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Swedish medical students abroad: a case of return migration policy-making

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CONTENTS

Abstract

Recent years have witnessed a dramatic increase in the number of Swedes studying medicine abroad, especially in Central and Eastern European countries. It is estimated that every third Swedish medical student studies abroad. Having such a large group of new potential people to draw on can be a real "wet dream" for both central and local governments struggling with increasing shortages of doctors. Return and integration of these students into the Swedish health-care system creates unprecedented opportunities for dealing with the increasing shortages of physicians in Sweden. On the other hand, failure to do so can have serious consequences for the accessibility and quality of health-care for the public. The sheer size of this phenomenon makes it one of the key issues for human resource management in the health-care sector at both state and employer levels. Yet, the phenomenon has received surprisingly little if any attention in the literature on human resource management in health-care. It has also received no attention in the literature on student mobility, which instead focuses predominantly on mobility from less developed to more developed countries. This study aims at filling these gaps. It draws on three theories of return migration (structuralist theory, social network theory and transnationalist theory) to analyze the structural conditions in Sweden that limit(ed) the opportunities of students to return and the strategies that students have used to remove some of these obstacles. Thus, the study also describes the changing policy towards Swedish return medical student-migrants both at national and local levels alike. In so doing, it highlights the role of return student-migrants as drivers of this change vis-à-vis passive state and employers. This discussion is embedded in a wider theoretical discussion about the role of actors and institutions, conceptualized as being "mutually-constitutive of one another" (Jackson 2010).

Key words: student mobility, student migration, return-migration, institutionalism

GLOSSARY

SLF – Swedish Medical Association

SYLF – Swedish Junior Doctors' Association

MSF – Medical Students' Association

MSF Utland – Medical Students' Association Abroad

1. Introduction

One of the core aspects of European integration is the mobility of people. Indeed, the free movement of people is one of the four pillars of the European Single Market and a large proportion of EU activity has been aimed at reducing nation-state barriers to the mobility of people across borders. The European Commission has argued that increasing mobility in Europe is a way to tackle the problem of skills shortages faced by different European countries and regions (Vandenbrande et al. 2006, 1).

An example of such a shortage is the scarcity of doctors in Sweden. This problem has been widely documented in media (e.g. Forsberg 2011; Bratt 2011) and acknowledged by all major actors in the health-care sector including the National Board of Health and Welfare (Socialstyrelsen 2010), Swedish Medical Association (SLF 2009), Swedish National Agency for Higher Education (Högskolverket), Swedish Association of Local Authorities and Regions (SKL) and employers (Anderson et al. 2009). The shortage is particularly problematic in some specializations such as psychiatry, cardiology and general medicine (Socialstyrelsen 2010).

So far the most common method of dealing with it has been to increase the number of places for medical study at Swedish universities so that more people can be educated as doctors (Anderson et al. 2009). Efforts in this area have been made both by the central government but also locally. For example, counties and regions in Sweden have cooperated with one another and/or with different universities to pool their resources for medical training. Cooperation among Kalmar County, Region Skåne, Linnaeus University and Lunds University is an example (Lund Universitet 2012). Another strategy used by local employers has been to recruit doctors from abroad, in particular from less-developed countries. Kalmar County, for example, set up a company in 2000 called *Kalmera* which has been recruiting doctors, mainly from Poland, to Kalmar County and elsewhere in Sweden.

Three years ago, however, Kalmar County developed a new policy. It initiated cooperation with the University of Gdansk (Poland), the school that educates the largest number of Swedish medical students outside Sweden. Within this framework it invites a number of Swedish medical students from this university to undertake clinical practice at local health-care centres or clinics (Närlid 2010). The programme is part of a long-term plan for the future supply of doctors (ibid.). Although Kalmar is a pioneer in this regard, it is not the only employer with such a strategy. Indeed, interest in Swedish students studying medicine abroad has been growing among employers, many of whom have developed programmes tailored to this particular group. At least in some counties, there has been a shift in strategy away from recruiting foreign doctors towards recruiting Swedish graduates from foreign faculties. This change can have significant implications not only for Sweden but also for lower-income countries from which Sweden has been recruiting doctors for decades. Theoretically, this strategy might be a panacea for the controversial problem of *brain drain* that countries like Sweden are often accused of causing.

Because of its significant implications both for receiving and sending countries, this profound shift in strategy is worth studying. Surprisingly, no such attempts have been made hitherto and the present study is the first of its kind. It attempts to explain how the shift came about, what factors made it possible and what actual shapes or forms it takes. In addition, it explores changes that took place on the national policy level. In the process, the study also investigates how students' engagement and activism directed at state institutions and employers have made this shift possible. Thus, one of the central aims of the study is to explore the interplay among different actors – state, employers and students, which is examined within its wider national and international institutional context. More specifically, the study looks at the extent to which national and international institutional environments have created a framework in which these different actors engage with one another and how it has empowered or disempowered some of them.

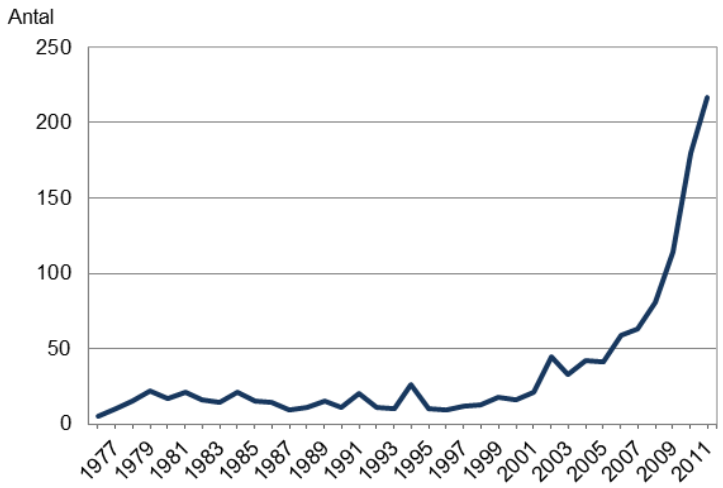
During the course of data collection it became clear that not many people are aware of the scale of the mobility examined here. This lack of awareness is reflected also in the lack of scholarly debate hitherto. Therefore, before spelling out the research questions in more detail it is necessary to briefly describe the scale of the phenomenon so that its importance can be fully appreciated and the specific focus taken in this study understood.

1.1. Scale of Swedish medical student mobility

The number of Swedish citizens who go abroad to study medicine has been growing rapidly over the last decade. In 2002 there were 759 Swedish medical students enrolled at universities abroad, while in 2011 the number reached 3342: a more than fourfold growth in less than 10 years (Socialstyrelsen 2013, 35). According to different media sources, every third Swedish medical student is enrolled at a foreign university (Svt 2009a; Svt 2009b; Sydsvenskan 2012). Therefore, these students abroad have become a significant group from the public policy point of view. They have even been taken into account in government projections of the future supply of doctors (Socialstyrelsen 2013).

The graph below vividly illustrates the magnitude of recent changes in Swedish medical student mobility. The vertical line indicates the number of doctors of Swedish background but educated abroad who received their licences in Sweden, whereas the horizontal line shows how this number has been changing over time with continuous and accelerating growth since 2005.

***Graph 1**: Doctors with Swedish background (born in Sweden or registered in Sweden before reaching the age of 16) under the age of 65, educated abroad, who received doctor's licences in Sweden, 1977 - 2011*



Source: Socialstyrelsen 2013, 36

Table 1 (below) shows where Swedish students go abroad for medical studies. It is clear that their mobility is concentrated within the EU, particularly in the new EU member states (2004 and 2007 accession countries). The size of the Swedish medical student community in the less developed countries of Central and Eastern Europe has been growing rapidly in recent years.

***Table 1:** The number of students abroad, 2002 - 2011*

Country	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Poland	*59*	*78*	*139*	*277*	*454*	*642*	*747*	*847*	*988*	*1 107*
Denmark	*323*	*380*	*489*	*602*	*709*	*780*	*752*	*778*	*775*	*691*
Romania	*12*	*19*	*24*	*33*	*38*	*100*	*213*	*306*	*361*	*439*
Hungary	*74*	*86*	*123*	*162*	*212*	*277*	*350*	*374*	*360*	*347*
Czech Rep.	*34*	*32*	*32*	*45*	*65*	*91*	*113*	*127*	*132*	*144*
Great Britain	*36*	*47*	*56*	*70*	*86*	*92*	*98*	*115*	*117*	*112*
Latvia	*x*	*x*	*3*	*x*	*4*	*22*	*35*	*50*	*76*	*112*
Norway	*40*	*41*	*40*	*41*	*42*	*46*	*41*	*57*	*65*	*63*
Slovakia	*0*	*3*	*4*	*8*	*10*	*20*	*40*	*39*	*49*	*49*
Lithuania	*x*	*x*	*0*	*x*	*4*	*5*	*8*	*27*	*33*	*45*
Serbia	*4*	*4*	*12*	*14*	*13*	*19*	*23*	*28*	*35*	*38*
Germany	*31*	*33*	*39*	*46*	*50*	*42*	*37*	*38*	*36*	*37*
Other	*146*	*146*	*141*	*157*	*163*	*152*	*122*	*133*	*157*	*158*
TOTALT	759	869	1 102	1 459	1 850	2 288	2 579	2 919	3 184	3 342

X = less than 3 people

Source: Socialstyrelsen 2013, 35

All in all, this short section has briefly described the proportions of the phenomenon under investigation. The sheer size of medical student migration makes it a central question for the HRM health-care policy at both national and employer levels. It also has some implications for other countries. For example, Swedish students bring substantial financial resources to medical universities in Central and Eastern Europe in the form of tuition fees which can have positive impact on medical education in these countries just like the fact that the universities become more internationalized as they take more international students. However, we can also think of potential negative effects such as, for example, crowding-out of domestic medical students as universities become more preoccupied with and direct their efforts and resources at more lucrative clientele of international students. Moreover, the phenomenon can have implications for countries which have so far been exporting their medical staff to Sweden because the demand for foreign doctors in Sweden might fall. Finally, countries where migrating Swedish medical graduates may go if they do not return to Sweden (e.g. Norway, Finland) can also be affected. No study has tried to investigate any of these issues yet and, unfortunately, there is no space to do it here neither. Instead, this study takes the approach that addresses the interests and concerns of key stakeholders in Sweden only: the government, counties and regions (employers), and, above all, Swedish medical students themselves. That being said, a specific perspective on this phenomenon, which puts emphasis on the return aspect of migration, is particularly desirable from the policy point of view. This point is further explained in the next section.

1.2. Perspective on student mobility

Swedish students who emigrate for their medical studies normally stay in their destination countries for at least six years, the usual length of medical programmes in European countries. Therefore, they probably fit all the definitions of a mobile student or student-migrant. The terms ‘student migration’ and ‘student mobility’ are used interchangeably in the literature to describe the same phenomenon. For example, according to Teichler et al. (2011, 27), a mobile student is a student who crosses national borders for educational purposes. Findlay et al. (2005, 193) define the student-migrant as “someone who leaves his or her country of usual residence to enroll at a higher education institution (…) for at least a term”. Definitions may differ in terms of the duration of studies abroad that is considered the cut-off point for the person to count as a mobile student or student-migrant. Some definitions may also identify different categories of student-migrants. For example, King and Raghuram (2013) distinguish between students who go abroad to obtain a degree and those who go only to obtain some credits. The students who are the focus of the present study fit into the first group, and are accordingly an ideal case of student-migrants.

However, this study looks into one particular aspect of the wider phenomenon of migration: namely, the return. The reason for this focus is that it is one of the most pressing issues from the points of view of public interest, of employers but also of student-migrants themselves. The reason is that students educated abroad can play an

important role in filling labour shortages in the health-care sector in Sweden. Indeed, the National Board of Health and Welfare (*Socialstyrelsen*) – the government agency under the Ministry of Health and Social Affairs – includes Swedish medical students abroad in its planning for the future supply of doctors. This fact indicates that that Swedish medical student-migrants form an integral part of public policy and that their return is important for the sustainability of the health-care system. By helping to fill labour shortages, the return can be a panacea for employers' problems, too. Finally, interviews with Swedish students abroad and with their union representative, as well as analysis of the secondary data, suggest that the majority of the students would like to come back to Sweden. Indeed, as the Results section will show, they have been fighting collectively but also struggling individually to make a return possible. Therefore, placing the focus of discussion on the return is a purposeful attempt to place this study where the interests of all the major actors involved lie.

This is particularly important in view of the risk that the return aspect might be overlooked in public debate and among policy makers. The risk stems from the fact that the phenomenon being discussed consists mostly of migration from high-income to lower-income countries. The majority of Swedish medical student-migrants go to Central and Eastern European countries where wages in the health-care sector are lower. This situation may blind some employers or policy makers to the problem by creating a false belief that higher wages are on their own a sufficient policy to bring students back and no special actions by the state or other stakeholders is needed. Indeed, it is illustrative but also startling in the eyes of the student union that *Socialstyrelsen* (2013) counts every single student abroad in its estimates of the future supply of doctors, with not even perfunctory reflection on how to bring them back. Therefore, another benefit of this study will be that it highlights the risk of taking the return of medical student-migrants for granted.

One flaw in the assumption that students will inevitably return is that, even if staying in the lower-income post-communist countries might in fact not seem as an optimal choice for Swedish medical graduates, at least from the viewpoint of neo-classical economics that sees migrants as rational income-maximizers (Cassariono 2004, 2), they may choose to go to another high-income country in Western Europe instead of returning to Sweden. The EU rules on mobility of physicians and the mutual recognition of educational diplomas make such a scenario more likely. Moreover, the fact that the vast majority of these students study in English can further increase their opportunities for international careers, as their familiarity with English medical terminology allows a smoother integration with health-care systems in English-speaking countries or with international working environments elsewhere. Finally, six years of studying and living in an international environment might make students less attached to their home country, both emotionally and in terms of social capital in the home country, which may wither away over such a long period abroad.

The quote from the representative of MSF Utland – a student union abroad – shows that none of these concerns is without foundation:

"people who have already been living abroad for six years… I mean they are quite likely not to go back home. We have some people who meet girlfriends and boyfriends who move to other countries, too. I mean, we have people going to England, we have people going to US, we have people going all over the world. "

MSF Utland representative

In light of these factors, it seems plausible to argue that Sweden might have to compete for its student-migrants with other countries, especially with the Nordic neighbors who also face shortages of medical staff and can offer high wages as well as geographical and cultural proximity to Sweden. Nevertheless, even if we assume that Swedish students abroad do come back to Sweden after completing their studies, the competition does not disappear but only shifts from the international level (between countries) to the national level (between different regions and counties in Sweden). If these returning migrants are channelled into areas facing the greatest shortage of doctors, the whole country can benefit from a more equal access to health-care.

The reason for this specific focus having been explained, it is time to clarify what is meant by return migration. The OECD (2001) defines return migrants as "persons returning to their country of citizenship after having been international migrants (whether short-term or long- term) in another country and who are intending to stay in their own country for at least a year". Applying this definition to our case, only Swedish graduates from medical schools abroad who have already come back to Sweden would be regarded as return migrants. This definition has serious analytical limitations as it ignores potential returnees – those who would like to return or are considering it but may be deterred by certain structural conditions. Indeed, return migration policy is concerned not only with integrating migrants who have already returned but also, in many cases, with bringing back those still living abroad. Likewise, data to be presented in this study show that many employers adopt a preemptive strategy by developing programmes aimed at students who are still living abroad to come back later when they graduate. Students themselves start to prepare for their return during their studies, often from the very first year of their migration. Therefore, if we focused only on the group of student-migrants who had already returned to Sweden, we would overlook a large proportion of employers' and migrants' actions and efforts. Consequently, in this study a wider understanding of return migrants is applied, to include students who are still studying abroad or, in other words, potential returnees. Considering their links with Sweden, all Swedish medical students abroad can be seen as potential returnees.

1.3. Research Questions

Having established the focus of the study, this section specifies the research purpose and research questions. Broadly, the study is concerned with return migration policy-making. Policy is understood here in comprehensive terms as a wider institutional framework and context, created by various central and local state

institutions. Within this approach, the study investigates structural conditions in Sweden which have been shaping medical students' opportunities for return, and also examines also how these structural conditions have been changing in recent years.

In so doing, it tries to answer a more general question of how return migration policies are made on different levels and how, during the process of policy making, different actors (state, employers, migrants) engage with one another and also with the wider institutional context – both national and international. In particular, the study explores how migrants themselves act within the framework provided by national and international institutions: to what extent are these actors socially constructed by these institutions; to what extent do these institutions shape their actions and choices; and to what extent, if at all, do they influence and shape these institutions?

Before addressing these questions, the next chapter will review the existing literature on return migration, student return migration and medical student migration to see if it provides any relevant answers. Chapter 3 develops a theoretical framework for analyzing the phenomenon of Swedish medical student migration. Chapter 4 describes the methodology used in this research as well as ethical issues that arose. Chapter 5 presents the results, while Chapter 6 integrates them more systematically into the theory. Finally, Chapter 7 assesses the benefits of this study, what it did and did not achieve, and identifies interesting areas for further research.

2. Literature Review

The history of academic studies on return migration dates back to the 1960s. (Cassarino 2004, 1). Based on the review of the return migration literature since then, as presented in Cassarino (2004, 1-12), it seems that studies over these decades have been mostly concerned with the impacts of return migration on origin countries; with the experiences, motivations and expectations of returnees; and with the development of typologies of different kinds of return. Even though new aspects and issues within these broader research areas have arisen, the focus of research has not changed fundamentally over the last decade. One can observe this when looking at the examples of return migration that have received the greatest scholarly attention most recently – namely, return migration from old EU member states to new EU accession countries (2004, 2007 EU enlargements). Topics covered in this literature can be subdivided into six larger categories.

The first group of studies aims at describing the phenomena through quantification. They concentrate on exploring the scale of the phenomenon and labour market outcomes for migrants (e.g. income levels, incidence of unemployment etc.). For instance, Reiner and Dragos (2012) use EU Labour Force Survey data to examine the scale of return migration to Central and Eastern Europe and labour market outcomes of return. At times, these studies also try to account for particular employment outcomes for return migrants. Many country-specific studies concerned with integration of return migrants into the labour market take such an approach (e.g. Gmaj and Malek 2010a).

In another group of studies, the reasons for return are investigated. Some try to produce typologies of return migrants based on this factor. The oldest such study is that of Cerase (1974), who distinguished four types of return: *return of failure, return of conservatism, return of innovation, return of retirement*. This typology has been referred to and further developed in more recent country-specific studies on Central and Eastern European return migrants (Iglicka 2002; Slany 2002 in Iglicka 2010). Both qualitative and quantitative studies can be found in this group.

The third group examines different patterns of return migration. Again, many of these studies attempt to develop typologies based on these patterns (see Engbersen et al. 2011). Research within this category has contributed to our knowledge on return migration by emphasizing that it is not a clear-cut phenomenon of emigration at a specific single point in time followed by a clearly distinguishable return. Rather, it can be a 'liquid' and complex phenomenon characterized by a great diversity of patterns among which return is difficult to define and distinguish (Engbersen et al. 2011). Studies within this group are mostly qualitative.

The fourth group investigates experiences of return migrants in their countries of origin. These studies explore the obstacles and difficulties that return migrants face regarding labour market integration and social inclusion. For example, Gmaj and Malek (2010b) use 200 in-depth interviews with Polish return migrants to investigate

their personal experiences, views and feelings before and after return. Studies within this field draw on structuralist theory. A more detailed review of this research tradition can be found in Cassarino (2004, 4-7).

Another group of studies inquires into the impact of return migrants on origin countries. For instance, Klagge and Klein-Hitpass (2010) explore the impact of high-skill return migrants on knowledge-based development in Poland. There is a sizeable literature analyzing return migrants' potential for bringing change and development to their origin countries. Arguably the most novel study in this area is that of Cassarino (2004), who proposes a new theoretical framework for understanding and analyzing the potential of returning migrants to become agents of change and development in their home countries (see Cassarino 2004 for further explanation).

The last group of studies that could be marked out during the literature review is concerned with state policy towards return migrants. This category consists mostly of country-specific studies or comparative cross-country analyses of return migration policy. The Centre of Migration Research (CMR) Working Papers 44/102 is just one example. Studies included in this compilation view the state as the main driver of return policy-making. For example, in Lesinska's (2010) section of the CMR Working Papers she argues that return migration becomes a subject of active state policy in two situations. The first arises when the scale of migration is large enough to be seen as a problem by public opinion. According to this argument, in a democratic environment it does not take long for politicians to realize the importance of a certain issue for public opinion and to take it up for their political purposes. At that moment the problem becomes a political one that needs to be addressed with a policy. In the second situation, the state recognizes the return of its citizens as a potential remedy for other problems, for example a demographic crisis or labour shortage.

Based on these two assumptions, Lesinska (2010) claims that that the state can be reactive or creative when making return policy. It plays a reactive role when migrants return to their origin countries independently of the state's efforts and the state is more or less forced to take a stand. For example, the economic crisis in the destination country might trigger a mass return of redundant migrants to their home country. By contrast, the creative role involves active state stimulation of return migration, with return migration defined in a strategic way. This study will discuss the extent to which this conceptualization can explain the role of the Swedish state in medical student return migration.

However, the problem with the thinking outlined above is that, despite acknowledging that the state may be reactive to external pressures and thus be forced to take a stand, it still sees the state as the main initiator and designer of return policy. Thus the existing literature fails to acknowledge that, where the state is passive or reluctant, other actors may play a leading role in return migration policy making. To compensate for this shortcoming, the present study will investigate the role of return migrants themselves, employers and professional associations in driving return migration policy, irrespective of state action or inaction.

Another problem with existing theoretical models of return migration policy-making is that they do not sufficiently account for the division between central and local state authorities. Lesinska's (2010)

conceptualization preserves a view of return migration policy-making as essentially a top-down endeavor that at best can be influenced by some bottom-up pressures. In contrast to this approach, the present study will explore the role of local authorities in developing return migration policy irrespective of central state action or inaction and explore how local authorities work out their own policies.

When it comes to the role of non-state actors, it is employers who have received the most attention in the literature on return migration policy-making. For example, Szczepanski (2010), in his section of the aforementioned CMR Working Papers, explains that employers faced with shortages of labour can be among the most visible advocates and lobbyists for policies aimed at bringing migrants back home. However, there is not even a brief discussion or mentioning of the role of return migrants, who thus appear as passive objects of either the state's or employers' actions. I have not found any study that explores the way return migrants themselves might become shapers, creators and designers of return migration policy in the face of rather passive state bodies and employers. The present study aims at filling this gap as well.

Nevertheless, since the study is concerned with a specific subgroup of return migrants (i.e. students), it is necessary to see whether the literature on return student migration has in some way closed any of the gaps highlighted above. Unfortunately, it seems that this has not been the case. Literature on student return migration forms another vast area of research in an even larger field of studies on student migration or mobility in general. Additionally, the literature spans a wide range of disciplines (e.g. migration studies, education, psychology, anthropology, intercultural relations and others), making it is difficult to review all the different issues covered or even to locate all relevant studies. However, the literature review for the present study suggests that literature on student return migration covers to a large extent the same range of topics as the literature on return migration in general. Thus, some studies explore reasons for return or stay (e.g. Lu, Zong and Schissel 2009; Bijwaard and Wang 2013; Soon 2012) whereas others investigate experiences upon return and labour market outcomes (Thompson and Christofi 2006; Butcher 2002; Pritchard 2011; Gaw 2000). Another significant group of studies explores the effects of student return migration on the sending countries. Research within this category highlights positive outcomes for countries of origin in terms of students bringing development and innovation to developing countries (Hugo 2003 in Gribble 2008; Gmelch 2008). Finally, some studies examine various state policies regarding return migration.

Gribble (2008) provides a good example of work in this last category. He argues that sending countries adopt three policy options or strategies for regulating the flow of students. First of all, the state can try to retain students or, in other words, prevent them from going abroad at all. To do this, the state needs firstly to understand the reasons why students go abroad to study. The reasons might be: insufficient education opportunities at home, advantages of having a degree from a foreign faculty, a native environment that does not facilitate research and innovation, and others. These internal factors are then addressed with specific policies. The second state policy option is to allow or promote migration among students but then to actively encourage them to return after completing their studies. Again, there is a set of different policies that can help in bringing

students back home. Thirdly, the state might accept that many students stay abroad and, instead of trying to bring them back, might try to extract benefits from them being abroad. This study will examine the extent to which the Swedish state's response to medical student migration fits this model.

But already at this stage two shortcomings of Gribble's (2008) study are apparent. First of all, his focus is explicitly on students emigrating from developing to developed countries. Therefore, his model might be ill-equipped to account for the case of students migrating from a more developed to a less developed country. This is a radically different situation because, for example, students who migrate from more developed to less developed countries are, at least from some theoretical standpoints (e.g. neo-classical economics), less likely to settle in the receiving country. Consequently, the perceived need among the policy-makers to try to bring them back home might be less pressing. In other words, policy-makers might assume that students will return anyway. This possibility was already discussed in the introduction where it was noted that, indeed, central authorities in Sweden have been taking the return of medical student-migrants for granted. By exploring the case of migration from a more developed country to less developed countries, this study further develops Gribble's model.

Another way in which the present study will expand on that of Gribble (2008) is that the latter does not examine how return policy is formulated on different levels: state and local. His study insightfully describes different policy options for the state but does not elaborate on the policy responses that can be developed by local authorities to complement or even fill the void left by the central state. Even more fundamentally, Gribble (2008) does not delve into the way the different policy options he describes are worked out or arrived at. This study will extend Gribble's model by going beyond the state-centric approach and focus on non-state actors – in particular, student-migrants. To my knowledge, based on the literature review (including a search for phrases 'student migrants' and 'student migration' on the Web of Knowledge within the fields of *Sociology, Social Sciences Other Topics, Public Administration,* and *Social Issues,* and on Google Scholar), none of the studies on student-migrants so far has looked at the student-migrants themselves as active creators of return migration policy in origin countries. Therefore, this study introduces a completely new perspective.

To narrow the search even further, a literature review on medical student migration has been conducted. In this relatively narrow field, the issue of return migration policy receives relatively little attention. Studies to date have been preoccupied with evaluating the performance of domestically educated medical graduates against those educated abroad (Benson et al. 1981; Case et al. 1997; Boulet et al. 2009; Norcini et al. 2006; Norcini et al. 2010). These studies have focused almost exclusively on American medical student migrants. Some studies have also explored the experiences of medical students returning from developed to developing countries (e.g. (e.g. Gaviria and Wintrob 1975), experiences of medical students from developing countries emigrating to developed countries (e.g. Leon et al. 2007; Chen et al. 2010; Jain and Krieger 2011), or effects of these migrations on health-care systems in both developing and developed countries, often leading back to discussion of '*brain drain*' (e.g. Mullan 2004; Hallock et al. 2007). As mentioned, the present study takes a completely

new approach by studying migration from economically more developed to less developed countries. It also brings a European or even Scandinavian perspective on the phenomenon to an area dominated by Anglo-Saxon studies.

To conclude, the review above showed that existing research on return migration has not sufficiently accounted for return migrants' role in return policy-making, especially where student-migrants are concerned. Instead, research so far has seen them as passive objects of state or employers' actions. While the role of employers was acknowledged, there seems to be no study enquiring whether return migrants can fill the vacuum left by passive state bodies and employers and incite these and other agents to act for change. Secondly, possible state policy responses that the literature has distinguished do not take account of migration of students from more developed to less developed countries. Moreover, few studies distinguish between central and local level policy-making. The study that follows attempts to close all these gaps.

Before moving on to a more theoretical discussion, one must be aware that the above categorization of return migration literature is only an attempt to simplify and structure the vast amount of studies in this research area. The studies discussed often cut across different categories of research in terms of their focus or methodological approach. They may address not one but several aspects of the phenomenon and, thus, cannot be placed in any one category. There might also be some niche topics that have not been included in the above analysis. Nevertheless, this literature review was sufficient to highlight some of the underdeveloped research areas, thus positioning the present study in relation to existing knowledge. In turn, the next chapter will position the study in relation to established sociological theories of migration.

3. Theoretical Considerations

Research on return migration has been based on theories originating from more general migration studies. Cassarino (2004) provides probably the most comprehensive recent analysis of how different theories of migration have been applied by researchers to the phenomenon of return migration. Therefore, it is his analysis that is used as reference point in this chapter. Three major theories are used in the present study: structuralism, transnationalism and social network theory. Although these are originally concerned with labour migration, this study takes a new approach by applying them to student migration.

The structural approach to return migration argues that social and institutional factors in home countries shape the returnee's adjustment process and experiences (Cassarino 2004, 4). According to structuralists, structural conditions such as institutional framework, traditional vested interests, local power relations, and values can block the reintegration of the returnees in their home country (Cassarino 2004, 5). Moreover, the theory argues that the migrants' expectations of institutional and social circumstances in origin countries shape decisions as to whether or not to return (Cassarino 2004, 4-5). This study will ask whether there are any structural conditions that have been shaping return experiences or decisions of Swedish medical student-migrants. The study investigates a wider range of potentially important structural conditions including: public law and regulations, state authorities, structure of the health-care system, and established local interests.

Another structuralist claim is that the return is "guided by the opportunities that migrants expect to find in their origin countries but also by the opportunities already offered in their respective host countries" (Cassarino 2004, 5). But what if people migrate to less developed countries where opportunities available are theoretically poorer than in the home country? Does this circumstance ensure that they will return? Studies within the structuralist theory have not sufficiently accounted for such a situation; the present study aims to make up for omission.

Structuralist theory contains other problematic aspects. Most importantly, structuralism perceives return migrants as being vulnerable vis-à-vis the institutional context in the home country (Cassarino 2004, 6-7). In other words, migrants are seen as powerless, unable to do anything but try to adapt to conditions in the home country, and often failing to integrate because of difficulties they face that are beyond their control (ibid.). Thus, structuralist theory to some extent denies agency to migrants. Secondly, the theory argues that links between migrants and origin countries become increasingly blurred and weakened the longer they stay abroad. This development makes returnees ill-prepared to face the structural conditions they encounter on return (Cassarino 2004, 7). However, scholars representing other theoretical strands (transnationalism and social network theory) have discarded both these claims. They show that returning migrants are not necessarily vulnerable vis-à-vis the state and that they have various means of influencing structural conditions in their home countries (Cassarino 2004, 7-12). This study tries to determine whether this has also been the case in regard to Swedish medical student migration.

Consequently, transnationalist and social network theories are of central importance in the present study. Transnationalists acknowledge the importance of social and economic linkages between returnees' host and home countries and try to understand how they increase return migrants' chances of re-integration (Cassarino 2004, 7). The theory argues that migrants prepare their reintegration into the country of origin through regular visits and maintenance of links with home countries (Cassarino 2004, 8). It also maintains that returnees carry out "goal-oriented initiatives that are collectively coordinated and that have been gradually institutionalized" (Cassarino 2004, 9). Thirdly, transnationalists acknowledge that governments are often "responsive to the political empowerment of their migrant communities overseas" (ibid.). This study attempts to test these three assumptions. Indeed, it aims to show whether just as the theory argues, Swedish medical students have been able to "reconstruct ties between the emigrant and the homeland" (Brand 2002 in Cassarino 2004, 9).

Finally, the study explores the extent to which social networks have helped medical student migrants to integrate into the Swedish labour market. Scholars who apply social network theory to study return migration usually claim that the resources which can facilitate return stem from cross-border interpersonal relationships (Cassarino 2004, 10). Even though Cassarino (2004, 10) argues that these interpersonal relationships may be derived from "the returnees' past experiences of migration", thus suggesting that they are exploited when a returnee has already returned home, there is no reason why interpersonal relationships could not originate also in returnees' home countries and why they could not be exploited while abroad as a means of preparation for return. The possibility of such a scenario is explored in this paper.

Another important concept within social network theory is that of social capital (Cassarino 2004, 11). There are countless definitions of social capital and entire research papers have been written with the aim of clarifying and defining this concept (e.g. Paldam 2000; see also overview in Portes 2000). However, when applying the concept to return migrants, Cassarino (2004, 11) significantly narrows it down to resources provided by the returnees' families or households. Arguing that families or households provide social and financial resources that may influence success upon return, he then summarizes that "social capital and the potential involvement of return migrants in cross-border social networks may be viewed as resources which complement and shape one another" (Cassarino 2004, 11). This process of mutual completion and shaping may work in the following way: if return migrants consider their social capital to be insufficient, they are more likely to become involved in cross-border social and economic networks in order to secure their return; on the other hand, participation in social and economic cross-border social networks might be lower if the perceived social capital of returnees is higher (Cassarino 2004, 11). On this basis he argues that returnees who have more social capital are less likely to engage in cross-border networks. Although this study cannot test this hypothesis (due to lack of a large enough sample from among student return migrants), it explores the extent to which return migrants have been drawing on their social capital to secure their return.

Because of incorporating these three different theories that are broadly concerned with the interaction between structural conditions and migrants, the study is embedded in a theory of institutionalism that can be seen as

encompassing all these different accounts of migration. There are different traditions within institutionalist theory but two major approaches can be distinguished. One of them sees actors as *rule-takers*, the other as *rule-makers* (Jackson 2010). Within the first approach, institutions are seen as exogenous to actors, shaping their preferences, opportunities and choices (Jackson 2010). In contrast, the second approach argues that actors shape institutions and that, thus, institutions are the expressions of actors' choices (ibid.). However, an increasing number of scholars have started to recognize the theoretical shortcomings of these separate approaches and tried to integrate them. The bottom line of these attempts is that actors and institutions are conceptualized as "being mutually constitutive of one another" (Jackson 2010). In the words of Jackson (2010[1]), actors "take existing rules as a starting point for defining their own identities and interests" but at the same time they can "modify or even overturn those rules from time to time". Thus, in addition the present study represents an attempt to integrate these different approaches and to enquire which tradition within institutional theory is best equipped to account for Swedish medical student migration and return migration policy-making.

To summarize, this chapter has discussed the main assumptions of structuralist, transnationalist and social network theories as applied to the phenomenon of return migration. It has also placed these approaches within a wider institutional theory and explained how this study attempts to use or contribute to the aforementioned theories. It has further established this study as probably one of the first to apply these theories to the phenomenon of student return migration.

[1] No page numbers given.

4. Methodology

To achieve the objective of understanding how different actors have engaged with a wider institutional context and with one another, all major actors involved in this phenomenon should be consulted. The main actors are: students, central state authorities, local state authorities, employers, and doctors' professional associations. All but one of them was consulted: no interview was conducted with a representative of the National Board for Health and Welfare (*Socialstyrelsen*) - a governmental agency under the Ministry of Health and Social Affairs whose responsibility is to regulate employment in the health-care sector through, for example, issuing doctors' licences. Therefore, the study does not present the perspective of one of the key players in the investigated phenomenon. This imbalance might at first appear as a serious limitation to the reliability of the study. Nevertheless, documents and press releases of *Socialstyrelsen* (2012, 2013) are used to inform discussion about the agency's policy, or lack of it, towards Swedish medical student migrants. In addition to this, data from other sources (e.g. a non-governmental organization called *Centrum för Rättvisa*, which was involved in a legal dispute with *Socialstyrelsen;* interviews with other actors) are used to account for *Socialstyrelsen*'s actions and their potential results for medical student-migrants. In the end, the study is interested in exploring the actual impact of the institutional context on return migrantion. From this perspective, students' and employers' interpretations and experiences with *Socialstyrelsen*'s actions are of central importance.

In regard to students, a two-hour voice-recorded semi-structured interview via Skype was conducted with the representative of the union of medical students abroad – MSF Utland. This interview was supplemented with follow-up e-mails and with analysis of internal documents of the union (i.e. yearly objectives, plans, analyses). Secondly, focus group in-depth interviews with three final year Swedish medical students in Poland were conducted. This choice was motivated by the assumption that final year students have more experience of studying abroad and that, being closer to the end of their studies, they are thus also closer to potential return – a central focus in this study. All were female and ethnic minority Swedes[2]: arguably the group that might face the greatest obstacles to entering the labour market even in such relatively egalitarian countries as Sweden. Certainly, a larger sample of students from different categories (year of study, gender, ethnicity) would have increased both the richness and validity of the data. However, financial resources were not sufficient to cover the costs of another trip abroad. On a positive note, though, three informal pilot interviews (with three Swedish male students in Poland) were also conducted before the actual data collection phase. These pilot interviews highlighted similar problems to those emerging from the focus group interviews.

As regards local authorities, these are the main employers of doctors in Sweden. The provision of Swedish health-care, including recruitment of doctors to local clinics and hospitals, is the responsibility of counties (*landsting*) and regions. There are four regions (Hallands, Västra Götalands, Gotland, Skåne) and 17 counties: Jämtlands, Blekinge, Dalarna, Gävleborg, Jönköping, Kalmar, Uppsala, Värmland, Kronoberg, Sörmland,

[2] It may be also useful to add that they were not of Polish background.

Västernorrland, Västmanland, Östergötland, Norrbottens, Västerbottens, Stockholm, and Örebro. In the first stage of the study, brief screening interviews were conducted by phone or face-to-face during the Career Fair (*AT-mässan)* that took place in Gothenburg on the 29th of January 2013. To start with, representatives from regions and counties were asked whether they had any policies or strategies addressing the issue of Swedish medical students abroad. Examples of such policies were given to clarify the question. If they had none, questions were asked as to why there were no policies and whether the authorities had been discussing or planning to implement any. Notes were taken on these short interviews because voice recording would have been inappropriate for such short social interactions, especially over the phone. However, if respondents said that they had some policies in place, a longer and deeper interview was scheduled which would be voice-recorded. In this way, 11 different employers were interviewed: three regions and seven counties. Interviews lasted between 15 and 35 minutes. In most cases only one representative from each employer was interviewed but in one case, two different representatives of two different functions were interviewed. In many cases the main interviews were supplemented with shorter follow-up phone interviews or, alternatively, additional questions were asked via e-mail. In one case, however, only one short interview was conducted followed by an exchange of organizational documents, but it was impossible to schedule a voice-recorded interview since the interviewee did not respond to subsequent e-mails and calls.

Finally, from the professional associations' side, two phone interviews lasting 20-25 minutes were conducted with a representative from the Swedish Medical Association (SLF) and a representative from the Swedish Junior Doctors'Association (SYLF). In addition, two interviews (lasting in total 1 hour and 15 minutes) with a representative of the Swedish Medical Student Association (MSF) were conducted, as this organization has acted as a link between the students abroad and the SLF. Data from all these interviews were supplemented with internal documents as well as press releases from these three associations.

The choice of semi-structured interviews as a method of collecting data from employers and professional associations was motivated by the fact that this is a first exploratory study on return migration policy towards Swedish medical student-migrants. There are no previous data or analysis to rely on in order to, for example, design a questionnaire. Even though questionnaires were considered at first as an alternative method, it soon became clear that this approach would not capture important information about the diversity of policy programmes that exist across counties and regions.

There was a similar motive in choosing in-depth interviews as a method of collecting data from students: that is, to capture the diversity and complexity of the reality. In-depth interviews are often defined as conversations that have a specific purpose (Legard et al. 2003, 165). In such interviews the researcher has a more or less defined set of themes that he/she wants to explore but, at the same time, there is a high degree of flexibility that allows the interviewee to raise new issues spontaneously (Legard et al. 2003, 141). Indeed, the flexibility of in-depth interviews enabled some new and interesting topics come to light (e.g. the overrepresentation of ethnic

minorities among return student-migrants). Additionally, as explained previously, one of the objectives of the study was to see what structural obstacles return student-migrants face. In-depth interviews provided a useful tool with which to allow respondents to express what they subjectively perceived as problems. Instead of imposing a rigid framework on the interviewees, in-depth interviews left space for exploring how they perceived the wider institutional context in which they act thus producing a more holistic and complete picture of the situation.

Of course, there are also some risks associated with this data collection method. First of all, the validity of the data produced by both in-depth and semi-structured interviews is a widely discussed problem, the role of the researcher in shaping the interviewee's responses being one of the key subjects of controversy (Legard et al. 2003, 139). Different research traditions hold different view on this. Some argue that knowledge resides in the interviewee and that the task of the interviewer is to extract it without shaping or influencing it; thus, any leading questions that may 'pollute' knowledge with the researcher's preconceptions are to be avoided (ibid.). In the present study, leading questions were indeed avoided but, in some instances, clear examples of responses had to be given to help interviewees better understand a question. Only these illustrative examples may be seen as somewhat suggesting the response. In defense of this study, however, many research traditions (postmodernism and constructivism) acknowledge that the researcher is "an active player in the development of data" and view knowledge as a product of the interaction between interviewee and interviewer in a specific, unique setting (Legard et al. 2003, 140). This tradition does not see the influence of the researcher as a weakness. Therefore, while potential risks of the methods chosen are acknowledged, they do not disqualify the findings of this study.

Another possible limitation of the methodology is that interviews were used to reconstruct the history of student organizing and produce a narrative of how student unions and other cross-national networks between students abroad and other actors in Sweden came into being. Therefore, the data rely on a relatively high proportion of retrospective accounts. Interviewees' recollections of what happened three, five or six years ago might not be complete or fully accurate. Nevertheless, owing to a lack of hard, written historical data this was the only way to reconstruct these events.

Once conducted, interviews were transcribed and data were sorted into different categories, which varied depending on the actor interviewed. This procedure was followed because different information was needed from different actors. For example, in the case of employers the study was interested in the policies that they had in place and the background to these policies. When interviewing representatives of professional associations, the study was interested in their perceptions of the problems that return student migrants face and the actions taken by these associations to address the issues, as well as their reasons for involvement. Where students were concerned, the focus was on the different sorts of obstacles that they experienced. Of course, there were many overlapping and common categories across interviews, and these were linked together to

create a complex web of data categories. On top of this, data from documents and press releases from all the aforementioned actors were connected and integrated into this web.

A few problems occurred during the data analysis phase, related to the fact that the voice-recording in some parts was not clear and a few single words could not be distinguished and transcribed. However, the whole argument was always easily understandable. If some individual words could not be transcribed, direct quotes were avoided.

Nevertheless, there is a more fundamental problem, namely that of interpretation of qualitative data by the researcher and the extent to which the researcher imposes his or her own meanings and understandings on the data. This is an inescapable dilemma with any research using similar methodology, but it might be even more strongly present in this study because both secondary data and interview data were collected and analyzed in non-native languages: English and Swedish. Furthermore, many interviewees were interviewed in a language that was non-native to them – English. Not only did this create potential risks for the validity of the data, but also raised certain ethical issues.

4.1. Ethical considerations

The major ethical problem in the study was that some interviewees expressed concern about being misunderstood or misinterpreted. Owing to the fact that many of them play important public roles, this became a pressing ethical issue. The fact that many interviews were conducted in languages that were non-native both for interviewees and interviewer might have contributed to these concerns.

To address them, data are presented anonymously. Secondly, a copy of a paper was sent to all interviewees before the official submission – starting with the interviewees whose identities were most likely to be discerned despite the anonymity principle. Thus, interviewees were given an opportunity to comment on the final draft. It was also a check on the success of anonymity policy. Depending on the interviewees' consent might be seen as posing a risk that only data that they found acceptable would come to light. On the other hand, assuring interviewees of the opportunity to comment on the final text put them at ease and increased the likelihood that they would talk openly, while minimizing the risk that they would avoid certain issues for fear of even seemingly innocent arguments being misunderstood and putting them in a bad light. Nonetheless, all interviewees were satisfied with the way the anonymity policy worked in practice and some suggested only technical changes.

Another ethical consideration arose in the focus group interviews with students. Since the group was only newly met, voice recording seemed inappropriate as it could disrupt the atmosphere, in which participants were to feel free to express all their views. Therefore, all sides agreed that notes should be taken instead. Afterwards

all notes were compiled within a single document and sent electronically to all three participants, who were asked to confirm, or otherwise, that the notes were taken accurately and reflected their opinions.

4.2. Generalizability

As far as the generalization of the results is concerned, a larger sample among Swedish medical student-migrants would have been desirable. Ideally, this sample would have been drawn from among students across different countries to see whether students returning or wishing to return from particular locations experienced or perceived any unique barriers not discovered here. But in the absence of a large sample of students, another strategy was used to increase generalizability. Specifically, the project leader of the student union that represents students abroad was interviewed. This person is likely to have a general understanding and overview of problems that students in different countries face because of his central role in the union. As for the generalization of results regarding employers' policies, as previously explained, all major employers of doctors in Sweden were interviewed; only private clinics are unrepresented.

To conclude, the methods used have certain limitations. At the same time, they also confer many benefits. In particular, since this study is only the first attempt to explore the phenomenon in question and arouse a greater interest in it, the methods used offer a solid starting point for future research by providing rich data that were collected and presented with careful attention to ethical issues.

5. Results

This chapter is divided into two main parts. The first explores the ways in which have shaped actors and their actions in the phenomenon under investigation. The section is additionally divided into smaller subsections, each highlighting a different aspect of the institutional setting. The second part takes the opposite approach and looks at how actors (students in particular) have made an impact on institutions. While the first part integrates structuralist theory to show how structural conditions in Sweden have acted as obstacles to the return of medical students, the second part integrates social network and transnationalist theories to explain the strategies students have used to overcome barriers raised by the aforementioned structures.

5.1. Actors as rule-takers

There are many instances in which the key role of institutions in setting the rules of the game can be spotted. Therefore, this part of the chapter is divided into subsections corresponding to these different instances. Firstly, it analyzes how institutions have shaped the very actors engaged in the phenomenon and their interests. The second and third sections discuss the role of central state institutions and the structure of the health-care system, respectively.

5.1.1. Institutions shaping the Swedish medical student migration

Analysis of the institutional context in Sweden can help us understand the rise of Swedish medical student migration and the different actors involved in it. First of all, even though Sweden has one of the highest numbers of doctors per inhabitant in Europe (OECD 2012), still the medical education system has not met the high demand for doctors among employers. The serious shortage of medical staff in Sweden was already discussed in the introduction. This shortage itself may be a result of specific institutional conditions which, unfortunately, could not be located during the research. Nonetheless, this high demand for doctors among employers could then spill over into higher demand for medical education among students. In other words, in a situation where doctors are in high demand and all projections suggest that this demand will continue or even grow, people are likely to perceive medical education as an investment in skills which will pay off. Thus, a high demand for doctors in the labour market can increase the perceived likelihood that a person with medical education will find a well-paid job, and will thus encourage medical education.

However, it is unlikely that all those willing to study medicine will be able do so. Admission to medical education in Sweden is based on high-school grades or scholastic aptitude tests (Lindgren et al 2011, 799). Some students might not have good enough grades to get into medical school in Sweden, and for these students,

medical studies abroad can be an alternative way of obtaining the desired education. In fact, some employers in this study expressed a view that students go abroad because it is easier to be accepted there.

But this account is an oversimplification of a much more complex reality. In a review of Swedish medical education commissioned by the government, Lindgren et al. (2011, 799) write that even the highest possible grades in high school do not guarantee admission to medical school in Sweden. This situation is popularly known as 'lottery admission', since the decision as to whether to accept a student for a medical programme is based on a random choice among people with equally good grades. In this context, migration to another country can be the only way to pursue a dream career in medicine even for people with the highest grades possible.

Another institutional factor that complicates the picture is that of structural discrimination against ethnic minorities in the Swedish educational system. Media and the Swedish National Agency for Education (*Skolverket*) have reported that foreign-born Swedish children and Swedish-born children of foreign background have lower grades and poorer exam performance in primary and secondary schools (Skolverket 2004; Bergling and Nejman 2010). Since secondary school grades are decisive in applications for medical education in Sweden, non-native Swedes are on average less likely than native Swedes to be accepted into medical schools. In contrast, many universities abroad do not take grades into account during the recruitment process; instead, examinations and interviews are used. Even if they do consider grades, only those in biology, chemistry, physics and mathematics are looked at, whereas in Sweden even grades from subjects which have little to do with medical science are considered (e.g. Swedish history or literature). This opens a door of opportunity for many people with lower grades from secondary school, including Swedes of foreign background, some of whom might face additional difficulty in obtaining the highest grades in humanities, because of not having Swedish as their native language. As suggested by MSF Utland's representative, a person with a brilliant nature-science oriented mind, who is ideal material for future medical practice but is not fluent in the Swedish language, might never get into medical education and, thus, never become a doctor, unless he/she goes abroad. This shows how the structure of the university application systems can shape actors (student-migrants) and their demographic composition.

Another institutional factor that might make students more prone to migrate for medical studies is that the state offers financial support for students who go abroad. It is provided by the same state agency that gives funding for students at Swedish faculties: namely, *Centrala studiestödsnämnden* (CSN). Just as in Sweden, students abroad can obtain financing in the form of both monthly subsidy/allowance and loan. Even though participants in the focus group expressed negative opinions on the functioning of CSN, complaining that the funds never come on time, the fact that the support is available may play a role in the decision to go abroad. At the time of making such a decision, a person has little first-hand experience of how CSN support works in practice and therefore, might have unrealistically positive view of the support available.

There may be other national institutional factors that encourage students to go abroad for medical studies but, unfortunately, no study so far has attempted to uncover the motives of Swedish students for doing so. The focus group interviewed highlighted only the issues above; a larger sample of students could provide richer information.

Nevertheless, national institutional factors are only part of the picture. Another important catalyst to Swedish medical student migration lies in the international institutions of the European Union. As shown in the introduction, migration of Swedish medical students is highly concentrated within the EU. Therefore, one can assume that EU integration has played some part in facilitating this movement. In 1993 the EU introduced the 'Council Directive 93/16/EEC to facilitate the free movement of doctors and the mutual recognition of their diplomas, certificates and other evidence of formal qualifications'. This directive began to take effect in Sweden with the Swedish accession to the EU in 1995. It gives Swedish citizens unprecedented opportunities to go study abroad, since their qualifications gained abroad would be automatically recognized back in Sweden. Although on Graph 1 (p. 6) we cannot observe any growth in 1995 in the number of Swedish doctors educated abroad, we must to keep in mind that the graph shows only those who received their doctor's licence in Sweden. Medical education in European countries usually lasts six years. Some of these students receive their licence directly after completing their studies and, according to the 1993 Directive, they are also automatically eligible for a licence in Sweden. In some countries students do not receive their licences directly after finishing their studies but must first complete an obligatory practice which in Sweden is called *Allmäntjänstgöring* (AT) and lasts at least 1.5 years. Additionally, there is a waiting time of a few months for AT. Consequently, in the most conservative calculation that does not include all possible interruptions or waiting periods, it takes at least 6 to 8 years from the moment an individual decides to study abroad till he/she receives the doctor's licence. As a result, if a decision to study medicine abroad was made in 1995, when the Council Directive 93/16/EEC took effect in Sweden, we would expect this to be reflected in Graph 1 at the earliest in 2001 (6 years) and then in 2003 (8 years). In fact, we can observe that there was a noticeable growth around that time (in 2002) and, except for a small decline in 2003, the number has been growing ever since. Therefore, there is reason to assume that EU regulations have had some impact on the international mobility of Swedish medical students.

Another possible contributory factor was the subsequent EU enlargements in 2004 and 2007. As evident from the Table 1 (p. 7), the majority of medical students abroad study in one of the New Member States, with Poland being the most popular destination, accounting for one third of all Swedish students abroad. The number of Swedish students studying in the New Member States has been continuously growing over the past decade. This can be partly explained by the fact that, following their EU accession, these Member States became included in the aforementioned Council Directive 1993. In addition, structural conditions such as the lower cost of living in post-communist countries, as compared with Western Europe, might have further encouraged students to go there.

To summarize, this section has shown how national and international institutional contexts created conditions for the acceleration of medical student migration. Furthermore, these contexts determined the shape of migration by channelling it to specific countries (mostly Central and Eastern Europe). Since these countries are characterized by specific and diverse health-care and medical education systems with differ from those in Sweden, students in these countries will face different problems surrounding integration into the Swedish health-care system. Thus, the needs, interests and actions of these actors are entirely shaped by this institutional context. These needs and interests are explored in the sections to follow, where it will also be demonstrated that even the interests of employers have been affected. Therefore, the analysis gives support to the tradition of institutional theory that sees actors as being socially constructed (Jackson 2010). The main actors that have emerged are, of course, migrating students themselves but other actors have also sprung up. For example, we have witnessed a proliferation of recruitment agencies that act as intermediaries between universities abroad and Sweden. They try to attract Swedes to particular universities and, in return, get a commission from those universities for the students that they have 'brought over'. However, these actors are not investigated in this study. Instead, the focus is on students and employers.

In addition, the section has suggested that, referring back to Gribble (2008, see Literature Review), the Swedish state has been (possibly unconsciously) encouraging student migration of students. The next section examines whether, as expected by Gribble (2008), the state has also been actively working to bring these students back.

5.1.2. Central state institutions as a structural obstacle to the return

Interviews with the representative of MSF Utland and with medical students in Poland, together with the secondary data, highlighted the very negative role of some aspects of Swedish law and of the authority assigned to control compliance with it – *Socialstyrelsen* (National Board of Health and Welfare). More precisely, the law formerly stated that, unlike students from Swedish universities, Swedish students from foreign faculties were not allowed to work in Sweden as junior doctors (*underläkare*) after the ninth semester of studies. This regulation was changed only in 2012, and since then students studying in other EU countries who wish to work as *underläkare* must apply for permission to *Socialstyrelsen* which will then assess every application on an individual basis to see if the applicant has sufficient work experience (at least 40 weeks of practice) (Socialstyrelsen 2012). In this way, the decision on employment is not made between an individual and employer; rather, the state has to pre-approve any contract between these two parties. This is just one example of how institutional context affects the scope of actions available to other actors: employers and students.

MSF Utland says that as a result of these unequal stipulations, many Swedish students from foreign faculties went to third countries (especially Finland) to work as *underläkare* because they were not allowed to take up similar jobs in Sweden (Ahlström 2011a). In this way their integration into the Swedish health-care system is

even further postponed or students might never return at all. In line with structural theory, this case highlights how structural conditions in a home country may act as obstacles to the integration of return migrants.

Martin Ahlström (2011b), a project leader for MSF Utland, also wrote a commentary about this problem, in a private capacity – that is, as a student abroad. He relates how he was offered a job as *underläkare* at Västerviks Hospital but was unable to accept it because *Socialstyrelsen* did not grant him permission. In his highly emotional article, he explains that students who do not have experience of working as *underläkare* during their studies are in a disadvantaged position when competing for jobs on the Swedish labour market. He complains that countries like Norway, Finland, Denmark and England do allow students like him to take up similar jobs, and it is only in his home country, Sweden, that he is not welcomed. In a similar fashion, another Swedish student in Poland expresses his disappointment and frustration with these regulations in a letter to the *Dagbladet* (Lindgren 2012). He concludes with the statement that he will work in Finland if his experience is deemed not good enough to care for Swedish patients. The student union's representative describes the problem in the interview:

> *There is a risk, people do it and it has already happened. I mean every summer people are working as junior doctors in Finland and in Norway because they are not getting work in Sweden. So they are already losing these junior doctors. And, of course, as I explained to you before, if people like the place where they are working they are very much likely to move to that place. And people who have already been living abroad for six years… I mean, they are quite likely not to go back home. (…) Because we have the same right to go to Finland to work, or we can go to Norway and work but we cannot go to Sweden to work. And that's crazy. I mean, all these special rules, these applications, these like really weird exceptions only apply to Sweden. I mean… you have to apply for permission in Finland too, for example, but they just embrace you and say: 'welcome, we fill in all the papers, it's just a formality, we just need to have your ID and see the diploma and put the stamp on the paper'. Basically, that's it. In Socialstyrelsen they just basically want you to send in the papers so they can say no. That's the feeling you get.*
>
> MSF Utland's representative

Of course, MSF Utland is an organization with certain political aims and one might claim that it can purposefully exaggerate the scale of the problem. Therefore, one should not take these statements at face value. However, students in the focus group said that they personally know people who decided not to return to Sweden. Furthermore, they expressed negative feelings about the attitude of the Swedish state and governmental agencies such as CSN suggesting that the state benefits from student migration:

> *"They actually make money on us because we have to pay interest on loans that we take from CSN"*

"CSN always makes problems and makes it more difficult for us. Every year there is the same story and I don't know anyone who would have a good experience with CSN."

Swedish law and governmental agencies' actions are often interpreted by students as hostile and, therefore, may act as disincentive to return. Union representative said:

To be honest, all the employers – they are embracing us. We are getting hugs and kisses from them, basically. They want us and we feel wanted… and that's wonderful. The only thing is that we have a huge struggle now with the Swedish authority - Socialstyrelsen (…) I even talked to a lot of politicians and the politicians - they are supporting us; the employers – they are supporting us, the doctors are supporting us, the Medical Doctors Association is supporting us. But Socialstyrelsen is not and it's amazing how they try to come up with methods to prevent us from coming home (…) 'They are actively working against the medical students abroad and I have no idea why

MSF Utland's representative

Even though the change in the law that took place in spring 2012 is seen as an improvement by various actors, including students and employers, it does not seem to be sufficient. In fact, the aforementioned article by Johan Lindgren was published just after *Socialstyrelsen*'s announcement of the reform. He writes that he is happy to see that *Socialstyrelsen* no longer overtly discriminates against students on grounds that they do not belong to the Swedish faculty; but he is far from saying that discrimination has disappeared. Discrimination was also brought up in the focus group:

'Even though there might be no barriers in terms of law and regulations, it is hard for us to get an underlakare position in Sweden. They don't value our education and diploma that much'.

'I applied to several places but have not received any answer. There was no interest on the side of hospitals.'

Martin Ahlström explains current forms of discrimination using his own experience:

I applied (for underläkare) already in Januar (…). So those rules will apply to me, too. But the thing is they were dealing with my errand for such a long time. I don't know if they did it on purpose or if they just have a lot of things to do at Socialstyrelsen but they gave me an answer so late that it was basically impossible for me to accept the offer. So even if they said 'yes', I wouldn't have been able to take the work (…) And it's also incredible that Socialstyrelsen wants 3 000 medical students to apply individually. I mean, they will not have resources in order to do that.

He seems to suggest that, even though reduced, the barriers to working as *underläkare* continue in more informal, less visible form. The barrier now is not an explicit prohibition but, rather, the time or even willingness on the part of *Socialstyrelsen* to evaluate students' eligibility. Indeed, as the Appeal Court (*Kammarätten*) judged this year, *Socialstyrelsen*'s rejection of Martin Ahlström's application was groundless and unlawful because he had a sufficient amount of practical experience. Therefore, there is a risk that the careers of hundreds of other students abroad might be affected, deliberately or otherwise, by wrong or sluggish decisions on the part of *Socialstyrelsen*. In fact, many careers have already been affected, creating resentment, visible in the media, internet and in the focus group with Swedish students in Poland towards the Swedish state.

One last problem highlighted by MSF Utland's representative regarded Swedish law stating that if a person goes abroad for more than one year, he/she ceases to be a resident in Sweden. MSF Utland's representative noticed that this removes students from health-care insurance coverage, thus making regular visits to Sweden more problematic. However, one can also read it as a symbolic way of breaking a connection with migrants abroad.

All in all, this section has gave credit to structuralist theory by showning that some aspects of Swedish law and the enforcement agency *Sociastyrelsen* create significant obstacles for the integration of Swedish medical students abroad into the Swedish health-care system and create resentment among students that may discourage them from returning. This resentment contrasts with a rather positive self-image of students abroad thus creating strong tension and imbalance between expectations and reality. In a focus group students compared themselves with students in Sweden:

> *We have more enthusiasm and are more passionate.*
>
> *Students in Sweden take their education for granted. For them is just a step towards a good and a stable job. We really fight for our education. It is a big challenge for us to study here. We are more motivated to be good doctors.*

Even though they acknowledge lower practical experience, they believe that they can make up for it if opportunities are given to them in Sweden. This further highlights their expectations towards actors in Sweden:

> *We might have less practice but it can be made up for if more possibilities are made for us in Sweden.*

The section has also illustrated how this law and *Socialstyrelsen*'s actions have shaped the scope of action available to other actors. Not only students' actions, but also those of employers, are constrained because their recruitment autonomy is limited by the state's power to sanction employment agreements.

Additionally, the previous section suggested that some actions of the state (e.g. financial support to students who go abroad), as well as a wider institutional context that the state creates, seem to encourage medical

student migration. On the other hand, this section showed that the state's institutions also create obstacles to the return of these students. Therefore, this case does not fit any of Gribble's (2008) categories of state policy responses to student migration, as discussed in Chapter 2 of the present study.

5.1.3. Health-care system

The way the health-care system is organized in Sweden can also shape the scope of actions available to other actors, and there are many ways in which the structure of the health-care system in Sweden creates obstacles to the integration of return medical student migrants. In the interest of clarity, this section is divided into two smaller parts, each discussing a different aspect of the health-care system.

Clinical practice

First of all, many universities abroad require their students to undertake four weeks of clinical practice every summer in order to be accepted for the next year (Törnberg 2012). Such a requirement exists, for example, in Poland, where more than 1000 Swedish students are enrolled at present. The majority of Swedish students seek practice in Sweden or in other Scandinavian countries (Sydsvenskan 2012). Not surprisingly, media have been reporting on the flood (sic!) of applications from students abroad for summer practice in Sweden. For example, Sydsvenskan (2012) wrote last year that Swedish hospitals are "overwhelmed" with applications from students abroad and that they find it difficult to process them. In the same article, the HR manager responsible for the supply of skills to the Region Skåne says that they had been bombarded (sic!) with applications for summer practice. Lotta Christoferson, the HR strategist for Region Skåne, is even quoted to say that this is a growing problem for Sweden and that her region has no overview of how many people apply.

These short quotes show that the Swedish health-care system is structurally unprepared to accommodate the needs of Swedish medical student-migrants and is thus not ready to integrate them smoothly. The importance of summer practice for the integration of Swedish medical student-migrants lies in the fact that for many of them it provides the only contact with or experience of the Swedish health-care system. Therefore, the circumstance that structural conditions in Sweden are not adapted so as to offer such practice for students again supports the structuralist theory that structural conditions shape the integration opportunities of return migrants.

At the moment only a handful of employers offer summer practice for Swedish students from faculties abroad. Two reasons were given. First of all, the majority of local authorities already have contracts with different universities across Sweden. For example, Dalarna cooperates with Uppsala University; Jämtlands, Norrbottens, Västerbottens and Västernorrlands cooperate with Umeå University, Kronobergs and Östragötalands with Linköping University, Stockholm with Karolinska Institute and so on. The universities send their students to partner regions and counties and also provide remuneration for employers who provide clinical training to students. Employers often say that this cooperation fully satisfies both their needs and capacities for providing

clinical training and that, as a result, they are not able to offer places for students from abroad. These established relationships between employers and universities in Sweden are an example of how established institutions and interests limit the opportunities for return migrants, thus supporting one of the key claims of the structuralist theory (see Chapter 3).

The other important reason for a lack of a suitable policy is that there are insufficient financial and human resources to organize this type of practice. Many interviewees stated explicitly that they do not have the money for it. While they receive remuneration for providing training to students from Swedish faculties, this is not so in the case of Swedish students from foreign faculties. Furthermore, many employers explained that organizing summer practice is difficult because it is a holiday period when many of the staff are on leave and there are too few doctors to supervise students. These two problems are examples of how the organization of the health-care system in Sweden is not adapted to address the needs for clinical training of students abroad. Students themselves seem to be very aware of it:

> *Hospitals don't get anything from it. It's just a paper work for them and extra effort because they need to designate a mentor for a student over the apprenticeship period. When it comes to students on Swedish universities, hospitals get public money for taking them on apprenticeship. But they don't get anything for students studying abroad. So they think it's not beneficial for them. At least not in bigger cities where there are many applicants. In the North of Sweden it's more likely. When I called to Karolinska to ask about opportunities for apprenticeships, they basically laughed at me over the phone and said that they take only students from Swedish universities.*
>
> Student in Poland

The student union representative also perceives this problem in terms of incompatibility between the foreign educational system and the Swedish health-care system: *It is very hard for students abroad to find that summer practice only because the system is not completely compatible with the education system abroad.*

In a context which lacks a systematic and institutionalized response of employers to the need for clinical practice, students abroad have for years organized their summer practice in informal ways and on an individual basis through direct and informal contact with employers, often using their family connections. Participants in the focus group said that many students organize their summer practice in Sweden through family or relatives. Likewise, MSF Utland's representative explained:

> *There have been these programs but individually-based because all the students have done their internships but they have sometimes arranged it privately through parents, or through connections, or they have been writing to hospitals… so people have been doing this. It just hasn't been organized before and the awareness among the hospitals has been lacking about these internships because they have been a little bit made under the carpet, so to speak… I mean… If someone is walking alongside his*

father or mother – no one will say anything; and if someone is walking with his mother and father who is a doctor and has a friend with him – no one will say anything either. So this has been like sneaking its way into the system.

MSF Utland's representative

This illustrates how the institutional framework has been shaping the actions of actors. It also supports social network theory, which argues that informal social networks and social capital are used by migrants to prepare for their return (see Chapter 3).

However, this reliance on informal social networks raises many problems, such as the fact that students working informally are uninsured and it is unclear who carries the responsibility if accidents occur. Therefore, over the past three years some employers have created standardized and formalized programmes tailored to Swedish medical students abroad; the next subsection describes the current state of development in this area. MSF Utland's representative describes how the shift towards these institutionalized programmes has been taking place:

Many hospitals have been scratching their heads and saying: 'but what is this practice? What do you want from it? What do you want from us and what can we provide? And what if we don't provide the right thing?' So basically it has been a one-to-one man struggle for every single student that comes back to Sweden who have had to explain himself in every single case, individually, to the employer. What they are trying to do now is to make kind of a more uniform way to accept (…)

MSF Utland's representative

Review of programmes for students abroad

This study located seven employers who have some sort of practice programmes for Swedish medical students abroad. Employer 1 has the oldest programme of clinical practice designed for students from overseas faculties. It began five years ago when Employer 1 went into cooperation with one of the universities in Denmark. Since then it has been providing clinical practice for 24 to 36 students a year, the majority of them Swedish. However, a practice lasts for 12 weeks and does not take place in the summer. Additionally, the programme is limited in that it is open only to students who have finished the ninth semester of studies – a time when they would rather work as *underläkare* if only allowed to. Furthermore, the partner university in Denmark provides Employer 1 with remuneration for students. This is rather uncommon among other medical schools where most Swedish students study. In fact, the programme itself was created at the initiative of the foreign university to ensure that students can do the obligatory clinical practice; it was not exactly a strategic move by human resource managers to secure the future workforce supply. Employer 1 does not offer any programme for students from

other universities abroad because it is too costly. Owing to all these specific limitations, the programme does not provide an answer to the problems that the majority of students abroad face.

Therefore, it is rather Employer 2 whose programme signified a new era in terms of addressing the problems of Swedish medical students abroad. Employer 2 introduced its programme in 2010. It is based on an agreement with a university in Poland which stipulates that every summer 20 Swedish students from this university can come to Employer 2 for four weeks of practice. Students in any year of study can apply. Moreover, long-term relationships, whereby the same students come year after year, starting as early as their first year, are welcomed or even desired. Successful candidates are selected by the local student union while the programme of practice is determined by the university.

A year later another employer (Employer 3) entered into cooperation with a different university in Poland. In the first year of its operation 6 people participated in the summer practice programme; this year (2013) 16 places are offered. The programme of practice is jointly agreed by the university and Employer 3. Students from the university apply for available places in an open competition and are chosen not by local student unions but by Employer 3: a fundamental difference from the programme design of Employer 2.

Employers 4 and 5 joined the group of pioneers in 2011. Every summer they offer 10 to 15 places for Swedish students from abroad at some of their hospitals. In the case of Employer 4, however, summer practice is offered only to those who have some kind of connection with the county – for example, they lived there, or have a family there. Moreover, unlike the other two employers, Employers 4 and 5 decided not to enter into cooperation with any specific university abroad. The representative of Employer 4 responsible for HR questions said:

> *We had this discussion (about going into cooperation with one university) and I presented for our political organization how this looks in Sweden… We decided that we will not choose and concentrate on one university only but that we will offer the possibility to all students abroad.*
>
> Employer 4

One more employer (Employer 6) introduced a summer practice programme in 2011. This employer also does not have a cooperative agreement with any specific university abroad, so that anyone is eligible to apply. However, the programme has a somewhat more limited scope than those described earlier, as it is only offered to students after their ninth semester of their study. During the programme they work as doctors' assistants (*läkarassistent*). What is interesting is the major expansion of this program. In 2011 and 2012, 10 students were invited whereas in 2013 it is expected that 25 places will be available.

In 2012 an additional employer (Employer 7) started to offer clinical practice for students abroad. The programme is provided in cooperation with a university in Sweden and is treated as a course at this university. However, since the content of the practice is decided by the course content, it might not be suitable for

hundreds of students abroad whose summer practice has to meet certain curricular requirements set by their universities. These students can instead apply on an individual basis to different hospitals in the region and compete for places with home-based students.

Nevertheless, Employer 7 represents yet another approach to the phenomenon of the return of Swedish medical student-migrants. By this approach, the employer decided to create a programme without any agreement with a university abroad but, rather, with an agreement with a university in Sweden. Another unique aspect is that it is not explicitly oriented towards Swedish students but, rather, to international students in general. On the University's website it is categorized as 'Exchange Studies'. Therefore, it is unclear to what extent this programme can help Swedish return student-migrants if many of the places turn out to be filled by applicants from other countries.

We can thus see substantial variation in the design of clinical practice programmes for Swedish medical students abroad. The common factor among all employers is that regardless of this variation they all admitted that they see Swedish medical students abroad as an increasingly important recruitment group. Employer 2, for example, said that their programme is a long-term strategy for the supply of doctors in the future. He explained that, in his experience, if contacts are established with students, these students are likely to come back in the future for their AT; after AT they are at the age when people start to think about setting up a family, which makes it likely that at least some of them will prefer to settle in this particular county or region. The ideal model, according to the interviewee, would be to bring back the same students each year so that long-term relationships are established. Employer 4 also said that their programme helps the county to establish contacts with future doctors during their study period:

> *It helps us with recruitment from a long-term perspective. We get to know the person already from the beginning of their period of studies.*
>
> Employer 4

Employer 3 went even further suggesting that their programme signifies a shift in the strategy for maintaining the supply of doctors. For many years Employer 3 has been 'importing' professional doctors from abroad, especially Poland. Now, through this new programme, the employer tries to bring back Swedish students from Poland. The interviewee said that there are certain benefits to this strategy. First of all, Swedish doctors educated in Poland do not need language training except in specialist Swedish medical terminology. Secondly, people born in Sweden or having grown up here tend to adjust to their workplace. Another advantage is that importing already educated specialists from abroad, especially from lower income countries, is a politically controversial policy. Bringing back Swedish youth, on the other hand, is viewed very positively by the public.

All in all, the overview of clinical practice programmes reveals a variety of ways in which employers try to adjust their systems and create new structures to address the needs of return student-migrants. At the same time,

the institutions that employers create bring new opportunities for students in terms of integration into the Swedish health-care system. This shows the mutual dependence of different actors (students and employers) but also of actors and institutions.

Students who receive licences directly after graduation

Another aspect of the Swedish health-care system that can shape the return experiences of students, as well as the scope of action available to employers, is that graduates of medical universities are required to undergo a period of at least 18 months' practice (AT) before they can be fully integrated into the system and obtain a doctor's license. Within Europe, similar systems can be found in the Nordic countries, Poland, Great Britain, Austria, Italy, Lithuania, Ireland and Portugal. In other countries, however, the doctor's licence is issued after graduation and no period of practice similar to AT is required. These graduates cannot apply for AT because by law they are already defined as doctors. Instead, they can only apply for jobs advertised for already registered doctors. However, because of their limited practical experience, they might be less attractive to employers than doctors who have done AT.

Therefore, as explained by MSF, MSF Utland and the Confederation of Student Associations (*Saco Studentråd*) in their joint letter, the Swedish system is designed in such a way as to exclude foreign students who obtained their licence after completing their studies (Ehlin-Kolk 2012). They do not fit the Swedish system and employing them creates additional difficulties for employers. As one employer put it:

> *This is an additional difficulty. It is hard to find a model for them because they fit neither there nor there. They themselves don't feel good because they know that they can much less… they want to gain practice… If you do not have a placement, you don't have practical experience. They themselves want some sort of mini-AT to be organized for them but the legislation is that if you have a license, you cannot do AT or placement.*

The problem for already licensed doctors who have little clinical experience might lie even deeper in the structure and organization of the health-care system. As explained by one respondent, employers have trouble finding time to train doctors because the health-care providers are above all expected to 'produce' health-care on a day-to-day basis. In a system which places much emphasis on 'production of health-care', employers often have to prioritize daily performance over the training of new staff. Short-term objectives take priority over long-term ones. Thus, they might be keener to employ someone with more experience than someone who has not done AT and requires more time to be trained. The following quote illustrates this point:

> *I think it also has to do with the system that we have in Sweden. (…) The hospitals are going minus financially and the doctors that are hired are meant to produce health-care. At the same time, they have a mission to train new doctors. But they don't have time and that is a problem. So even if you are*

coming and have a license and would like to work within a specialty that we are in need of – maybe we have difficulties to train this person cause the doctors are meant to produce and are hired to produce. I think this is a problem nationwide.

Employer 11

The situation described above is an illustration of how the Swedish institutional context limits the actions and opportunities available to different actors. On the one hand, it makes it difficult for employers to train or employ licensed graduates from foreign faculties because they 'do not fit the system'. On the other hand, it limits the opportunities for these graduates to enter the Swedish labour market. This example also supports the structuralist theory by showing that the structural context in Sweden creates major obstacles to the integration of return migrants.

However, employers in Sweden have recently started to recognize these problems. They have created so-called pre-ST or mini-AT programmes which are designed for returning medical student-migrants who have already received a doctor's licence. These programmes introduce overseas-educated doctors into the Swedish health-care system. Mini-AT and pre-ST are thus examples of how actors (employers) adapt and adjust their actions within the national framework (of the health-care system and medical education system) that constrains them.

In this study, only one county (Employer 8) reported that they offer pre-ST, one region (Employer 9) said that they used to do so but that the programme was stopped[3], and one county (Employer 10) said that they were planning to start mini-AT. However, the majority of counties said that they have been discussing this topic and thinking about possible policies. Additionally, one region (Employer 11) is starting to run, in 2013, a pilot version of a programme that prepares its participants (doctors who have employment contracts and who have received basic medical education in another European country) for working in the Swedish health-care sector.

All the aforementioned programmes are motivated by recognition of the potential that student migration brings in terms of human capital:

These Swedes who study abroad are needed in Sweden. Our county must work for a good growth of doctors and our recruitment base has to be expanded. If there are young clever people educated as doctors who besides this know our small Swedish language, we have to work so that they come here into the Swedish health-care.

Employer 8

[3] Reason being the lack of funds. The evaluation of the programme showed that it was successful in its aim of integrating Swedish graduates from foreign faculties into the Swedish health-care system and all stakeholders involved regretted that the programme had to be stopped.

We have 3000 Swedish students who study medical programmes all over Europe. And they want to come back to Sweden. And to make them employable in Sweden, because they are a future resource for us, we made X programme to make them employable.

Employer 9

The reason why we think that this is an interesting group is that there are a lot of Swedes who are desperate for finding a good placement in Sweden. At the same time we have a big shortage of specialists in psychiatry and general medicine so we need to employ many people in ST within psychiatry and general medicine. So then we think like this: if these young people are so motivated to come back to Sweden and want to start working in psychiatry or general medicine – this is a good group to work with. This group has in fact gone through education in English. They must have been very motivated to gain this education (…) they made an effort to gain their education.

Employer 10

The programmes discussed above illustrate how actors (employers) try to work out their strategy within a rigid and disfunctional framework created by the wider institutional context. However, associations of doctors (SYLF and SLF) have highlighted problems with these locally-designed programmes regarding salary issues and terms of employment (see SLF 2011). To address them, SLF created guidelines for employers (SLF 2011). Moreover, SYLF argues that pre-ST/mini-AT go against EU regulations in a way that these doctors, although licensed to practice, cannot start ST until they have completed mini-AT/pre-ST. Therefore, according to SYLF, the problem must be addressed nationally rather than locally. They advocate the establishment of an *introductory employment* programme to replace AT. Such a programme would be obligatory for all doctors at the beginning of their professional careers, regardless of whether they had studied in Sweden or abroad. This idea is also supported by MSF, MSF Utland and Saco Studentråd (Ehlin Kolk 2012). In 2012 the proposal reached national level when the government launched an inquiry into the renewal of medical education in Sweden, to ascertain how the Swedish medical education system might adapt to the new demands springing from intensified mobility of students and doctors (SOU 2012).

In fact, the results of the inquiry, published in 2013, recommend a radical change in the Swedish education system. By this change, licences would be given directly following undergraduate medical studies. If this should take place, it would be an illustration of how actors can be rule-makers, shaping the national institutional context. Although the outcome of this proposal has not yet been determined, the second part of this chapter will give other examples of how actors have played an active role in shaping the institutions affecting them.

5.2. Actors as rule-makers

This part of Chapter 5 approaches the issue from the opposite direction to that taken in the previous section, by investigating the extent to which actors have been able to influence the wider institutional context. Here the central role of return migrants is explored, although a role played by other actors – SLF and SYLF – is also highlighted. Moving away from structuralist theory, the analysis draws on transnational and social network theories in explaining which strategies students have used to modify the institutional context. The analysis is divided into three subsections, each representing a different strategy used by students in their struggle.

5.2.1. Bottom-up organizing

Students abroad have used a variety of methods to change state-level and local/employer level policies. One important aspect of their activity was their organization of student unions. At the moment, MSF Utland is the only organization that represents Swedish medical students abroad. It consists of 20 local associations at different universities across Europe. MSF Utland was officially created in 2008 by the decision of the SLF. In fact, however, the organization appears to have emerged from a grassroots, bottom-up movement of students. There is evidence that, even before MSF Utland was officially created, students had begun to organize local unions which helped them to address some of their problems collectively. Such a union already existed at the Medical University of Gdansk. The project leader for MSF Utland, recruited in 2011 by the SLF, who at the same time comes from the Medical University of Gdansk, describes the very beginning of these structures:

> *Why did I got chosen? Well, because we have a lot of medical students here in Gdansk. We realized that we have a lot of issues, among others this thing that we couldn't work as underläkare. So we started to organize ourselves here in Gdansk. We started to create meetings, we created agenda. And in order to be a respectable association we also started with a yearly meeting… we had a Board, we had members, rotations and everything according to the rules of non-governmental organization. So we basically created this organization structure only for our university here in Gdansk. But still very active Board, we were working with many issues. (…) We also took the opportunity to spread some student traditions, Swedish student traditions. We created a choir, we created study groups for certain subjects, we had introduction meetings where we had courses in study methodology, and we also arranged the EKG courses in Swedish in order to integrate Swedish vocabulary. We created lots of different events. We also created some social events, (…). Basically organized ourselves. And in the middle of all this organization, this project leader mission came up and I had been involved in this MSF Gdansk for such a long time then. Or I was one of the founders. So we created this organization. And I got an idea that this is a good structure and this should be applied to many more places.*
>
> MSF Utland's representative

Moreover, it turns out that the very idea of creagin MSF Utland under the SLF came from students abroad. Even though the SLF founded MSF Utland and played some role in the development of this organization, it seems that its role consisted more of enabling and giving support to students rather than organizing them in a top-down manner. A representative of the SLF describes the background to the foundation of MSF Utland:

> *The idea came from one of the Swedish students that were studying abroad. He was studying in Romania…. And, of course, this was not any new information for us. We knew that a lot of students have started to study to doctors abroad. But we had not had so much contact with them. So he called us and wanted to meet us and tell us about his idea of starting an organization for Swedish students that study abroad. And we, in Swedish Medical Association… we thought that his idea was quite good and thought that we can help them to find means and a way to get home and start working.*
>
> SLF's representative

In 2009 the constitution of MSF Sweden was changed to allow Swedish students at foreign universities to become members. Therefore, this date can be taken as marking the real beginning of MSF Utland. Since then the SLF and MSF Sweden have tried to establish contact with Swedish medical students in different European cities. As recalled by SLF's representative, they sent out e-mails and organized trips to various places to talk to students about what they can do for them and how students can organize themselves. However, MSF Utland was more of an organization on paper at that time. MSF Utland's representatives describes this period as follows:

> *So there was a guy who started MSF Utland, he came up with a logo and basically he represented mostly himself. There was no networking done… it became nothing in the end. I mean, he raised a couple of issues but there was no organization created, there was no organizational structure and so on. Also the person who was responsible for MSF Utland was always a person in the board of the MSF Sweden which means that one of the people from one of the Swedish universities had a responsibility for MSF Utland. And, of course, as a medical student in Sweden you are not very involved in those matters and it became almost like a formality. Someone just had to have it on the paper that he was the person that was responsible for it but not very much happened. Which I can't blame anyone for… But with our last MSF chairman, he came up with an idea to make MSF Utland as project form.*
>
> MSF Utland's representative

It was in 2011 that a project leader was recruited from abroad and responsibility for driving MSF Utland was transferred from Sweden to students abroad The project leader was given the general task of developing the organization but it was up to him and the students themselves to decide how the organization would be run, as long as it abided by the regulations of SLF and MSF Sweden. Here is how the project leader describes this period:

I started to contact, to network with people, mainly through facebook. I contacted students who were studying in other universities. I said that this MSF thing, which we have in Gdansk, is fantastic. You should try it too. Then we got a little bit of a budget from MSF and then I could go abroad. So I was travelling to Hungary, to Budapest, to Romania to Cluj, and I also visited Warsaw, I went to Krakow, I met students from Lublin and also from Szczecin (…) and by networking, we created this network and we encouraged other associations to be created in each university. So basically right now there are 20 active MSF associations abroad out of which 10 have properly chosen boards with a chairman.

This organization has helped students to bring many important issues onto the agenda in Sweden. An example, discussed earlier, is the problem of *underläkare* practice for students after semester nine. As recalled by the current MSF President for Sweden, the problem was first communicated through MSF Utland to the central board of the MSF in Sweden and then presented to SLF meetings by the then MSF President. In turn, as recalled by the SLF representative, the SLF sent a letter to *Socialstyrelsen* regarding this particular problem and took it up further at meetings with *Socialstyrelsen*. Therefore, through their organization abroad, which was connected via cross-national links with the organization in Sweden, students could put their issues onto the SLF agenda and, in the end, onto that of *Socialstyrelsen*. Consequently, the decision in 2012 by *Socialstyrelsen* to remove from its regulations the clause about the *underläkare* position has its beginnings in the students' effort to highlight this problem. Thus, it can be read an example of how students using cross-national networks were able to make an impact on structural conditions in Sweden.

Just recently MSF Utland oriented its activities towards entering the mainstream of MSF organization. The last president of MSF Sweden encouraged MSF Utland to become more democratic so that it could be fully incorporated into MSF structures:

We want that MSF Utland should be a part of MSF just like the other local departments. Want I want, as a president, and what I've been trying to do this year is to make that a reality. If we want MSF Utland to be a part of organization, it has to be democratic. So the people that represent MSF Utland need to be voted on democratic base.

Previous MSF's President

This aim was achieved on the 17th of March, when the status of the MSF was changed to enable MSF Utland to become an integral part of the organization with full voting rights, just like domestic MSF divisions. The integration of MSF Utland with the MSF in Sweden creates an even stronger cross-national link between the two organizations, allowing students abroad to be more effective in communicating their interests.

Student organizing has also helped to bring about changes at the local/employer level. First of all, by placing their issues on the SLF's agenda, students became visible to employers across Sweden. Secondly, MSF Utland carried out an information campaign among Swedish counties and regions. Besides contacting them via e-mails,

it organized, on 2 to 4 November 2012 (2-4 November), a Congress in the city of Krakow to which all the Swedish regions and counties were invited. MSF Utland's representative describes this initiative:

> *Let's go to Krakow, let's sell the concept, let's promote it for the municipalities because we want people to exhibit. So we had a work market (career fair). And we invited six famous speakers, like one person talking about ethical dilemmas of living with HIV, another person was talking about surrogate mothership for homosexuals. Then we had leadership problems in communication technique. We had also Doctors without Borders coming here (…). And then we had a gala dinner, and we had a party and we arranged a lot of social activities.*
>
> MSF Utland's representative

The initiative can be seen as a way to attract the attention of employers and present students abroad as a large and active group. Social activities and a gala dinner created an encouraging atmosphere for networking between students and employers. Additionally, a career fair was organized at which various employers had their stands so that direct contact between them and students could be established.

Around one month before the Congress, its originator was invited to the Conference on Rural Medicine in Hemavan (*Glesbygdsmedicine Konferens*) to talk about Swedish medical students abroad. He describes this experience in the following way:

> *I went to a rural medicine conference where I was promoting medical students studying abroad and the interest was enormous for those students (…) I was standing there, talking to them, and everyone was listening. It looked like children seeing a big bag of candy basically when I was talking about these students. Because there were so many people that saw so much potential in these students (…). This conference was meant to end up in some suggestions for municipalities: how to solve recruitment problems in Northern part of Sweden. And during this conference we had work groups (…). I went from one group to another talking about students. They were all very excited and they all agreed (…) to start working actively within municipalities in order to be able to receive medical students from abroad. And they also all agreed that, seeing that there are so many students coming back, that if you represent a municipality that is more active or is the first municipality to be active in the recruitment of the medical students, you have much greater opportunity to recruit them. So what they said is that they want to be first, they want to be on the edge, they want to be leaders of recruitment.*
>
> MSF Utland's representative

Therefore, we can see that, at least according to the MSF Utland representative's recollection, information about the size of medical student migration and the potential that this phenomenon represents was something new for many employers. Regarding the Conference in Krakow, he said:

For most of the people it was news, a lot of people didn't know that there is so many students studying abroad.

MSF Utland's representative

Through its activities, MSF Utland helped to raise awareness among employers, thus changing the structural conditions in Sweden previously characterized by a relatively low level of awareness.

The representative from Employer 4, one of the pioneers of policies aimed at Swedish medical student-migrants, also acknowledged that students abroad had brought this awareness to employers; he further emphasized the importance of student organizing themselves:

The most counties had known that there are Swedes who study abroad (…) But I think we had not have a grasp of how many there are who study abroad. It is only when you organize yourself that you become visible in a completely different way. All of a sudden you can say that there are over 3 000 Swedes who study abroad. They become a group that is interesting for future recruitment purposes. The fact that they organized themselves helped incredibly a lot.

Employer 4

The employer also said that, by organizing themselves students created points of contact for employers who were already interested in this group. In this way, the foundations for the future cross-national networks between employers and students were established:

In Sweden we meet a lot of Swedish students; they have their MSF in each city. Outside of Sweden they didn't have any union. So it was difficult for us to go outside Sweden because we have no one to talk to. Then they started MSF and these meetings, events. They fixed it and we can go there. So MSF Gdansk was the first and the biggest union organization for Swedish students outside of Sweden (…) [Before] we had no person to turn to. We would have to contact each person separately. It was an advantage that there was a union so that we could go through the unions (…)

Employer 4

These cross-national networks were reviewed in section 5.1.3. What needs to be added here is that the origins of these institutionalized networks lie in informal social networks. For example, as recalled by Employer 2, the background to the agreement between Employer 2 and a medical university in Poland was that a Polish doctor working for Employer 2 was in contact with Swedish students and their union at the Polish university. The students asked for help with summer practice and, by 2010 these initial informal cross-border connections became an institutionalized and formal agreement between Employer 2 and the university. The experience of Employer 3 further highlights this pattern of transformation of informal social networks into institutionalized networks. Employer 3 related that the initiative to create the programme came from a local politician who had

an informal social network of Swedish medical students abroad and became interested in this topic. The politician asked a doctor employed by this hospital for help because of his connections with one of the medical schools in Poland. These informal social networks were then formalized and institutionalized, leading to the programme of summer practice.

All in all, the role of students and student organizations abroad can be summarized in the words of MSF Utland's representative:

> *There is certain knowledge about it. But the knowledge comes from us abroad. We have been an active organization spreading the news rather than being looked up by the municipalities.*
>
> MSF Utland's representative

From the data presented in this section it seems that MSF Utland helped the majority of employers to recognize and truly appreciate the scale of Swedish medical student migration. Through their organizing they created points of contact for interested employers. Through their informal social networks they contributed to the establishment of the first programmes of summer clinical practice.

The driving role of students by contrast with the somewhat passive role of the majority of employers is also apparent from the statements of many employers that the reason why some policies are being developed or discussed is that they have received numerous questions from individual students abroad. This shows that employers have been more or less forced to take a stand instead of proactively developing policies regarding return medical student-migrants. It is somewhat surprising that the initiative did not come from employers themselves, considering the opportunities that this phenomenon offers, which many of them have only recently started to recognize. The words of the HR strategist from Skåne, who defined the Swedish medical student migration in terms of "a rapidly growing problem for all counties in Sweden", rather than an opportunity for them, are illustrative of this situation.

5.2.2. Legal battle

Another important feature of the activity of Swedish medical students abroad in bringing about institutional change was the legal struggle against *Socialstyrelsen*. The conflict began with one of the students (Martin Ahlström) bringing a court case against *Socialstyrelsen*'s rejection of his application for a position as *underläkare*. This case has been widely documented in media, and the organization *Centre for Justice* has been involved in it by representing Martin Ahlström in court. *Centrum for Justice* (2013) argued that *Socialstyrelsen*'s decision violated the EU's freedom of movement principle. The Administrative Court (*Förvaltningsrätten*) upheld Socialstyrelsen's decision but the Appeal Court (*Kammarrätten*) decided that

Socialstyrelsen had no right to reject Martin Ahlström's application because in fact he had had a sufficient amount of practical experience.

This decision was very important for all Swedish medical students abroad. Before, even following the aforementioned 2012 amendment to the regulations, obtaining permission was in reality impossible. According to MSF Utland, none of the students abroad who applied to *Socialstyrelsen* was granted permission. The decision by the Appeal Court imposes an obligation on *Socialstyrelsen* to look closely into each application and provide reasons for negative decisions. This example shows how actors (students) used an international institutional framework (EU regulations) to put pressure on national institutions and constrain the latter's autonomy.

5.2.3. Engaging media

The third strategy that medical students adpoted to raise awarness of their problems was the use of media. Individual students have been active in bringing up relevant problems in both social and commercial media (e.g. Lindgren 2012). Martin Ahlström commented on his own case: *So I was writing a lot of articles about it, I got media on my side, like Rapport came down and did an interview with me.* His case and the problem of Swedish medical students abroad more generally was reported in many newspapers, doctors' professionals magazines, and in the mainstream television channels including the SVT.

The role of the media in bringing about a new approach towards Swedish medical students abroad, on both the state and employer levels, cannot be overestimated. The following quote by Martin Ahlström is a good illustration of the power of media and the role they played:

> *We were a whole team trying to put pressure on Socialstyrelsen, on politicians, trying to do it the legally correct way. For many years… we were actually writing to them but we got the cold hand all the time. No one was giving us any attention at all. Until I went to media. And all of a sudden it became a big debate in media and it was in the news…. Then Socialstyrelsen went out and said: 'Ok, maybe we can start to interpret our rules slightly different.*

To summarize, the second part of Chapter 5 has shown how students have been engaging with other actors and with the international institutional context to make an impact on the national institutional context. These events demonstrate that actors have been not just rule-takers but rule-makers; that they found their own ways of changing structures on a national and local level to prepare for return migration. The chapter also showed that, as argued by social network theory and transnational theory, they achieved it through exploiting their informal social networks and through creating institutionalized cross-national networks.

6. Discussion

The first part of the Results chapter showed, in line with a tradition of institutional theory that sees actors as rule-takers, that actors and their interests have been constructed by a specific institutional context (Jackson 2010). First of all, section 5.1.1. showed how a constellation of certain national (i.e. educational system, structural discrimination against ethnic minorities in the educational system, state financial support to emigrating students) and international institutional factors gave birth to new important actors in the Swedish health-care system: migrating medical students, who now constitute one-third of all Swedish medical students, together with their political representation in the form of MSF Utland. In turn, this development created new interest among employers, who are increasingly inclined to benefit from this group of students.

But not only did the institutional context create these actors and their interests. It also significantly shaped the scope of actions available to them. In other words, it shaped the rules of the game actors were forced to play (Jackson 2010). For example, section 5.1.2. showed that the central state regulations had denied students the opportunity to take up certain types of jobs, thus creating obstacles to their return to Sweden. The employers' hands also had been tied by these regulations, as employers were not allowed to hire students from abroad for *underläkare* position. Furthermore, section 5.1.3. highlighted how the structure of the health-care system in Sweden limits the scope of action for students abroad and for employers. For example, a) the emphasis on short-term objectives among health-care providers and b) the system of obligatory practice after studies (AT) before a student becomes fully integrated into the health-care system may exclude many return medical student-migrants from the labour market. Likewise, both a) and b) shape the preferences of employers for a certain category of students (i.e. those who had gone through AT). In similar fashion, structural factors such as lack of financial and human resources among health-care providers, especially during the summer period, may deny potential return student-migrants their only opportunity for contact with the Swedish health-care system. In addition, section 5.1.3. showed how employers have been adapting individually to address these issues. Thus, some of them have created completely new structures (e.g. summer practice programmes and mini-AT/pre-ST). These structures/institutions are local responses embedded within a wider national institutional framework; they are a logical result of and a response to this national institutional framework.

Thus, besides exploring the impact of the institutional context on actors, the first part of the Results chapter gives support to the structural theory of return migration. The structural approach to return migration argues that social and institutional factors in home countries shape the returnee's adjustment process and experiences (Cassarino 2004, 4). Structural conditions that influence the adjustment process for Swedish medical student-migrants are: central state regulations, the structure of the health-care system, and level of employers' awareness and knowledge of Swedish medical student-migrants and their needs. Existing local interests and established connections were also found to limit opportunities for the integration of Swedish medical students

from abroad. For example, established partnerships between employers and Swedish faculties close the door on summer practice for many medical students abroad (see 5.1.3.).

At the same time, the second part of the Results chapter disproved some of the key claims of the structuralist theory. First of all, it showed that return migrants have not been vulnerable vis-à-vis the state. Sections 5.2.1., 5.2.2. and 5.2.3. described a variety of strategies that students have used to force changes in the institutional context on both the central and local levels. Through bottom-up organizing students were able to create cross-national networks that reach across different European countries. Most importantly, these cross-national networks connected return migrants with Sweden and with the SLF. Through these networks students were able to influence the agenda of the SLF and gain its support in negotiations with the central state agency, *Socialstyrelsen*. In addition, students created cross-national networks on a local level. Cooperation between Employers 2 and 3 and respective universities in Poland are examples of such local cross-national networks. On these grounds the strucuralist claim that links between migrants and countries of origins become increasingly blurred and weakened while the migrants are abroad was also rejected (Cassarino 2004, 7).

These results give support to the three assumptions of transnational theory discussed in Chapter 3. Indeed, returnees seem to maintain links with their home countries in order to prepare for return and, moreover, carry out "goal-oriented initiatives that are collectively coordinated and that have been gradually institutionalized" (Cassarino 2004, 9). MSF Utland and cooperation with Employers 2 and 3 are examples of such institutionalized and collectively coordinated initiatives. Transnational theory acknowledges also that governments are often "responsive to the political empowerment of their migrant communities overseas" (ibid.). In fact, this study suggested that political organization of students abroad, supported by other actors (SLF and MSF Sweden), might have played a role in bringing about changes in national policy.

Additionally, the results give credit to social network theory by showing how cross-border interpersonal relationships were used by student-migrants to advance their interests. For example, these relationships helped to create networks between students and some employers in Sweden, which were later institutionalized. At the same time, these results enrich social network theory on return migration by showing that interpersonal relationships can be derived not only from the host but also from the home countries and can be exploited while the person is still abroad (see Chapter 3). Last but not least, the results show that student-migrants have been using their social capital to facilitate their return (Cassarino 2004, 10) (e.g. organizing summer practice programmes through family connections).

The results demonstrate that return migrants, supported by other actors (SYLF, SLF, MSF Sweden), have managed to change the institutional context in Sweden. Another interesting finding was that they used international institutions (EU regulations on the mobility of physicians) to force changes in national institutions. Therefore, the study upholds the conceptualization that actors and institutions are "mutually constitutive of one another" and that actors "take existing rules as a starting point for defining their own identities and interests",

while at the same time they can “modify or even overturn those rules from time to time” (Jackson 2010). Only this integrative conceptualization of actors and institutions is able to account for the phenomenon of return policy-making in the case of Swedish medical student-migrants.

While exploring these broader theoretical questions, the results also shed some light on the under-researched area of Swedish medical student migration, thus raising awareness of what is going on in this field. It was shown that return policy towards Swedish medical student-migrants is very new and is in the early process of being shaped at both central and local levels. On the central level, it seems that either no policy, or actual anti-return policy, is still in place, but attempts to change this situation are visible. On the local level, more than three years ago there was no single programme designed to help Swedish medical student-migrants return to Sweden. However, we have recently witnessed a proliferation of summer clinical practice and mini-AT/pre-ST programmes.

These changes at both central and local levels have been driven in large part by return migrants themselves (section 5.2.1.). The existing literature has not sufficiently acknowledged this scenario, rather emphasizing the role of the state, either active or reactive, and the role of employers (see Chapter 2). The present study shows that return migrants are able not only to influence the state but may also awaken passive employers, raise their awareness, help them to recognize the benefits available to them and, thus, induce them to act. Swedish medical student-migrants show that return migration policy-making can be a bottom-up process in which subjects of this policy are also its main drivers.

The findings also confirm the claim made in the Literature Review that existing models of the state’s strategies to regulate the flow of students do not accommodate the return migration policy towards Swedish medical student migrants. Contrary to Gribble (2008), the state that allows or even (unintentionally) promotes migration among students does not necessarily actively work to bring them back later. At least this has not been the case so far in the phenomenon discussed here.

7. Conclusions

This study presents the first attempt to look at the migration of Swedish medical students through the lens of different sociological theories. It is arguably also the first study to apply the theories of return migration to the phenomenon of student migration. Finally, it is the first study to analyze the role of students' own organizing and activism in return migration policy-making.

In addition, unlike many other studies on student migration, this study has adopted a new approach by exploring the migration from more developed to less developed countries, since it is to Central and Eastern Europe that the majority of Swedish medical students move. This novel approach showed that the established theories of return migration can be applied successfully even to this type of migration; at the same time, it provided new insights into these established theories and highlighted some of their limitations.

Certainly, this study itself is not free from limitations. These were discussed in Chapter 4, but new limitations became apparent after the analysis of results. For example, it would be desirable to interview a student from Romania who first approached the SLF with an idea of creating student unions. It would also be interesting to approach graduates from different universities across Europe who might know whether any other local student organizations had been created before MSF Utland officially came into being. However, it was difficult to track down and establish such connections.

Nevertheless, since this is the very first study to conduct a review of policies directed at Swedish medical students abroad, it provides a good starting point for future research. Further policy-oriented research that could inform policy-makers and HR managers in Swedish counties, regions and hospitals is particularly encouraged. Future studies could look into the experiences of Swedish medical students abroad; explore their intentions to return, using a larger sample of students; explore the effect on their identity of six years spent in an international environment; assess how effective the programmes reviewed in this study are and what else could be done; and ask how students experience working in Sweden once they actually return – how well do they integrate with doctors educated locally; what benefits, if any, do they bring to the Swedish health-care system and how are they changing it; what is the impact of this migration on health-care or medical education in the receiving countries of Central and Eastern Europe?

Before further studies shed more lights on the phenomenon, a few immediate recommendations for policy-makers are readily available. Above all, the Swedish state should send a clearer signal to students abroad that they are welcome back. This could reduce the resentment that has been growing for years. Secondly, it should not take the return of medical student-migrants for granted.

Alternatively, the state could look at the problem from a different perspective and in the first place reorient its efforts towards reducing migration of Swedish medical students by addressing structural factors in Sweden that facilitate this mobility (e.g. increasing number of places at Swedish universities). In other words, the state could

"move" towards the first category of state policy proposed by Gribble's (2008) typology. The present study can serve as a starting point for developing such policy since it highlighted some of these structural factors. However, the likelihood of such development is compromised by the fact that it would require substantial investment of resources on the part of the state. Student interviewed in the focus group rather bluntly expressed that the Swedish government benefits from the status quo and, thus, they see any dramatic change in policy unlikely:

> *'It is in the interest of the government to keep the status quo. If we studied in Sweden, the government would have to pay a lot of money for our education. But here we have to pay for our education by ourselves so government does not spend anything. They actually make money on us because we have to pay interest on loans that we take from CSN'.*
>
> *Student in Poland*

The coming years will bring new dynamic developments in the phenomenon of Swedish medical student migration. Many employers interviewed in this study said that they have been discussing the introduction of some relevant policies. As more of them gain awareness of the size of the phenomenon and the opportunities it offers, proliferation of new programmes across the country is likely. Likewise, the topic has reached the national agenda, with the government commissioning a review of the medical education system. The results of this review propose fundamental changes in order to adapt the Swedish system to the international environment (Lindgren 2011). We have entered a truly exciting period for health-care in Sweden. It is surprising that in the midst of such dynamic changes, with new policies taking shape and decades-old strategies under reconfiguration, there have been so few attempts to explore the situation. It is the hope of the author that this paper will inspire the debate that this phenomenon deserves.

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