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# Mismatches in the Formal Sector, Expansion of the Informal Sector: Immigration of Health Professionals to Italy

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## DIRECTORATE FOR EMPLOYMENT, LABOUR AND SOCIAL AFFAIRS

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This paper is one in a series of case studies undertaken as part of a project on Health Workforce and International Migration. The project was jointly undertaken by the OECD and the World Health Organization, which seconded a WHO official to the OECD to work on the project. We are grateful to the Swiss authorities for the financial support which supported this secondment.

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## SUMMARY

Italy has an aging population which is placing a strain on the public health system and on families. At the same time, it has a distorted market of supply of health professionals. Past over enrolment in medical faculties has produced a current glut of doctors, although shortages will appear as this cohort retires. It is difficult for foreign-trained doctors, and Italian-trained foreigners, to practice medicine in Italy. In nursing, the situation is more critical, with far fewer graduates of nursing schools than necessary even to meet replacement needs. Care for the aged, which was traditionally borne by families, has increasingly been delegated to informal immigrant workers. In the absence of major changes in the care industry, recruitment efforts for nurses and other health technicians has expanded to include other source countries. Obstacles to international recruitment of nurses have been reduced, both by simplifying recognition of foreign qualifications and by exempting nurses from limits on labour migration to Italy. However, a ban on permanent employment in the public sector has relegated foreign nurses largely to private sector and shorter-term contract work. National and local health authorities have also become involved in supporting international recruitment of nurses, often through private agencies. In the home-care sector, families have been granted more opportunities to hire care workers from abroad legally, and many local authorities are attempting to integrate this spontaneous private care into their eldercare system through skill upgrades and support. Nonetheless, international migration will not be sufficient to solve Italy's health care professional needs.

## RESUMÉ

Le vieillissement de la population en Italie pèse lourdement sur le système de santé public et les familles. Parallèlement, l'offre de professionnels de la santé sur le marché du travail est déséquilibré. Dans le passé, le nombre excessif d'inscriptions dans les facultés de médecine a entrainé une surabondance de médecins, mais des pénuries apparaîtront au fur et à mesure qu'ils partiront à la retraite. Il est difficile pour les médecins ayant étudié à l'étranger et les immigrés qui se sont qualifiés en Italie d'exercer la médecine dans ce pays. En ce qui concerne les infirmières, la situation est plus critique, avec un trop petit nombre de diplômés des écoles d'infirmières, même pour satisfaire uniquement les besoins de remplacement. Les soins aux personnes âgées, incombant traditionnellement aux familles, ont été de plus en plus délégués aux immigrés du secteur informel. En l'absence de changements majeurs dans les politiques de la santé, des efforts ont été faits pour recruter des infirmières et personnels de santé dans d'autres pays d'origine. La simplification de la reconnaissance des qualifications acquises à l'étranger et l'exemption de quotas d'infirmières étrangères sur le marché du travail en Italie ont réduit les obstacles au recrutement international d'infirmières. Cependant, l'interdiction de les employer de façon permanente dans le secteur public a relégué la majorité des infirmières étrangères dans le secteur privé et dans les contrats de travail à court terme. L'administration sanitaire nationale et locale a aussi contribué au recrutement international des infirmières souvent par le biais d'agences privées. Dans le secteur des soins à domicile, les familles se sont vu octroyer plus d'opportunités pour recruter légalement à l'étranger du personnel de soins à domicile. Beaucoup d'autorités locales s'efforcent d'intégrer ce type de soins privés dans leurs systèmes de soins aux personnes âgées en assistant les personnels soignants privés et en renforçant leurs compétences. Néanmoins, les migrations internationales ne seront pas suffisantes pour répondre aux besoins de l'Italie en professionnels de la santé.

## TABLE OF CONTENTS



### Tables

**Figures**

# INTRODUCTION

## Increasing demand for health care

1. The Italian population is aging rapidly, raising and changing the demand for care. At the same time, and due to the same trend, the number of Italians entering the labour force is declining. The health care system therefore finds itself in difficulty.

2. The main difficulty lies in finding the human resources. Italy has one of the greyest populations in the world. Almost 20% of the population is over 65, and the median age in 2005 was 42.3 years old (Figure 1). By 2050, ISTAT projects a median age of over 52 and almost 8% of the population over 85 years old. This aging population has already placed increasing demand on the health care system.

3. The Italian eldercare system has not yet evolved to meet this growing demand. The lack of a policy has been most strongly felt in the form of a nursing shortage. There are different estimates of the size of this shortage, but all estimates place it above 50 000 nurses needed nationally. Every year, 17 000 retire and only 8 000 enter the field, making the shortage even worse.

4. Attention has therefore shifted to recruitment from abroad. Recruitment, however, is made more difficult by international competition and complex national regulations. Despite concerted efforts to make Italy attractive and to reduce obstacles, international recruitment has not contributed significantly to resolve the shortage.

5. The striking aspect of the Italian situation, however, is not the shortage of nurses, but the sharp contrast of the highly regulated nursing sector with the vast universe of home care assistants. Some are informal, while others are haphazardly regulated. Certification and recognition are far from harmonised. Still, the sector has no shortage of human resources and it's easy to recruit relatively affordable home care assistants, even if they are of unproven quality.

6. The paper will cover these issues. It will start by looking at inefficient allocation of human resources to the health sector – especially the overabundance of doctors and increasingly severe shortage of nurses. Italy is a full participant in the international labour market for health care workers, and suffers from its own "brain drain", especially among doctors. On the other hand, it has also become a major importer of unskilled care workers.

7. How are all these flows managed? What new solutions and mechanisms have been proposed and implemented to solve the problem?

## Human resources in the health sector

8. The Italian public Health Service (SSN) is entrusted to the 20 Regions under the ongoing decentralization of health care; health care represents about 10% of total public spending and is the largest budget item for the Regions. The health system is divided into Local Health Corporations (variously known as ASL, USL or other abbreviations, and Hospital Corporations. In 2003, the public health sector employed about 660 000 people, of whom 104 000 were physicians (including dentists) and 263 000 were

nurses (Cengia, 2006). About 55% of the physicians working in the public system were in hospitals, with most of the rest primary care physicians.

9. The past 20 years have seen a sharp rise in the number of medical doctors, from 240 000 to 370 000, while the number of registered nurses trebled from 110 000 to 335 000 (Table 1). This increase has not kept pace with the demand for nurses.

10. While the health sector is an important employer in Italy, jobs in the health sector are relatively stable. In fact, the preponderance of the public sector guarantees long-term job stability and limits turnover. Data from the workplace insurance institute INAIL show that the health sector represents only 2.2-2.4% of job turnover, with about 120-130 000 job starts annually (Table 2)[1]. The quality jobs in health care are already taken and protected, leaving only a subset of highly precarious jobs with high turnover.

11. The Excelsior system provides detailed information on private sector labour needs on an annual basis, including for a number of professions in the health sector.[2] Excelsior covers private sector hiring, so it does not reflect shortages or demands in the public health sector. Public sector employment, however, is considered more attractive for most health professionals, so it faces less difficulty than the private sector in attracting staff. Private sector demand for different health care staff varies (Table 3). Doctors are not particularly sought after, with businesses predicting demand of about 200 doctors in 2007; of these, much of the demand is just to replace retiring doctors. Difficulty is expected in finding doctors only a third of cases, representing less than 100 specialists. The private sector demand for nurses has exceeded 4 000 annually 2005-2007, (with a rising proportion of demand to meet turnover), and most businesses expect difficulty in finding personnel. The greatest demand in the health sector is in less skilled workers: aides and assistants (6 430 in 2007), personal care assistants for institutions (5 600), and home care (1 430). Private sector demand in the health sector is generally from larger enterprises, and offers the permanent contracts which are ever harder to find in Italy (Table 4).

12. Excelsior also predicts the private sector demand for non-EU workers. Within the health sector, for 2007, total demand was predicted to reach a maximum of almost 35 000 workers, and non-EU workers were expected to comprise 20-40% of the total demand.

**Too many doctors…**

13. Italy has the world's highest rate of medical doctors to population. In 2005, 370 000 doctors belonged to the Italian Medical Association (FNOMCEO), yielding a rate of more than 600 doctors for every 100 000 inhabitants. Only about a third of these doctors work for the Public Health Service. Competition is fierce for public sector employment, and young doctors suffer from a high unemployment rate (unheard of elsewhere) and often face a long job search before finding regular employment

[1] The number of job terminations suggests an increase in the number of employed nurses, but INAIL data invariably undercount job terminations: employers face risks if they fail to declare a job start, while failure to report job termination bears no risk.

[2] The Excelsior Information System is run by Italian Union of Chambers of Commerce, Industry, Crafts and Agriculture. It surveys businesses to produce an annual analysis of expected Italian labour market demand (http://excelsior.unioncamere.net). The system examines at planned hires in the following year according to a number of parameters: sector and geographic location of business activity, experience level of personnel sought, intention to train, etc. Excelsior uses a telephone sample of more than 90 000 of the 5.8m registered businesses, and face-to-face interviews with all 4 000 with more than 250 employees. For more information on the role of Excelsior and its implications, see Chaloff 2005, pp. 10-11.

14. In part this excess of doctors is due to past over-enrolment in medicine (for example, in 1980 alone 17 000 enrolled). The number of doctors doubled in 1974-84 and increased by 40% in 1984-1994. Limits were placed on enrolment (*numerus clausus*) in the 1990s, and from 1994-1999 the number of doctors rose by only 5.4%. The number of students enrolling has fallen sharply – from about 9 000 in the mid-1990s to 7 200 in 1999 and 5 623 in 2006. Almost 90% of those enrolling finish their studies, a much higher retention rate than other University programmes in Italy.

15. Overall the short-term employment outlook for physicians in Italy is not promising. In 1998, for example, of physicians who had received their degree in 1995, only 45.2% were working, and 36.1% had left the labour market (Istat, 2000). In 1999, more than 10% of the doctors enrolled in the FNOMCEO were not working as doctors (i.e. were not contributing to the physicians' pension system ENPAM). There is a shortage of qualified specialists in certain sectors, such as anaesthesia and radiology. The aging of the medical labour force will cause an increase in retirements in the next decades. In paediatrics, the number is expected to halve from 2015 to 2030 if the current enrolment and turnover trends continue. Even with Italy's low fertility rate this will cause a shortage in the sector.

16. The public sector does not offer many opportunities for stable employment. The local health authorities saw their staff budget fall by 2% from 2004 to 2007 and favour short-term contracts. This leads some doctors to go abroad.

17. Italy, in fact, suffers from a noteworthy brain drain and is, with Spain, the only EU-15 country to suffer a net loss of university graduates. Many are physicians, especially in research: medical researchers account for 16.4% of the Italian Foreign Ministry Database of Italian researchers abroad, and 15% of a 2001 survey of Italian researchers abroad (Censis, 2002). The same survey highlighted the reasons for departure: limited research funds; poor career opportunities due to lack of merit considerations and rampant nepotism; low salaries and poor infrastructure. The Italian Ministry of Health also sees this expatriation in a positive light, as doctors seek career and learning opportunities abroad.

18. It's no surprise that there aren't many immigrant doctors in this unpromising labour market. Foreign-born doctors account for 12 527 of those registered with the Italian medical association, or about 3.4% of all physicians in Italy (Table 5). Almost 45% are from developed countries, led by Germany (8.3%), Switzerland, France, Greece and the USA. A significant contingent comes from South America. About 25% of all foreign doctors working in Italy are in the major metropolitan areas of Rome and Milan (Ercolini, 2004). There is no data available regarding whether they received their medical training in Italy or abroad.

19. The Italian Ministry of Health notes that a major obstacle for foreign doctors is the language barrier, since Italian is not widely spoken abroad. Yet most foreign and foreign-born doctors have trained in Italy rather than immigrating after studying abroad, and given the use of oral exams can be considered to have mastered the language. 80% of the members of AMSI, the main association of foreign doctors, were trained in Italy. The recognition of non-EU medical degrees is a lengthy and cumbersome process, and while the Ministry of Health certifies degrees within a year of filing a complete application, it often takes applicants 5 years to assemble the appropriate documents. The exam for foreign-trained doctors is held every 6 months. An alternative is to enrol in the 6$^{th}$ year of medicine, take 7 exams and receive an Italian degree, converting the non-EU degree into an Italian degree.

20. According to a census of members by the Italian Medical Association, the number of foreign doctors – that is, with non-Italian citizenship – is much lower than the number of foreign-born doctors, and amounts to a mere 3 525, of whom 1 562 are EU citizens (tab 6). This discrepancy between the foreign-born and foreign citizens among doctors can be explained in several ways. First, many of the foreign-born doctors are simply Italian citizens born abroad to Italian parents. Second, many of the foreign doctors have

been in Italy for decades and have married Italians or received Italian citizenship through naturalisation. The resistance of Italian institutions to foreign doctors - in a context of oversupply[3] – make acquisition of citizenship almost essential for a successful career. Access to specialization, for example, is limited for non-EU citizens even if their medical degree is Italian. Until recently, the professional association required a work permit as a condition of enrolment, placing Italian-trained foreign doctors in a catch-22 where they could not convert their study permit unless they have a job offer, could not join the medical association with a study permit, and could not find a job without being a member of the medical association. Even now, the number of such conversions is capped by an annual decree and aspirant doctors must compete with all other foreign students who are attempting to stay in Italy. In the past, the number of conversions allowed has been low – about 1 250 – and only in 2007 did it reach 3 000.

21. The significant number of German doctors and dentists – 593, about a third of the EU total (tab 6) – can be attributed to two factors. First, Italian doctors and dentists are free from the limits on fees and caseloads that prevail in Germany. Second, many work in the German-language province of South Tyrol.

22. The real number of foreign doctors is only about 1% of the total, much lower than that claimed by some analysts, including a recent Caritas review of these data (Mellina, 2006). Italy is far from attractive for a foreign-trained physician and even for an Italian-trained doctor.

**… but not enough nurses**

23. The nursing sector faces the opposite problem. There are fewer nurses than doctors (348 415 were registered with the provincial professional registries in 2005). In sharp contrast to physicians, most registered nurses work in the public sector (about 70%), with 20% working in the private sector and 10% working on a contract basis.

24. While Italy trains more physicians than it needs, it does not train enough nurses to meet current demand. In 2004, according to Ministry of University figures, 8 868 students received nursing degrees from Italian universities. Enrolment in nursing programmes has reached about 35 000; the basic degree is a 3-year course. The National Federation of IPASVI (Professional Nurses, Health Assistants and Childcare Workers), the umbrella body for the professional organisation for nurses, registers fewer graduates: only 6 700 graduated in 2004. Estimates of the number of nurses leaving the profession annually – for retirement or other reasons – range from 13 000 to 17 000. In any case there is a chronic shortfall in the number of new nurses. For 2006, the Federation estimates a national shortfall of 60 000 nurses, and about 15% of listed jobs for nurses go unfilled.

25. Italy has addressed this crisis and has increased the capacity of its university nursing programmes enormously. In 2006, 13 000 nursing students enrolled, up from 10 700 in 2003, and 9 200 graduated in 2006. While the number of nurses (including those recruited from abroad) has been increasing at about 2% annually since 2000, the demand for nurse training is higher than the supply of space in the university. Applications to nurse training programmes are much higher than availability, especially in the southern regions (Figure 2), where unemployment is higher and the number of new entrants to the labour force is higher for demographic reasons. Budget cuts in the health sector have prevented the creation of new nursing courses to meet the number of applications and have also prevented the public health sector from hiring new nurses. The effect of this shortfall is a nursing care shortage.

26. The main sectors of shortage of nursing staff are in emergency care and in hospitals, where holidays often mean a shortage of nurses.

[3] According to a government source, the Medical Association unsuccessfully pressured the government to explicitly limit migration to Italy by foreign doctors.

27. Faced with this chronic shortage of nurses, some Regions have attempted to expand the certification of nurses' assistants and personal care personnel, in order to reduce the burden on the more highly-trained nurses who historically also performed such tasks as cleaning and moving patients. This introduction has been slow. At the same time, wages have not risen significantly in the nursing sector, although opportunities for overtime and internal mobility have increased.

**The nurse shortage and innovations to improve recruitment**

28. Italian nurses are sometimes attracted abroad, in the pursuit of better wages and working conditions, although there is no systematic recruitment of Italian nurses for foreign employers.[4]

29. The number of foreign nurses is lower than the number of foreign doctors, although it has increased sharply since the start of the decade. By 2005, there were 6 730 nurses in the professional registries (Table 7), of whom about a third were from new EU member states (mainly Poland), and another third from Romania and Bulgaria.

30. As of April 2007, the entry procedures for a non-EU nurse, trained outside the EU, were the following:

- Recognition of diploma.
- An offer of a nursing contract from an Italian employer.
- Authorisation of entry from the One-Stop Immigration Counter at the Prefecture in the employer's province.
- Issuance of a subordinate employment visa, for the length of the contract or two years, whichever is less.
- Entry in Italy and the signing of the residence contract at the Immigration Counter.
- Enrolment in the provincial IPASVI, which requires passing an Italian language test.
- Only then can the nurse start working.

***Recognition of foreign qualifications***

31. As for doctors, there is a significant difference between the legislation governing nurses trained in the EU and those trained outside the EU; there is also a significant difference between the treatment of EU citizens and non-EU citizens.

32. The Italian Ministry of Health, Department of Human Resources, Section IV, reviews the documentation for each individual application for recognition issues a decree of authorization and informs the applicant of the decision directly. Prior to 2002, recognition was published in the Official Gazette of the Italian Republic. Since then, however, there has been no public record of these decisions, although the direct recognition speeded up the process by two-three months. Even the Ministry itself keeps no count of the number of nurses or other foreign health professionals whose qualifications are recognized. There is no

[4] IPASVI reports a positive experience with the Norwegian Ministry of Health, which received 10 Italian nurses in a pilot programme with the Italian Ministry of Labour. There are also *transfrontalieri*, Italian nurses living along the French and Swiss border and working in those countries.

database of decrees issued, nor is any monitoring conducted. In response to a special request, the Department of Human Resources, Section IV, counted the foreign health qualifications recognized in 2005. Section IV is responsible for most health professions (except physicians and some other categories). In 2005, according to the Ministry review, 4193 non-EU health qualifications were recognized, of which 3 864 were as nurses; 1 399 EU health credentials were recognized, of which 1 130 were as nurses (Table 8).

33. As far as nursing is concerned, by far the leading nationality was Romania, with 2 420 nurses (60.6% of the total), followed by Poland, with 1 000 decrees and 25% of the total. Other nationalities with more than 100 cases of recognition were Peru, Albania, Serbia and India.

***Easing entry procedures***

34. Italy has a labour migration policy where foreign workers with employment are allowed to enter the country, subject to annual ceilings (quotas). The acute nursing shortage in Italy first led Italian policy makers to establish set-asides for nurses within the annual quotas (2 000 nurses in 2001) and then to enshrine a permanent exemption from quotas in the 2002 migration framework law.[5] Nurses need to have their degrees recognized by the Ministry of Health, after which they may be offered a job by an Italian employer – as a nurse – and receive a visa to enter the country for work. The visa duration is related to the length of the first contract and may be for up to 2 years, and is, like all other work visas in Italy, renewable.

35. In 2004, at least 2 597 foreign-trained non-EU nurses were authorized to enter Italy (Table 9). Most of the contracts were for 12-24 month periods. Most of the nurses coming to Italy were 20-39 years old. The main nationalities were Romania (about half of all nurses) and Poles (459). Poles, like citizens of other new EU states, benefited from a change in entry requirements from 1 May 2004, when the overall quota was set so high that the nurse exemption no longer represented an advantage in access.

***Entry to Italy, issue of work permit, IPASVI language and professional exam, enrolment in IPASVI***

36. Once arriving in Italy, and before starting work with the employer who has offered them the job, foreign nurses must receive a work permit, issued by the Immigration Service of the Police through the Prefectural Immigration Office. In order to receive the permit, the nurse must show a job contract specifying that he or she will work as a nurse. If the nurse changes employer, he or she must return to the Immigration Office with the new contract, which must be for nursing.

37. Non-EU nurses entering Italy through the quota exemption are in fact required to work as nurses; they may change employer but only if they still work as nurses.[6] While this requirement expires after the first renewal of the work permit for the other quota-exempt categories, there is no expiration for the job-linked permit for nurses. This is the only professional category with such a "permanent" link to professional category, although in practice this recent requirement has yet to be challenged.

38. In order to work as licensed nurses, non-EU nurses must enrol in the IPASVI, paying a licensing fee and annual dues. Non-EU-trained nurses are required to pass a nursing qualification exam offered by the provincial IPASVI. The IPASVI also require all non-Italian nurses to pass an Italian language exam before they are allowed to enrol. Prior to 2007, EU nurses were exempt from the language requirement. This exemption started to create concern in 2004, when Poland entered the EU and Polish nurses were exempted from the language exam. The national federation of IPASVI lobbied to eliminate this exemption before the accession of Romania.

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5 Art. 27 (r) of Law 286/98 as revised by Law 189/02.

6 Regulation no. 334, 18/10/2004, art. 37 ¶ 23.

39. In addition to the above qualification and language tests, the provincial IPASVI also insists on a valid work permit as a requisite to enrolment. This excludes students (who are allowed to work up to 20 hours a week) and other categories, although family reunification and refugee status are both valid permits for enrolment.

***Recruitment from abroad***

40. The 2004 regulations for the application of the 2002 immigration reform grant "public and private health care facilities the right to hire nurses, including for an unlimited contract, through 'specific procedures'. Temporary work agencies may apply for authorization to hire [nurses from abroad] using contracts offered by public or private health care facilities. Cooperatives have the right to apply for authorization if they are directly responsible all or part of the health care facility, or for services therein provided."[7] Despite this provision, very few "specific procedures" have been approved, forcing employers to exploit legal loopholes.

41. In fact, although the Italian public sector employs most nurses in Italy, the normal recruitment mechanism – public examinations offered through announcements – make hiring directly from abroad impractical. The main reason is that non-EU citizens are excluded from permanent public employment examinations in Italy. This has long excluded non-EU citizens from all levels of public employment from the postal service through university and research positions. Some recent civil court decisions have ruled this rule discriminatory. Nonetheless, the examination system has not yet changed.

42. To deal with the nursing shortage, hospitals have found a way around this obstacle. They first hold an examination for an unlimited contract, open to EU citizens. When there are few or no applicants, as is usually the case, the hospital then holds another examination for fixed-term contract nurses, open to non-EU citizens. Because of requisites such as certification of enrolment in the nurses' professional order, participation is essentially restricted to foreign nurses already in Italy whose training has been certified and who are licensed nurses.

43. In practice, public recruitment occurs through direct inter-institutional contact or through private agencies.

44. One example of direct inter-institutional contact is in the recruitment of Spanish nurses. Italy has recruited Spanish nurses since 2004. Spain has an excess of nurses, including a seasonal surplus in the summer, following graduation. Following contacts between the respective nursing associations, a mechanism for recruitment was created. The Spanish Ministry of Labour has held three job fairs for Spanish nurses interested in working in Italy. The Italian delegation to the job fair, which comprises a representative of IPASVI, and Italian public hospitals and a representative of the Italian Ministry of Health, collects applications and speeds up the recognition process.[8] The Italian public hospitals recruiting Spanish nurses also provide Italian language courses.[9] Spanish nurses adapt well to Italian culture, language and workplace conditions.

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7 Regulation no. 334, 18/10/2004, art. 37 ¶ 21.

8 A single standard for EU nurse training, the Strasbourg European Agreement on the Instruction and Education of Nurses (25.10.1967), adopted by Italy in 1973, guarantees rapid recognition, with a minimum training of 4 600 hours. For most EU degrees, recognition in Italy requires only a copy – untranslated – of the national nursing certification document.

9 These courses were provided even before the 2007 requirement. While all EU nurses are now subject to language tests, new EU member states, who were not signatories to the Strasbourg agreement, are still subject to different treatment than those from the old EU-15. The national certification in new EU countries

45. The role of agencies is much more prominent in recruitment from non-EU countries. In order to speed up the process of recruitment, in 2004, IPASVI requested and received Ministry of Health approval to set up evaluation commissions abroad. These commissions are composed of:

- An Italian nurse nominated and sent by provincial IPASVIs;
- A certified Italian language teacher licensed to work in the country where the commission is held;
- A commission secretary.

46. The cost of the exam is borne by the applicant, while the cost of organizing the commission is borne by the agency.

47. These commissions are instituted only in the framework of recruitment by Italian temporary work agencies.[10] The choice to limit commissions to such agencies – about a dozen - was motivated by the fact that the agencies are licensed by the Italian Ministry of Labour, and in the event of abuse or inappropriate practices, IPASVI can request that their license be revoked. No similar leverage exists for the myriad of cooperatives which would also like to recruit abroad, so IPASVI chose not to work with cooperatives.

48. Applicants who pass the exam of the commission receive a certificate; when they arrive in Italy, they present the certificate to their local IPASVI, which checks its authenticity with a copy held at the national office and enrols the nurse. Between 2004, when these commissions started, and mid-2006, 61 commissions had been held in Romania, Bulgaria, Serbia, Bangladesh, Paraguay and Peru, with 2 439 certificates issued. Most have been held in Romania. Only 500 have so far arrived in Italy and enrolled in the provincial IPASVI, since they still have to have a job offer through the agency which organized the commission or through another agency. This may be explained by the bureaucratic requirements faced by non-EU citizens, including the requirement of a residential address and a permit of stay, which may take some time to issue.

49. The Ministry of Health claims that the number of cases of nursing qualifications recognized – about 5 000 in 2005 – has been fairly steady in the past few years. This raises a troubling discrepancy between the number of foreign nurses who receive recognition of their qualifications, and the number of foreign nurses who belong to the provincial nursing association (IPASVI). If most of the foreign-trained nurses receiving recognition in Italy actually enter the country, one would expect foreign membership in the provincial associations to have risen much more than it has. Either these nurses are not coming to Italy, despite having applied for recognition, or they are working as nurses without having taken the language and qualification exam, without a license, and without the wage and contract protection of a recognized nurse.

50. IPASVI confirms concerns that many non-EU nurses start working without enrolling in the professional association and therefore without licenses. This may be due to misinformation, or to avoid the nominal fees associated with enrolment (60-70 euro/year). In the event of a workplace inspection, these nurses would be found to be working without a license. They may rush to enrol in the IPASVI, but the

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(EU-10 and EU-2) is not considered sufficient, and nurses trained there must send their CV to the Italian Ministry of Health for verification of conformity in terms of course hours and classroom and workplace training. Not all nursing academies are accepted.

[10] Obiettivo Lavoro, one of the larger recruitment agencies, claims to have placed 1 000 foreign nurses between 2003 and 2006 through direct contact with public authorities in South America and East Europe, and to have prepared more than 500 in the first three semesters of 2007.

recognition decree issued by the Ministry of Health is only valid for 2 years, so nurses who work without a license may risk losing the right to certification if they don't enrol soon after arrival in Italy.

51. Most of the 7 000 foreign nurses working in Italy at the end of 2005 (2% of the workforce) were in the private sector, since it is easier for a private employer to offer the contract necessary to obtain a visa. It's practically impossible for a foreign nurse to participate in a public employment competition from abroad. The private sector, therefore, is the importer of foreign nurses, some of whom later try to make the leap to the public sector.

52. Most of the public health budget is planned and spent at the regional level, through the hospital corporations and the local health corporations (ASL) which answer to the Regional Health Department. The nursing crunch affects different parts of the country differently, with a greater shortage felt in northern regions. These are the Regions that have explored recruitment channels to attract foreign nurses.

53. Italian Regions are also allowed by law to collect applications from nurses abroad, review their credentials, and send the package to the Ministry of Health for approval and issue of the decrees of recognition.

54. Some Regions have started to recruit nurses from abroad – in Romania – through bilateral programs with nurse training institutes. Nonetheless, most of the 7 000 foreign nurses – who represent about 2% of all registered nurses in Italy – work in the private sector, and it is the private sector that is able to offer the initial contract necessary to obtain a visa.

55. Another area of collaboration is in distance learning and bilateral training agreements. One experimental project – SkyNurse – combines on-line training with satellite video links between classrooms in Padova, in the Italian region of Veneto, and partner institutes in Bucharest and Pitesti. The project involves 180 candidates in a 14-month training programme designed to guarantee the language and technical skills necessary to pass the required exams once in Italy. The project includes three months of distance learning and 1 month of training in Veneto.

56. The Province of Parma, which has a bilateral agreement for cooperation with the Province of Cluj-Napoca, involved the medical schools in both Parma and Cluj. While the long-term goal is to support the Cluj University in the development of a joint degree in nursing, recognized according to EU standards, the cooperation has already led to recruitment of nurses. The Bilateral Agreement between the two local authorities and the relative medical schools started in the 2003/2004 academic year. Fully funded by the Province of Parma, the project added modules to the existing Cluj nurse training program, covering the Italian language and Italian health regulations and professional standards. Approval of equivalency is granted by a commission composed of representatives of the University of Cluj, of the Province of Parma, of the Parma Nurses College and the Italian Embassy in Bucharest. 26 nurses arrived in 2005 and 40 are expected in 2006. Upon arriving, a commission comprising the Province, the local hospital corporation and the Nurses College orients and places the nurses.

57. A similar programme exists between the Veneto Region and Timis County in Romania. In 2002, the two local authorities signed a framework cooperation agreement, under which the University of Padua and ULSS 9 in Treviso – the local health service – organized courses in Romania. 22 Romanian nurses received diplomas in Padua in 2006. Many Veneto businesses have shifted part of their production to the Timis region, and many Veneto entrepreneurs live part- or full-time in Timis. This led to a remarkable decision, in the framework of an agreement signed on 22 March 2006, to send an Italian doctor from the Treviso public health authority to Timisoara to serve the Italian community there. A telemedicine link is also planned between Veneto and Timisoara and Bucharest.

58. The public sector is willing to use private agencies for recruitment. One example is a Protocol signed in 2004 between the Modena USL (Health Service) and a private Romanian recruitment agency, International Staffing[11]. Under the terms of the protocol, the latter provides 80 hours of Italian language training so that the nurses can pass the language exam once in Italy. The private agency also supports all bureaucratic steps in the recruitment, recognition and visa process. The nurses pay only administrative and travel costs, although they sign a contract stating that if they withdraw from the process they must pay a penalty of up to €250 to the agency and €400 to Emilia-Romagna. The Italian region pays the agency €600 for each nurse who actually starts working in public structures in Italy.

59. The only example of recruitment which directly involves the national authorities is a bilateral agreement with Tunisia signed by the Italian Ministry of Health. The framework agreement sets a limit on the number of workers who can be "borrowed" by Italy. So far, only the Vimercate Hospital Corporation has taken advantage of the bilateral agreement with Tunisia to sign a protocol (22 March 2007) for the temporary recruitment of a small number of Tunisian Public Health Service employees for a period of time. The protocol starts with just 15 nurses and 6 radiological technicians, who are allowed to keep their job in Tunisia. The Italian hospital interviews candidates to "exclude those who have problems treating patients of the opposite sex" and provides a language course.

60. Albania, a major source country for immigration to Italy, has largely sent nurses through private agencies. The nursing sector is one where Albanian employment agencies have been able to establish a niche, in sharp contrast to their difficulty in matching supply and demand in other trades. The agency "La Speranza", for example, has an office in Tirana and an office in Milan, and handles only nursing personnel. It has sent 500 nurses from Albania to northern Italy since 1999. The Milan office contacts private hospitals and nursing homes. The Tirana office verifies the qualifications – only the new post-1995 Albanian nursing schools are recognized in Italy – and prepares the documentation for recognition of nursing skills. "Nursing education is of good quality in Albania", according to the Italian embassy. The agency also provides language lessons and preparation for the nursing exam in Italy. Nursing is a traditional profession for Albanian women, but about half of the agency's clients are men. According to the agency, "these men went to nursing school only so they could emigrate". There is little doubt that the expansion of the nursing sector – schools in at least six cities, with Tirana alone producing 300 graduates annually for a nursing sector where there is no demand – is due to emigration opportunities. La Speranza reports that not one of the 500 nurses sent to Italy has returned. One Albanian Ministry of Labour official expressed concern, noting that there is "a crisis with the loss of nurses." There is also concern about the fee structure: while Albanian law prohibits workers from paying fees, requiring the employer to cover costs – and agencies deny that nurses themselves pay – other advocates, and the workers themselves, report having to pay steep fees and then finding themselves stuck in unpleasant working conditions in private structures where their contract is not respected.

61. The private sector is also very interested in streamlining the recruitment and recognition process. One example can be found in a collaborative project in Veneto, where the owners of private health care structures pushed for a new recruitment channel. An association identified Bangladesh as a potential source and lobbied the Ministry of Health to recognize the Bangladesh Nursing Council degree as equivalent. A manpower company recruited the first 18 Bangladeshi nurses and offered a two-month intensive language course in Bangladesh. The 2002 immigration law grants up to 6 months for on-the-job training, so the new arrivals start working even before they have taken the language and nursing exam. Their housing and other costs are covered by two temporary work agencies, Umana and In Time. Such an expensive scheme indicates the value of nurses on the Veneto market and the willingness of temporary work agencies to

[11] The protocol is titled:"Accordo operativo per il reclutamento, la selezione, la formazione di infermieri provenienti dalle nazioni Romania e Moldavia per soddisfare il fabbisogno delle strutture sanitarie pubbliche e private della regione Emilia Romagna".

invest in training and providing for them. The scheme also highlights some of the danger of exploitation of recruited workers: during their training period, they work legally but without the necessary credentials, and may receive only a nominal training wage.

62. The reaction to the inflow of nurses from abroad has been largely positive and has not raised major concern among trade unions. Some concern persists over poor language skills, on the one hand, and over the fact that these nurses also require the support of an experienced Italian nurse during their initial period on the job. This mentoring and supervision responsibility falls on nursing departments which are already understaffed and overburdened.

63. Overall, the health sector attracts immigrants in large numbers, although these workers are concentrated in the lower-skilled segments of the health care labour force. In fact, as noted above (Table 3), much of the demand for workers in the health sector is for personal care workers in the institutional setting; demand for such workers is three times higher than that for nurses. The issue of qualifications is less important, since such workers don't require any training, or are to be trained by the employer. Low-skilled care workers can be drawn from the immigrant workforce in Italy. In 2004, 10% of all new contracts in the health sector were offered to foreign-born workers (Table 10). This included nurses and doctors but also many other health workers. In addition to nurses, other foreign-trained immigrants are certified to work in Italy; in 2005 alone, the Ministry of Health recognized 330 foreign-trained physiotherapists and 134 social and health assistants (Table 11).

64. However, the question remains: why can't Italy attract significant numbers of foreign nurses? It is poor competition for other countries vying for foreign nurses. The national nursing contract foresees a gross salary of EUR 1 600 monthly, which cannot compete with other European salaries, let alone those in North America. No ties have developed with nurse training schools in sending countries, such as those in the Philippines which train for other countries. The limited use of the Italian language abroad is no doubt a factor. Only Albania and Romania have nursing schools with significant numbers of graduates headed for Italy, and these countries cannot supply a sufficient number of nurses to meet current Italian demand.

65. It should be noted that the Italian Ministry of Health sees foreign recruitment as a means of addressing short-term shortages. Its objective is rather to improve access to training in Italy and produce the necessary human resources within the country, in order to provide more opportunities to residents and to prevent the drain of human resources from poorer countries.

**Foreign students in Italian medical and nursing schools**

66. Italy has never been a major destination for foreign students, and the percentage of foreign students in Italian universities has slowly increased to 2.8% over the past decade. Total foreign enrolment in 2005-2006 amounted to 41 589 of the 1.8 million university students. Albania has become the leading sending country of foreign students in Italy, accounting for a quarter of the total foreign enrolment. Enrolment by foreigners is sometimes attributed to misuse of the student visa, since enrolment is necessary to obtain a visa, but no follow-up is done to confirm that the foreigner has actually applied for a permit once in the country, or has taken exams. In any case, Italy does not recruit foreign students, but has, in the words of one observer, "historically viewed foreign students as a nuisance. They require more paperwork from the bursar's office and usually need housing. They have been more tolerated than welcomed". The availability of scholarships is limited, and the Ministry of Foreign Affairs provides scholarships to only 400 foreign students. Tuition fees for foreigners are the same as for Italians.

67. Only in 2005 did the Italian Ministry of University provide information in English to prospective students on its website. This interest by Universities is generally attributed to falling enrolment – after all, the demographic decline has meant that the university-age cohort in Italy is continually shrinking – and

changes in the funding to Universities which reward higher enrolment. Such factors have led Italian Universities to offer mobility programs, distance learning, and even instruction in English rather than Italian – which was previously prohibited.

68. While the Italian Ministry of Foreign Affairs funds scholarships for African doctors, both for attending medical school in Italy and for specialisation in Italy, it is with the idea that these doctors will return to Africa. At the same time, health-sector development projects funded by the same Ministry in Africa employ only Italian doctors.[12] There has been no attempt by Italian authorities or universities to maintain ties or to promote the Italian-trained doctors once they have returned to their home countries.

69. In the absence of an overall policy, foreign University students are largely left to their own resources. The difficulty in obtaining information has also meant that the Universities cannot meet their own foreign-student quotas: there is space for four times as many foreign students as actually enrol.

70. Foreign students often study in the health professions, medicine and pharmacy (Table 12), fields where there is already a glut of graduates in Italy. Foreign students represent 6.9% of students graduating in medicine. While most students plan to go back to their own countries, Italian migration legislation places them in a difficult position. If they leave after graduation to return to their home country, they lose residence rights in Italy. The current immigration law allows foreign students to stay in Italy and work, but only subject to the quota system. Annual quotas set a maximum number of conversions of study permits to work permits, usually half the total number of self-employment permits. Those foreign students who do not apply for a work permit upon graduation, or whose application is rejected, lose their right to stay in Italy, and their permit is cancelled. They must leave the country or face expulsion.

71. Half were Greek (Table 13). Greeks have long come to study medicine in Italy because of the numerus clausus limits on capacity in their own universities. During the 1980s Israelis also came to Italy in large numbers for the same reason, but since 1990 have preferred medical schools in central European countries. Few of these students plan to stay in Italy.

72. While medicine attracts foreign students, the same cannot be said of nursing. Even though nursing has excellent employment prospects, only 2.9% of nursing students are foreigners. This low interest may be explained by the fact that nursing is a full-time three-year degree, and therefore a significant investment requiring support from one's family, while the starting salary is low. The relatively favourable policy of recognition of foreign nursing credentials means that it is more cost effective to study nursing in the home country. Only scholarships would make a difference, and there are none available for resident foreigners. For Italian employers interested in recruiting nurses, the main interest has been in drawing directly on foreign-trained nurses rather than Italian-trained foreigners. The training cooperation projects cited above testify to the fact that training in the home country is more efficient not only for the nurses themselves for also for recruiters.

73. There is no data on the number of conversions of study permits into work permits, nor is it possible to determine how many of those conversions were for medical doctors or nurses.

**Institutional and Home care workers**

74. No discussion of international mobility of health workers to Italy can neglect the overwhelming role played by immigrant care workers, who meet much of the home care demand from the elderly and from the disabled. The demand for home care workers is much higher than that for nurses (Table 3). These

[12] Comments by Dr Remy Mbuya, OB/GYN Resident in Italy, quoted in "Amicizia: Student Esteri", Vol 43, No. 3-4/06, pp. 26-27.

workers are hired without concern for their certification and any training necessary can be provided. There is no shortage of such workers in Italy.

75. Half of the 700 000 applicants for the 2002 regularisation were domestic workers, of whom many were taking care of the elderly or disabled. Current estimates of the legal population of foreign elder-care workers reach 500 000, representing about 1% of the total population of the country.

76. Definition of this work is especially difficult since the past decade has seen the multiplication of job titles. Care workers include *assistenti socio-sanitari* and *operatori socio-sanitari* (ASS and OSS), whose profiles vary from region to region.

77. Foreign workers hoping to establish themselves in the care profession face two main obstacles: the confusing certification system and the precarious employment outlook. In part this is due to the preponderant role of cooperatives in the provision of low-skilled care, since the tender system imposes cost restrictions and employment is usually short-term and with the least favourable contracts. Cooperatives rarely pay higher salaries to workers with non-university training, especially when such training is certified only by a single region or even municipality.

78. The effect is to create a sort of pyramidal distribution of foreigners in the health sector. There are few doctors and few nurses at the top, as shown above. More immigrants can be found in health care cooperatives, including the ASS and OSS. The Excelsior system, in its predictions for 2007, found that one-third of private health care providers expected to hire immigrants. Finally, there is a predominance of immigrants among untrained and uncertified home care workers. In May 2007, the Ministry of Labour, citing INPS data, claimed that 750 000 people were working in home care, adding another 500-600 000 irregulars in the same sector. An estimated 90% were immigrants.

79. The Italian public health system provides needs-tested home care for the non-self sufficient within the limits of its local staff resources, which are usually chronically overstretched in this field. Social assistance is means-tested and provided by municipalities. Both the health services and municipalities often tender these services to third-sector cooperatives. Costs are high in any case: integrated domestic care, guaranteeing 24 hours/week of medical, nursing and social home visits costs €200/day per recipient; the least qualified home care visit still costs no less than €16/hour. Collective solutions (such as homes for the aged) are limited and also suffer from cultural resistance. Families seek to keep the elderly at home for as long as possible.

80. Faced with limited public supply, many Italian families have hired private live-in or hourly caretakers. The past decade has seen the expansion of this private social expenditure, due to changing family structure and priorities, with some surveys showing that 2.4% of those over 65 have a live-in caretaker, almost always a recent immigrant.

81. Privately employed home care workers may be paid just over €5/hour, if declared; with social contributions the cost to the employer is about €6/hour. The declared average wage in the 2002 regularisation was €475/month for carers. Most of these live in carers actually work 10-12 hours/day in work weeks which approach 70 hours; overtime is almost never declared or paid.

82. Most of these workers have been invisible, either because they are in Italy without a work permit or because they are working off the books. The 2002 regularisation included three different categories for applicants: dependent contract work, domestic work (cleaning, etc.), and care work. The latter category attracted about 140 000 applications, mostly from Ukrainian, Romanian, Polish, Moldovan, Ecuadorean and Peruvian women. The domestic work category represented an additional 200 000 applicants; in many of these cases, this category overlaps with that of carers.

83. Official data – from the pension institute INPS, for example, or from the workplace insurance institute – conflate different categories of domestic workers, from cleaners to babysitters to "minders" (*badanti*), those taking care of the non-self sufficient. This makes estimating the true number difficult. There may also be some overlap between the above categories.[13] The boom in registered domestic workers according to INPS – more than 371 000 in 2003 (Table 14), with almost half a million foreign workers contributing to the domestic work pension fund at some point – tracks the growth of the sector without specifying how many actually provide nursing or home care. Considering the official statistics, it is reasonable to assume that the number of home care workers in Italy was close to 500 000 in 2004 (Mesini, 2004) and, if the Ministry of Labour is correct, the workforce has doubled in the past three years.

84. Not all scholars agree that foreign home care workers have become a universal phenomenon; official surveys and the census show that the Italian workforce is still important, and that domestic work is not universal (Colombo, 2005). Nonetheless, private home care for the non-self sufficient is recognized to be the undeniable domain of foreign workers.

85. A number of local and national studies have been conducted in recent years looking at the foreign home care labour force. These studies have provided a detailed overview of gender, age, nationality, migratory project, educational level, workplace organisation, pay levels, savings, and relationship with local institutions. What is perhaps most important for this discussion of the international mobility of health workers is that most of these workers – predominantly women, especially from East Europe – do not have a background in the health professions. Those who do have medical training face enormous difficulties in achieving recognition for their training, since they lack the resources to undertake the lengthy retraining described above.

86. The large number of untrained home care workers is a concern for many local social service departments. An analysis on transnational welfare conducted by CeSPI (Pastore and Piperno, 2006; Piperno, 2006) included an analysis of the response of local authorities. In order to improve the quality of care offered to the housebound, many local authorities in Italy have attempted to provide training, support and integration into the local care system. The main criticism of these courses is that they are highly variable in content and the certification is worthless outside the local area.

87. Many local authorities offer short courses on first aid and basic care. In other cases, local authorities have attempted to create a role in mediation and support for these women, even integrating private home care into the public employment mediation system. For those with legal status, local authorities can play a role in matching supply and demand and, above all, in integrating private home care with public services ranging from drop-in centres to home visits. These initiatives are sometimes accompanied by support services for the care workers themselves.

88. It is useful to cite two examples. The first model is that of the municipality of Rome, which offers a 130-hour course to about 230-250 care workers annually. The programme provides a substitute worker to the family which employs the care worker, enrols graduates in a municipal care worker registry and provides mediation with families. However, the course is not recognised by the Region and does not count towards certification as an OSS.

89. The second example is a more ambitious – and EU-funded – project in Reggio Emilia. Public social services attempted to draw private care workers into an integrated network, offering tutoring, home visits and support from trained care workers in the local cooperative. The objective was to improve the

[13] In a survey by Acli Colf, 25.9% of all domestic workers claimed to provide nursing care in some form, even if only 20.7% had been explicitly asked to do so. Acli Colf, "Cosa penso di voi: Le opinioni e la condizione delle colf in Italia", research report, Rome, 11 March 2005.

quality of care provided but also to support the care workers themselves, offering them a social centre to escape from the isolation of their long work hours and to help them interact with existing services.

90. These projects – and others around Italy – try to address the informal nature of the work. Both families and workers benefit from the informal system. For families, labour is cheap and workers are immediately available to meet a need which the public sector cannot answer. For workers, informal work is a way around strict entry quotas, and co-residence can maximise earnings.

91. Of course, international recruitment of carers is possible under Italian law, subject to the strict – and clearly inadequate – limitations of the quota system. Starting in 2006, quotas included a set-aside of for "domestic workers and personal care assistants"; this referred to the type of contract and not to any qualifications of the worker. The quota authorised 45 000 workers for such contracts in 2006 and 65 000 in 2007. The problem with international recruitment of personal care workers is the same problem as with international recruitment under the Italian quota system: few employers are willing to commit to a foreign worker they have never seen, especially when the burden on the employer – to demonstrate housing, offer a contract and guarantee to cover repatriation costs – is quite high. Families seeking care workers for the elderly not only prefer to meet and evaluate the candidate, they also often require a worker immediately, and cannot wait for the authorisation and visa procedure. Most of the care workers for whom an application is filed are presumed to already be in Italy. Further, the quotas are also oversubscribed: more than half a million applicants in 2006 for 170 000 visas. In 2007, more than 140 000 potential employers asked for one of the 65 000 available home care worker authorisations.

92. Some attempts to make the quotas and recruitment mechanism function for care workers have been made. The International Organisation for Migration, with local authorities in Tuscany and the Italian Ministry of Labour, ran a pilot project for international recruitment from Sri Lanka for care work in Tuscan families.[14] Candidates received Italian language training in Sri Lanka and about 60 were supported in their initial period in Italy. Obstacles included difficulty in finding families willing to take a stranger into their home, and insufficient language skills among those who arrived. Compared to informal matching of supply and demand, the pilot project had much higher costs and faced more long term difficulty in integrating workers into families.

93. International recruitment of carers is unlikely to play a major role in meeting demand, while informal migration is likely to continue to provide workers, who later acquire documents through regularisation or through the annual quotas. Current proposals to lift the quota from the care sector may help reduce this lag time to regularisation, but can't solve the problem of international mediation for co-residential care work.

**Conclusion**

94. Italy is facing a number of challenges regarding human resources in the health sector. Medical school enrolment has sharply declined, although the excess of doctors will persist at least in the medium term. Short and medium range analyses show a shortfall in the nursing staff. An increasing number of places in nurse training schools are starting to reduce this shortfall, but for the moment nurses are in great demand. International recruitment is increasing in the nursing sector, taking advantage of the quota exemption for nurses. Private agencies, with and without collaboration with the public sector, have been active in expanding recruitment channels and streamlining the bureaucratic procedures. Nonetheless,

14 http://www.solidarietasociale.gov.it/SolidarietaSociale/tematiche/Immigrazione/formazione_estero/progetti_pilota.htm

language barriers and low salaries remain significant barriers to widespread recruitment. In addition, the Ministry of Health does not see international recruitment as a structural element of the solution.

95. One reaction of the health care system is to increase the use of other health workers to try to reduce the need for nurses, although this process of rationalisation of tasks has been slow. An increased use of nursing aides could also occur in conjunction with the facilitation of certification of immigrant workers for semi-qualified health care (ASS or OSS). On the one hand, it would increase the productivity of nurses – and perhaps even their wages – while opening a pathway to qualified work and a career for immigrants.

96. The main obstacle to this facilitation is the fact that each Region determines its own qualifications for care workers, while nursing is subject to national standards. Hospitals and health districts operate according to their own regional rules, and the reorganisation of care work is already highly differentiated.

97. The ever-expanding demand for private home care – in large part due to the absent or insufficient public services – remains a draw for untrained and often undocumented women. One challenge for the future will be to ensure respect for labour law and minimum care standards, integrating these private workers into the health care system.

98. At the same time, many of the immigrants working in the private care sector are not interested in investing in a care career – they have only taken up this work because it is available and accessible. Most did not work in the health sector prior to immigration, and are only interested in maximising their earnings and going home. Any proposal to provide skill upgrades for a poorly paid and low-status career may find few takers, and such a policy cannot be expected to resolve both labour shortages and the poor working conditions and quality in the informal care sector.

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# ANNEX 1: TABLES AND FIGURES

**Figure 1. Demographic structure of the Italian Population, by sex and citizenship, 2007**

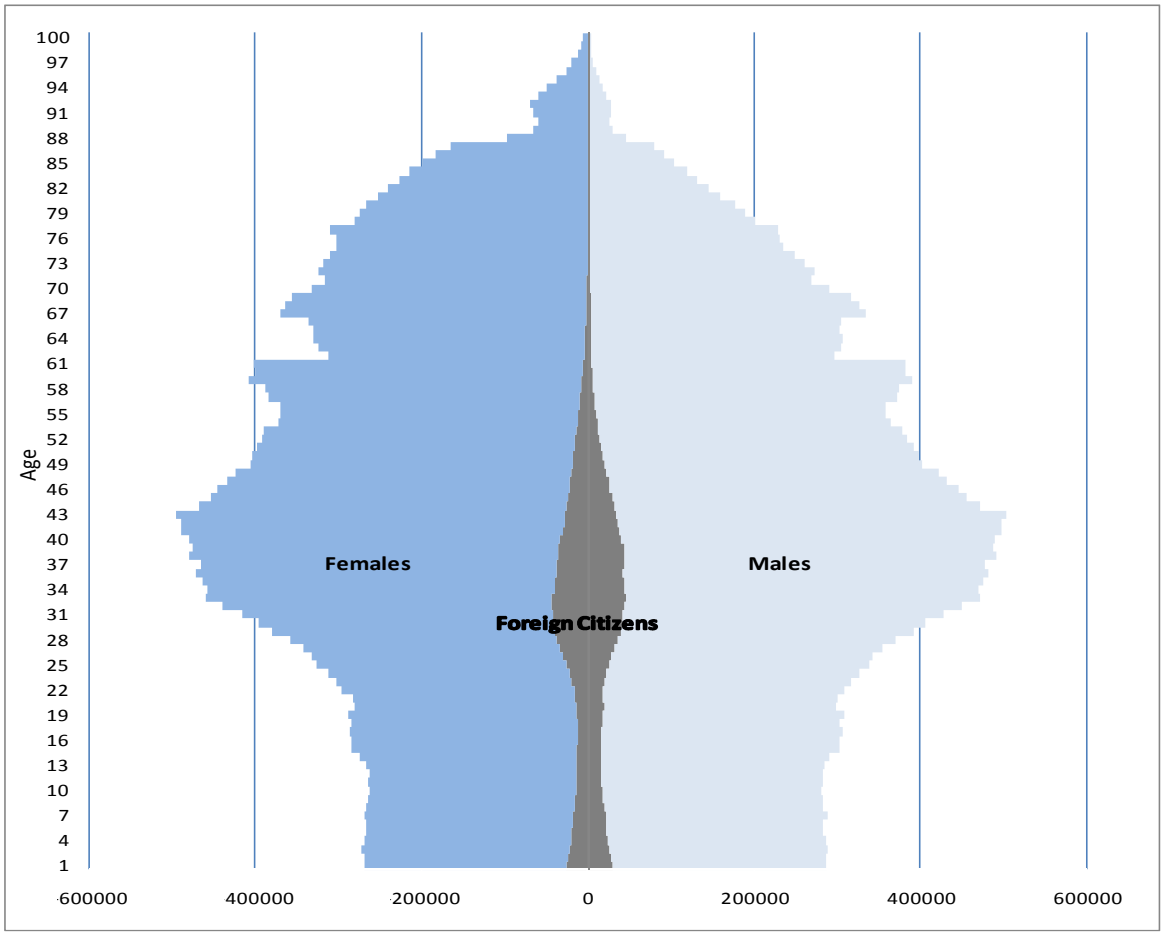



**Table 1. Health Professions according to Professional Associations, 1985-2006**

| | Year | | | |
|---|---|---|---|---|
| **Profession** | **1985** | **1995** | **2005** | **2006** |
| Medical doctors | 240429 | 342283 | 370374 | 353.945 + 51.975 |
| Nurses | 110000 | 268796 | 334178 | |
| Obstetricians | 17000 | 15846 | 15821 | |
| Radiological Technicians | 15000 | 19261 | 20701 | |

Source: Censis, 39° Rapporto Censis, FrancoAngeli, Rome, 2005, p. 235; FNOMCEO 2006.

**Table 2. Job starts and endings in the health care sector, 2001-2007**

| | Year | | | | | | |
|---|---|---|---|---|---|---|---|
| | **2001** | **2002** | **2003** | **2004** | **2005** | **2006** | **2007*** |
| Contracts started | 131,151 | 126,812 | 117,297 | 123,300 | 119,013 | 115,557 | 108,293 |
| Contracts terminated | 110,194 | 111,225 | 104,764 | 107,008 | 106,290 | 101,927 | 81,197 |

Source: INAIL, 2007. * Data extrapolated from reports through 14 May 2007.

**Table 3. Expected hires in the private health sector, 2005-2007, according to specific jobs in the health sector, difficulty of recruitment and turnover rate**

| | | | 2005 | | | | 2006 | | | | 2007 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ISCO code | ISTAT code | Occupation | Hires | Hard to find | Turn-over | Staff expan-sion | Hires | Hard to find | Turn-over | Staff expan-sion | Hires | Hard to find | Turn-over | Staff expan-sion |
| 2221 | 241 | Doctors | 360 | 27.9 | 60.1 | 16.2 | 230 | 27.9 | 28.8 | 0.9 | 200 | 38.3 | 46.3 | 11.4 |
| 2224 | 2315 | Pharmacists | 1250 | 35.4 | 20.9 | 20.1 | 1750 | 15.0 | 43.4 | 3.3 | 2090 | 32.0 | 39.5 | 1.7 |
| 3221 | 3217 | Medical assistants | 60 | 67.9 | 25 | 1.8 | -- | -- | -- | -- | -- | -- | -- | -- |
| 3224 | 3212 | Optometrists and opticians | 180 | 90.3 | 99.4 | 0.6 | 170 | 34.1 | 64.7 | 0.6 | -- | -- | -- | -- |
| 3225 | 3213 | Dental assistants | 150 | 23.6 | 29.1 | 16.2 | 400 | 47.8 | 25.5 | 6.7 | 460 | 57.0 | 50.8 | 5.8 |
| 3226 | 3214 | Physiotherapists and similar | 1380 | 47.1 | 37 | 2 | 1350 | 35.5 | 31.5 | 12.4 | 1510 | 37.7 | 47.6 | 8.7 |
| 3229 | | Modern Health Ass. Prof. (excl. Nurse) | 70 | 16.4 | 52.1 | 0 | | | | | | | | |
| 3231 | 3211 | Nursing Associate Professionals | 4230 | 79.5 | 54 | 3.6 | 4380 | 76.7 | 57.2 | 3.5 | 4820 | 65.1 | 62.8 | 3.0 |
| 3232 | 3215 | Midwifery Associate Professionals | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| 5132 | 5534 | Institution-based personal care workers | 12050 | 43.3 | 50.6 | 5.1 | 5600 | 46.4 | 48.1 | 2.9 | 6430 | 40.5 | 53.7 | 4.3 |
| 5133 | 5535 | Home-based personal care workers | 2220 | 15.5 | 42.4 | 10.8 | 1210 | 32.1 | 61.1 | 2.2 | 1430 | 30.5 | 72.6 | 2.4 |
| | 8320 | Hospital stretcher bearers, etc. | | | | | 60 | 38.1 | 38.1 | 0,0 | 190 | 17.6 | 35.8 | 12.4 |
| | 5410 | Certified health assistants | | | | | 7800 | 35.0 | 52.6 | 1.6 | 9400 | 31.5 | 51.4 | 2.2 |
| | | Total of above | 21950 | | | | 22950 | | | | 26530 | | | |
| | | All expected hires | 647740 | 32.2 | 35.3 | 10.7 | 695770 | 29.1 | 37.1 | 11.0 | 839460 | 29.6 | 39.6 | 10.0 |

Source: Unioncamere - Ministero del Lavoro, Sistema Informativo Excelsior, 2007

**Table 4. Expected hires in the private sector, 2007, according to specific jobs in the health sector, size of business, contract type, need for training and age**

| | | | % of all hires | | | | | |
|---|---|---|---|---|---|---|---|---|
| **ISTAT code** | **Profession** | **Hires** | **Business size <50** | **Permanent hires** | **No experience required** | **Further training required** | **>29 y.o.** | **Age unimportant** |
| 5410 | Certified health assistants | 9,400 | 13.8 | 46.0 | 24.6 | 43.9 | 14.0 | 71.1 |
| 5534 | Institution-based personal care workers | 6,430 | 21.4 | 43.4 | 25.9 | 52.2 | 23.5 | 63.1 |
| 3211 | Nursing Associate Professionals | 4,820 | 8.6 | 80.8 | 32.9 | 53.8 | 23.9 | 58.6 |
| 2315 | Pharmacists | 2,090 | 90.5 | 58.1 | 42.2 | 13.4 | 26.6 | 35.4 |
| 3214 | Physiotherapists and similar | 1,510 | 49.7 | 62.0 | 41.3 | 42.3 | 25.5 | 52.9 |
| 5535 | Home-based personal care workers | 1,430 | 19.3 | 60.9 | 34.2 | 47.9 | 5.2 | 75.5 |
| | **Total all professions** | **839460** | **62.1** | **45.4** | **45.7** | **22.8** | **37.8** | **38.9** |

Source: Unioncamere - Ministero del Lavoro, Sistema Informativo Excelsior, 2007.

**Table 5. Foreign-born doctors registered in Italy, by country of birth, 2004**

| Country of birth | Number enrolled in Italian Medical Association | % of total |
|---|---|---|
| Germany | 1.034 | 8,3 |
| France | 649 | 5,2 |
| Greece | 646 | 5,2 |
| Belgium | 256 | 2,0 |
| Poland | 207 | 1,7 |
| UK | 206 | 1,6 |
| Other EU-25 | 831 | 6,6 |
| Switzerland | 760 | 6,1 |
| Ex-Yugoslavia | 437 | 3,5 |
| Romania | 389 | 3,1 |
| Albania | 204 | 1,6 |
| Other non-EU Europe | 359 | 2,9 |
| USA | 602 | 4,8 |
| Venezuela | 575 | 4,6 |
| Argentina | 526 | 4,2 |
| Brazil | 226 | 1,8 |
| Canada | 169 | 1,3 |
| Other Americas | 426 | 3,4 |
| Iran | 713 | 5,7 |
| Lebanon | 334 | 2,7 |
| Jordan | 328 | 2,6 |
| Syria | 311 | 2,5 |
| Israel | 280 | 2,2 |
| Other Asia | 362 | 2,9 |
| Oceania | 107 | 0,9 |
| Africa | 1.590 | 12,7 |
| **Total** | **12.527** | **100,0** |

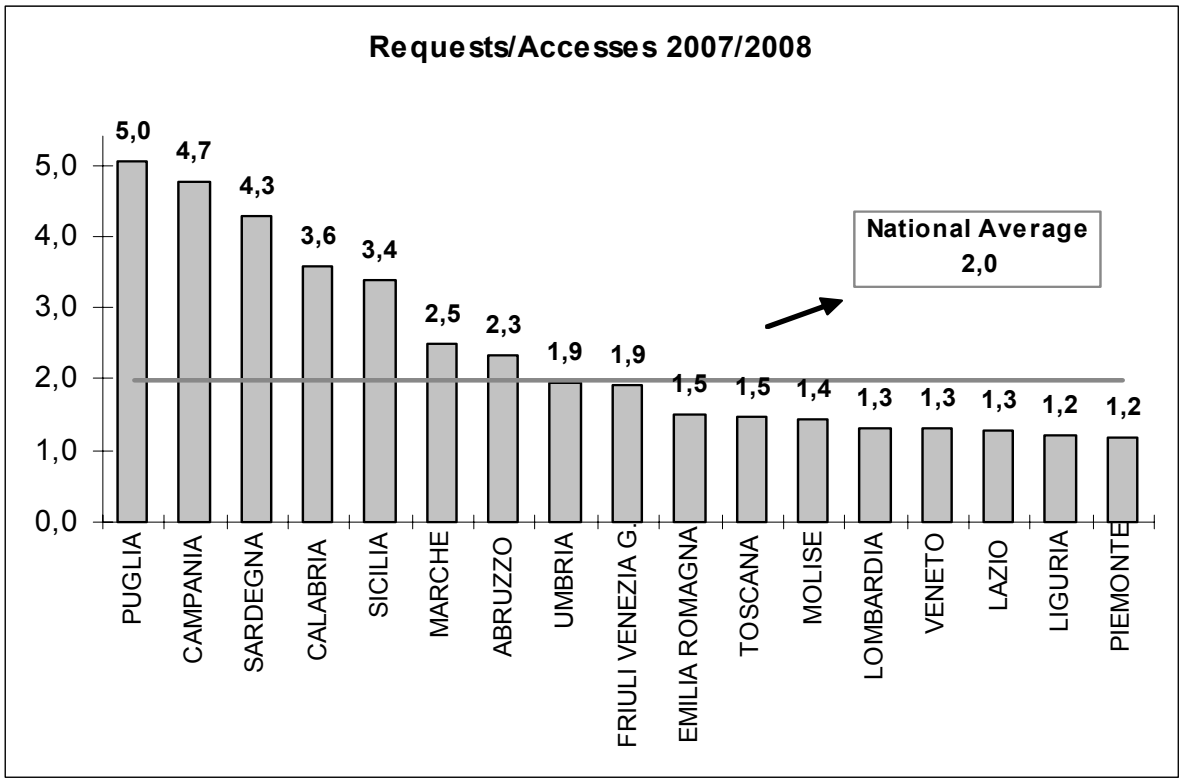
Source: Ercolini 2004, based on ENPAM and Ministry of Interior Data. This figure includes 10.3% who are dentists

**Table 6. Foreign doctors and dentists in the Italian Medical Association, by nationality, 2006**

| Nationality | Doctors | Dentists | Both | Total |
|---|---|---|---|---|
| Albania | 153 | 9 | 1 | **163** |
| Argentina | 24 | 4 | 0 | **28** |
| Belarus | 3 | 0 | 0 | **3** |
| Benin | 3 | 0 | 0 | **3** |
| Bolivia | 6 | 0 | 0 | **6** |
| Brazil | 22 | 1 | 1 | **24** |
| Bulgaria | 15 | 1 | 0 | **16** |
| Cameroon | 97 | 1 | 0 | **98** |
| Chad | 6 | 0 | 0 | **6** |
| Chile | 4 | 1 | 0 | **5** |
| China | 20 | 0 | 0 | **20** |
| Colombia | 15 | 5 | 0 | **20** |
| S Korea | 1 | 0 | 0 | **1** |
| Croatia | 25 | 1 | 1 | **27** |
| Cuba | 13 | 1 | 0 | **14** |
| Ecuador | 4 | 1 | 0 | **5** |
| Egypt | 18 | 7 | 0 | **25** |
| Ethiopia | 10 | 0 | 0 | **10** |
| Japan | 2 | 0 | 0 | **2** |
| Jordan | 63 | 6 | 15 | **84** |
| India | 17 | 0 | 0 | **17** |
| Iran | 294 | 15 | 32 | **341** |
| Iraq | 12 | 0 | 1 | **13** |
| Israel | 65 | 8 | 19 | **92** |
| Kenya | 5 | 0 | 0 | **5** |
| Lebanon | 135 | 8 | 18 | **161** |
| Macedonia | 4 | 0 | 0 | **4** |
| Morocco | 3 | 1 | 0 | **4** |
| Nicaragua | 1 | 0 | 0 | **1** |
| Nigeria | 29 | 0 | 1 | **30** |
| Pakistan | 5 | 0 | 0 | **5** |
| Paraguay | 3 | 0 | 0 | **3** |
| Peru | 13 | 1 | 0 | **14** |
| Czech Republic | 8 | 0 | 0 | **8** |
| Moldova | 20 | 0 | 0 | **20** |
| Serb Republic | 13 | 1 | 0 | **14** |
| Slovak Republic | 9 | 0 | 0 | **9** |
| Romania | 71 | 20 | 3 | **94** |
| Russia | 42 | 2 | 0 | **44** |
| San Marino | 3 | 0 | 0 | **3** |
| Syria | 59 | 22 | 10 | **91** |
| Somalia | 48 | 0 | 0 | **48** |
| South Africa | 3 | 1 | 0 | **4** |
| Switzerland | 60 | 3 | 0 | **63** |
| Togo | 5 | 0 | 0 | **5** |
| Turkey | 4 | 0 | 0 | **4** |
| Ukraine | 16 | 1 | 0 | **17** |
| Uganda | 2 | 0 | 0 | **2** |
| Hungary | 5 | 0 | 1 | **6** |
| USA | 52 | 7 | 5 | **64** |
| Venezuela | 20 | 2 | 1 | **23** |
| Zaire | 13 | 0 | 1 | **14** |
| Other countries | 143 | 25 | 7 | **175** |
| Stateless | 3 | 0 | 2 | **5** |
| **Total Non-EU** | **1689** | **155** | **119** | **1963** |
| Austria | 107 | 7 | 0 | **114** |
| Belgium | 49 | 13 | 3 | **65** |
| Denmark | 1 | 9 | 0 | **10** |
| Finland | 5 | 2 | 0 | **7** |
| France | 156 | 64 | 1 | **221** |
| Germany | 400 | 174 | 19 | **593** |
| Greece | 240 | 12 | 30 | **282** |
| Ireland | 2 | 0 | 0 | **2** |
| Luxembourg | 2 | 0 | 0 | **2** |
| Netherlands | 29 | 73 | 0 | **102** |
| Portugal | 6 | 0 | 0 | **6** |
| UK | 23 | 7 | 0 | **30** |
| Spain | 62 | 3 | 3 | **68** |
| Sweden | 8 | 20 | 0 | **28** |
| Cyprus | 0 | 0 | 0 | **0** |
| Estonia | 1 | 0 | 0 | **1** |
| Latvia | 0 | 0 | 0 | **0** |
| Lithuania | 0 | 0 | 0 | **0** |
| Malta | 0 | 0 | 0 | **0** |
| Poland | 11 | 2 | 0 | **13** |
| Czech Republic | 8 | 1 | 0 | **9** |
| Slovenia | 6 | 0 | 0 | **6** |
| Hungary | 2 | 1 | 0 | **3** |
| **Total EU** | **1118** | **388** | **56** | **1562** |
| **Total** | **1807** | **543** | **175** | **3525** |

Source: Italian National Federation of Doctors, 2006.

**Figure 2. Applicants/Available Spaces in University Nurse Training Programmes, by Region, 2007-2008**




Source: Ministry of Health, 2007.

**Table 7. Foreign nurses working in Italy, by continent of origin, 2002-2005**

| | Origin | | | | | | |
|---|---|---|---|---|---|---|---|
| **Year** | **EU*** | **Non-EU Europe** | **Africa** | **Asia** | **Americas** | **Oceania** | **Total** |
| **2002** | 16 | 1.821 | 366 | 105 | 302 | 2 | **2.612** |
| **2005** | 1.989 | 2.616 | 443 | 820 | 838 | 24 | **6.730** |

Source: Caritas, based on IPASVI data. *EU-15 in 2002; EU-25 in 2005.

**Table 8. Recognition of foreign nursing qualifications, 2005**

| Country of Nationality | Number of Nurses Recognised | | |
|---|---|---|---|
| Albania | **174** | Macedonia | **10** |
| Algeria | **5** | Morocco | **3** |
| Angola | **1** | Mexico | **2** |
| Argentina | **45** | Moldavia | **24** |
| Australia | **1** | Niger | **1** |
| Azerbaijan | | Nigeria | **12** |
| Belarus | **2** | Panama | **1** |
| Bolivia | **4** | Paraguay | **17** |
| Bosnia | **23** | Peru | **348** |
| Brazil | **65** | Dominican Rep. | **4** |
| Bulgaria | **121** | Romania | **2420** |
| Cameron | **1** | Russia | **11** |
| Chile | **9** | Serbia | **155** |
| China | **2** | Sri Lanka | **4** |
| Columbia | **50** | South Africa | **1** |
| Congo | **5** | Thailand | **1** |
| South Korea | **1** | Togo | **1** |
| Ivory Coast | 2 | Tunisia | **45** |
| Croatia | **12** | Turkey | **1** |
| Cuba | **33** | Ukraine | **30** |
| Ecuador | **27** | Uruguay | **5** |
| Egypt | **1** | USA | **6** |
| El Salvador | **1** | Venezuela | **2** |
| Eritrea | **4** | Zaire | |
| Philippines | **35** | | |
| Georgia | **1** | *Total non-EU* | *3864* |
| Ghana | **3** | | |
| Japan | **3** | Poland | 1000 |
| India | **127** | Other EU and Switzerland | 130 |
| Iran | **2** | | |
| | | **Total** | **4994** |

Source: Ministry of Health, Human Resources Directorate General, Section IV, 2006.

**Table 9. Authorisation to enter Italy under the quota exemption for nurses (Art. 27, Par. 1, § r(bis), Law 286/98), by nationality, gender, length of contract and age of nurse, 2004**

| Nationality | Total | % of total |
|---|---|---|
| Albania | 102 | 3,9 |
| Czech Republic | 2 | 0,1 |
| Croatia | 17 | 0,7 |
| Macedonia | 9 | 0,3 |
| Poland | 459 | 17,7 |
| Romania | 1297 | 49,9 |
| Slovakia | 44 | 1,7 |
| Hungary | 2 | 0,1 |
| Other Europe | 184 | 7,1 |
| China | 1 | 0,0 |
| India | 10 | 0,4 |
| Other Asia-Oceania | 3 | 0,1 |
| Algeria | 1 | 0,0 |
| Mauritius | 5 | 0,2 |
| Senegal | 9 | 0,3 |
| Tunisia | 41 | 1,6 |
| Other Africa | 6 | 0,2 |
| Brazil | 36 | 1,4 |
| Columbia | 49 | 1,9 |
| Ecuador | 12 | 0,5 |
| Peru | 177 | 6,8 |
| Other America | 101 | 3,9 |
| **TOTAL** | **2597** | 100,0 |

| Gender | Total | % of total |
|---|---|---|
| Men | 341 | 13,1 |
| Women | 2256 | 86,9 |
| | | |
| Length of authorisation (first contract) | | |
| Less than 6 months | 153 | 5,9 |
| 6-12 months | 528 | 20,3 |
| 1-2 years | 1916 | 73,8 |
| | | |
| Age | | |
| 20-39 | 2072 | 79,8 |
| 40+ | 527 | 20,3 |
| | | |
| **TOTAL** | **2597** | 100,0 |

Source: Ministry of Social Solidarity, Directorate General for Immigration, 2006. Data represent a slight undercount because of partial data for Sicily (only April-August), Trent (first semester) and Bolzano (through September).

**Table 10. Contract starts and terminations in the health sector, 2003-2004, by place of birth**

| | Year | | | |
|---|---|---|---|---|
| | 2003 | | 2004 | |
| **Continent of birth** | **starts** | **terminations** | **starts** | **terminations** |
| Europe | 5.192 | 2.884 | 6.522 | 4.001 |
| EU-25 | *796* | *421* | *1.037* | *619* |
| *Non-EU Europe* | *4.396* | *2.463* | *5.485* | *3.382* |
| Africa | 1.843 | 1.426 | 2.195 | 1.551 |
| Asia | 708 | 483 | 767 | 557 |
| America | 2.955 | 1.950 | 3.389 | 2.190 |
| Oceania | 58 | 34 | 57 | 33 |
| **All Foreign Born** | **10.756** | **6.777** | **12.930** | **8.332** |
| **All Italian-born** | **106.541** | **97.987** | **110.370** | **98.676** |
| **Total** | **117.297** | **104.764** | **123.300** | **107.008** |

Source: INAIL, 2006, and Caritas reporting of place of birth according to INAIL, 2006.

**Table 11. Recognition of foreign health sector qualifications by the Italian Ministry of Health, by category and nationality, 2005**

| | Category | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Nationality | Obstetrical Nurses | Physio-therapists | | Health/social Workers Masseuse and Head | Lifeguard Speech Therapist | Medical Radiology Technician | Dental Hygienist | Occupational Therapist | Podologist | Dietician | Bio-medical Lab | Technician | Total |
| Argentina | **1** | 16 | 2 | | 3 | 21 | | | | 3 | | | **46** |
| Romania | | 16 | 18 | 6 | | | 1 | | | | | | **41** |
| Brazil | | 33 | 2 | | 1 | | | 2 | | | | | **38** |
| Peru | **17** | 6 | 11 | | | 3 | | | | | | 1 | **38** |
| Ukraine | | | 34 | | | | | | | | | | **34** |
| Moldavia | **1** | | 19 | | | | | | | | | | **20** |
| Bulgaria | | 5 | 10 | | 1 | | | | | | | 2 | **18** |
| Tunisia | | 1 | | | | 10 | | | | | | | **11** |
| Colombia | | 5 | 3 | | | | | 1 | | | | | **9** |
| Albania | **1** | | 6 | | | | | | | | | | **7** |
| Serbia | | 6 | | 1 | | | | | | | | | **7** |
| Uruguay | | | 6 | | | | | | | | | | **6** |
| USA | | 1 | | 1 | 2 | | | | 1 | | | | **5** |
| Australia | | 2 | 1 | | | | | | | | | | **3** |
| Canada | | 1 | | | | | | 2 | | | | | **3** |
| Cuba | | 3 | | | | | | | | | | | **3** |
| Iran | **2** | | | | | | | | | | 1 | | **3** |
| Venezuela | | 3 | | | | | | | | | | | **3** |
| Angola | | | 2 | | | | | | | | | | **2** |
| Bosnia | | 1 | | | | | | | | | | 1 | **2** |
| Chile | **1** | | 1 | | | | | | | | | | **2** |
| Ecuador | **2** | | | | | | | | | | | | **2** |
| Philippines | | 1 | | | | | 1 | | | | | | **2** |
| South Africa | | 1 | | | | | | | 1 | | | | **2** |
| Azerbaijan | | | 1 | | | | | | | | | | **1** |
| Belarus | | | 1 | | | | | | | | | | **1** |
| Croatia | **1** | | | | | | | | | | | | **1** |
| Egypt | | 1 | | | | | | | | | | | **1** |
| El Salvador | | 1 | | | | | | | | | | | **1** |
| India | | 1 | | | | | | | | | | | **1** |
| Kazakhstan | | | 1 | | | | | | | | | | **1** |
| Morocco | | | 1 | | | | | | | | | | **1** |
| Senegal | | 1 | | | | | | | | | | | **1** |
| Zaire | | | 1 | | | | | | | | | | **1** |
| *Total non-EU* | *26* | *105* | *120* | *8* | *7* | *35* | *1* | *6* | *1* | *4* | *4* | ***317*** | |

| Nationality | Obstetrical Nurses | Physio-therapists | | Health/social Workers | Masseuse and Head | Lifeguard | Speech Therapist | Medical Radiology Technician | Dental Hygienist | Occupational Therapist | Podologist | Dietician | Bio-medical Lab | Technician | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Austria | | | 3 | 1 | | 13 | | 2 | | | 1 | | | | **20** |
| Belgium | | | 2 | | | | | 1 | | | | | | | **3** |
| Finland | | | 1 | 1 | | | | | | | | | | | **2** |
| Francia | | | 6 | 4 | | | | | | | | | | | **10** |
| Germany | | | 22 | 3 | | | | | 1 | | | | | | **26** |
| Netherlands | | | 2 | | | | | 1 | | | 1 | | | | **4** |
| Poland | | | 49 | | | | | | 1 | | | | | | **50** |
| Portugal | | | 1 | | | | | | | | | | | | **1** |
| Czech Republic | | | 1 | | | | | | | | | | | | **1** |
| UK | | | 2 | | | | | 1 | | | 1 | | | | **4** |
| Slovakia | | | 4 | | | | | | | | | | | | **4** |
| Spain | | | 100 | | | | | | | | | | | | **100** |
| Sweden | | | 3 | 1 | | | | | | | | | | | **4** |
| Switzerland | | | 29 | 4 | | | | | | | 1 | | | | **34** |
| *EU Unspecified* | | *4* | | | | | | | | | | | | | ***4*** |
| **EU Total** | | **4** | **225** | **14** | | **13** | | **5** | **2** | **0** | **4** | **0** | | | **267** |
| Total | | 30 | 330 | 134 | | 21 | | 12 | 37 | 1 | 10 | 1 | 4 | 4 | **584** |

**Table 12. Italian university degrees, by nationality and degree, 2004**

| | Foreigners | | | Total | | | |
|---|---|---|---|---|---|---|---|
| Degree received | Men | Women | Total | Men | Women | Total | *% foreigners of total* |
| Medicine | 234 | 225 | 459 | 2619 | 3996 | 6615 | *6,9%* |
| Nursing | 35 | 226 | 261 | 2262 | 6606 | 8868 | *2,9%* |
| Physiotherapy | 21 | 18 | 39 | 1243 | 2428 | 3671 | *1,1%* |
| Other Health* | 32 | 108 | 140 | 3395 | 6890 | 10285 | *1,4%* |
| **Total** | **322** | **577** | **899** | **9519** | **19920** | **29439** | ***3,1%*** |

*Other includes: technicians, phys. ed. specialists, dental and optical technicians, oral hygienists, speech therapists, etc. There was a slight rise in the number of nursing degrees with the university reform: 9810 (2006) and 9904 (2007).

Source: Ministry of University, 2006.

**Table 13. Nationality of Doctors graduating from Italian Universities, 2004**

| Nationality | Men | Women | Total | Nationality | Men | Women | Total |
|---|---|---|---|---|---|---|---|
| Greece | 148 | 110 | 258 | Belarus | 0 | 2 | 2 |
| Israel | 18 | 8 | 26 | Chad | 1 | 1 | 2 |
| Cameroon | 12 | 13 | 25 | Congo | 1 | 1 | 2 |
| Albania | 10 | 12 | 22 | Croatia | 1 | 1 | 2 |
| Romania | 1 | 10 | 11 | Jordan | 1 | 1 | 2 |
| Lebanon | 9 | 0 | 9 | India | 0 | 2 | 2 |
| Russia | 0 | 9 | 9 | Slovakia | 0 | 2 | 2 |
| Switzerland | 4 | 4 | 8 | USA | 1 | 1 | 2 |
| San Marino | 2 | 5 | 7 | Hungary | 0 | 2 | 2 |
| Germany | 4 | 2 | 6 | | | | |
| Iran | 3 | 3 | 6 | Other | | | |
| Moldavia | 3 | 3 | 6 | Countries | 8 | 17 | 24 |
| Argentina | 0 | 4 | 4 | Stateless | 2 | 2 | 4 |
| Bulgaria | 1 | 3 | 4 | | | | |
| France | 2 | 2 | 4 | **Total** | **234** | **224** | **458** |
| Yugoslavia | 1 | 3 | 4 | | | | |
| Poland | 1 | 2 | 3 | **Italians** | **2385** | **3771** | **6156** |

Source: Ministry of University, 2006.

**Table 14. Number of registered non-Italian domestic workers, by area of origin, 1995-2003**

| Area of Origin | Year | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | **1995** | **1996** | **1997** | **1998** | **1999** | **2000** | **2001** | **2002** | **2003** |
| Eastern Europe | 7 991 | 18 247 | 15 098 | 15 781 | 19 051 | 26 329 | 26 672 | 179 189 | 199 709 |
| South America | 5 795 | 15 864 | 15 765 | 15 681 | 17 046 | 21 057 | 19 325 | 52 667 | 56 400 |
| East Asia – Philippines | 20 111 | 35 179 | 35 974 | 36 798 | 36 606 | 42 106 | 39 089 | 48 151 | 47 486 |
| Asia – Other | 9 197 | 16 039 | 14 268 | 13 064 | 12 416 | 15 079 | 15 200 | 24 624 | 24 522 |
| North Africa | 7 648 | 12 254 | 8 622 | 8306 | 8199 | 9515 | 8 649 | 16 751 | 16 728 |
| Central/Southern Africa | 9 355 | 17 084 | 13 725 | 12 572 | 11 470 | 12 084 | 11 828 | 15 735 | 15 061 |
| Central America | 3 227 | 4 806 | 4 668 | 4763 | 4728 | 5 392 | 4 864 | 7 111 | 7 058 |
| Western Europe | 2 949 | 3 029 | 3 077 | 3 020 | 2 926 | 3 027 | 2 830 | 3 114 | 2 933 |
| Asia - Middle East | 236 | 316 | 229 | 208 | 192 | 229 | 205 | 1 388 | 1 554 |
| North America | 1 148 | 1 976 | 1 670 | 1 562 | 1 505 | 1 753 | 1 630 | 158 | 175 |
| Oceania | 40 | 42 | 41 | 41 | 43 | 48 | 42 | 80 | 90 |
| **Total** | **67 697** | **124 836** | **113 137** | **111 796** | **114 182** | **136 619** | **130 334** | **348 968** | **371 716** |

Source: INPS (Pension system), 2005, with corrections for 2002 (retroactive contributions paid for the 2002 regularisation).

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