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Organized interests and foreign-educated professionals: The case of the associations for physicians and nurses in Sweden

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Organized interests and foreign-educated professionals: The case of the associations for physicians and nurses in Sweden

Olle Jansson

WORKING PAPER 2017:18

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Organized interests and foreign-educated professionals: The case of the associations for physicians and nurses in Sweden^a

by

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Abstract

The role and importance of employee organizations (i.e., unions) on policies concerning international migration have been studied extensively for decades. However, we know very little about the strategies of the organized interests of health care professionals. This paper will contribute to previous research, both internationally and in the Swedish context, on issues concerning the (re-)action of professional organizations towards migration reforms that might endanger the profession's control over their segment of the labor market. Through a study of the associations representing the two largest licensed health care professions in Sweden – physicians and nurses – the study investigates if, and how, they try to limit the competition in the labor market against reforms that are promoting increased mobility and international migration. The conclusions are mixed, suggesting that the long-term goals of professional associations are more important than strategies that might reduce the competition of foreign-educated practitioners in the short run.

Keywords: International migration; Regulated occupations; Physicians; Nurses; Professionalism; Migration policy; Sweden

JEL-codes: J44, J48, J51, J61

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1 Introduction

The role and importance of employee organizations (i.e., unions) on policies concerning international migration have been studied extensively for decades (see for example Hollifield, 1992; Freeman, G., 1995; Geddes, 2003; Freeman, R. B., 2006; Menz & Caviedes, 2010; Castles et al., 2014). Most of these studies have focused on labor unions representing workers, mostly in the manufacturing industries or services. There has been considerably less interest in organizations for health care professionals and their influence on policies concerning migration and the access to their occupations for foreign-educated professionals. What are their agendas and strategies? What are their views on globalization, international migration, the free labor market of the European Union, and policies that aim to facilitate increased mobility? This paper will contribute to this important but arguably ignored issue through a study of the organizations in Sweden that represents physicians (the Swedish Medical Association, SMA, *Sveriges Läkarförbund*, with 47 000 members, 80 percent of all physicians in the country) and nurses (the Swedish Association of Health Professionals, SAHP, *Vårdförbundet*, 114 000 members, also including midwives, biomedical scientists, and radiographers), and their opinions on policies concerning international migration of health care professionals since the early 1990s.

There has been considerable interest from both academics and policymakers on the mobility and migration of health care professionals and the importance of government regulations in recent decades (for example Salt, 1997; Iredale, 2001; Kingma, 2006; Bach, 2007; Inoue, 2010; OECD, 2015). Governments in several countries are interested in enabling immigration of health care professionals as they are suffering from labor shortages. Others express concern that such migration leads to a brain drain as physicians and nurses are moving from developing countries, where they are badly needed, to the developed world. There has however only been limited attention on the opinions and influence of organized professions on policies concerning migration and their involvement in the policy-making process (as pointed out in a recent research overview by Grignon et al., 2013).

Studies on the organized interests of employees on migration policies are not uncommon. A common, although neither unchallenged nor unqualified understanding of the goals and preferences of employee organizations is that they want to limit and

control immigration. Migration and increased liberalization of labor markets are often, due to increased market competition, perceived as threats to their member's jobs and incomes. If this applies to large, encompassing labor unions, it ought to apply to smaller employee organizations as well. There are however reasons to think that the organized interests of health care professionals are different in some regard in comparison to labor unions. Not necessarily different in their interest in controlling and limiting competition in their segment of the labor market, but in the way they accomplish this goal. Previous research on professions and professionalization argues that while the common interest of employees is usually associated with influence on issues such as wages and salaries, job security and work environment, the common interest of professions are centered on their particular body of knowledge, their education, and their credentials (Parkin, 1979; Abbott, 1988). While a union uses strikes and collective bargaining to reach its goals, a professional association tries to establish and change regulations that determine who can practice their professional occupation. It is in this way they can protect their member's interests against other occupational groups and control the supply of labor (cf. Torstendahl, 1997). As professions are thought to use other strategies than most other organized groups on the labor market, this ought to reflect in how they are trying to control and limit the effects of immigration of foreign-educated professionals.

The main argument of the paper is thus that professions in the health care sector, such as nurses and physicians, and their organizations, differ from organizations representing blue-collar workers and most other employee groups. These are regulated occupations which mean that a practitioner needs a professional license to be allowed to work. It might under such conditions not be in an immediate need for an organization representing regulated professionals to try to influence regulations of migration to control competition on the labor market. What they instead ought to be interested in is to what degree and how a foreign-educated health care professional can gain a license to practice within the country. This means that to investigate the influence of these organizations on international migration and mobility one has to look at other policy arenas than investigations of the policies and influence of labor unions.

1.1 Aim and contribution

This Working Paper will contribute on matters concerning the (re-)action of professional organizations towards increased international mobility and the potential

risks such developments entail for the professions ability to control the market for their services. This is achieved through a study of organizations representing the two largest licensed health care professions in Sweden: physicians and nurses. While studies on other employee organizations opinions on migration policies are common, there are few studies of professional associations. The point of departure is that such associations should use other strategies than most other unions and that this difference hinges on them being regulated occupations. The study investigates if, and how, they try to protect their national regulations and systems against the attempts to reform them with the aim to facilitate increased mobility in the labor market. The study covers the period from the implementation of the EEA-agreement in the early 1990s to the present.

The aim is to investigate if and how the professional organizations of nurses and physicians, the Swedish Medical Association, SMA (physicians) and the Swedish Association of Health Professionals, SAHP (nurses), have tried to influence the regulations that affect the requirements for foreign-educated professionals to acquire a professional license to practice in Sweden. The results are analyzed through a comparison with a research hypothesis on how professional organizations try to limit market competition from foreign-educated professionals.

There are at least two overarching reasons why it is of interest to study and compare the organized interests of physicians and nurses in Sweden during this period. The first reason is that both professions differ somewhat from each other. Physicians are one of the archetypical professions, usually attributed to a higher status (Freidson, 1970). They also have a longer history as an established profession than nurses, who at times are labeled as a sort of semi-profession, something between a “proper profession” and an ordinary occupation (Etzioni, 1969). There is consequently reason to think that the organized interests of the established profession, the physicians’ SMA, might differ in both their strategies and their ability to affect policies than the nurses’ SAHP.

The second reason is that the signing of the EEA-agreement was arguably the time when the Swedish labor market for health professionals opened up for professionals educated in other countries. Although Sweden had already established a Nordic agreement on the mobility of health care professionals in 1982, the EEA-agreement, and with Sweden joining the EU some years later, put significant pressures on national legislations and enabled migration of health care professionals to Sweden. Furthermore,

within the EU there have been continuous attempts of harmonizing the education and requirements of health care professionals as well as developing systems of recognition of qualifications to enable increased mobility, most notably through the Professional Qualifications Directive (Directive 2005/36/EC). How the professional organizations have responded to this increasing pressure relates directly to the aim of the Working Paper.

1.2 Outline of the working paper

The outline is as follows. Chapter 2 presents theoretical perspectives and previous research concerning the political economy of migration and the role of stakeholders, as well as perspectives on professional groups and their strategies. It ends with a summary and a preliminary hypothesis on what we expect to find in the investigation of the organization's stance on migration, migration policies and the regulation and validation of foreign-educated health professionals. Chapter 3 concerns methods and materials. Chapter 4 gives a brief background on the Swedish case, including significant reforms during the period studied in the investigation. The empirical chapters focus on three policy areas: *migration and migration policies* (chapter 5), *validation and complementary training of professionals with an education from a foreign country* (chapter 6) and *responses to the needs to adapt to the EU/EEA* (chapter 7). Chapter 8 summarizes and concludes the findings of the study.

2 Theoretical perspectives and previous research

This chapter will give an overview of theories and previous research about the objects of study, aim and research questions of this Working Paper. It will conclude with a preliminary hypothesis and three research questions for the different policy areas that will be investigated.

The main argument of the study is that professional organizations differ from other employee organizations. Most employee organizations act as a form of open cartels. As an open cartel, unions try to control the price of labor by attempting to draw in all potential employees into one price-setting cartel. This view has been common in historical studies on the strategies of unions in Sweden, both regarding unions in general and in reference their views and policies on migration (Åmark, 1990; Lundh, 2008; Lundqvist, 2000, 2002; Waara, 2012). Professional organizations, on the other

hand, try to establish closed cartels. By creating and promoting barriers of entry to the profession, such as occupational licensing, a successful profession can control competition on their segment of the labor market (Åmark, 1990). While a union strategy is thought to be characterized by unions putting forth demands on wages, working conditions, and contracts, a professional strategy is believed to focus on the barriers to entry into the profession, such as educational requirements, with the intention to close off their part of the labor market from competition (Parkin, 1979; Torstendahl, 1997). These differences between professional organizations and other employee organizations ought to mean that their strategies also differ regarding migration and migration policies.

The differences between the observed strategies of unions and professional organizations are often blurred, however, at times making it hard to distinguish between professions and other occupational groups. Torstendahl (1997) has, with the help of some examples, including organizations representing nurses in Sweden (based on Emanuelsson, 1990), argued that professional organizations tend to use a mix of both union and professional strategies and change their strategy over time. Sometimes they rely more on trying to control access to the occupation and warding off competition from other occupational groups, at times they act more like ‘normal’ unions, focusing on salaries and benefits.

2.1 Migration policies and organized interests

The conventional view in the study of interest groups and migration policies is that unions want to restrict and control migration with the aim of limiting labor market competition. An increased labor supply might cause a downward shift in remunerations and rising unemployment for their members. Organizations’ representing the employers hold the opposite view for the same reason, as an increase in labor supply might help keep wages down (Freeman, 2002). Empirical studies have often shown that reality is somewhat more complex, with other intervening factors also contributing to unions’ attitudes on migration policies. In a comparative historical overview, Penninx and Roosblad (2000) found that the reactions and demands of labor unions have differed widely within Europe depending on such factors as union strength, economic and labor market conditions in the country, as well as a range of other societal factors. Labor immigration policies advocated by unions can, for example, and perhaps most notably,

vary due to institutional factors (Bucken-Knapp, 2009; Menz & Caviedes, 2010; Ruhs, 2013). Particularly the access of the organized interests of employers and trade unions to the government decision-making process, and their integration in the policy-making process is often considered crucial. As unions rarely have been able to stop migration they have often tried to cooperate with the government and other key stakeholders to seek to minimize the perceived dangers of immigration. Some researchers have also claimed that immigration is framed and perceived differently in different countries and contexts, regardless of the presumed self-interests of different actors (Hansen, 2002; Haus, 2002; Watts, 2002; Lahav & Guiraudon, 2006; Stratham & Geddes, 2006).

A common theme in studies of unions and migration policies in Sweden (Lundh, 1994; Johansson, 2008; Yalcin, 2010; Svanberg, 2010) is that the organized interests of labor often prefer an orderly form of labor migration and arguing for equal rights and wages for migrants. This strategy ensures that migrant workers are included in the open cartel instead of becoming a cheaper, more controllable alternative to employers. However, as argued previously, these studies mainly focus on organizations representing blue collar workers. For example, studies of the 2008 Labor Migration reform in Sweden have mostly looked at the arguments from the unions of the Confederation of Labor (*Landorganisationen*, LO) and their counterpart on the private labor market, the Confederation of Swedish Enterprise (*Svenskt Näringsliv*, SN), not the arguments by organizations representing professionals (Bucken-Knapp, 2007, 2009; Johansson, 2014). An article by Murhem and Dahlkvist (2011) did however also include the positions of the other employee organizations on the labor market. They found that Saco, the Swedish Confederation of Professional Associations (that includes SMA, but not SAHP, who are members of TCO), and the Swedish Association of Graduate Engineers (a Saco-association), were much more positive towards a liberalization of labor migration policies than LO or the Swedish Confederation of Professional Employees (TCO). The explanation for this, they argue, is that migration does not threaten those employees that are organized by Saco, due to lower unemployment and shortages. At the same time salaries for engineers and other professional groups sometimes are higher outside Sweden (cf. Cerna, 2009). Murhem and Dahlkvist, therefore, argue that increased migration might, in fact, be in the best interest of engineers as increased mobility might lead to higher salaries in Sweden as well.

To conclude, there is plenty of previous research on unions and employer organizations, together with other interest groups, on migration and migration policies, their preferences, strategies, and influence on policy outcomes. There is however very little previous research on the preferences, roles, and influence of professional associations on migration and migration policies, even if several researchers (and policymakers) have noted the important role of regulations and licensing in the migration patterns of health professionals. Perspectives from previous studies on the influence and role of organized employee' interests are however not enough. To understand and investigate the impact of professional associations and unions on international mobility of medical and health professions, we will therefore now turn to the academic field that has specialized on professions and professionalism. These theories help us understand how they are different from other occupational groups, or at least how they can control their segment of the labor market by successfully claiming to be different.

2.2 Professionalism as a form of market control

The regulation of occupations is hardly a new area of study in Economics. In the *Wealth of Nations*, Adam Smith noted the role of a limiting the number of apprentices to reduce competitions between artisans, ensuring higher earnings. Proponents of Positive theories on regulations are working in this tradition when they argue that regulations are mainly created and upheld by interests that want to reduce competition (for example Friedman, 1962; Arrow, 1963; Olson, 1965; Stigler, 1971). However, the agency and role of interests and organizations that establish and support such institutions have received comparatively little attention in the last decades. Economists studying occupational licensing (that are common to a range of occupations in the US) tend to focus on the effects of such regulatory arrangements rather than how they come about (Kleiner, 2000). As this paper investigates the role of organized interests in shaping regulations, rather than the effects of such regulations, the focus here will be on the academic study of professions and professionalism that has a long tradition of dealing with such issues.

The study of professions and professionalization has its equivalents to the normative and positive perspectives in theories on regulation. Older studies mostly worked in an essentialist tradition, where professions were considered to be distinctly different from other occupations (Greenwood, 1962; Millerson, 1964). What distinguishes a profession

was, according to this view, their reliance and use of a shared body of theoretical knowledge, a professional competence guaranteed through examinations, and a code of conduct that guarantees that members of the profession provide their services for a common good, rather than their own or their employee's self-interest. A common critique of such perspectives is the criteria for professions were mostly uncritical summaries of the descriptions and narratives members of the professional and their organizations had of themselves (Hellberg, 1978; Brante, 2014).

Following the critiques of the essentialist school, research that viewed professionalism as a form of market control emerged from the 1970s onwards (Larson, 1977; Parkin, 1979; Freidson, 1986, 2001; Abbott, 1988). For example, Larson (1977) argued that professions purposefully and systematically organize themselves to monopolize selected segments of the labor market with the aim to create demand for their services. Thus, Larson (1977, p. xvii) claimed that...

“professionalization is ...an attempt to translate one order of scarce resources – special knowledge and skills – into another – social and economic reward. To maintain scarcity implies a tendency to monopoly: monopoly of expertise in the market, monopoly of status in a system of stratification.”

In a similar vein Parkin (1979), and others have used Weber's term *social closure* for different ways of achieving occupational monopolies and controlling the access to the knowledge, education, skills, and legitimacy that the profession is relying upon to control the market. Credential demands – such as specific education or tests – are created and encouraged by professions with the aim to “control and monitor entry to key positions in the division of labour” (Parkin, 1979, p. 48). This strategy is called *Credentialism*. In practice, this is thought to create marked insider-outsider situations, where insiders try to protect barriers of entry which shut out the potential competition of outsiders (cf. Lindbeck & Snower, 1988). In this case: nurses and physicians from other countries.

The relationship between the state and the profession is often considered important in the study of professions. Several researchers have argued that the professions dependent on the state for their very existence. Without any recognition of the state, professions have a hard time gaining acceptance for their professional knowledge and even greater

problems in establishing regulations that close off competing groups from their segment of the labor market (Johnson, 1982). Furthermore, while the archetypical profession – the physician – emerged as a group of autonomous and independent practitioners they and many other professions have been pulled into, or formed within, the modern welfare state (Burrage & Torstendahl, 1990; Erichsen, 1995). The state is thus potentially of paramount importance to the organized profession, as it enables establishing closures that are stronger than those that the professions can establish on their own. If representatives of the profession at the same time are given the possibility to influence or work with government agencies, these agencies can become vehicles of regulatory capture (Stigler, 1971).

Current studies on migrant professionals have predominantly focused on everyday working life. Including studies on how groups that are not deemed fit (depending on class, gender, ethnicity or personal characteristics) are treated differently and excluded (Salmonsson, 2014). It is arguably important for other reasons to study how their peers treat migrant professionals in the workplace. It is however not, I would argue, a fruitful way of studying how professions as a group manage their *professional project* (Larson, 1977), creates their *jurisdiction* (Abbott, 1988), or uses *social closures* (Parkin, 1979). For such an endeavor the study of organizations is necessary, and it is, therefore, important to examine the actions and statements of the organization of the profession (Evertsson, 2002, p. 202f). In this regard, there is little previous research to go on.

One of a handful of academic studies on how professional associations can affect the supply within their segment of the labor market is Groutsis (2003). It is a historical study on how the organized interests of physicians in Australia have been able to control and restrict access to services provided by migrant physicians, despite excess demand. The Australian government has placed the responsibility of assessing the standards of overseas physicians on the professional licensing bodies, i.e., institutions controlled by the Profession. This institutional arrangement has created a situation where attempts from the government to speed up the accreditation process, and thus enable increased immigration of physicians from abroad, have achieved very little. Another article is Finotelli's (2014) comparison of international recruitment of physicians in Germany and Spain. A centralized organization of the Spanish training system, together with the weak corporatist strength of the medical profession, allowed

for quick integration of foreign (non-EU) physicians into the health care system. Germany, in contrast, had institutions and systems that initially were less favorable, including a high level of autonomy and influence for professional organizations. Both these studies thus point to the importance of the interplay of health care systems, and the state, together with the institutional role of professional organizations in explaining the possibilities of foreign health care professionals to enter the national labor market (or, in countries such as Germany, establish an independent practice).

2.3 Hypothesis and Research Questions

A central argument of this paper is that organizations that represent regulated professions primarily use other strategies than labor unions to limit and control competition in the labor market. Professional organizations, this perspective argues, tries to establish closed cartels. The ability to create such closed cartels depend on their claim on privileged knowledge and expertise, an argument that their organizations use as an argument for regulating and closing of their segment of the labor market from competing groups. Credentials are therefore essential. Such differences have to be taken into consideration when trying to investigate if and how organizations representing a profession try to limit market competition from migrant professionals.

Credential requirements are what close off a profession from competing groups. Credential demands, therefore, have to be upheld and defended against any attempt to lower the threshold for entry into the profession. To be able to do so, professions are often dependent on the government. The state has the power to regulate markets in a way that is harder, or even impossible, for professional organizations to achieve on their own. The institutional arrangements between different government agencies, professional associations, and bodies and other key stakeholders thus have significant effects on rules and regulations that affect the possibilities of foreign-trained professionals in regulated occupations to acquire a license to practice.

Grounded in the theoretical perspectives of the study of professions and professionalism it is possible to formulate a preliminary hypothesis on the aim and strategies of professional organizations regarding mobility and international migration. The hypothesis is that *professional organizations will defend the need for certain specific credentials for foreign-trained nurses and physicians to gain a license to practice and to advocate increased state supervision and control.*

Based on this hypothesis, together with previous research on migration policies and health care professions in Sweden, three research questions can be formulated:

- How did SMA (physicians) and SAHP (nurses) respond to migration and migration policy reforms?

The expected result of the first research question is that they ought to have a liberal, or possibly uncommitted, take on migration policies in general. At least as long as they perceive that the controls of foreign-educated professional's credentials are sufficient. As a profession with claims to specific knowledge and working for the common good, references to supply and demand on the labor market or the work environment ought to be rare. If they have anything negative to say regarding the immigration of nurses or physicians it will be by referring to the safety of the patient or the overall quality of health care. However, considering that professional versus union strategies are ideal types and that the both SMA (physicians) and SAHP (nurses) also function as unions within the framework of Swedish labor market relations a mix of union and professional strategies might be expected. At least before the liberal reform on labor migration in 2008, when the system allowed them to stop work permits by referring to labor market conditions (see chapter 2.1).

- How did SMA (physicians) and SAHP (nurses) respond to issues that concern differences in credentials between those educated and trained in Sweden and in- and outside the EU/EEA?

The second research question relates to the importance of the state in regulating the occupation, regulations that give a regulated profession a certain level of protection from competition. Regulated health care professions in Sweden are dependent on the state and the public sector for employment and protection and will tend to support the notion of increased regulations and government intervention to mitigate potential risks and conflicts. The expected result is therefore that the associations will call for greater government control and involvement in the regulation and supervision of health care professionals that have been educated abroad. Again, as with the expected results for the first research question, this will not primarily be justified with references to labor market conditions, but by referring to the security of the patients and the quality of work in the health care sector.

- How did SMA (physicians) and SAHP (nurses) respond to proposed changes to the credentials needed for a license to practice that emerged as a result of adaptation to the EU/EEA?

The expected results from the third research question are that when changes threaten the national system of regulations of health care professionals, the organized professions will defend the Swedish regulations if they are stricter than those proposed by the EU/EEA. On the other hand, they will accept and even promote proposed changes that will increase regulations and credential demands on the profession. Regarding regulatory changes due to membership in the EU/EEA, the professional organizations will, for this reason, be expected to advocate for adaptation to stricter demands for market access, regardless if the stricter rules are the ones currently in effect in Sweden or elsewhere. If the stricter requirements are not implemented in Sweden, the members of the national organization might be disadvantaged or closed off from the EU/EEA market while at the same time being threatened with competition from other countries within the common market. This, in turn, also means that they will argue against any adaption to the lowest common denominator within the EU/EEA. Such a policy is in line with the professional strategy of credentialism, with the aim to control access to their segment of the labor market.

If the results of the empirical investigation are in line with the hypothesis, it could be argued that the organizations representing the regulated occupations under scrutiny are using a strategy aimed at the closing off the cartel to limit market competition from foreign-educated professionals. If the results do not corroborate with the hypothesis, this ought to mean that other aspects, such as the institutional framework, or that different, perhaps conflicting, preferences affect their strategies, demands, and propositions.

3 Methods and material

The aim is to investigate if and how the professional organizations of nurses and physicians have tried to influence migration policies and the regulations that determine the requirements for professionals educated in another country to acquire a license to practice in Sweden. In order to fulfill this aim, three different policy areas will be investigated: views on *migration and migration policies* (chapter 5), views on the *validation and complementary education of professionals with a foreign education*

(chapter 6), and *responses to the needs to adapt to the EU/EEA* (chapter 7). The investigation starts with the EEA-agreement in 1992. The reason for starting the investigation at this time is that it could be considered an important step towards increased labor market integration for regulated health care professions with the rest of Europe.

The primary material used for the empirical investigation consists of government inquiries and memorandums and responses to these from SMA and SAHP. Responses from organizations can be interpreted as rhetorical documents that criticize what they do not like and aims to replace them with suggestions based on their vision of how it ought to be. In most cases, the focus will be on responses of SMA and SAHP. However, in some cases, the responses from other stakeholders will also be included in the study, mostly as a way of contrasting the positions of SMA and SAHP to that of others.

This material has been collected from several archives – the archives of NBHW (*Socialstyrelsens arkiv*), the Swedish National Archives (*Riksarkivet*), and the archives of the Swedish Government (*Regeringskansliets arkiv*) – plus the webpages of some of the stakeholders and in some instances through personal e-mail correspondence with the associations. To supplement the primary source material, articles from the papers of SMA, *Läkartidningen*, and SAHP, *Vårdfacket* and *Vårdfokus* (The paper changed its name in 2010), as well as a few other opinion pieces and news articles. These articles have mainly been used to gather statements by representatives from the professional associations.

4 Background and context

This chapter will give some background and context for the empirical investigation of the paper. It will present the labor market conditions and the immigration of foreign-educated health professionals in recent decades (chapter 4.1), the regulations of the occupations and process of validation and complementary education for foreign-educated health professionals from countries outside the EU/EEA (chapter 4.2), and a summary of the most significant reforms that concerns the associations during the period (chapter 4.3).

4.1 The labor market and migration of health care professionals

Labor shortages are often described as affecting both the migration of health care professionals to high-income countries and on policies trying to facilitate and promote such a migration. Since the mid-1990s the supply of health care professionals has increased. However, the development in the number of specialists, especially nurses but also specialist physicians, has been less positive (NPS, 2012, table 1). Despite these increases, the number of physicians has not been enough to meet a growing demand for health care professionals and particularly the shortages of experienced physicians have been chronic (NPS 2016, tables 39-41).

Table 1 Share of foreign-educated physicians and nurses in Sweden and the OECD average in 2012–14

	2000	2006	2012–14	OECD-average
Physicians	13.9 %	19.3%	24.3 %	17.1 %
Nurses	2.7 %	2.8 %	2.7 %	6.1 %

Source: OECD (2015), Table 3.3 and 3.4.

Foreign-trained physicians make up a sizable minority of all physicians in Sweden, and their share of the professional workforce has increased during the last fifteen or so years (see Table 1). In November 2012 76 per cent of physicians active in the health care sector had been educated in Sweden, three per cent in other Nordic countries, thirteen per cent in other EU/EEA countries and eight per cent in other, non-EU/EEA-countries (NPS, 2015). Shortages of physicians have probably contributed to the immigration of a large number of physicians since the early 2000s (NPS, 2006, p. 35f; OECD, 2009). However, as the salaries were not much higher than in most of the rest of the EU/EEA, the immigration did not increase much until after the enlargement of the EU in 2004, when several new member countries with significantly lower salaries for physicians joined the union (Lundborg, 2014).

The role and importance of foreign-educated nurses for the Swedish health care sector are much smaller, as their share does not make up more than two or three percent of the total number of registered nurses in Sweden. 98 per cent of nurses in Sweden has a Swedish education, one per cent educated within the EU/EEA (most notably Finland) and one per cent outside the EU/EEA (NPS 2015) This is considerably below the OECD-average, and foreign-educated nurses are more common in most other EU-countries. Furthermore, their share has not increased during the last fifteen years in the

same way as the share of foreign-trained physicians has, despite frequent reports of shortages.

4.2 Validation and complementary education for foreign-educated health care professionals

As regulated professions, practicing nurses and physicians have a license to practice issued by the National Board of Health and Welfare (*Socialstyrelsen*, NBHW), a government agency under the Ministry of Health and Social Affairs. To become a nurse or physician, the applicant needed to have fulfilled the demands and passed an educational program regulated and supervised by the Swedish Higher Education Authority (*Universitetskanslersämbetet*, (UKÄ), before 2013 the Swedish National Agency for Higher Education, *Högskoleverket* (HSV)). The stated principal function of the requirements for a license to practice is to guarantee practitioners have a certain level of knowledge in order to guarantee the safety of the patient. These authorities are involved in the validation and complementary education of foreign-educated health care professionals.

The explicit aim of the validation process is to ensure that those that have been educated in another country have credentials that are deemed equivalent of those that have been trained and educated in the country's own educational system. The problems of validation of the education, knowledge, and skills of migrants with an education within a regulated health care occupation have been a perennial issue in policy reports and reviews since (at least) the 1990s. Because of this, the basic steps of the process are described here instead of in the empirical chapters of the paper.

To acquire a professional license for a regulated health care occupation for someone with an education from outside the EU/EEA consists of several steps. While these steps have been essentially the same since the 1990s the requirements, the providers and the number of places open for individuals in the validation process have shifted over the years. The numbers of persons that have applied for the validation process have also varied significantly. The description in the paragraph below describes the formal process for physicians in the late 1990s. The process for nurses and most other regulated professions in the health care sector was in principle quite similar to the process for physicians.

The first step to acquire a license to practice as a foreign-educated physician from outside the EU/EEA-area was a mandatory language test arranged by the educational association *Folkuniversitet*. The taking of this test was normally precluded by optional courses in Medical Swedish. These courses were financed by NBHW and the County Labor Market Boards (*Länsarbetsnämnderna*). To be accepted for such a course the applicant had to have completed the course “Swedish for Immigrants” (*Svenska för invandrare*, SFI) and been approved for additional training by NBHW. After the obligatory language test applicants had to pass the Medical Knowledge exam (called the *Tule-test*), or, in the case of specialists with at least five years of professional experience, go through a six-month-long probationary period. The examination consisted of a three-day test of both practical and theoretical knowledge held twice a year at KI. Those that failed the test could re-sit it to a total of three times. In most cases, those that had passed the test had to complete the process through a pre-registration training that corresponded to the AT-service. (AT-service, *allmän-tjänstgöring*, is a form of salaried supervised service position during at least 18 months that a physician has to finish before (s)he obtains a full license to practice, also see chapters 6.1 and 7.1.2.) The applicant would have to arrange for such a position in a relevant clinical field themselves. Their supervisor would issue a report on the applicant’s clinical knowledge, his or her medical judgment, relations with patients as well as staff, general suitability as a physician and competence as a specialist. After the applicant has passed these hurdles, he or she has to attend and pass a course in Swedish medical laws and regulations.

4.3 Major reforms regarding migration, mobility and the European Union

There have been several suggestions and reforms concerning the possibilities for foreign-educated health professionals to migrate and have their education recognized and to acquire a license to practice in Sweden. While relevant regulations were changed on several occasions, especially regulations of the validation and complementary education of foreign-educated health care professionals, four reforms could be considered of particular importance. Of these, three concerned the EC/EU. These were the signing of the EEA-agreement, the modernization of the Professional Qualifications Directive and the enlargement of the European Union during the 2000s. The fourth major reform consisted of changes to the regulation of labor migration in 2008.

In the late 1980s the countries of EFTA, the European Free Trade Agreement, which included Sweden, began looking at possibilities of joining the EC. After some deliberation, the EC proposed the creation of the European Economic Space (EES) in 1989, later renamed as the European Economic Area (EEA). The agreement was signed by seven EFTA-countries and the twelve member countries of the EC in 1992 to take effect in 1994 (Bache & George, 2006). With the EEA-agreement there was no legal basis for any tests or controls of the skills and knowledge, language or medical, of physicians or nurses from other EU/EEA-countries where the education and certification of the regulated occupations reached the standards of the agreement. Before this, the NBHW had been very restrictive in recognition of professional certificates from outside the Nordic countries (Prop. 1992/93:83, p. 18; RRV 1992:9). The signing of the agreement thus had considerable effects on the mobility of health professionals to Sweden – at least in principle.

After the signing of the EEA-agreement and 1992, and the subsequent membership in the EU, the regulations of the health care professions have had to adapt to the directives of the European Union. At the time of the EEA-agreement, regulated professions were regulated through several general and sectoral directives. Several of these directives were replaced with the Professional Qualifications Directive in 2005 (Directive 2005/36/EC). This Directive was aimed at enabling and ensuring that self-employed and employed persons in the EU would be able to exercise their rights to establish themselves, temporarily offer their services or seek employment in another membership country, without being hindered by national legislations and regulations. The Directive was considered an important part of the efforts to promote growth and employment in Europe. Later on, a process for a modernized directive was initiated with the stated aim to clarify the regulatory framework, especially the relations between the Professional Qualifications Directive and the Service Directive (Directive 2006/123/EC), where some interpretative difficulties had surfaced. The new, or updated, Directive, called the Modernized Professional Qualifications Directive (Directive 2013/55/EU) included some clarifications and detailed procedural rules for the authorities' processing of applications, most notably regarding checks on language skills.

Both these reforms concerned the regulations of the professions and the demands that a member country could, and could not, make on professionals that had been educated,

and who had a license to practice, in another member country. With the enlargement of the EU with several new member countries in 2004, the other countries had the right to implement transitional rules that meant that the older national regulations would still be in place for up to seven years. It was also possible for older member countries that did not establish such rules from the beginning to invoke a safeguard clause. If and how Sweden should enact such a clause was the subject of a government Inquiry that produced its report in 2002. The report suggested that Sweden should use the transitional rules for a time of two to seven years (SOU 2002:116, chapter 2).

While the first three reforms thus concerned the EC/EU, the fourth concerned relations with other countries and the possibilities of foreign-educated professional from a third country to migrate and practice their profession in Sweden. In 2004 the government started to investigate opportunities for reforming the regulations of labor migration from outside EU/EEA and appointed a government Inquiry to investigate and make suggestions for such a reform. The goal was to make the system more flexible and to promote an increase in labor migration from outside the EU/EEA (SOU 2005:50; SOU 2006:87; see also Ds 2007:27). After some deliberation, the regulations of labor migration were reformed in 2008. The most significant change from previous regulations was that the assessment by AMS (*Arbetsmarknadsstyrelsen*, the National Labor Market Board. At about the same time AMS was reformed and renamed *Arbetsförmedlingen*, AF; the Swedish Employment Agency) of national labor market needs before granting a work permit was removed. This assessment was now completely up to the employer. It also entailed that the organizations of employees lost most of their direct influence on the granting of work permits.

5 Migration and migration policy reforms

This chapter will summarize the comments and responses from the associations on migration and migration policies. It will then analyze these comments and responses based on the theoretical framework and hypothesis. More specifically, it will investigate if the policies of the associations could be characterized as being derived from a professional strategy, as discussed in chapter 2, rather than what could be characterized as a union strategy.

The implementation of the EEA-agreement, and Sweden joining the EU in 1995, meant that it became easier for employers in Sweden's health care sector to recruit health care professionals from abroad, at least from within an expanding EU. Arguably, issues concerning migration and migration policies, therefore, became more important for the organized interests of physicians and nurses from the mid-1990s onwards. Furthermore, in the mid-2000s two other reforms that could potentially increase international market competition for health professionals in Sweden were enacted. The first reform concerned if Sweden should include exemptions from the mobility of people from countries that joined the EU in 2004. That same year the government also initiated reforms on the regulations of labor migration from outside the EU/EEA. Both these reforms would increase the opportunities for health care professionals from other countries (often with significantly lower salaries) to migrate to Sweden. The government also promoted the immigration of health care professionals. For example, during 2000-2002 a special, temporary regulation meant that work permits were given for 36 months at a time, instead of 18 months, for physicians, dentists and nurses from Poland, Hungary, Slovakia, and Estonia due to shortages in these occupations.

How did the associations react to increased migration and policies that aimed to enable enhanced international mobility? The expected result derived from the hypothesis is that they ought to have a liberal, or possibly uncommitted, take on migration in general. At least as long as they perceive that the controls of foreign-educated professional's credentials are sufficient. As professions with claims to having a specific knowledge and working for the common good, references to supply and demand on the labor market or the work environment ought to be rare. However, considering that professional and union strategies are Weberian ideal types and that both SMA (physicians) and SAHP (nurses) also function as unions within the framework of Swedish labor market relations (the so-called "Swedish Model"), a mix of union and professional strategies might be expected.

5.1 Responses and comments from SMA and SAHP

The active recruitment of health care professionals from abroad has been a common reason for representatives to state their organization's position on migration policy. In 2000 SMA board member Matz Widström, argued against the recruitment of physicians from Poland. He gave two arguments. The first was that active recruitment initiated by

the employers, which was the case here, was against the principles of foreign labor migration established in the 1960s and that employers should try to hire from the domestic workforce (which now explicitly included all EU-citizens) before recruiting from abroad. The second argument was that it could be considered wasteful from a societal point of view to be recruiting from abroad, as there already were 1600 physicians in Sweden with an education from a third country (i.e., from outside the EU/EEA-area) that had not yet acquired licenses to practice in Sweden. He also pointed out that the primary interest of SMA was that physicians educated abroad were treated equally and were given the same working conditions and salaries. However, at the same time he also argued that they would have to reach the same minimum skill requirements as everyone else (“Läkarrekryteringen från andra länder behövs inte, hävdar Läkarförbundet”, *Läkartidningen*, 7/2000; “Över ån efter vatten”, *Läkartidningen*, 8/2000. See also “Remissvar om arbetstillstånd”, *Läkartidningen*, 39/2000; “Läkarrekrytering utomlands – en personlig betraktelse”, *Läkartidningen*, 46/2005, for similar arguments).

In 2002 SMA rejected the hiring of foreign physicians that required work permits to the Örebro County Council. They claimed that this was not a principled position against migration of physicians to Sweden, as they acknowledged the continued need for such migration. Their argument was instead that the introduction (complementary medical education, education in Swedish required for work within the health care sector, and an introduction to the Swedish health care systems culture and organization) of physicians recruited abroad was lacking. The chairperson of SMA, Bernhard Grewin, thus stated that while the association was positive to labor migration in principle, it was an absolute necessity that the immigrated physicians reached established standards regarding their competence. He claimed that it would hurt the esteem and authority of the medical profession as a whole if this generated a perception amongst the general public that immigrant physicians were less competent (“Rekrytera med ansvar!”, *Läkartidningen* 38/2002).

It was during the early 2000s that the SMA was the most critical of practices concerning labor migration – as illustrated by the two paragraphs above. In the years that followed critical comments were rare and manifest conflicts few. This might be because SMA had started to adopt a more liberal and pro-mobility point of view (“Fri rörlighet över EUs gränser viktig fråga för Europas läkare”, *Läkartidningen*, 45/2004).

For example, Johan Zalano, then chairperson of MSF (The Association for Medical Students within the SMA), argued in 2005 that it employment security for the individual physician no longer came from a shortage of physicians but from being competent. By securing that the Swedish medical education was of the highest quality the future would still be bright for Swedish physicians (“Bra med EU-konkurrens!”, *Läkartidningen*, 15/2005).

This was the policy position from the SMA when they responded to the government Inquiry regarding the need for transitional rules for the enlargement of the European Union (SOU 2002:116). SMA reasoned that while there had been periodic surpluses of physicians during the 1990s, this was no longer perceived to be the case. The number of newly approved professional licenses each year and the expected number of retirees during the following decades meant that there would be a continued need for recruitment from abroad – from the EU/EEA-area as well as from third countries– and therefore no need for any transitional rules. (They did, however, support the notion that the safeguard clause ought to be used in the case of serious disturbances on the Swedish labor market as an effect of the EU enlargement.) When responding to the government Inquiry on the expansion of the EU, they also argued against the need for work permits in general as well as the suggestion that work permits should be limited for one year at a time. Their policy standpoint was thus more liberal than that expressed in the government's Inquiry. Instead, foreign physicians should, reasoned SMA, be treated equally as those from current member countries. Finally, they argued for the need to secure that newly arrived physicians got a sound introduction in order to understand the culture and traditions of the Swedish health care system (“... att förstå den svenska sjukvårdskulturen och traditionen”) and that SMA should be invited to be involved in all these issues, from the recruitment to introduction and mentorship for foreign physicians (SMA response 9/4 2003, from SMA webpage).

With regard to the 2008 migration reform, SMA expressed support for most of the proposed changes. They did, however, note that many physicians with a temporary position worked under a special appointment from the NBHW, which meant that they did not apply for a license to practice. It was, according to SMA, essential that resources were provided so that physicians without a license would be able to acquire a Swedish

license to practice, and that their employer gave them appropriate opportunities to do so (SMA response 31/10 2007, from SMA webpage).

The international migration of nurses to Sweden has hardly been mentioned in *Vårdfacket/Vårdfokus*, until quite recently, and even less so any active recruitment by the employers. This is perhaps not surprising since the migration of non-Nordic nurses to Sweden has been quite small during most of the previous decades. It seems that the mobility of nurses from the poorer countries of the EU did not take off until the 2010s (“Rika EU-länder lockar”, *Vårdfokus*, 9/2015). In 2013 nurses passed physicians as the most mobile occupational group within the EU. However, the mobility of nurses was not so much to Sweden as from it. Swedish nurses were the second most mobile nationality in 2013, most of the movement going to Norway (“Sjuksköterskor byter land mest i Europa”, *Vårdfokus* webpage, September 2015).

As the number of nurses migrating to Sweden has increased in recent years, articles regarding international migration and the active recruitment of employers have become more common. *Vårdfokus* duly reported on these developments, and the actions of employers and recruitment companies, but the representatives of the organization rarely commented or expressed opinions in the paper. One of a few examples of a representative from SAHP commenting on and critiquing international labor recruitment practices is in the case of Lithuanian and Hungarian nurses hired by the County Council of Dalarna in 2015. According to the chairperson of the regional association, Kerstin Erlandsson, these nurses could not perform some of the most important routines, such as documentation, nor speak to patients or relatives. The association did not question the credentials of the nurses *per se*. They did, however, make the argument that the lack of language proficiency was a problem that could not be solved by having these nurses not do the documentation, as this was something every nurse had to be able to do (“Inhyrda sjuksköterskor har svårt med språket”, *Vårdfokus* webpage, September 2015). At the same time many conflicts concerning migrant nurses seem to gravitate to the dispute over salaries, where the association claims that the shortage of nurses is an effect of the salaries being low while employers argue that the shortages of nurses are absolute and cannot be resolved by higher salaries (see for example “På väg: filippinska sjuksköterskor”, *Vårdfokus*, 8/2016).

5.2 Summary and analysis

The policy of SMA regarding migration is characterized as a distinctive shift in the early 2000s. In the 1990s and the first years of the 2000s, SMA spoke out against active recruitment of physicians from abroad, expressing concerns regarding the need for further immigration, making the argument that there were sufficient numbers of physicians already in the country. Then SMA quite quickly changed their arguments and adopted a much more pro-mobility standpoint. They have however kept on expressing concerns over if foreign-educated physicians have the competence needed for work in Swedish health care sector. While the policies of the late 1990s could be described as a mix of union and professional strategies, the policies of the last fifteen years have been that of a professional strategy. This shift predated the 2008 labor migration reform that made the union strategy less efficient and can thus not solely be explained as an adaptation to external institutional changes.

SAHP, on the other hand, did not have much of an explicit policy on migration and migration policies until quite recently. It has only been during the last couple of years that representatives of the association have expressed opinions on nurses' migration. These views seem to indicate a mix of union and professional strategies. While they do express concerns regarding the competence of foreign-educated nurses that are associated with a professional strategy, they do tend to mix in demands concerning working conditions and salaries in their responses.

6 Validation of foreign-educated physicians and nurses

Regulated health care professions in Sweden are dependent on the state for the protection from market competition that occupational regulations entail. The associations are, therefore, according to the hypothesis, expected to promote increased government control and involvement in the regulation of health care professionals that have been educated abroad.

The results from chapter 5 included several observations of representatives from SMA and SAHP questioning the credentials and qualifications of foreign-educated professionals for working within the Swedish health care sector. The question in this chapter is if the associations, in light of such concerns, have suggested and promoted reforms of the validation process for foreign-educated (non-EU/EEA) professionals that

would raise the barriers to entry (see also chapter 4.2). More generally, it concerns if foreign-educated professionals are treated as outsiders that the associations are trying to keep away, by restricting their access and possibilities to acquire a license to practice, or as insiders that might need the help and support of the organization of the profession.

6.1 SMA and SAHP responses and policy suggestions

SMA's policies on validation and complementary education for foreign-educated physicians were formulated in the late 1990s. In 1996 SMA and SSM (*Läkarsällskapet*, the Swedish Society of Medicine) jointly decided to start an investigation and gather information regarding the situation facing physicians from outside the EU/EEA. The results were summarized in a report that described the problems and presented an action program on how they wanted to solve the problems they had identified (Läkarförbundet, 2001). Their key point was that the average time of five to six years from the time the application reached NBHW and registration of a professional license was way too long, almost as long as the standard education in itself, and that this was a waste of valuable human resources. Furthermore, at the time NBHW only provided additional training to those that had a residence and work permit for political, humanitarian or family reasons. The solutions presented in their report aimed at shortening the time the process of validation took as well as opening up the process for larger groups of applicants, in principle making labor migration for physicians from third countries at least feasible.

SMA and SSM also argued for different ways of helping foreign-educated physicians establish themselves on the labor market. They stated that to “enable immigrant doctors to work and function effectively in the Swedish health system [... they must be] helped in integrating into the organization and in gaining an understanding of the Swedish health care’s culture and tradition” (Läkarförbundet, 2001, p. 9). The way the process of validation worked in the 1990s was not perceived as satisfactory, and as a result, a couple of collaborative regional projects that involved SMA that tried to find ways of making the process quicker and more efficient were developed (Lindgren, 2003).

In 2004 SMA criticized a report (Socialstyrelsen, 2004) that suggested that responsibility for complementary education and its administration should be moved from NBHW to the National Agency for Higher Education and that the language tests conducted under NBHWs supervision should be replaced with requirements similar for

those wanting to study at a Swedish university or college. SMA expressed fear that the reform would mean that more responsibilities for moving the process forward would be placed on the shoulders of the individual physician and depend on discretionary decisions by employers. They argued that this would put the applicants in a position where they would be dependent on the employer, and the ebb and flow of the labor market (SMA response 9/9 2004, from SMA webpage). They also considered the ability to get a Swedish professional license for those with an education from a foreign country without unnecessary delays were an issue of justice (SMA response 9/4 2003, from SMA webpage). Another memorandum from the Ministry of Education in late 2007 (Ds 2007:45) had a couple of suggestions to speed up the process of validation and complementary training and education for health care professionals educated in countries outside the EU/EEA. The most important suggestions of the 2007 memorandum were that the responsibilities of providing complementary education to a larger degree than before would rest on the universities. All in all, both SMA and SAHP approved (SAHP response 3/5 2008, from SAHP webpage; SMA response 29/4 2008, from SMA webpage).

In 2013 (probably as a reaction to the findings in RiR 2011:16) the Department of Social Affairs had Professor Ingvar Karlberg from Gothenburg University's Sahlgrenska Academy (i.e., Medical Faculty) write a report on ways of making the process of validation, complementary education and training quicker and more efficient. Besides suggestions to make the division of responsibilities between different stakeholders clearer Karlberg's report (somewhat surprisingly considering his instructions) added additional steps to the process and proposed stricter language requirements as well as an obligatory introductory course of 5-8 weeks for everyone, including specialists (Karlberg, 2013). SMAs international coordinator Joel Hellstrand did approve of the latter but thought that the increased language demands would unnecessarily prolong the process. As there were no language demands whatsoever to acquire a license to practice for those educated within the EU/EEA he stated that the differences in demand were unjustifiable (*Läkartidningen*, 9/10 2013). SMA thus argued against policy suggestions that would reduce the potential of market competition from foreign-educated third country physicians.

Another example of this difference of opinion between SMA and representatives from the Medical Faculties is from 2015. That summer the AT-service board, consisting of representatives from the seven universities with educational programs for physicians, critiqued the Minister of Labor Ylva Johansson. In a Public Service radio program (*Kaliber* on SR P1) the minister had stated that many physicians were kept from practicing their occupation because of too much administrative red tape, advocating a fast track in order to speed up the process. The AT-service board argued against this in their response, specifying the so-called red tape was essential to ensure a reasonable level of knowledge and a basic education and thus the safety of the patient. They also expressed concerns regarding what they perceived as “the deterioration of the medical skill level of physicians trained abroad” (*SvD*, 12/6 2015). A few days later the minister replied together with SMA chairperson Heidi Stensmyren, arguing that there was no conflict between making the process quicker while at the same time ensuring equal and high requirements on those that were given a license to practice (*SvD*, 17/6 2015). SMAs chairperson was thus siding with the minister against excessive controls by the AT-service board and other administrative bodies. On the other hand, in an article one year later Stensmyren, while stating that the association approved attempts to make the process quicker, she also implied some concerns by stating that the safety of the patient must not be jeopardized by doing so (*DN*, 12/7 2016).

There was, however, one potential problem with SMAs policy of supporting foreign-educated physician’s access to validation and complementary training. The number of open AT-positions is often fewer than the number of medical students finishing their university education. If positions were given to non-EU/EEA physicians, this might entail that physicians educated in Sweden would lose their positions. This potential problem was made explicit in a letter to *Läkartidningen* in 1996. A specialist in Family Medicine and director of studies at a regional hospital argued that newly educated Swedish physicians were being crowded out by physicians from other countries. She questioned the wisdom of accepting large numbers of foreign-educated physicians in times of increasing unemployment amongst physicians in Sweden. At the same time, those newly educated Swedish physicians that did not gain AT-service positions had problems finding positions as substitutes (a common employment for unlicensed physicians that have yet to start or finish an AT-position). She, therefore, suggested that

there should be a quota of AT-service positions for foreign-educated physicians (“Inrätta en särskild AT-pott för läkare med utländsk examen”, *Läkartidningen*, 50/1996). In a response from SMA and SYLF (*Sveriges yngre läkares förening*, a SMA-association for younger physicians, such as those conducting their AT-service) argued against the idea of AT-quotas for foreign-educated physicians. They stated that those that had problems with the current situation were not the physicians educated in Sweden but foreign-educated physicians. What was needed, they argued, was that the government used their authority to remind the County Councils of their responsibility of providing for the further education of physicians; that there should be enough AT-service positions to go around (“Replik: Tillräckligt antal tjänster ska finnas”, *Läkartidningen*, 50/1996. See also ”Regeringsförslag: AT åt alla med läkarexamen”, *Läkartidningen*, 37/1997).

The organizations for nurses also acknowledged the problems associated with the validation process. A common problem was the lack of complimentary educational courses for nurses educated in other countries that wanted to acquire a Swedish license to practice. In many cases, foreign-educated nurses had to learn on their own before trying to pass the test. Perhaps not surprisingly, the share of candidates that passed NBHWs examination at the first attempt was as low as ten percent in the 1990s (“Vår kunskap är ingenting värd’. Invandrade sjuksköterskor stupade på test”, *Vårdfacket*, 6/1997; ”’Det är en absurd situation.’ De nya reglerna för legitimation får kritik” *Vårdfacket*, 6/1997). It has however not been possible to find any comments on the situation from representatives of SAHP during the latter part of the 1990s. Unlike in *Läkartidningen*, articles about the validation and complementary education for nurses from a third country in *Vårdfacket* almost never presented the opinions of SAHP representatives on the matters at hand. Instead, the focus is on statements or decisions by NBHW or the government and the responses from teachers or other representatives of the nursing colleges. This makes it somewhat problematic to characterize the policies that SAHP wanted to see during most of the studied period on this issue.

The statements from SAHP that do exist nevertheless indicate that their standpoint was not that far from that of SMA. In 2002 SAHP, together with *Kommunförbundet* and *Landstingsförbundet*, (the organizations for Communes and County Councils in Sweden, i.e., employer organizations in this context) sent a letter to the ministries of

Social Affairs and of Enterprise urging for a simplified road to a Swedish license to practice for migrant nurses from outside the EU/EEA. The solutions they advocated were not that the demands on credentials would be lowered *per se* but that the financial support should be modified with the aim to simplify the process for nurses (N2002/3428/A). A similar response came from the stakeholders when NBHW in early 2003 decided to close down the complementary university courses that enabled individuals to pass the credential requirements outside the regular educational program for nurses. All the organizations mentioned above protested against this decision (“Genväg till svensk legitimation stoppas”, *Vårdfacket* webpage, January 2003).

6.2 Summary and analysis

The results of the chapter do not readily conform to the hypothesis that SMA and SAHP would attempt to use their influence on the process of validation and complementary education as a way of closing off the cartel from foreign-educated professionals. While the associations do not question the need for the process of validation as such, their policy recommendations and comments do not suggest that they want to make the process harder or provide fewer positions in programs and courses for validation and complementary education. Nor are foreign-educated physicians from outside the EU/EEA directly treated as outsiders by the associations. Instead, the associations advocate more resources from the government. Demands for stricter tests and longer processes usually come from academic institutions such as Medical Faculties, not the associations.

Theories on professionalism imply that academic institutions and associations would be in cahoots, as they have a common interest in guarding the status of their professional knowledge, but this seems not to be the case here. The policies of the associations could instead be described as a form of inclusive professional strategy with regard to foreign-educated professionals; a strategy that tries to protect the credential requirements of the profession while at the same time enabling immigrant professionals to reach these requirements with the help of government resources.

7 The EEA-agreement and adjustments to the European Union

The EEA-agreement and Sweden’s subsequent membership in the EU have had considerable effects on the mobility of health care professionals to Sweden. The

implementation of EC/EU directives that promoted increased mobility might entail a race to the bottom as these define minimum requirements for professional qualifications that all countries have to recognize. Professionals in countries with higher requirements for those educated domestically might thus find themselves in a position where employers can replace them with professionals from countries where requirements are closer to the bare minimum in the directives. It is therefore important to investigate and analyze the responses from the associations to such policy changes.

There have been two such changes that have been of principal importance, and that will be dealt with in this chapter. The first was Sweden signing the EEA-agreement in 1992, and the other one was the modernization of the Professional Qualifications Directive almost a quarter of a century later. The focus will be on the issues of language proficiency and knowledge of medical ordinances, the length of the education, and the title of *Europaläkare*. The latter was a Specialist certificate that was created after the signing of the EEA-agreement, and that was later removed in 2012.

The expected result derived from the hypothesis is that the associations will support the continuation of regulations and state intervention and will defend the Swedish regulations if they are stricter than those proposed by the EU/EEA. On the other hand, they will accept and even promote proposed changes that will increase the barriers to entry to the profession.

7.1 Regulatory changes and SMA and SAHP responses

7.1.1 Language proficiency and medical knowledge

The directives that Sweden agreed to abate to by signing the EEA-agreement in 1992 meant that NBHW had a couple of consequences for national regulations. Sweden was no longer allowed to assess the applicant's language skills or their knowledge medical ordinances regulating Swedish health care before granting a license to practice. Such tests were not considered to be in accordance with the directive, as it could be considered as a form of discrimination based on nationality (Ds 1992:34, p. 34). As this makes the regulations for foreign-educated professionals less strict, the hypothesis is that the organizations will express concern regarding the removal of such tests. With the Modernized Qualifications Directive, it again became possible for government agencies to test the language skills of professionals applying for a license to practice. On this issue, the Inquiry for the implementation of the new directive proposed that NBHW

would be allowed to issue regulations for regular checks of language skills (albeit in a somewhat bureaucratic and awkward way that will not be discussed here) for the health care professions (SOU 2014:19, chapter 8.3.2). As this makes the regulations stricter and impedes international mobility within the EU, the hypothesis is that the organizations will support this.

SAHP was critical to the fact that NBHW could no longer perform language-tests as a result of Sweden signing the EEA-agreement. They stressed the importance of language proficiency to communicate with patients, colleagues and other employees. They also criticised what they perceived as vague phrases in the proposal and argued that NBHW ought to be allowed to continue assessing the knowledge skills of the applicants (S92/3842/J/[SAHP]). SMA on the other hand hardly mentioned this issue in their response and did not object to it. This was contrary to SAHP and several other stakeholders such as Medical Faculties and employers' organizations (S92/3842/J/[Medical Faculty, UU; Kommunförbundet]).

When the Professional Qualifications Directive was modernized in 2013, both SAHP and SMA welcomed the introduction of clearer rules concerning the demands for language skills of professionals trained in other EU/EEA-countries. SMA also welcomed that this meant that the requirements for physicians educated within and outside the EU/EEA approached each other. However, they also argued that the language requirements implemented by NBHW should not be too strict and that the employer should continue to be partly responsible for the language proficiency of their employees. At the same time, SMA stressed that these new demands increased the need for more language training courses adapted to the needs of professional work. They argued that the government should take greater responsibility for the existence of such courses. They also suggested that NBHW should be instructed to procure such courses, as they had done in the past (S2015/1433/FS/[SMA; SAHP]).

7.1.2 Educational requirements

The EC directives at the time of Sweden signing the EEA-agreement in 1992 stated that the physicians must have a university-level education that should be at least six years or 5500 hours long. The modernized directive in 2013 stated that the minimum requirement for the education of physicians should be at least five years long (instead of six) and consist of at least 5500 hours of theoretical and practical training at a university-

level (Article 24). The requirement for a license to practice for physician educated in Sweden has been 5½ years of university-level education during the period studied. While the number of hours in a physician's education in Sweden is not explicitly stated in the regulations, it has been calculated to correspond to roughly 8000 hours (SOU 2014:19, chapter 8.3.3). The education is then followed by at least 18 months (previously at least 21 months) of so-called AT-service (*allmäntjänstgöring*). The AT-service is a form of salaried supervised service position that has to be completed before a person acquires a full license to practice (SOU 2010:65, p. 196f).¹ While a person that has completed the education to become a physician but not the AT-service can work, they can only do so in subordinate positions. It could thus be argued that, if the time for the AT-service is included, the Swedish requirements are significantly higher than minimum requirements determined by the EU. Those physicians that have been educated in other EU-countries but have not done an AT-service (or something similar, such as the *Foundational programme* in the UK) are not restricted to subordinate positions by regulations and requirements, as they have a license to practice that directly after finishing their university education and training that has to be automatically recognized by NBHW. This means that Swedish physicians are at a competitive disadvantage in comparison to the minimum requirements of the EU. The hypothesis is that SMA should be skeptical about this.

For SMA the length of the education, as well as the length and existence of the AT-service, has been a perennial issue for debate and the comments. However, SMA has more often than not ignored the potential risks of a double standard regarding educational credentials for physicians with a license to practice from Sweden compared to the minimum requirements of the EU. In 1992 it was SSM, not SMA, that commented on the length of education, and they were more concerned if the Swedish education reached the levels of the EC, not the other way around (S92/3842/J/[SSM]). One explanation for SMA's responses (or lack thereof) was that they did not think it would be of any major concern. In fact, in 1992 they stated that they thought that almost all physicians would be from the Nordic countries in the future as well (S92/3842/J/[SMA]). Foreign-educated physicians were apparently not perceived as a

¹ The latest government inquiry into the education of physicians (SOU 2013:15) suggested removing the AT-service to adapt to other countries within the EU and prolonging the education to six years, but these suggestions have not been implemented.

threat by SMA in the early 1990s. Twenty years later, during the policy process for the modernization of the Professional Qualifications Directive, SMA had some comments on the educational requirements, but they did not point to any concerns regarding the differences between the Directives minimal requirements for a license to practice and those of Sweden. Most of the comments could be perceived as pro-mobility arguments. For example, they agreed with the notion that parts of the AT-service for those educated in Sweden could be conducted in other countries to promote the mobility of academics (S2015/1433/FS/[SMA]). Considering that the share of foreign-educated physicians was roughly twenty percent at the time, SMAs opinions could hardly be seen as being based on any assumptions that foreign-educated physicians is a residual phenomenon in the Swedish health care sector. Perhaps they could do so in 1992, but not in 2015.

SMA has however been working on other ideas that might be interpreted as a way of reducing market competition from foreign-educated physicians. At roughly the same time as the new directive was debated another government Inquiry worked on a reform of the medical education (SOU 2013:15). In response to this report, SMA supported suggestions to make the education six years long while at the same time removing the AT-service as a requirement for a license to practice. This was explicitly suggested as an adaptation to international standards (SMA response 1/7 2015, from SMA webpage). SMAs idea was (and arguably still is) to replace the AT-service with an introductory year called *Bastjänstgöring*, or BasT for short. This period, supervised by NBHW, would take place after the license to practice but would be mandatory for *everyone* that wanted to work in the Swedish health care system, or at least for those that want to start a ST-service to become a specialist. (It should be noted that this idea is not compatible with the Professional Qualifications Directive.) They argued that this mean that EU/EEA-physicians also would get the benefits of a proper introduction to the Swedish health care system (Läkarförbundet, 2012; “Alla tjänar på bastjänstgöring”, *Läkartidningen*, 36/2012; “Flera bra förslag med ny läkarutbildning”, *Läkartidningen*, 12/2013.)

Compared to the arguably lukewarm responses from SMA on educational requirements, the responses from SAHP on the educational requirements for nurses are more telling. The reactions in 1992 and two decades later, when the EU directive was modernized, was quite different from each other. The EC directive that Sweden had to

adapt to in the early 1990s stated that nurses should have at least ten years of schooling followed by a three year or 4,600 hours long theoretical and clinical education (Ds 1992:34, p. 41f). SAHP did not comment on this issue in their response to the memorandum for the implementation of the EEA-agreement. There is a simple explanation for this seemingly complete lack of interest in a key issue for the profession. In 1993 Nursing became a professional degree with a three-year-long university education (SOU 1993:12), replacing the older two-year-long education (Ds 1991:81). This change was, in fact, an adaption to EC directives that stated that Nurses education should consist of at least three years of schooling. As this was something that members of the profession had strived for (Erlöv & Petersson, 1998), Sweden signing the EEA-agreement helped them in their cause. That SAHP did not make any comments at all on this issue in 1992 is akin to the proverbial dog that did not bark as they got precisely what they wanted.

The responses from SAHP was quite different when the issue was revisited with the modernization of the Professional Qualifications Directive. The reform of the Nurses education in Sweden before the signing of the EEA-agreement and the reforms of the secondary education of the 1990s meant that nurses educated in Sweden had 12 years of schooling followed by a three-year nurses education at a university level. This was now the credential benchmark for the association. The education to become a nurse must, according to the modernized Directive, be three years long and consist of at least 4600 hours of theoretical education, clinical practice, and training. The current Swedish education for nurses is close to the requirement of the Directive, being three years long and consisting of 4800 hours of education and training (SOU 2014:19, chapter 8.3.3). Understandably, SAHP did therefore not have any serious problems with the requirements of the Directive, even if they stressed the need to strengthen the minimum education and training requirements that would, they argued, lead to an increase in the quality of services (SAHP response 1/9 2011, from SAHP webpage).

The key issue for SAHP was not the demands of the Directive on the length of education to become a nurse *per se*, but the requirement *before* starting the education to become a nurse. The problem from SAHPs point of view was that article 31 in the modernized Directive allowed for those that had finished a three-year vocational (not university-level) education following ten years (not twelve) of prior schooling should

also be automatically recognized as nurses and be given license to practice within the EU. SAHP saw this as a dangerous threat to the safety of patients. (“Sjuksköterskeutbildningen riskerar att bli sämre inom EU”, *Vårdfacket* webpage, October 2009; “Gränslöst 2. Fri rörlighet ställer krav på utbildningarna”, *Vårdfokus*, 3/2011).

It was particularly nurses from Germany and Poland that were perceived as a problem. The chairpersons of SAHP and the Swedish Association of Midwives (*Svenska Barnmorskeförbundet*) expressed their concerns in an opinion piece in the morning paper *Dagens Nyheter* (DN, 30/11 2012), arguing against the suggestion and portraying it as a threat to the safety of the patients, efficiency and the development of health care. In the opening paragraph, they stated that...

“Germany is a male-dominated society where educations dominated by females are not ranked highly. There the education of nurses and midwives is at the level of secondary education. The education of nurses is equivalent of the competence of nurses’ assistance in Sweden.”²

They also argued that German nurses in Sweden have problems performing their job, as they lacked the competence needed; implying that the immigration of German nurses to Sweden constituted a risk to patient safety.

7.1.3 Europaläkare and Specialists in Family Medicine

To acquire a specialty in Sweden a physician³ needs to finish at least five years of ST-service (*specialisttjänstgöring*). While five years is the standard in Sweden, the number of years needed for a specialty differed in the directives of the EC, as some areas of specialty demanded five years, some four or three. These differences were something that worried some commentators at the time of the EEA-agreement. For example, the Medical Faculty of Uppsala University wanted the country where the specialty had been acquired to be stated explicitly next to the title (S92/3842/J/[Medical Faculty, UU]). Presumably, this was so that others (i.e., employers, colleagues, and patients) would be able to differentiate between different levels of competence; if they were “real” specialists. SMA also argued, in their comments during the modernization of the

² My translation. ”Tyskland är ett mansdominerat samhälle där kvinnodominerade utbildningar inte står särskilt högt i kurs. Där genomförs sjuksköterske- och barnmorskeutbildning på gymnasienivå. Utbildningen till sjuksköterska motsvarar undersköterskans kompetens i Sverige.”

³ While there was, and are, nurses’ specialties in Sweden, these have not yet been regulated by the EC or EU and have thus never been an issue with regard to EC/EU-regulations.

Professional Qualifications Directive, for the desirability to increase the minimal requirements of many Specialties to four or five years, as this would reduce the differences in credential requirements that existed for medical specialists within the EU (SMA to Saco 11/8 2011, from SMA webpage).

The problems concerning specialties for physicians were most evident in the case of Europaläkare. Europaläkare was an entirely new title created with the purpose to adjust to the demands of the EC that a physician needed at least two years of practice to run a general medical practice. Furthermore, as of 1995, this level would be required to practice within the countries' public social insurance systems (Ds 1992:34, p. 39f; Directive 86/457/EEC). To qualify as a Europaläkare, a Swedish physician would have to complete a further nine months of practice after the AT-service. The problem this new title should solve was that in some countries, such as Germany, Family Medicine (*allmänmedicin* in Swedish) was not a specialty and it was not included in the list of specialties listed in the Directive. The title of Europaläkare was thus created with the purpose to have a title for those that had some further training and reached the requirements of the EC but did not reach the credentials necessary to become *allmänläkare*, a Swedish specialist in Family Medicine. This is directly related to the way health care is organized in different countries. The competence and qualifications of the Specialist in Family Medicine considered important within the Swedish system of primary care (previously called *distriktsläkare*), but similar specialist functions do not exist in most other EU/EEA-countries.

In their response to the creation of the Europaläkare-title in 1992, SMA stressed that they hoped that the creation of the certificate of Europaläkare would not mean that Sweden could not preserve Family Medicine as a specialty with higher demands (S92/3842/J/[SMA]). A possible interpretation of this is that SMA wanted the system to be configured in such a way that practitioners of Family Medicine within the social insurance system would need to have a five-year specialty. Such a configuration would, considering the encompassing Swedish healthcare system, effectively make Europaläkare into a Specialist certificate for nothing. Academic institutions also supported SMA's point of view. For example, the Department of Family Medicine at KI feared that, in the long run, such a reform would lead to a degrading of the specialty (S92/3842/J/[Department of Family Medicine, KI; Medical Faculty, UU]).

This two-tier system, with both Europaläkare and Specialists in Family Medicine, existed for fifteen years, until a Dutch physician, who got a license as Europaläkare instead of as a specialist in Family Medicine which she had applied for, reported this to the European Commission in 2009. In response to the commission the Swedish government explained the role of and requirements for Specialist in Family Medicine within the Swedish health care system but the Commission, and later the Court of Justice of the European Union disqualified the Swedish two-tier system (Ds 2012:2). The Swedish regulation had to adapt, just as some stakeholders had feared back in the early 1990s.

SMA and other professional organizations closely followed and commented on the legal process that led up to the ruling. Annika Eklund-Grönberg, the chairperson of the Swedish College of General Practice (*Svensk förening för allmänmedicin*, SFAM), argued that the County Councils recruitment of physicians from other EU-countries caused problems as they sometimes were not competent enough for the work they were expected to perform. She also claimed that colleagues around the country had informed SFAM that they had had to spend a lot of time teaching and to supervise EU-physicians to secure the safety of patients. ("Sfam oroar av okunnighet hos läkare från EU", *Dagens Medicin*, 6/2009).

After the decision by the commission in late 2010 Ove Andersson, chairperson of the Association for Specialists in Family Medicine and other Specialists working in Primary Care (*Distriktsläkarföreningen*, DLK) and a member of SMAs board, expressed disappointment with the verdict. He stated that this meant that foreign-educated physicians could now claim the credential of a Specialist in Family Medicine without having the knowledge and competence associated with this title. He elaborated by pointing out that there were several profound differences between a Specialist and a Europaläkare and that the responsibility now fell on the employers to uphold the quality of services in primary care ("EU på väg att sänka kraven för svenska specialister på allmänmedicin", *Läkartidningen*, 47/2010). Later on, Andersson of DLK claimed that the goal, in the long run, was to increase the minimum requirements in the Directive and add the Specialty of Family Medicine to the list of specialties recognized in the Professional Qualifications Directive. This was and is something that both the association, as well as other organizations within Europe worked for, stressing the

positive effects on quality of care provided by the Swedish model with a comprehensive primary care (“Fortsatt strid för allmänläkarkompetensen”, *Läkartidningen*, 24/2011).

7.2 Summary and analysis

Only SAHP was skeptical regarding the removal of language proficiency tests and controls that followed from the signing of the EEA-agreement. While SAHPs responses are consistent with the hypothesis on this issue, SMAs lack of concern is not. Both associations were, however, positive that it again became possible to introduce such tests with the modernization of the Professional Qualifications Directive. This is consistent with the hypothesis.

SAHPs and SMAs lack of comments on the educational requirements in 1992 are seemingly at odds with the hypothesis. There are however a couple of contextual factors that can explain at least part of these discrepancies. That SMA did not think that the EEA-agreement would not lead to increased migration and market competition this might help explain their lack of concerns on this issue at the time. Still, SMA has not been overly concerned about educational requirements during the modernization of the Professional Qualifications Directive either. SMA has almost consistently been pro-mobility and pro-migration during the last fifteen years. This lack of criticism is harder to reconcile with the hypothesis.

The responses from SMA and others on the issue of Europaläkare and Specialty in Family Medicine is, in contrast, the way a well-organized profession is expected to act. When adaptation to the EC/EU entails changes to a group of specialists, a coalition of associations and medical faculties join forces, trying to safeguard the *status quo* by refereeing to the safety of patients and the Swedish health care system.

SAHPs responses on educational requirements, on the other hand, are consistent with the hypothesis. When Sweden signed the EEA-agreement the educational requirements for Swedish nurses were increased from two to three years, something that the profession had aimed at for decades. Fifteen years later the situation was reversed. That SAHP has been critical of the automatic recognition of nurses with a vocational rather than university-level education is also as expected.

8 Conclusions

The aim has been to investigate if and how the professional organizations of nurses and physicians in Sweden, SMA and SAHP, have tried to influence the regulations that affect the requirements for professionals educated in other countries to acquire a professional license in Sweden.

The study is based on a theoretical framework with the underlying assumption that organizations representing employees strive for market control and to limit competition. The main argument is that professional associations, such as SMA and SAHP, are different from other employee organizations and that this entails that they have different strategies in order to control immigration and reduce market competition from foreign-educated professionals than “normal” unions. According to the theoretical framework, most employee organizations (i.e., unions) act as a form of open cartels. As an open cartel, unions try to control the price of labor by attempting to draw in all potential employees into one price-setting cartel. Professional organizations, on the other hand, try to establish closed cartels. They do this by creating and promoting barriers of entry to the profession, such as occupational licensing and government regulations. In this way a successful profession can control competition on their segment of the labor market. While a union strategy is thought to be characterized by unions putting forth demands on wages, working conditions, and contracts, a professional strategy is believed to focus on the barriers to entry into the profession, such as educational requirements, with the intention to close off their part of the labor market from competition. These differences between professional organizations and other employee organizations ought to mean that their strategies also differ regarding migration and migration policies. For this purpose, the policy areas of migration and migration policies (chapter 5), validation and complementary education of professionals with a foreign education (chapter 6), and regulatory adoptions to the EU/EEA (chapter 7) have been studied.

Before turning to the question on *how* these organizations have acted, we need to address the question on *if* they have tried to influence the regulations. It is in fact not always clear if the associations have tried to affect the possibility of foreign-educated professionals to acquire a license to practice in Sweden – at least not all the time, and not always in a way that would appear to limit market competition. It is however clear

that SMA has taken a much more active role than SAHP in all the policy areas studied. Whether this is because SAHP has been less interested in these issues (perhaps because the number of foreign-educated nurses in Sweden has been comparatively low), if they lacked organizational resources to do so, or if they have preferred other channels to influence policies and regulations, is unclear.

On the other hand, one of the motives for studying both SMA and SAHP was that they might differ in their mix of union and professional strategies; as physicians often are considered a “proper profession” and nurses a “semi-profession,” perhaps this difference is because SAHP focuses more on union strategies than SMA.

- How did SMA (physicians) and SAHP (nurses) respond to migration and migration policy reforms?

The responses from the associations have been a mix of what could be characterized as a union strategy, with references to labor market conditions when debating migration issues, and a professional strategy, which is marked by references to the credential of migrant physicians or nurses. The focus has however drifted towards the latter strategy during the 2000s. At the same time, the rhetoric has become more liberal and pro-mobility and -migration. This is most apparent in the case of SMA, who defended the Swedish labor migration model and argued against active recruitment of physicians abroad during the late 1990s and early 2000s. A few years into the new millennium SMA, together with the rest of Saco, abandoned this policy standpoint and adopted a more liberal point of view about migration.

Arguing against migration because of its effects on unemployment and wages or salaries is a common union strategy that is not expected to be part of the professional organization's repertoire. Salaries have however at times been an explicit issue for SAHP in recent years. This because the issue of migration has been connected to the discussion over shortages of nurses and over if these shortages are in fact a result of a limited pool of educated nurses in the country or if it is a result of low salaries and unsatisfactory working conditions in the Swedish health care sector. SAHP does however not primarily oppose immigration of nurses from Poland, Germany or elsewhere due to its effects on salaries or labor market conditions, but on their (lack of) credential qualifications (including language proficiency). They are, in other words, employing a professional strategy.

Skepticism over the credentials of foreign-educated professionals and their ability to function within the Swedish health care system is not uncommon amongst representatives from both associations.

- How did SMA (physicians) and SAHP (nurses) respond to issues that concern differences in credentials between those educated and trained in Sweden and in- and outside the EU/EEA?

The associations have often had a rather liberal position, accepting or even promoting international mobility and migration. At the same time, their arguments regularly rest on underlying assumptions that foreign-educated physicians and nurses lack something that is specific to a Swedish physician and nurse. While this includes language proficiency – the ability to communicate with patients and colleagues – it often embraces more than this. In this regard, the statements of the associations reflect perceptions of foreign-educated professionals that have been investigated in previous sociological research, where foreign-educated professionals in some regards are perceived as inferior to native professionals. These kinds of statements often underscore policy standpoints that argue that foreign-educated physicians and nurses do not only need to have their formal credentials validated but also go through some form of introduction or probationary period.

Physicians and nurses, particularly those from outside the EU/EEA, are however usually not portrayed as outsiders to the profession by representatives from the associations, but as insiders that need the help and support from them and government agencies to become fully functioning members of the profession. It should, however, at the same time be noted that SMA started advocating an increase in resources to help immigrant physicians having their knowledge validated and complemented in the 1990s, while at the same time arguing against the active recruitment of physicians abroad. This could be interpreted as an attempt to reduce the immigration of foreign-educated physicians by referring to unused foreign-educated but domestic professional labor resources. However, as SMA has continued with this policy standpoint regarding foreign-educated physicians even after they started to take on a more pro-mobility and market-friendly attitude, such an interpretation might be incorrect.

The results contradict those of Groutsis (2003) on the role of the medical association in Australia, one of few previous studies of professional organizations actions and policies towards foreign-educated physicians. These differences in results might have to

do with different institutional settings. As the medical profession in Australia had much more direct influence and control of the validation process, but perhaps also with public societal attitudes towards migrants and differences in migration policies overall, that presumably differs in Sweden today compared to those in Australia in the Post-war period. Compared to the Australian case both SMA and SAHP have employed a more inclusive professional strategy with regard to foreign-educated professionals. They are trying to defend the credential requirements of the profession while at the same time enabling their foreign-educated colleagues to reach these requirements.

- How did SMA (physicians) SAHP (nurses) respond to proposed changes to the credentials needed for a license to practice that emerged as a result of adaptation to the EU/EEA?

While the associations, most notably SMA, are pro-mobility, -market and -migration there are limits to their acceptance of changes to the credential standards that are the cornerstone of their professional status and ultimately their market control. This has been most apparent in SMAs and SAHPs responses to the proposed changes to minimum credential requirements within the EU.

For SAHP the EEA-agreement was initially beneficial as it helped to establish the three-year educational requirement as a credential standard for nurses educated in Sweden. The situation has been the reverse during the modernization of the Professional Qualifications Directive as the compromise on minimum credential requirements in the Directive have led to the association portraying the immigration of nurses from Germany and Poland as a potential threat to patient safety.

SMA has had a more liberal attitude towards the differences in the educational requirement in EU-directives. While they in many instances have defended the AT-service as an important introduction into the medical profession, this position has not consistently been used in ways that would close off of the profession from foreign-educated physicians. The obvious exception from this has been the case of *allmänläkare*, or the Specialty of Family Medicine, where members from SMA, SSM, and Medical Faculties, together with other associations and societies, have argued against the directives lack of recognition of the Specialty in Family Medicine.

In conclusion the results of the Working paper indicates that the hypothesis professional organizations will defend the need for certain specific credentials in order

for foreign-trained nurses and physicians to gain a license to practice and to advocate increased state supervision and control is not in itself sufficient to explain the positions of SMA and SAHP in the policy areas that have been studied. There are other considerations than the aim to limit the competition from foreign-educated professionals on the Swedish regulated labor market at play here. Whether this is a result of trade-offs with other preferences, such as the interest of protecting the credential requirements overall or an honest concern for the Swedish health care and its patients is somewhat harder to determine.

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