following countries: Germany 74; Greece 69; and Italy 45. Between December 1976 and December 1998, the UK recognised 18 851 doctors.

In 1998, the UK also recognised the qualifications of 1 156 nurses from the EU/EEA, responsible for general care. The majority of these applicants originated from the following countries: Germany 229; Finland 226; Ireland 143; Sweden 140; and Spain 126 nurses.

The UK further recognised 75 midwives in 1998, with 19 from Ireland and 17 from Finland.

(j) Finland:

In 1999, the coordinator supplied an address from which statistics and information on mobility among health professionals could be found. Unfortunately this did not lead anywhere.

(k) Liechtenstein:

In 1999, Liechtenstein supplied information showing that between 1995 and 1999 only 28 people requested recognition, of whom nine were doctors and five were dentists.

(l) Norway:

In 1998, Norway received a total of 313 applications from the sectoral directives and of these only six were not accepted. These included: 230 applications from doctors (166 from Germany); 12 applications for dentists (seven from Denmark); 69 applications for nurses, of which five were not accepted (32 from Germany); and, two midwives, one of whom was not accepted and the other from Belgium.

There were 489 other health-profession applications in the period of 1997-98. Of these, 395 obtained a positive response, 199 were subject to a period of training and 26 others received a negative decision.

(m) Sweden:

In 1999, the coordinator supplied an address to obtain statistics, but this did not materialise. They suggested that we contact DG Internal Market.

(n) Austria:

In 1999, the following were recognised: in the sector for general medicine, 146 doctors from EU countries; in the sector for specialists, 353 from EU countries; and in the sector for dental surgery, 58 doctors from EU countries. Since 1994, a total of 483 nurses from EU countries have been recognised. Also, in 1996, there were 21 veterinarians recognised, followed in 1997 and 1998 by 19 and 20 veterinarians, respectively.

The overall picture shown above by the different countries is that there is not a great flow of health professionals moving from one country to another. The other main impression (after discussing this matter with different competent authorities and some health professionals who have actually moved from one country to another) is that there are no big obstacles to moving.

6.3. Possible policy measures to support mobility among health professionals within the EU/EEA

There seems to exist a genuine wish to make it possible for people to move from one country to another within the EU/EEA, at least if we use the political decisions at European level as

our reference point. A lot of goodwill can be detected in existing documents from the EU/EEA on the matter.

The same seems to be the case at administrative level where the 'guide for users of the general system for the recognition of professional qualifications' exemplifies this. This guide is designed for those wishing to practise their profession in a Member State other than that in which they obtained their professional qualifications. It describes the main aspects of the general system for the recognition of professional qualifications. The guide is divided into two parts, both of which are in question and answer form. The first part answers the questions most frequently asked about the general system, such as: Who does it apply to? How does it work? The second part answers a number of specific questions which may arise in the course of applying for recognition under the system. There is also a flow chart giving a summary of the conditions which must be satisfied in order to be covered by the general system. The guide also supplies three annexes: an illustrative list of regulated professions covered by the general system; two lists of regulated professions not covered by the general system; and, a list of contact points for the recognition of qualifications.

As mentioned, we can clearly see that there is good political will to encourage mobility. This is also shown through 'the code of conduct' approved by the group of coordinators for the general system of recognition of diplomas. As stated in their introduction:

> 'However, directives, by their nature, set out administrative formalities very broadly and the implementation of these rules varies from one Member State to another. Experience has shown that some of these administrative formalities could be justified on the basis of the smooth operation of the system, while others created excessive obstacles to the right to freedom of movement of the migrant.'

This is an effort actually to define best practice, acceptable practice and unacceptable practice. According to best practice, a migrant should be notified of what documents might be missing within one month of application and when all documents are gathered the four-month period begins.

The Commission recently carried out a survey on social workers, childcare professions and psychologists/psychotherapists. The aim was to get an overview of current training and the standards applied by different national professions. While providing useful information, the biggest finding was the lack of follow-up by Member States. Between five and seven countries did not respond to the survey. This might indicate that questions related to recognition of qualifications are not given high priority by these Member States. This has partly been confirmed by the lack of follow-up to Council resolutions regarding transparency of qualifications. Top-down legal and political actions cannot alone solve the problems faced. These instruments have to be supported by a genuine willingness at national and regional levels to comply with the rules and procedures laid down. If this is not the case, the individual user will eventually be the one to suffer.

A few cases have been taken to court (regarding Directive 89/48/EEC) but to our knowledge, none of these involved health professionals. The case most frequently referred to is the 'Vlassopoulou case' (ECJ 340/89). A Greek lawyer, registered with the Athens bar and holding a doctorate in law from the University of Tubingen (Germany) was prevented from registering at the German bar as a *Rechtsanwaltin*. Her legal qualification was deemed to be inadequate. The European Court of Justice (ECJ) ruled that an individual's professional experience must be taken into account as well as his/her original qualifications. However, the existing Treaty rights and ECJ case law do not oblige Member States to accept qualifications gained in other Member States; they merely uphold the legal principle that national authorities may not reject such qualifications without good reason.

Attitude towards foreign labour is an interesting issue. Random enquiries indicate that most employers favour a national candidate to a foreign one. One reason given is that the foreign professional cannot carry the same workload, their language is poorer and they take longer to fill in patient reports and forms. There is no systematic research evidence to confirm this, it is more an assumption that needs investigation.

One aspect of labour mobility in the health sector which has been stressed by CPSM is the matter of public protection. Today, there is no guarantee, in the case of a person who has been struck off the professional register because of incompetence, fraud or criminal convictions in one country, that this information will be passed along to the next country. These are difficult matters, but it should not be possible to continue to work in a host country if your home country has stricken you from the professional register and declared incompetence.

Two local examples encountered during this study serve to illustrate how two similarly-situated women can have entirely different experiences. Both women were Greek nationals, both were educated in Sweden, and both returned to live and work in Greece. One of the women, a dentist, had no problems whatsoever in opening a dental practice in Greece. In her case, the basic agreements set out in the sectoral directives worked well, and her Swedish qualifications were transferred into the Greek system. By contrast, however, the other woman, a nurse, had big problems having her qualifications recognised by public hospitals (in the same way as dentists, general nurses are covered by the sectoral directives). Her only recourse was to take the case to court which she could not afford to do. It should be mentioned that her problem was limited to the public health sector, private hospitals welcomed her qualifications and experience. These two different scenarios indicate that barriers to the transfer of qualifications are not entirely linked to legal and formal rules, but also to the attitude of bureaucracy.

6.4. The aspect of information

While transfer of qualifications depends on the removal of basic legal and administrative barriers, this in itself is not enough. Individuals wishing to move must be made aware of what is legal and what is not, where to seek support and advice and whom to address. The question of access to information is thus an important one; how easy is it to get the necessary information?

To get at least an initial impression we must put ourselves in the position of potential migrants seeking information, mainly through the Internet. The Internet has big potential as a provider of information in this respect and our general impression is that this potential is still not being fully realised. The first problem is finding a logical entry point to mobility-related information. Web pages on mobility exist, but to find those pages containing critical information describing in a simple way which rules apply, what support can be sought and where to go for further information, is the difficult part. There is valuable information put on the net; the problem is it tends to disappear in the sea of not-so-valuable information. Logical entry points with follow-on logical information paths tailored to the needs of the user are sorely needed.

The EURES site, administered by the EURES network (European employment service) is a positive exception to the somewhat confusing and not very user-friendly Internet. Established in 1994, EURES is a Commission initiative linking national employment services in all Member States and the EEA. Besides having more than 500 EURES advisers throughout Member States, all services are also available via the Internet. However, while the access and set-up of the service is good, what is actually offered in terms of vacancies is somewhat disappointing.

In September 1999, we approached the EURES job-search site to see what was available within the European healthcare and life science professions. The result was 110 vacancies. At the same time, the municipality of Oslo (Norway) announced 510 vacancies. Those positions were not visible on the EURES system. We repeated the search in March 2000 and all vacancies in all occupations on EURES totalled 5 734, in Norway alone there were 1 236 vacancies. Checking on healthcare and life science associate professionals, there were 159 vacancies, for nurses alone in Norway there were 1 043. The EURES job-search site is supposed to be linked to national employment services, but this does not appear to be the case. This exemplifies an important problem; mobility presupposes information on available jobs.

The coordinators of Directives 89/48/EU and 92/51/EU have previously been presented as important sources for information. During our search of the Internet, this structure immediately became visible. On the EU Commission's website, both DG Internal Market and DG Education and Culture present lists of contact points and coordinators (as well as NARIC, for academic recognition). Having found the lists, we began our attempt to gather information.

This was done firstly by telephone, many times and at different times, to no avail. This was obviously not the way to go. This was followed by sending first one fax and then another. Table 12 below indicates the results of this endeavour.

Table 12

Country	DG Internal Market/ DG EAC Contact point 89/48/EU	DG Internal Market/ DG EAC Naric	Telephone contact	Fax 1 14 July 1999	Fax 2 7 September 1999
Austria	Same name/adr/tel	Different name/adr/tel	No	No	OK 24 February
Belgium (French)	Same name/adr/tel	Same name/adr/tel	No	OK 16 July	
Belgium (Dutch)	Different name/adr/tel	Different adr/tel/fax	No	No	
Denmark	Different tel/fax	Same name/adr/tel	Yes		OK 17 January
Finland	Different name adr/tel/ fax	Different name/adr/tel/ fax	No	OK 16 July	
France	Different name/adr/tel/ fax	Different name/adr/tel/ fax	No	No	OK 4 November
Germany	Different name/adr/fax	Different name/adr/fax	Yes	No	OK 19 Nov.
Greece	Different tel	Different tel	No	No – fax number is a café	No contact tel or fax
Iceland	Same name/adr/tel	Same name/adr/tel	No	No	No
Ireland	Different name/adr	Different name/adr/tel/ fax	No	No	OK 8 February
Italy	Different fax	Different name	No	No	No
Liechtenstein	Only listed on DG EAC	Only listed on DG EAC	No	OK 20 July	
Luxembourg	Different name/tel	Different name/tel	Yes	No	OK 15 Sept.
Netherlands	Same name/adr/tel	Different name/tel	No	No	No

Norway	Different name/tel	Different adr/tel/fax	No	No	OK 22 Sept
Portugal	Different tel	Same name/adr/tel	No	No	No
Spain	Different name/tel/fax	Different name/tel/fax	No	No	No
Sweden	Different name/tel/fax	Same name/adr/tel	No	OK 31 August	
United Kingdom	Same name/adr/tel	Different name/adr/tel/ fax	Yes 14 July		

As seen above, a seemingly very easy task turned out to be one of the most interesting parts of this study. While there is a lot of goodwill and potential to obtain information freely and quickly, it would seem that goodwill is not always enough. Both DG Internal Market and DG Education and Culture offer lists of contact points and coordinators, yet upon closer examination and comparison of these lists it becomes apparent that the two lists are different. Only two countries have the same name, address, telephone number or fax number listed the same way on both lists.

We managed to make telephone contact with only four coordinators, but spoke to a lot of nice, helpful people along the way. It must be said that many tried to help by giving new phone numbers or names to contact. In spite of repeated attempts by phone and/or fax, however, six countries were impossible to contact. We received the last response by 24 February 2000, eight months after we began our struggle to collect information.

The intention behind the coordinator group is to support a smooth flow of information between the Commission, the Member State and its inhabitants. It is implemented from the top down. Given the results of our study and the difficulties we encountered in getting information, it is hard to imagine how an 'ordinary person' would achieve much by following the same path. When systems are created it is vital to remember who they were created for and to keep looking at them from the user's point of view.

We wanted to investigate how easily accessible the information was to 'real people.' Evidently, everything does not work as smoothly as suggested in the documentation. We tried to get in contact with four different health professionals from four different parts of Europe. We wanted to reach the most common professionals like nurse, midwife, doctor and veterinarian. This was far more difficult than anticipated. We did get hold of some professionals who were willing to send their papers across Europe to see what would happen but the endless wait for addresses from coordinators/contact points led to the experiment being abandoned.

6.5. Conclusion

The main political and legal instruments (sectoral and general directives) seem to work and health sector professionals are the main users of these instruments. There is also evidence that the use of compensation requirements are declining, indicating that competent authorities are becoming increasingly familiar with qualifications awarded elsewhere and therefore see less need for them.

Taking into account the relatively small number of people actually transferring their qualifications from one country to another, there seems to be substantial potential for further initiatives and support.

Basic information on the availability of jobs can be improved. The EURES system is a good instrument in this context but our experience indicates that only a small percentage of the jobs (in the health sector) announced nationally are announced by EURES.

From a user's point of view, it is difficult to get in contact with the support system established as a result of the directives. While the system is logical and well-constructed from a 'systems point of view,' it tends (in part) to be impossible to access from a user's point of view. The attitude to migrants in general and to the transfer of qualifications in particular tends in some cases to counteract the intentions expressed by the legal and political initiatives at Community level. This is a problem faced by the individual user and there are no measures in place to help.

The conclusion is that while a number of positive steps have been taken at legal and political levels, the full effect of these advancements relies on the availability of information and support structures aimed at the individual migrant, not at bureaucracies or politicians.

7. Conclusions

Generally speaking, the right to free movement has so far not led to large-scale exchange of workers between Member States. In spite of considerable differences between countries and regions with regard to income and unemployment rates, labour migration has still remained at a lower level than expected. The number of EU national residents in another Member State is only 5.5 million out of 370 million, approximately 1.5 % of the population. A total of 12.5 million third-country nationals reside within the EU. Approximately 5 % of the population living within the EU are 'foreigners.' The situation within the health sector is not much different. In the period 1993-98, 57 331 health professionals asked to have their qualifications recognised in another Member State. This means an average of less than 10 000 a year. Even considering an additional group of 'health migrants' which has not been counted in the statistics, the fact that these are figures cover 18 countries underlines that migration is still very low.

There are many factors indicating that this will change. An increasing need for mobility among health professionals can be detected. Some countries such as Germany educate more health professionals than they need, while others are in desperate need of some professions. The UK in particular is advertising for health professionals. According to both coordinators and CPSM, the UK is in desperate need for almost all kinds of health professionals. In Norwegian professional magazines there are several international recruitment agencies who advertise and assist the health professional to get in contact with hospitals, communities, accommodation and registration/recognition of their qualifications. This shows there is a need for mobility and that jobs exist within the EU/EEA area. The other side of the coin is illustrated by Sweden - educating far too many dentists and forcing them to go abroad to find work. According to some dentists with whom we have spoken, transfer is normally not a problem within EU/EEA.

This is the core of the matter. We can observe imbalances both in educational supply and in the labour market itself. Increased mobility could probably contribute to solving some of these problems. Summarising the discussion so far, we will try to isolate the various factors supporting and preventing transfer of qualifications, i.e. mobility within the health sector.

7.1. Factors supporting transfer of qualifications

The directives: the evidence presented in this report clearly demonstrates that the main intentions behind the different EU directives have been fulfilled for health sector professionals. More than in other sectors, individuals working in this area use the opportunities provided by the directives. The numbers are not high compared to the total workforce, but a substantial number of individual health workers are allowed to transfer their

qualifications between the different Member States every year. There is also evidence indicating that a certain *de facto* harmonisation takes place. The number of compensation requirements have decreased meaning that the authorities in various countries are getting used to each other's qualifications and/or that certain adjustments have been made in the education and training provisions of the Member State.

The following example can be used to illustrate this. A German couple, a doctor and a midwife were interviewed in a newspaper from northern Norway (Nordlands Framtid, 4.8.1999). They were newly arrived from Germany and looking forward to working in a small community. According to them there was some unemployment among health professionals in Germany. They had found jobs through the Internet and had spent two years planning the move. Learning the language had been a big task but while not fluent, they managed to master it. Likewise, the example of teacher migration to the UK also demonstrates that the general system is capable of responding to socioeconomic demands of the internal labour market and therefore of contributing to a reduction in unemployment. It also illustrates, incidentally, that such demands may influence the way in which Member States apply the directive. It is noteworthy that the application of Directive 89/48/EEC to teachers in the UK has raised few problems; in other Member States however, where there is a surplus of teachers, the application of the directive has given rise to a considerable number of complaints.

Networking and cooperation: the group of coordinators have shown great interest and enthusiasm through both their 'codes of practice' and their 12-page user's guide, which explains by way of questions and answers how the general system works. This illustrates the importance of 'networking' national systems. As long as each Member State operates on its own, it will be difficult to introduce common procedures. Networking is of course vital to the exchange of experiences in general and to support for mutual learning.

***User pressure*:** Europe is currently entering a situation where the total population is decreasing and the number of old people is increasing, consequently affecting the burden to be carried by the health sector. This is not a situation where national health systems should insist that only national qualifications are acceptable. Reactions from the public and the press show that such an approach is becoming less and less acceptable or legitimate. The future indicates that users of the health services will require that all available competences be used irrespective of their nationality.

7.2. Factors preventing transfer of qualifications

Language is a practical barrier to migration, especially within the health sector where dialogue with the patient is of ultimate importance. It is interesting to note the connection between language and border/culture and which diplomas different countries recognise. No programmes or support have been introduced to provide language training for health sector

professionals seeking to move within Europe. It is possible that such an offer, considering the specific demands of the sector, would be of some value. One idea would be to look at how existing language programmes supported by the EU (for example, Lingua) could provide support. There is evidence that language training has been offered by some Member State authorities attempting to attract specific professional groups, so perhaps these examples could form a point of departure for Community initiatives in the future.

Statistics on mobility among health professionals are not easily available and traditional sources like Eurostat and the labour force survey do not capture these professionals. The statistics gathered by the European Commission are valuable but not sufficient. As indicated, the rate of mobility is probably higher than our statistics show. Many categories (short-term movers, vacation workers, those moving for educational purposes), do not count. All this points to a need for better statistics. These data are necessary to assess developments in the sector. Combined with data on the employment situation and educational output they would make it easier to tailor initiatives and programmes.

Current ***information policies and practices*** are too unsystematic to release the full potential of mobility. This is proven at contact points and by coordinators responsible for providing information on the application of the directives. Their role is an important one; their task to ensure the uniform application of the directive to all professions concerned while fulfilling their role at an administrative level as liaisons between the Member States and the Commission, their ability to react to direct questions from users seems to be less developed. Contacting coordinators was far more difficult than expected. This illustrates the importance of upgrading information. A website for instance, does not automatically upgrade itself. Some sort of quality assurance must be built into the system to make sure that information is updated on a regular basis and that coordination between relevant authorities takes place. The quality of these support systems depends of course on available resources; satisfactory services can only be provided if the tasks and responsibilities are clearly defined and if sufficient time and money are made available to handle them.

Even more crucial is the need to develop and define one single entry point for access to this kind of information. Different sources should be linked together and structured at this point making it possible for individuals with no specialised knowledge or prior experience to find relevant information. Such an entry point should be defined at Community level, the EURES system could be considered. Since not everybody has access to the Internet, it is also important to have brochures available giving simple and accurate information and paying specific attention to current telephone numbers for contacts. A brochure recently produced in the UK entitled: 'Europe - open for professions,' is a very good example of how to present simple yet crucial information.

Differences in structures of national educational systems cause difficulties in recognition of qualifications. One example is in relation to specialised nurses. In Member States like Germany and Luxembourg, those qualified as nurses responsible for general care may take

post-diploma specialist courses. The activity of a specialist nurse is a regulated activity distinct from that of a nurse responsible for general care. In other Member States like the UK and the Netherlands, separate training courses exist for general (and some specialist) nurses (e.g. psychiatric nurses, paediatric nurses). This means that you are no longer a general nurse, but rather, a specialist. Movement between Member States (such as from the United Kingdom to Germany or Denmark) gets complicated. No longer able to rely upon the sectoral directive (Directive 77/452/EEC) because the specialist diploma in question is not what is listed in Article 3 thereof, neither can these nurses rely upon Directive 89/48/EEC as a result of the second paragraph of Article 2. The Commission has suggested an amendment which would enable a specialist nurse to obtain recognition as a nurse responsible for general care in Member States where nursing specialities are not legally regulated (report to the Parliament, 1996).

Attitudes to foreign qualifications and labour: surprisingly enough, relatively little systematic research has been done in this area. Anecdotal evidence shows that attitudes and idiosyncrasies sometimes mean more than formal political and legal decisions. In many cases employers will choose a national over a foreigner without even looking at the qualifications in question. While not speaking about direct racism (which clearly occurs), the problems of interpreting documents and making sense of foreign diplomas leads to such practices. The suggestions by the 'European forum on transparency' (February 2000) to introduce a common European format for supplements to certificates could contribute positively in this context. The same can be said of the diploma supplement now being tested for higher education. Both initiatives try to introduce a standardised way of presenting qualifications, thus making it easier for employers to make a choice between available candidates, both nationals and foreigners.

Traditionally, migration flows have been strongly determined by different levels of income between the home country and the immigration country. Motivation for migration has to come from different sources as the peripheral countries of the EU have levelled out economic development and rates of pay in Europe. Economic differences between EU countries are no longer sufficient to give rise to migration on a massive scale. There is some evidence that most moves within the Community are made for personal reasons, for example through marriage. French nationals are making increased use of their right to study in another Member State (in this case Belgium), knowing that their diplomas will give them access to their chosen profession when they return home. This certainty that qualifications actually can be transferred is of course an important motivation. As long as doubt (even unfounded) exists, it will be a big factor against migration.

So why should a person move from one country to another? European employees have so far preferred (and afforded) to stay unemployed at a certain location waiting for a job. This reflects the lessons learned from the Nordic experience; the large majority of people want to live, work and stay immobile but close to their roots (Fisher and Staubhaar, 1996).

As history has shown, given the right conditions people may actually look upon migration as a positive alternative. In the particular case of the European health sector, an increasing need for health services along with serious imbalances (in education output and labour demand) may lead to increased movement in the years to come. This requires, however, that the political, legal and administrative systems put in place to support such movement are improved and perfected.

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Mobility in the European health sector: The role of transparency and recognition of vocational qualifications

Mariann Skar

Luxembourg: Office for Official Publications of the European Communities

2001 – VI, 69 pp. – 21.0 x 29.7 cm

(Cedefop Panorama series ; 5 – ISSN 1562-6180)

ISBN 92-896-0051-9

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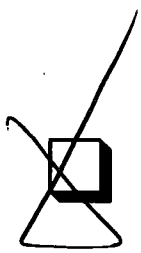

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