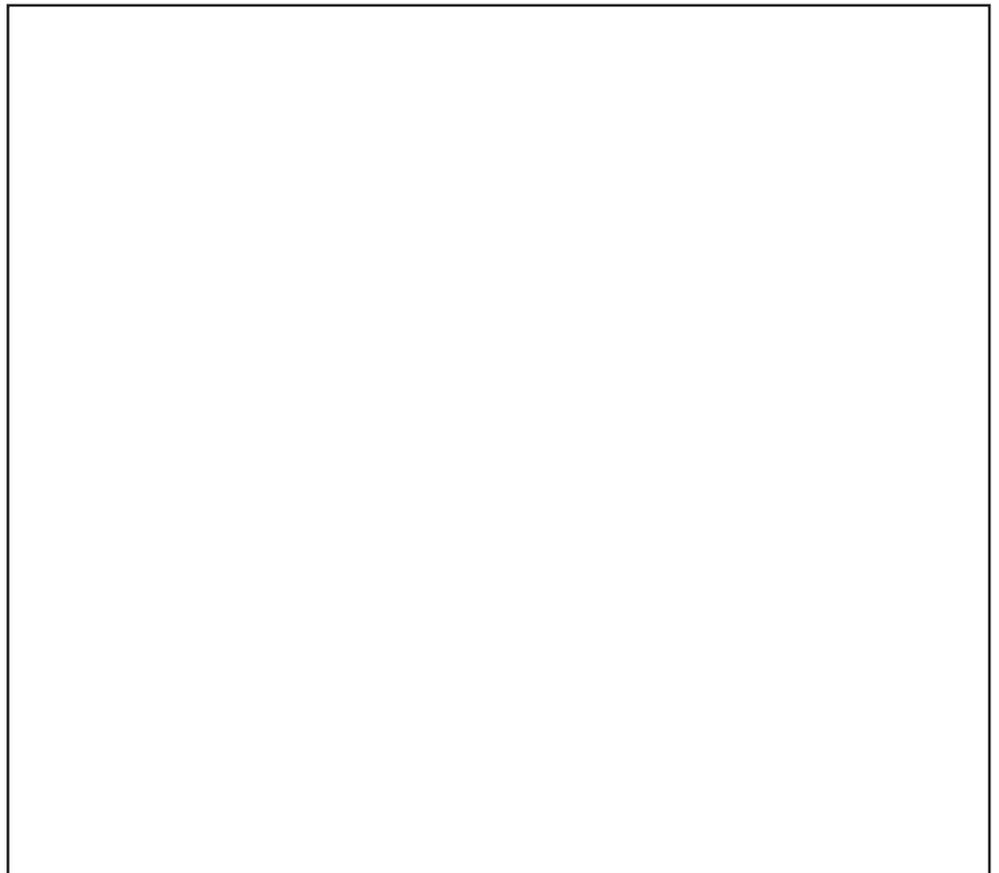




Eurofound

Mobility and migration of healthcare workers in central and eastern Europe



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Executive summary

Introduction

With EU enlargement to eastern Europe, much attention has focused on the effects of migration from the 10 central and eastern European Member States (referred to in this study as EU10) to the former EU15 countries. While research on the topic has already explored the causes, extent and consequences of the outward migration of one particular group, healthcare professionals, there has been less emphasis on identifying specific common problems (such as shortages of this group in some occupations) and possible solutions for the EU10. However, it is a more complicated task to find solutions as the shortages are due not only to high outward migration, but also to other problems in the health systems of these countries, such as attrition, or regional and occupational imbalances.

This report highlights the key challenges facing the EU10 as a result of the high number of health professionals leaving to work abroad, focusing on specific problems and identifying topics for further research. A thorough analysis of the consequences is critical, since it appears the inflow of third-country nationals or return migration would not make up the shortfall caused by the outflow. However, as this is not equally true for all the countries, the report presents a differentiated picture between the countries concerned. The study draws on the results of two European research projects: Mobility of Health Professionals (MoHProf) and the Health Professional Mobility in the European Union Study (PROMeTHEUS). Three countries have been selected to illustrate the challenges faced by the healthcare sector – Hungary, Lithuania and Poland – and the report focuses on the latest available information for these countries. The three countries vary not only in the scale of outward migration and its trends, but also in how their economies and labour markets have been affected by the crisis.

Policy context

The increasing migration of healthcare professionals from the EU10 is a growing concern in the countries directly affected, and also across the EU as a whole, since this could deepen the already existing disparities between western and eastern European countries. The adverse effects have already been acknowledged in several EU policy documents, including the Commission's 2008 *Green Paper on the European Workforce for Health* which states that 'free circulation can also have negative effects in that it can create imbalances and inequalities in terms of availability of health staff'.

Labour shortages in the health and social care sector affect not only the EU10, but also other Member States. The large outflow of workers from the EU10, however, could certainly exacerbate the situation in this country group. The European Commission's 2012 Employment Package 'Towards a job-rich recovery' recognises how significant the role of the health and social care sectors is in expanding employment opportunities. It also identifies the increasing labour shortages as one of the major EU challenges, combined with 'an ageing health workforce with insufficient new recruits to replace those who are retiring; the emergence of new healthcare patterns to tackle multiple chronic conditions; the growing use of technologies requiring new skill mixes; and imbalances in skills levels and working patterns'.

The mobility of healthcare workers within the EU could help to ease labour shortages in the EU15. But within this context, it is important to focus on the EU10 countries in order to find possible options and solutions for them.

Key findings

The migration of third-country healthcare professionals to most of the EU10 countries is marginal, being much lower than in the EU15 countries. Their migration to Slovenia is higher than any other country in the EU10.

Despite the large outflow and the already visible labour shortages in the EU10 in certain professions, there are no policies currently in place that aim to attract health professionals from third countries. The reason is partly political and partly

economic – policymakers are reluctant to opt for this solution because of deteriorating living conditions, a shrinking economy and high unemployment.

In addition, there is a general perception that labour shortages in the healthcare sector should be solved by other means, such as wage increases, improving working conditions and (re)training, as some Member States have already explored. Moreover, there is a pressing need for replacement labour in specific areas of healthcare.

Return migration accounts for a large proportion of migrants in some countries, with family being the main reason cited for returning. This form of migration has intensified in Poland but not to the extent that it had been envisaged. Despite expectations caused by the crisis, no mass return migration has been experienced overall by the EU10.

Although there is some evidence that healthcare professionals who migrate take up positions at a lower level than they are qualified for, the better living and working conditions in the host countries of the EU15 seem to offset this negative aspect. Therefore, return migration cannot be expected on a large scale.

Due to the ageing health workforce and the high demand for new staff in the EU15, it remains to be seen how the EU10 would be able to cope with such challenges as in many of these countries there is no replacement for their ageing health workforce or strategic preparation for this in place, and it seems unlikely that health expenditures could be increased.

Policy pointers

The countries concerned by labour shortages have no choice but to rely on a long-term strategy to solve the problems in their health sector, with possible support from the EU. Such a strategy should be based on sound empirical findings. As the research shows, however, there are substantial problems with collecting data for this across the EU. For this reason, the Commission's Joint Action on Health Workforce Planning and Forecasting is of great significance and its implementation could be key to helping the Member States to define their own long-term strategy.

After identifying the sources of current inefficiencies within the healthcare sector, one of the main objectives of any long-term strategy should be to find the most appropriate means of dealing with the problems. For example, it would be worthwhile to conduct a thorough analysis of the reasons for high differences in total qualification requirements in the health and social work sector across the EU.

The strategy should also address the role of private schemes. The extent to which these schemes in the healthcare sector are to be extended remains to be seen. An accelerated extension may slow down emigration, but this could lead to a widening of social inequalities, which have already been a source of tension in the EU10 Member States. Therefore, long-term strategies should be designed within the context of wider societal implications.

To provide support for designing these long-term strategies, there is a need for a clearer picture on the combined existence of private and public health schemes and the implications for health systems as a whole. Therefore, this issue, including the relationship between the two schemes, should be the subject of further research.

Introduction

As a consequence of EU enlargement to eastern Europe, much attention has been focused on migration from the 10 central and eastern European Member States (referred to in this study as the EU10) to the ‘old’ EU15 members (that is, those prior to the 2004 enlargement). The 10 countries are Bulgaria, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, Slovakia and Slovenia. However, there has been little focus on migration to the EU10 countries. The outward migration of health professionals, in particular, is a big problem for the affected Member States, and there has been research into its causes, extent and consequences. However, less emphasis has been placed on identifying common problems and possible solutions in this area, with a focus on the EU10. The adverse effects of the increased migration of health professionals have already been acknowledged in several official EU policy documents, such as the European Commission Communication ‘Towards a job-rich recovery’ (European Commission, 2012a). Previously, the Commission’s *Green Paper on the European Workforce for Health* of 2008 emphasised the mobility of health professionals as having a dual effect, because:

...it can allow supply to be adapted to demand. Professionals can indeed go where they are most needed. This free circulation can also have negative effects in that it can create imbalances and inequalities in terms of availability of health staff.

(European Commission, 2008)

In view of recent developments (such as increased outward migration in the wake of the crisis), negative effects, especially in the EU10, have intensified. In a WHO-Europe observatory study, Maier et al concluded, ‘the net winners of EU enlargements have been predominantly those in the EU15’ (Maier et al, 2011, p. 64). It is true that shortages of healthcare professionals (especially in some occupations) in the EU10 are due not only to high outward migration, but also to other problems in these countries’ health systems (such as attrition or regional and occupational imbalances). Therefore, when analysing the consequences, it is not sufficient to refer to the well-known ‘brain drain’ argument only. High outward migration, however, certainly adds to these problems (it is a symptom of underresourced health systems in these countries) and could therefore accentuate the already existing disparities within Europe.

At the same time, labour shortages in the health and social care sector are not just a feature of the EU10, but also of other Member States. The European Commission’s 2012 Employment Package, detailed in its Communication ‘Towards a job-rich recovery’, identifies the increase in labour shortages as one of the major challenges of the EU, as well as:

- an ageing health workforce with insufficient new recruits to replace those who are retiring;
- the emergence of new healthcare patterns to tackle multiple chronic conditions;
- the growing use of technologies requiring new skill mixes;
- imbalances in skills levels and working patterns.

In addition, recruitment and retention are hampered by demanding working conditions and by low and slowly growing wages. The communication states: ‘Maintaining an adequate supply and quality of health services under increased budget constraints is both a social and employment challenge’ (European Commission, 2012a, p. 6).

The aim of this report is to identify the key challenges the central and eastern European Member States face as a consequence of high outward migration of health professionals, focusing on the common (or similar) specific problems of this country group. In addition, it will identify some related important issues that could be the subject of further research. A thorough analysis of the consequences is all the more important, as previous research (partly done by Eurofound) has shown that migration of third-country nationals to the EU10, and the return of some health professionals who have left, does not match the outflow. However, this is not equally true for all the countries, therefore the report will

present a differentiated picture that clearly distinguishes between the countries concerned. The report will use the main results of two major European research projects on the mobility of health professionals – Mobility of Health Professionals (MoHProf) and the Health Professional Mobility in the European Union Study (PROMeTHEUS). To illustrate the challenges, it will focus on the latest available information in three countries, Poland, Hungary and Lithuania. These countries vary not only in the scale of outward migration, but also in how their economies and labour markets were affected by the financial and economic crisis.

The analysis on inward migration in general is based on two previous projects by Eurofound: a research project, ‘Labour mobility within the EU: The impact of return migration’, and a conference on the ‘Social and economic impact of migration: Central and east-European perspectives’ in Warsaw, Poland on 17–18 November 2011. The project on the impact of return migration not only examined the extent of the phenomenon but also explored initiatives by home countries to attract back people who left.

Although none of these projects focused specifically on health professionals, the departure of these types of workers draws the attention not only of policymakers but also of the wider public. The number of migrants leaving is increasing from almost all central and eastern European Member States, which could undermine these countries’ health systems, unless policies are implemented to mitigate the consequences. In principle, these policies could include attracting third-country nationals to replace those who have left. Although, in most cases, this has not happened yet, it is interesting to note not only the current migration patterns, but also the patterns before the accession of these countries to the EU, because they could point to future potential movements.

The report is structured as follows. First, the main trends of inward migration are presented including migration of third-country nationals and some aspects of return migration. The second chapter provides an overview on mobility of health professionals, identifying the key issues. The overview will be complemented by the most recent data and information from the three selected central and eastern European countries. The third section presents the measures taken to respond to the challenges posed by the increased outflow of health professionals. Conclusions will be drawn and issues for further research identified in the last section.

Migration of third-country nationals to EU10 and return migration

This report is concerned with two types of migration to the EU10 countries: that of third-country nationals and return migration. There are good-quality data available on the former group, so the extent of migration among this group could be estimated in a relatively reliable way (even if the estimate for illegal migration is more challenging). This, however, is not the case for return migration. Therefore, in this paper only some data will be given, for example, on motivation and status changes, based mainly on Eurofound's previous research. At the same time, it has to be noted that in some countries, such as Estonia or Lithuania in 2010, return migration can constitute a substantial part of the inflow of workers. For example, in Estonia, their share stood at 57% of all immigrants in 2010, which is 14 percentage points higher than in 2009 (OECD, 2012). Although the overall level of migration to Estonia is relatively low, the country is an interesting case from the point of view of the inflow of health professionals from third countries. In this section, it is mainly the data on foreign nationals that will be presented (using the OECD data) and not that concerning migrants coming to work in EU10 countries. Since, however, in most cases the inflow of foreign nationals is closely connected to migration for work purposes, when the data are interpreted, some trends on labour migration will also be mentioned.

Intra-EU10 migration flows could also be part of inward migration. This is, however, not addressed in detail. This is not only because of the lack of good-quality data, but also because this is not a general concern in the region. As will be seen later, only a few countries are affected, for example when looking at the migration from Slovakia to the Czech Republic; but even there, although the numbers are relatively high, there is no massive flow of workers that would be a major source for policy concern.

Inflow of third-country nationals

It is well known that the migration of third-country nationals to the central and eastern European Member States, and their presence there generally, is much lower than in the EU15 countries. When looking, for example, at the working age population (15–64 years), the share of third-country nationals in the EU15 stood at 5.5% in 2010 (with the total share of foreign nationals, including citizens of the 27 EU Member States, at 9%). In the EU10, the share of all foreign nationals of working age was 1.1% in 2010 and was even lower in previous years (European Union Labour Force Survey data¹). However, in all EU27 Member States, the share of third-country nationals stood at 3.1% in 2003, increasing to 3.7% by 2007 and to 3.9% by 2010 (Fotakis, 2011).

There are, however, wide cross-country differences in the eastern part of the EU, depending on historical and geographical circumstances and other characteristics. The extent of the inward migration, which will be presented, is based on data available mainly from the Organisation for Economic Co-operation and Development (OECD) and previous research.

¹ <http://epp.eurostat.ec.europa.eu/portal/page/portal/microdata/lfs>

Table 1 (below) indicates the permanent inflow of all foreign nationalities and estimates of third-country nationals.

Table 1: *Permanent migration of foreign nationals to selected EU10 Member States and estimated share of third-country nationals (2000–2010)*

	Destination countries					
	Czech Republic	Poland	Slovenia	Slovakia	Estonia	Hungary
2000	7,800	15,900	5,300	4,600		20,200
2005	55,900	38,510	13,290	7,670	980	25,580
2006	63,000	34,210	18,250	11,310	1,490	23,570
2007	98,800	40,640	27,500	14,850	1,950	22,610
2008	71,800	41,830	28,060	16,470	1,930	35,550
2009	39,000	41,280	27,390	14,440	2,230	25,580
Share of third-country nationals out of total number of foreign nationals, 2000–2009, annual average (%)	52	56	82	32 ^a	24 ^b	27
2010	30,500	41,060	12,710	12,660	1,200	23,880
Share of third-country nationals out of total number of foreign nationals, 2010 (%)	38	61	65	35	40	31

Notes: The data include status changes, namely people in the country on a temporary status who obtained the right to stay on a longer-term basis. Czech Republic: standardised data. Other countries: national statistics. Estonia 2000: data not provided.

^a 2003–2009 annual average

^b 2004–2008 annual average (data available on Russian nationals only)

Source: *OECD International Migration Database*

As can be seen, the migration of foreign nationals to selected central and eastern European countries is very low, far from the average level of that in the EU15 where numbers far exceed 100,000. Only in the Czech Republic, and even there only once, in 2007, did it approach 100,000. Even in the Czech Republic, however, a high share of this inflow comprised Slovaks (they are the second most migrant nationality, constituting 20% of all incoming foreign nationals). Not only is the absolute level of inward migration small, but in most cases it is also low in comparison to the population of the host country. In Poland, for instance, which had the highest number of migrants in 2009 and 2010, this translated in 2010 to only 1.1 migrant per thousand inhabitants. The same indicator ranges from 0.3 in Romania and Lithuania to 6.2 in Slovenia. However, it has to be noted that the migration of third-country nationals to Slovenia plays a more significant role than in any other Member State in this region. In Slovenia, there were just under 230,000 foreign-born people at the beginning of 2011, about 11% of the total population (OECD, 2012). In 2010, citizens from western Balkan countries constituted 88% of all Slovenia's foreign nationals, with the share of migrants from Bosnia and Herzegovina alone at about 47%.² The share of nationals from other countries is as follows:

- the former Yugoslav Republic of Macedonia, 11%;
- Serbia, 11%;
- Croatia, 9%.

² Their inflow increased in recent years, especially from 2007, when it grew to 12,500 (from 7,900 the previous year). In 2008, the inflow was 13,000, and despite the crisis, it remained basically at the same level in 2009 when it was 12,900. It may well be that this is related to the negotiations Slovenia conducted on bilateral agreements with Bosnia and Herzegovina. Although this has not been signed, 'there are protocols in place that are based on mutual cooperation between employment agencies', and one of them was signed in 2007 (OECD, 2012, p. 320).

According to the OECD report, ‘most immigration is temporary labour migration, in particular for construction. The vast majority of the corresponding work permits that are issued to migrants are tied to a specific employer’ (OECD, 2012, p. 320).

The dominance of workers from the region is obviously related partly to traditional ties, but partly also to a recent policy (in the wake of the economic crisis) of setting up quotas, 95% of which are reserved for nationals of the former republics of Yugoslavia (see OECD, 2012, p. 320). Slovenia’s example shows how the fluctuation of third-country migrants is influenced by policy measures. The sharp reduction in inflow between 2009 and 2010 (see Table 1) is due to a cut in the annual quota of work permits for migrants from outside the European Economic Area (EEA). According to the latest OECD data, there is still a high share of people from Bosnia and Herzegovina, although at a somewhat lower level (more than one-third), with a further 15% coming from Kosovo, 9% from the former Yugoslav Republic of Macedonia, 8% from Serbia and 7% from Croatia (OECD, 2012, p. 270).

Despite these and other restrictive measures (OECD, 2012, p. 270), it seems clear that Slovenia relies heavily on foreign labour, and since demand for labour in declining sectors, such as construction, is also shrinking, restrictions on permits seem rational. Therefore, from the point of view of this study, it is relevant to explore whether there are any plans for attracting foreign labour – and indeed, the government has adopted a strategy aimed at attracting highly skilled migrants. The Strategy for Economic Migrations 2010–2020 adopted by the Slovenian government in December 2009 recognises the importance of an active economic migration policy, which could be ‘a fundamental tool to respond to labour shortages expected to arise in the context of ageing population’ (OECD, 2012).

Another country apparently specialised in receiving third-country migrants is Lithuania, even if their absolute number is very low (accounting for only 0.3 people per thousand). The top three foreign national groups in Lithuania come from Belarus (about 24% in 2010), Russia (23%) and the Ukraine (14%). People from India (2.5%), Turkey (2.5%) and Moldova (2%) also comprise some of the migrants (OECD, 2012, p. 248).

The majority of migrants to Poland in 2010 comprised citizens from the Ukraine (25%), Belarus (7%) and, interestingly, Vietnam (about 6%). The number of Chinese citizens also exceeded 5% in 2010. As can be seen from Table 1, Poland is the only country where the inflow of foreign nationals continuously increased up to 2009, and even after this it decreased only slightly. This contrasts with Slovakia, where the increase was continuous, but declined much more after the crisis. The main reason for this is that Poland was less affected by the crisis, and therefore it could afford to tighten ‘simplifying’ procedures introduced initially in the 2000s, and even extend them indefinitely from 2010. These simplifying procedures allow people from Belarus, Georgia, Moldova, Russia and the Ukraine to work without a work permit for up to six months in a year on the basis of a declaration by their Polish employer. This meant that the number of work visas issued increased from 22,000 in 2007 to 180,000 in 2010 (OECD, 2012, p. 260).

Similarly, there used to be a significant number of citizens from the Ukraine migrating to the Czech Republic, especially between 2000 and 2009, when they represented about 32% of all foreign nationals, more than those from Slovakia. In 2010, however, their number decreased to such an extent that the ‘decline in immigration from the Ukraine accounted for more than half of the decrease in the total inflow’ (OECD, 2012, p. 222). The number of Vietnamese migrants also fell considerably (according to the annual average between 2000 and 2009, Vietnam ranked third among the source countries whereas, in 2010, it fell to sixth place). The decline in migrants to the Czech Republic, beginning in 2009 and continuing in 2010, interrupted a trend of increasing migration, and was obviously a consequence of the economic crisis (see Table 1). The number of migrants from Russia, however, increased in 2010, representing about 12% of all foreign nationals (moving into second position among the source countries), but this has not compensated for the general decline.

Russia remained top of the list of the source countries for migrants to Estonia; although their number slightly decreased by 2009. Compared to the annual average for 2004–2008 (24%), their share still stood at 23%. This is understandable due to strong traditional ties between Estonia and Russia, which can be traced back to the time of the Soviet occupation. As the OECD (2012) report states:

After Estonia regained its independence in 1991, Estonian citizens were defined as those who were Estonian citizens prior to the 1940 occupation by the Soviet Union, and their descendants. Others had the opportunity to become naturalised Estonian citizens or apply for citizenship of their country of origin. Many did not determine their citizenship status.

The number of people in Estonia with undetermined citizen status amounted to 98,000 at the beginning of 2012. They constitute more than 7% of Estonia's population. In 2011, out of the 9,700 resident permits granted to foreign nationals, 37% were given to Russians, 31% to foreigners with no determined citizenship and 13% to Ukrainians. Family reunification plays an important role in granting residence permits, and this category comprises one-third of all resident permits issued annually (OECD, 2012, p. 226). This must play a significant role in the fact that foreigners represent 16% of Estonia's resident population, according to the most recent data (OECD, 2012).

The Ukraine is also an important source country for migrants to Slovakia and Hungary. In the case of Slovakia, the Ukraine was the second on the list as home country of foreign migrants (after the Czech Republic), whereas for Hungary, the neighbouring Ukraine was the third most important source country (after Romania and Germany) in 2010. Between 2000 and 2009, annual average figures show that it had been the second most important source country, just in front of Germany at that time (OECD, 2012, pp. 236 and 268, respectively).

Although migration to Romania is also quite low (less than 5%), its immigrant population increased by 10% in 2010 compared with the previous year. As regards the inflow of migrants, the source country pattern is different from most other countries of the region, Moldova being top of the list (accounting for about 41% of all citizens from other source countries between 2005 and 2009, although its share decreased to 29% in 2010). According to the OECD, 'most immigrant workers come from Turkey (21%) and China (18%)'. Current data also reflect the importance of these countries as source countries, but in 2010 more citizens arrived from Italy, Germany and the United States than previously.

In conclusion, even if migration to these countries is low in absolute terms, it is interesting to see that there is a certain pattern as regards countries of origin. Table 2 presents an overview of the most important source countries in the central and eastern European Member States.

Table 2: Top source countries for migrants to selected EU10 countries (2000–2010)

Selected EU10 destination countries	Top three source countries, ranked					
	First		Second		Third	
	2000–2009, annual average*	2010	2000–2009, annual average*	2010	2000–2009, annual average*	2010
Czech Republic	Ukraine	Slovakia	Slovakia	Russia	Vietnam	Ukraine
Estonia	Russia	Russia	Finland	Finland	Ukraine	Ukraine
Hungary	Romania	Romania	Ukraine	Germany	Serbia	Ukraine
Lithuania	Russia	Belarus	Belarus	Russia	Ukraine	Ukraine
Poland	Ukraine	Ukraine	Germany	Belarus	Belarus	Vietnam
Romania	Moldova	Moldova	Italy	Italy
Slovakia	Czech Republic	Ukraine	Ukraine	Czech Republic	Romania	Hungary
Slovenia	Bosnia and Herzegovina	Bosnia and Herzegovina	Serbia	Serbia	Former Yugoslav Republic of Macedonia	Former Yugoslav Republic of Macedonia

Notes: ‘...’ = not applicable since share is very low.

* Estonia: 2004–2008 annual average; Lithuania: 2001–2009 annual average; Romania: 2005–2009 annual average; Slovakia: 2003–2009 annual average.

Source: *OECD, 2012*

The Ukraine is top of the source countries from where third-country nationals arrive in the EU10, but Russia and Belarus also play a prominent role in this respect. In addition, Moldova and Serbia seem to be important (although not shown in Table 2, it should be noted that Serbia ranked as the fourth most important source country for third-country nationals in Slovakia during the period 2003–2009).

As already mentioned, the financial crisis led to a decline in immigration in most countries and, in many cases, fewer residence and/or work permits were issued (with the exception of Poland, where the crisis did not have such a severe impact). It is interesting to see, however, that despite some difficulties with adopting the EU Blue Card Directive (2009/50/EC), which originally came into force in 2009 and was aimed at attracting highly skilled migrants from non-EU/EFTA (European Free Trade Association) countries, other efforts to attract highly skilled migrants and/or those whose skills are needed have gone ahead.³ Due to problems such as amending existing laws, some Member States, like Poland, were unable to meet the 2011 deadline for adopting the Blue Card Directive (OECD, 2012, p. 114). However, separate national schemes, such as the Green Card scheme introduced in the Czech Republic, are of special relevance to this study (see Table 3). An overview of such measures has been given in reports by Kahanec and Zimmermann (2010) and by Eichhorst et al (2011, p. 26). According to these, among the EU10 countries, Hungary and Estonia applied similar measures to those in place in the EU15 countries (such as educational or skill thresholds to qualify as high skilled in Estonia, or a list of occupations or sectors with skill shortages and with quotas applied in Hungary).

³ In the Czech Republic, the High-Skilled Migration Programme in place since 2003 was finally abolished in 2010 (OECD, 2012, p. 222).

Table 3: *Measures to attract highly skilled or needed migrants from third countries*

	Date of adoption/ introduction	Current status	Title of the document/ initiative	Content/aim
Bulgaria	July 2011	Adopted	National Migration, Asylum and Integration Strategy for the period 2011–2020	Integration; prevention of illegal migration; targeting ‘highly skilled’ workers
Czech Republic	January 2009	Introduced	Green Card scheme	Facilitating access of qualified workers to labour market from selected countries – however, so far its effects remain limited
Lithuania	February 2011	Adopted	Internationalisation of Higher Education in Lithuania	To facilitate academic mobility of students and teachers
Poland	July 2011	Adopted by the Inter-Ministerial Committee on Migration	The Polish Migration Policy: Current state of play and further action	To be more open to migrants with required skills and to facilitate their integration
Slovakia	November 2011	Adopted	Migration Policy of the Slovak Republic with Horizon 2020	A ‘Slovak card’ (modelled on the EU Blue Card), plus a labour-shortage list with the aim of filling vacancies
Slovenia	December 2009	Adopted	Strategy for Economic Migrations for 2010–2020	Promoting active migration policy to respond to labour shortages caused by an ageing population

Source: *OECD, 2012*

It remains to be seen when most of these measures could really be implemented. The fact that such strategies/initiatives are in place shows that once the crisis is over and growth begins, there will be more demand for applying these measures, and new ones could be introduced.

Return migration

The policy approach to third-country migrants is quite different to the attitude towards return migration in the EU10 Member States. Due to current or potential labour shortages in certain professions, return migration is an issue in these countries. In some, measures for encouraging nationals to return, or at least strengthening links with those who are living abroad, appear in migration strategies or other, more general development plans. For example, Lithuania integrated not only migration issues into its Global Lithuania Strategy, but also included initiatives to reinforce links with emigrants abroad (OECD, 2012, p. 99). Another example is Bulgaria, where one of the main priorities of the new strategy on migration (see Table 3) is to encourage the return of highly skilled Bulgarian nationals.

Labour shortages in some highly skilled professions are obviously quite pressing in certain countries, which are reflected by the initiatives of some employers. For example, in Estonia, the Chamber of Commerce and Industry launched ‘Talents Back Home’, a project aimed at attracting Estonians who have graduated from universities abroad. Employment opportunities are offered to these graduates and a website has been set up ‘to connect Estonians abroad with possible employers in Estonia’ (OECD, 2012, p. 226).

Return migrants account for a large proportion of total inward migration in some countries – for example, in Estonia, where return migrants represented 57% of the total inflow in 2010 (14 percentage points higher than in 2009), and in Lithuania, where return migrants represented 80% of the total inflow (OECD, 2012, pp. 226 and 248, respectively). In other countries, such as Poland, return migration seems to have recently intensified. According to the OECD report, ‘Poland now appears to be in a phase of post-accession emigration, with stabilisation of outflow for settlement abroad and intensification of return migration’ (OECD, 2012, p. 260).

However, according to the country report for Poland submitted for this study, the scale of return migration to Poland is not as high as had been envisaged – obviously, as a consequence of the crisis. Nevertheless, the process barely meets even the most obvious labour market needs and those of service provision, particularly in the healthcare and social care sector.

Even if return migration is high on the agenda in all countries with a high outflow of workers, and there seems to be a consensus that there should be some measures in place to attract them back, there is a general scepticism among the public (as voiced in the media) around the effectiveness of the measures, since they cannot compensate for those strong underlying factors that led to the outflow. For example, even in Lithuania, where its Global Lithuania Strategy addresses the issue of return migration, the emphasis is on maintaining cultural and other ties with emigrants rather than on concrete measures to attract them back.

An additional problem is lack of reliable data. If estimates are drawn from different resources, they could vary to a great extent, not only due to differing methodology, but also to different definitions. For example, the number of returnees is highly influenced by the duration of stay. If the definition of a return migrant is restricted to those who stayed in the host country for more than one year, their numbers would drop substantially. The example of Poland illustrates this well: the number of returnees between 2004 and 2008 is estimated at 580,000, whereas this number drops to 180,000 when the definition of returnee is restricted to those who are away for only one year. There is no doubt there are serious problems with estimating the scale of outward migration (due to lack of registration when leaving the home country), but in this case, statistics from the destination country could remedy the problem. In the case of estimating the number of migrants who return to their home country, however, these data cannot be relied on, since those who leave the host country may not necessarily return to their home country. Therefore, the temporary and circular nature of this phenomenon, closely associated with return migration, poses a particular challenge to monitoring return migration.

In some cases certain trends could be clearly identified, such as the conspicuously high return migration to Latvia and Lithuania during the period of high economic growth between 2006 and 2007. Various research, for example the EU Labour Force Survey and the study by Eurofound on return migration (2012), shows that, despite expectations caused by the crisis, no mass return migration was experienced by the EU10 Member States. Apart from this, however, the general picture is quite vague. Therefore, instead of presenting data on the phenomenon (which, in any case, is not possible when focusing on health professionals), some relevant findings of qualitative research on return migration are presented here, with special reference to that of professionals in the healthcare and social care sector.

When the potential of return migration of health professionals is examined, one of the most important starting points is their heterogeneity in terms of their educational attainment, gender, age, occupation and family status. However, not only do socioeconomic characteristics influence the composition of returnees, their nationality, general economic conditions and the economic and political climate of the home and host countries also have major effect. Romania is a case in point in this regard: a national report on return migration, prepared in 2012, found that returnees were mainly men because they were more likely to have lost their jobs as a consequence of the crisis in the host country. In most cases, they were employed in sectors that were most severely hit by the crisis: construction, domestic services and agriculture (as mentioned in the country report for Romania).

Recent research findings show that returnees tend to have relatively high qualifications, which means those with upper-secondary-level attainment are overrepresented (European Commission, 2012c; Eurofound, 2012). According to the summary report from the MoHProf project, this finding shows:

Nurses are more prone to temporary migration or have been more affected than physicians by the recession leading them to return to their country of origin. Indeed, Bulgarian nurses, for instance, tend to work abroad only for a limited period of time while physicians go for longer stints or may not be likely to return.

(Tjadens et al, 2012, p. 35)

Other findings on return migration seem also to support this argument. As the research project by Eurofound showed, one of the key motivations for return is family reasons. Actually, this reason was most commonly mentioned by the return migrants themselves. Even when it was identified in combination with other factors that contributed to their return, family reasons were always mentioned in the first or second place (Eurofound, 2012, p. 25). In Romania, 73% of the interviewed return migrants indicated family reasons as a motivation for return. Since doctors are more likely than nurses to bring their families with them, this motivation could be less important to them even if their extended families could also motivate them to return. That motivation, however, which may well apply to nurses as mentioned in the Romania case study, with married women ‘most likely to return for the sake of family cohesion and for children’, is more characteristic of nurses than doctors. As emphasised in the MoHProf research, the need to take care of ageing or sick parents could also be a strong pull factor. The important role family plays in the decision to return is also linked to the careers of migrants’ partners. Family formation is highlighted in the MoHProf summary report (Tjadens et al, 2012). The report states that migrants

may feel caught between conflicting emotions and priorities, which tend to become bigger, or more suppressed, due to, for instance, family formation. In some cases the thought of returning keeps a migrant health worker from fully committing to the receiving country, while the receiving country may feel inclined not to put much effort into making optimal use of the health professional, even though there is a need to retain workers in the workforce, including those who have immigrated. Sometimes lack of improvement in the situation in the country of origin, or when no socio-economic future can be perceived, prevents return.

Eurofound’s project confirms this last statement. For example, as the country case study on Latvia showed, as a consequence of deteriorating economic conditions in the country, much fewer emigrants planned to return now than just after the country’s EU accession (Apsite, 2012, p. 142).

The MoHProf summary report points to the important role of money sent home by migrants in easing the financial hardship of those who stay behind in the home country. Indeed, reliance on remittances could even hinder a migrant’s wish to return. Nurses are often under pressure to send large amounts of remittances home, ‘leaving the nurse in relatively dire circumstances in the receiving country’ (Tjadens et al, 2012, p. 35).

Eurofound research and other research projects have pointed out that return could result in major disappointments for migrants (Tjadens et al, 2012; Albert and Hárs, 2012). The findings emphasised the major role of changes in individual circumstances and in the home country during the returnees’ absence, which could strengthen the feeling of ‘not fitting in’ (Tjadens et al, 2012, p. 35). Negative reactions from colleagues could also add to any frustration felt (Eurofound, 2012). A country case study on Hungary (within the framework of the project on ‘Social impact of emigration’) reported difficulties of reintegration ‘into an envious and not inclusive community’ (Albert and Hárs, 2012). ‘And sometimes failure to succeed in the receiving country can be devastating for a return’ (Tjadens et al, 2012, p. 35). This kind of experience is also confirmed by Eurofound’s research (Eurofound, 2012). As the MoHProf report states, this could happen with nurses who, despite their new skills acquired abroad, could find themselves on their return at the bottom of the career ladder, with lower salaries. In Poland, for example, nurses have lost their licences because they cannot prove they have worked abroad on an ongoing basis as a nurse.

It can be assumed that the return of doctors is very rare now in the EU10 countries whereas, although it is too early to prove this, more nurses return at a later stage in their career. In the long term, it may well be that some doctors will return. Their experience, and any further qualifications and savings acquired abroad, could help them establish private practices in their home countries. In the MoHProf summary report, an example is given of Irish doctors who, after acquiring qualifications abroad, came home to become well-paid consultants or to start their own private practice at home (Tjadens et al, 2012, p. 37).

Mobility of health professionals

This chapter first summarises key issues in the mobility of health professionals, highlighted by previous Eurofound research and by other studies (notably the two major EU-funded projects, PROMeTHEUS and MoHProf). Then an overview of estimates on outward migration will be given, followed by a general outline on inward migration and more detailed data on this for Slovenia, the only EU10 Member State where the inflow of workers is substantial. Finally, some recent information will be used to focus on three EU10 countries – Hungary, Lithuania and Poland. These countries were selected on the basis of their diversity both in terms of the magnitude or trends of outward migration and the impact of the crisis.

Issues identified by previous studies

In the EU, despite the financial crisis, healthcare sector⁴ employment expanded to a considerable extent, not only for native workers but also for foreign-born ones. Between the second quarter of 2008 and the second quarter of 2012, some 389,000 jobs were created for foreign workers and 1,421,000 for native ones (EU Labour Force Survey, data also recalculated by Eurofound – see Hurley, 2011). Even in the other two most expanding sectors (accommodation/restaurants and education) fewer jobs were created for foreign nationals. It is understandable therefore, that health workforce issues are high on the agenda at EU level. The PROMeTHEUS and the MoHProf projects were devoted to the topic of migration and mobility of health professionals. Both had large country coverage⁵ and included receiving and sending countries. This report focuses on those findings that refer to the EU10 and that can help in understanding the implications of migration for the healthcare sector.

At the same time, it has to be noted that this report focuses less directly on the impacts of mobility by health professionals on the health system than the PROMeTHEUS project, although the assumption here is that these effects play an important role in widening the disparity of health systems between western and eastern Europe (in other words, between the source and destination countries). Due to a greater focus on the context of migration, this study is more concerned with labour shortages. Yet it is acknowledged that labour shortages are caused not only by migration, but also by other workforce issues within the health systems, such as:

- attrition;
- poor distribution of resources;
- ageing, of both the general population and the health workforce.

Specific features of mobility of health professionals

Since mobility of health professionals was analysed within the context of general migration trends and patterns, the question of how the two relate to each other was addressed in the MoHProf study. It concluded that the ‘mobility of health workers follows different pathways than labour mobility in general, or that of lower-skilled labour mobility’ (Tjadens et al, 2012, p. 158).

⁴ Under the Statistical Classification of Economic Activities in the European Community (NACE), this sector is covered by NACE Q ‘Human health and social work activities’.

⁵ The PROMeTHEUS project covered 17 countries: Austria, Belgium, Finland, France, Germany, Italy, Spain, the UK, Estonia, Hungary, Lithuania, Poland, Romania, Slovakia, Slovenia and two candidate countries: Serbia and Turkey (see criteria for selection: Wismar et al, 2011a, p. 14). The MoHProf project covered 25 countries: Austria, Germany, France, Ireland, the Netherlands, Portugal, Sweden and UK (mainly receiving countries); India, Philippines, Angola, Egypt, Ghana, Kenya, Morocco and South Africa (countries sending to the EU); Lithuania, Poland, Bulgaria and Romania (new EU countries sending to the EU); Ukraine and Russia (‘eastern’ countries sending to the EU); the United States, Canada and Australia (non-EU countries receiving from the EU) (see the objectives and criteria for the selection of the countries in detail: Tjadens et al, 2012 pp. 2–4).

The study also distinguishes between migration patterns of doctors and nurses, arguing that whereas the former migrate for career advancement and professional development, the latter tend to migrate for economic reasons, such as better living standards for themselves and their families. It can be assumed, however, that this difference is less relevant for mobile health workers from the EU10 countries because of the strength of economic motivations in both cases (the motivation of professional development, however, could be stronger in the case of medical graduates and/or of young and junior doctors, than in the case of their older colleagues). Although the differences in migration pathways between health professionals and other workers are quite understandable and could well be explained by the generally much higher demand for those who are medically trained, there could also be certain similarities between all groups of workers, such as:

- career prospects;
- the time, investment and efforts needed in order to be employed in roles matching their qualifications.

Scale of migration from EU10

The PROMeTHEUS study concludes that post-accession outflows from the EU10 ‘have been lower than expected’. It should be noted, however, that these expectations had not been precisely defined, and that there is a lack of reliable data, especially as regards the outflow of nurses and their decisions to leave their profession (for example, taking up jobs in social care) (Wismar et al, 2011b). In addition, the PROMeTHEUS study acknowledges that more recent data, from 2009 and 2010, show some increase in outward migration in the case of Estonia, Hungary and Romania (other data including, for example, those of the EU Labour Force Survey also indicate that there is a new surge in general migration from these countries, related to the recent economic downturn).

Motivations for migration

From a policy point of view for the EU10 Member States, the motivations for people to leave, stay and return is of special relevance. Both the PROMeTHEUS and the MoHProf projects covered these important issues. Experiences from some countries (for example, Lithuania and Poland) show that some increase in wages could prevent higher outward migration. At the same time, the broader context of the general economic and social conditions as well as political climate, which play an important role in driving migration in general have, of course, a great deal of relevance to the mobility of health professionals as well. Specific to this group is, however, that working conditions are often identified as among the most important motivations to emigrate. At the same time, lack of professional and career advancement among doctors, and the low social status of nurses are also among the most frequently cited push factors for this group. From the perspective of the EU10, as sending countries, the emigration of certain specialists is certainly related to the lack of professional advancement and is adversely affecting these countries’ health systems. For example, the PROMeTHEUS study mentioned evidence of Romanian doctors emigrating to Belgium because they wanted to specialise in fields for which there were no adequate facilities in Romania. The issue of migration of some specialists in crucial areas, such as anaesthesiology, intensive care and emergency medicine, is high on the agenda in Hungary, Poland, Lithuania and Slovakia. The study concludes that in these cases it is not necessarily the volume of professionals leaving that should be examined, but rather the seriousness of repercussions this phenomenon could have on these countries’ health systems. Migration could also aggravate already existing distortions in the regional distribution of health personnel. This is the case, for example, in the economically deprived regions of Romania, especially in the northeastern areas, which have ‘the lowest coverage of medical doctors in rural areas and are disproportionately affected by the emigration of both medical doctors and nurses’ (Maier et al, 2011, p. 49). From the point of view of this research, this is an interesting example because these are the areas that are on the border with Moldova, and an influx of doctors from that country could certainly ease the shortages. Therefore, in this specific case, a potential for the inflow of third-country nationals can be seen.

Impact of outward migration on health systems

It is challenging to measure the impact of outward migration on health systems in some specific areas, for example, as regards the quality of delivery. The PROMeTHEUS study was concerned with this issue from the point of view of the host countries, quoting case studies from Germany and the UK, which mentioned the importance of integration of health professionals in order to familiarise them with the host country's language and culture (Maier et al, 2011, p. 50).

It is obviously much more difficult to assess the impacts of the outflow of healthcare workers on health systems of the sending countries since an analysis would be needed of what would have happened if they had not left the country. In addition, as mentioned, it is often difficult to discern those impacts that are caused by migration from other workforce issues such as attrition or an ageing health workforce. Perhaps well-designed qualitative research projects could show the effects in some specific cases, for example in some hospitals, of the impact of the absence of specialists who have gone abroad. The other reason for difficulties in making such an assessment lies in the various forms that the mobility of health workers (especially doctors) can take such as taking up weekend work abroad.

Other common features concerning mobility of health professionals in EU10

Country studies on a number of the post-2004 enlargement Member States, carried out within the MoHProf project, revealed some interesting features, which appear to be common in the central and eastern European region.

- Within the individual EU10 countries, there is a trend of rural to urban mobility of health professionals that began during the political changes in the late 1980s and early 1990s. This is exacerbated by the ageing of populations and of health personnel in resource-poor and rural or remote areas. Whereas in the EU15 the consequences of these processes can be mitigated by migration from the EU10, the problem in the EU10 is that there is no replacement. Moreover, poorer services could induce further migration from these areas. Specific remedies are needed for these countries, such as providing accommodation for medical professionals in these areas and/or offering financial bonuses for those who are ready to take up a job in these areas.
- Health professionals often work simultaneously both in public and private health services. At the same time, not many of them move from public to private practice on a permanent basis (this is the case, for example, in Bulgaria, Hungary, Poland and Romania). There might be different reasons why health professionals work in both sectors and it would be interesting to explore these reasons and their impacts. The assumption here (based on interviews in Hungary, Poland and Lithuania) is that the private healthcare sector has experienced limited growth (there is not much demand for private insurance schemes as relatively few people can afford such cover).
- Some key conclusions of the MoHProf study are related to this phenomenon of dual employment in relation to the effectiveness of the Working Time Directive (2003/88/EC). It points out that the directive does not deal with complexities of time arrangements, caused, among others, by dual employment in public and private healthcare, or in different regions or even countries. Under these circumstances, the relevance of the directive is diminished.

Estimates of migration from EU10 and inward migration trends

When analysing estimates of outward migration, the focus will be on data about medical doctors and nurses. Data on dentists are usually also included in international comparisons, but will not be examined here in great detail. Their status and situation is quite different from medical doctors and nurses, since they mostly have private practices (for example, in Hungary public dental services are scant – dental treatment is free only for children, pregnant women and elderly people, and for other groups only in emergencies and for specific services (Hungarian National Health Insurance (OEP) website, 2012). Moreover, 'dental tourism' is flourishing in several EU10 countries, creating additional demand (this may explain the relatively high inflow of foreign dentists into Hungary; 9.7% among all new entrants in 2010). In addition, in some countries, there are fewer data on them. But where data are available, they all show a much smaller scale of outward migration among dentists. Therefore, their migration appears to exert less impact on health systems.

Review of estimates of outward migration

In order to get a picture of the scale of the phenomenon and cross-country differences and specificities, it is worth having a look first at the estimates of outward migration. It has to be emphasised, however, that they are based on ‘intention-to-leave’ data. This means that not all of those who applied for certificates of recognition of their diplomas are actually leaving the country, although in some countries the application for recognition is an expensive and tiresome procedure (for example, in Hungary). In other countries, however, this is less the case. Perhaps this is the reason why the PROMeTHEUS study concludes that the intention-to-leave data tend to overestimate the rate of migration. It mentions that this could be the case especially in Romania and Estonia, where studies indicated that actual departures were two or three times lower than intentions to leave (Wismar et al, 2011b, p. 74). Another part of the study indicated, however, that because not all destination countries require certificates of recognition of qualifications, underestimation is also possible (Maier et al, 2011, p. 34). There is also the fact that some nurses start working in the care sector, especially in private households, which could be one of the reasons why data on doctors are considered to be more reliable than for nurses. Due to all these caveats, cross-country comparison seems particularly challenging and must be regarded as estimates only.

Some trends, however, do seem to be emerging. As Table 4 shows, there is an increasing migration of doctors from most countries where data for complete years are available, such as Hungary, Lithuania and Estonia. As for Bulgaria, this is only true between 2009 and 2010, while 2009 is not fully covered in Romania. If the analysis is to rely strictly on the data, however, Slovakia might be an exception, as Beňušová et al indicate that:

Slovak health professionals do not need confirmations of equivalency of their education as before. The numbers of medical doctors, dental doctors and nurses asking for confirmation of equivalency of their education in accordance with EU regulations peaked 2004 and 2006 but since then have tended to decrease...European Commission (2007) data indicate that EU Member States have become accustomed to Slovak health professionals' qualifications and foreign employers do not always require equivalence confirmations.

(Beňušová et al, 2011, pp. 488 and 490)

The Beňušová study adds that the migration of nurses is particularly underestimated since they do not always need certificates of professional qualification when they take up a job abroad. It also points out that recent increases in salaries of both doctors and nurses may have contributed to declining applications for certificates. During the period 2005–2009, the average monthly salaries increased by 53.5% for doctors, and by 51.7% for nurses (Beňušová et al, 2011, p. 500).

It is also interesting that, for example in 2008, the migration of doctors seems to be high from Hungary, where general emigration has not been regarded as high and has shown an increase only in the most recent data. It also seems as if more doctors than nurses leave some countries and vice versa. For example, according to intention-to-leave data, fewer nurses than doctors leave Hungary, whereas in Lithuania the migration of nurses is usually at the same level or higher than that of doctors.

The differences in migration of doctors between Poland and Romania could be surprising, with more than 10 times the number of Romanian doctors leaving than that of Polish doctors. However, the effects of the earlier accession of Poland to the EU should be taken into account, as well as the fact that the cumulative number of doctors who obtained certificates of professional qualification there between 2005 and 2008 is also high (7,138). The figure for nurses over the same period is not as high, but is still considerable at more than 2,000, although their proportion among all nurses practising in Poland is lower than that of both doctors and dentists. Despite the official data, it seems that a massive migration from Romania is continuing. Romanian experts refer to some unofficial data which ‘show substantial increases in requests for verification certificates in 2010 – with applications averaging over 300 per month’ (Rohova, 2011).

These experts refer to a paper that quotes the minister of health who admitted that ‘over 9,000 doctors have requested verification certificates since 2007’. Since the intention-to-leave data on nurses in Romania are even less reliable, doubt could also be expressed on their rate of migration suggested by official data. Indeed, the MoHProf Romania country study quotes a report of the Nurses’ and Midwives’ Association, which states that about 5,000 nurses have left Romania since 2007. Since this number constitutes about 6% of all nurses practising in Romania, if migration continues at a similar pace, the exodus of nurses could have serious consequences for the Romanian health system. Data from the main destination countries (Italy, Germany and the UK) confirms a high presence of Romanian nurses (Rohova, 2011).

Table 4: *Estimates of the number of doctors and other health professionals and of their migration from selected EU10 countries (share of all doctors/nurses in brackets)*

	Number of medical professionals	Data on migration flows							
		2008		2009		2010		2011	
		Doctors	Nurses	Doctors	Nurses	Doctors	Nurses	Doctors	Nurses
Bulgaria	11,000^a (1,856 doctors)^b	780		590	1,275*	680	900*	500	400 (1.4)
Czech Republic	1,809^c		247 ^d		150 ^d				
Hungary		803 (2.4)	179	887 (2.7)	419	1,111 (3.9)		1,200 (4.1)	
Lithuania		88	272	94 (0.7)	215 (0.9)	279	211		
Estonia		79 (1.8)	97 (1.2)	106 (2.4)	134 (1.6)				
Romania	1,523 (doctors in EU countries in 2005, which is about 3.4% of the total number of doctors**)	4,990 ^e (10.2)	1,813 ^f (1.6)	2,683 ^g	612 ^h				
Slovakia		250 (1.5) ^j	183 (0.5) ^j	217 (1.33) ^j	146 (0.4) ^j				
Slovenia		65 (0.9)							
Poland	1883 (nurses)ⁱ	414							939

Notes: ^a doctors, dentists, pharmacists, healthcare managers together, in 2010 (estimate by the International Medical Association); ^b working in OECD countries around the year 2000 (source: Tjadens et al, 2012); ^c doctors in 2006 (source: WHO, quoted in Annex of the Matrix Insight and Centre for Workforce Intelligence study, 2012); ^d general care nurses; ^e 2007 data; ^f issued number of certificates for nurses and midwives; ^g applications between 2008 and January–May 2009; ^h number of applications from nurses and midwives between January and April 2009, based on which 172 certificates were issued during the same period; ⁱ working in European countries, around the year 2000; ^j estimates based on the number of active medical doctors and nurses in 2007, respectively.

* Source for nurses for Bulgaria: Tjadens et al, 2012

** Source: Romania – Mobility of Health Professionals (see: Rohova, 2011, pp. 14–15)

Sources: Stock data for Bulgaria: Matrix Insight and Centre for Workforce Intelligence, 2012b, Country profile, pp. 41–44; flow data: MoHProf project, see Tjadens et al, 2012; for the Czech Republic: Matrix Insight and Centre for Workforce Intelligence, 2012b, Country profile, pp. 52–55; Hungary: PROMeTHEUS project, see Wismar et al, 2011b; Estonia: Wismar et al, 2011b, Romania: Rohova, 2011; Slovakia: Wismar et al, 2011b; Slovenia: Wismar et al, 2011b

Data in the table indicate that, in the case of Bulgaria, a large number of its medical professionals work abroad. Although the migration of its healthcare workers seems much higher than any other country, this figure includes all medical professionals, which is not the case elsewhere. In addition, the Romanian data refer to a much earlier period, well before its EU accession (and even prior to the process of easing mobility). Nonetheless, Bulgaria is a good example showing that the migration of health professionals had already started well before its EU accession in 2007 (although interestingly, data do not show a massive outflow during the last couple of years).

As an illustrative example, data from Ireland, a major destination country, could provide at least some opportunity for comparing EU10 health professionals' presence there. Using the most recent census data (2011), the results (see the annex) confirm those tendencies that were evident from other data sources.⁶ It is interesting to see, however, that in the case of Hungary the data do not entirely support the usual assumption that it is a country with low emigration (other sources also confirmed that there has been a recent increase in migration from this country, making it now one of the middle-ranking source countries). The Irish data show a strong participation of women in all main health and care occupational groups: the share of women among all workers by country is consistently higher than for men. This means that in the individual health occupational groups, women are dominant in most cases. For example, of the Lithuanian health and care professionals who work in Ireland, 92% are women.

General trends of migration to EU10

Apart from examining the scale and characteristics of mobility among health professionals, one of the key objectives of the PROMeTHEUS project was to analyse the level of reliance on foreign health professionals, such as medical doctors, nurses and dentists. These professions all fall under the automatic diploma recognition procedure specified in Directive 2005/36/EC on the recognition of professional qualifications, making their qualifications portable across borders. As both the PROMeTHEUS and the MoHProf projects revealed, reliance on foreign health professionals⁷ is a characteristic mainly of EU15 countries, and because reliance levels 'gradually decrease towards the eastern part of Europe', a tendency towards east-west asymmetries can be observed (Maier et al, 2011, p. 26). However, in one of the EU10 countries, Slovenia, foreign medical doctors account for more than one in every 10 doctors, which is similar to Austria, Belgium, Ireland, Portugal, Spain, Sweden and the UK (data on Slovenia will be detailed later). It must be noted in this case, though, that 'foreign' is defined as foreign-born, foreign-trained or foreign-national health professionals (Glinos et al, 2011, p. 73). It is also true, that, in Slovenia, the migration intentions seemed to remain at a low level (expressed by less than 1% of health professionals). It is an interesting question whether, within the context of past high outward migration and as a consequence of labour shortages, an increased reliance on foreign health professionals can soon be expected in the central and eastern European region. This question seems all the more relevant since, if the analysis looks at the proportion of newly arriving foreign health professionals among all the new migrants (including domestic health professionals), Hungary appears to have quite a high share of foreign dentists (9.7%) and a 4.7% share of foreign doctors. This shows that foreign presence of medical professionals in Hungary is lower than in the EU15, but not negligibly so. As for Poland, the proportion is 3% for foreign doctors and dentists.

⁶ See the Central Statistics Office website for Ireland's Census 2011 data, available at <http://www.cso.ie/en/census/census2011reports/census2011preliminaryreport/>.

⁷ Reliance on foreign health professionals is defined as 'the share of foreign health professionals within a country's health workforce in a given year, expressed as a percentage of the stock of the workforce' (Maier et al, 2011, pp. 25). Due to the nature of stock data, reliance changes on a gradual basis only.

Migration from third countries

The migration of foreign healthcare professionals, however, is very low to most EU10 countries. For example, the share of foreign doctors in Slovakia was 0.8% in 2004, with their share in Poland amounting to 0.6% in 2005. This compares with 5.8% of foreign-trained doctors in France in 2005 (OECD data).

In Estonia, health professionals from third countries constituted only 0.1%–0.2% of the active health workforce (Matrix Insight and Centre for Workforce Intelligence, 2012a). In addition, although inflow data are more readily available and much more reliable than in the case of outflow of workers, due to its limited scale, it is not worth making a direct cross-country comparison. As an illustration, however, some trends can be observed in Poland, and some interesting data from Slovenia are also presented.

As regards the case of Poland, in Table 5, it should be emphasised that although the permits granted are distributed among newcomers from many countries including Mongolia (but not from Belarus), it is clear that Ukrainians represent the biggest share, and this is why their numbers along with total numbers are presented here. Data for nurses are also known, with most coming from the Ukraine, but their number is extremely low; three arrived in the first half of 2009, one in the first half of 2008 and one in the second half of 2008 (MoHProf national report on Poland, see Kołodziejaska et al, 2012, p. 89).

Table 5: *Work permits issued in Poland for health and social care professionals (total), medical professionals and doctors, and for Ukrainians*

	Ukrainians	Total
2008, first half:		
Total	52	127
Medical professionals	27	71
Doctors	12	42
2008, second half:		
Total	67	150
Medical professionals	27	83
Doctors	17	40
2009, first half:		
Total	110	212
Medical professionals	39	92
Doctors	19	38
2010:		
Medical professionals	No data	76

Note: 2010 may not be compared to previous years.

Source: Kołodziejaska et al, 2012, p. 89 (data from the Polish Ministry of Labour and Social Affairs)

The most important reasons for the low migration of third-country health professionals to the EU10 countries are well known:

- low pay;
- poor working conditions;
- low prestige;
- lack of proper infrastructure and equipment (especially if compared with countries of the EU15).

Conditions in the EU15 are all the more relevant in this respect since, after the EU enlargement to include the EU10 in 2004 and 2007, access to labour markets in the EU15 does not seem to be any more difficult than in the EU10.

Even if the migration of health professionals is currently very low to most other EU10 Member States, as is the case in Poland, there seems to be some potential for migration, especially from neighbouring countries. For example, some health professionals from Moldova (mainly medical doctors and general practitioners) have migrated to Romania, but this trend slowed after Romania joined the EU in 2007.

As with other countries, however, even in this case experts do not think immigration could be a solution for the health system's numerous problems. This is all the more remarkable since the MoHProf country report for Romania identifies rural areas of the country's northeastern region of Moldavia (next to Moldova) as already showing a serious 'deficit of health professionals'. The lack of language knowledge is also identified in the report, although in the case of Romania this is less of a problem, as many migrants coming from Moldova speak the language (Rohova, 2011, pp. 198–199).

One could assume several reasons why policies for attracting third-country migrants in order to ease labour shortages in the health and social care system are not in place. In this sector, a knowledge of languages is particularly important, and most potential migrants lack this knowledge. Therefore, an investment in language training would be needed, which would be expensive and may not be worthwhile since these countries would be used rather as transit countries to the more affluent western European countries than as a final destination. Instead, other solutions are being looked at, such as financial incentives for retaining and recruitment of health personnel. Even if policies to attract third-country migrants are not proposed currently in the EU10, national experts usually regard this as a possible option, since present problems could become more acute (Balázs, 2012; Rohova, 2011). Some of the EU15 countries already provide examples for attracting health professionals: Germany has included medical doctors in its new 'positive list' of occupations, where labour market tests are suspended for certain professions. Similarly, in Ireland from 2010, work permits are no longer required for certain categories of doctors, and labour market tests are not necessary for them, either.

Because of the general inflow pattern characterising the central and eastern European region (see Table 1), the number of healthcare professionals who arrive is not having an observable impact on the labour composition in the sector or on service provision. Also, those healthcare professionals who have come so far to the EU10 Member States seem to be part of the overall flow from the main source countries, rather than a specific flow which comes due to pull factors or incentives specific to the healthcare sector.

Slovenia in this respect is an exception as mentioned before, being the only EU10 country where there is a large inflow of foreign health professionals from the other former republics of Yugoslavia, where language knowledge is not an obstacle (as citizens from the former Yugoslavia can understand each other). According to data of the Medical Chamber of Slovenia, the share of foreign doctors here ranged from 21.5% to 16.7%, between 1992 and 2008. The pattern of sending countries (in the case of health professionals) also reflects that of the general inflow of migrants, with Bosnia and Herzegovina being on top of the list, followed by other western Balkan countries (such as Croatia and Serbia – see the annex, Figure A2). Their close relationship can well be explained by these countries having previously formed one country, and by the fact that language is not a barrier.

Return migration

With regard to return migration of health professionals, there are even less data available, and lack of even proxies makes the analysis more difficult (unlike outflow figures, where intention-to-leave data are used for estimates). In most cases, return migration is low, and due to the pressing reasons behind leaving (such as income differentials or differences in working and living conditions) most of the countries have no illusion about hoping for their citizens to return soon. It

can be assumed that this may be one of the reasons why they do not invest more in documenting return migration. Slovenia, however, is also an exception in this regard, since its Medical Chamber does keep data on this phenomenon. According to it, between 2003 and 2006 about 0.2% of all active medical doctors returned each year, with the latest data showing that in 2007 and 2008 this share dropped to 0.1% each year (Albrecht, 2011, p. 534).

The PROMeTHEUS project mentions Poland as ‘an example of a country in which health professionals are reversing outflows by returning’ (Glinos et al, 2011). However, no data seem to support this conclusion.

The cases of Poland, Hungary and Lithuania

In order to gather new data and contextual information about the migration of health professionals, in the autumn of 2012 Eurofound conducted interviews with representatives of national chambers of doctors, government ministries, employers’ organisations, hospitals and associations of doctors, nurses and other health professionals in Poland, Hungary and Lithuania. For the sake of comparability, a common template for semi-structured interviews, listing the key areas of interest, was prepared (see the annex). The information was used in preparing concise country profiles, presented in the boxes below (they mostly contain country-specific information, whereas the more common features are mentioned elsewhere in this report).

Within the framework of this exploratory research, there was no plan for a comprehensive overview, and, as mentioned in the introduction, examples of certain circumstances from the three countries highlight some challenges facing the sector. This study, however, does not intend to draw generalised conclusions from these case studies, or to extrapolate their current problems to the future or to other countries. The three countries were selected on the basis of the following criteria:

- substantial outflow in absolute numbers (Poland);
- substantial outflow in terms of the share of the population (Lithuania);
- not particularly large outflow, but recently increasing (Hungary);
- varying trends in outward and return migration (Lithuania, two phases of outflow: just after accession, then some return, and an upsurge and no return as a consequence of the crisis; Hungary, a continuous trend, no evidence of return; Poland: continuous trend, some evidence of return);
- diverse impact of the crisis (Poland seems less affected than any other country in the region).

Poland

As the MoHProf study has pointed out, there are numerous problems with the Polish healthcare system, such as difficulties with organisation, funding and constant changes to the system (Kołodziejaska et al, 2012). There is also a lack of trained management; in most hospitals and medical practices, managerial positions are still occupied by medical professionals. The issue of migration of healthcare professionals, particularly those who are leaving, has attracted much media attention focusing on the negative economic and social consequences. Numerous newspaper articles have outlined not only the negative consequences but also highlighted the low salaries and bad working conditions of healthcare staff working in Poland. However, the available data and interviews with experts and government officials as well as representatives of healthcare organisations give a more complex picture.

Outward migration

The number of certificates of recognition of diplomas (see Table 4) does not capture what type of mobility medical professionals are contemplating. It seems that a considerable number of the registered professionals take up short-term contracts and participate in the systems of two countries. This has been confirmed by the interviews carried out for this project.

According to the Polish Chamber of Doctors and Dentists, between EU accession in 2004 and October 2012, 8,668 doctors (6.89% of all the doctors in Poland) were issued such certificates. There are big differences among specifications and the number of certificates issued in each category. The biggest proportion of certificates was issued as follows:

- anaesthesiologists (18.04% of all anaesthesiologists registered in the Chamber);
- plastic surgeons (17.96%);
- thoracic surgeons (16.53%);
- pathologists (12.28%);
- dental surgeons (11.11%);
- radiologists (11.09%).

In the same period, the Chamber issued recognition certificates to 931 dentists (2.72% of all dentists practising in Poland). Nurses mainly leave due to economic reasons; their salaries are considered to be low and have not risen as substantially as those of other medical professions. Two other main reasons given are working conditions (nurse–patient ratio), which are considered to be much better abroad, and opportunities for career development. Nurses are also considered to be held in less respect and have a lower status in Poland than in other countries.

The type of migration depends very much on marital status. Married women with families tend to prefer short-term or circular migration whereas single people leave for longer periods.

To find a job, most potential migrants rely on personal connections and advertisements in the professional press, and not so much on recruitment agencies. Some agencies do not have a good reputation as the offers advertised have little in common with the actual job (many examples and anecdotal evidence of these were cited, with the most prevalent example of jobs as domestic carers being given). Experts stress that the position of nurses and their jobs are slowly improving in Poland. Nurses are given the opportunity to acquire more skills and greater autonomy. While for most nurses migration is considered temporary, there is little discussion about return migration on a large scale, and there is not much discussion about third-country nationals filling the posts. However, the nurses' organisation acknowledges that many nurses are ageing, and the profession may face labour shortages in the future.

Another reason for the outward migration is education. There is a mismatch between the number of students being educated in a particular specialisation and the demands of the labour market. In the last few years, there have also been numerous changes to the medical education system, which contributed further to the confusion. The reform of the education system (planned for October 2012, at the time of writing) aimed to remedy this (Kołodziejska et al, 2012).

Inward migration

Migrants to Poland experience difficulties in getting their qualifications recognised. In addition to passing a medical exam in Poland, proof of being able to speak Polish is needed (since 2012 an advanced level is required) and labour market tests are also conducted. Therefore, it can be assumed that most foreigners who plan to work in the healthcare

and social care sector are most likely of Polish origin, or speak Polish well because they have studied in Poland, for example. Consequently, those foreigners coming to Poland to work in medicine have had previous ties with the country. It seems that Polish medical universities are pursuing an active recruitment policy among foreign students studying there and that the number of foreign students has been increasing. In 2009, there were 4,808 foreigners studying at medical universities in Poland (Kołodziejska et al, 2012). One of the main reasons for this influx is the much lower cost of studying there than, for example, in other EU countries. This is also the case for the nurses attending medical schools, where there has also been an increase in numbers, particularly from Lithuania and Latvia. It is also assumed that those who arrive would like to settle on a permanent basis, since acquiring a job in Poland's healthcare sector requires high investments on their part. There is no specific arrangement for facilitating the recruitment of third-country nationals to the healthcare and social care sector at government level, and no bilateral agreements are in place. Although migration is high, it is not perceived as a major factor undermining the health system in general, though there are certain problems, as already mentioned.

According to the Chamber of Doctors and Dentists, the main reasons for migrants to return are increasing salaries and greater prospects of professional development. The latter seems to make sense as, according to previous studies, most doctors migrate to small villages and towns in western Europe. These suffer most from labour shortages as most native doctors are reluctant to move to such places. The career prospects in these small places are limited; there are also reports of medical doctors performing jobs well below their qualifications and being motivated to stay only by money. Interestingly, the Chamber did not cite personal or family reasons as a cause for return, even though, according to Eurofound research on return migration, these reasons are among the most important causes of deciding to go back to Poland (Eurofound, 2012).

Hungary

The emigration of highly skilled young people in general, and that of health professionals in particular, are the focus of much public attention, with media coverage on the issue almost on a daily basis. As in other countries, media attention is centred primarily on the outflow of doctors, although a shortage of nurses has already been identified as one of the greatest challenges the health system has faced for quite some time. Besides emigration, the rapid ageing of health workers poses another serious problem. For example, doctors aged between 50 and 60 form the highest share of all doctors (27%) (Jávorszky Nagy, 2012). At the same time, there is an increased demand for health services due to the fact that the population is also ageing.

Although information provided by the media on the outward migration of health professionals should be treated with caution, a scientific analysis, based strictly on the available data, estimates that in the long term almost one-fifth of all Hungary's newly trained doctors are lost, mainly due to emigration (Balázs, 2012, p. 83). Between 2006 and 2011 a considerable shortfall developed. The health administration data show quite a small shortfall, of 600, but for various reasons this cannot be regarded as reliable and therefore could be considered as the lowest estimate. A model estimate, however, shows that the shortfall could be as high as 5,100. According to Balázs (2012), the following reasons could provide an explanation:

- not everyone who applied for certificates left the country;
- many of those who work abroad do so on a part-time basis while also being employed in Hungary;
- doctors who have taken up a full-time job abroad occasionally return home to keep their registration in the system.

However, there is no estimate or information available (even indirectly) as to the proportion of these groups (Balázs, 2012).

According to data supplied by the Office of Health Authorisation and Administrative Procedures (OHAAP), 30,000 medical doctors have a valid licence. This figure includes those who have left the country (registration lasts five years, so the most recent outflow might not appear yet in the registration data). The Hungarian Hospital Association data suggest that 26,000 doctors are employed in the public healthcare sector (about 90% of the total above) and 5,000–6,000 are working abroad. This confirms the dominance of the public sector in doctors' employment (Makara, 2012). This dominance is even stronger if dual employment (both in the public and the private sector) is taken into account.

Outward migration

As can be seen in Table 4, the number of applications for certificates contained in the intention-to-leave data⁸ show an increase between 2009 and 2011:

- in 2009, the number of applications was 887;
- in 2010, the number was 1,111;
- in 2011, the number was 1,200.

Prior to this, the numbers peaked (906) at the time of EU accession, between May and December 2004. The recent increase can partly be attributed to the fact that, from 2008, the number of applicants also included those foreign nationals who had previously had their qualification recognised in Hungary. The share of these applicants stood at 7.7% (Balázs, 2012, p. 81). The latest data, from 2012, again show an increase (at least in the first half of the year, as data from the second half were unknown at the time of writing), with 543 doctors applying for certificates, the highest number at this period since 2010.⁹ The number of nurses, 244, shows a similar trend, being by far the highest figure at the same time of the year since 2010 (the numbers stood at 134 and 131 during the first part of 2010 and 2011, respectively).

Data on medical graduates also indicates high outward migration: for example, the percentage of those who finished their studies between 2007 and 2010 and have not registered with the system is high, at about 40%. Moreover, even if all new medical graduates did stay in the country, they could not match the number of those who have left since 2009 (Jávorszkyne Nagy, 2012).

In the case of dentists, however, the picture is not so straightforward since figures vary between a surplus of 432 (data supplied by the health administration) and a deficit of 510. According to Balázs (2012), however, one could realistically assume a zero balance, or even a surplus. Balázs assumes that in the case of dentists, the net balance has not changed since 2006. Data on new dental graduates also indicate a greater willingness to work at home since more of them registered with the system (18% of them leave the country, as opposed to 40% of the medical graduates).

⁸ 'Because this is an expensive and time-consuming procedure, many applicants are committed to migrate and these figures are considered as a good indicator of mobility trends' (Matrix Insight and Centre for Workforce Intelligence, 2012b, p. 84).

⁹ Source: All data from 2012 are from the OHAAP. Interview with Dr Nándor Rikker, Acting Head of Department of Migration and Monitoring, September 2012.

The number of nurses who applied for certificates has also increased considerably; in 2009, 419 nurses applied, triple the number (137) in the first period after EU accession (Eke et al, 2011, p. 369). However, as is the case in other countries, data on nurses are even less reliable than for doctors, as confirmed by the president of the Hungarian Nurses' Association during an interview with him.

The government has made several attempts to remedy the situation: its Markusovszky programme, for example, tops up the very low starting salaries of residents. Several schemes have also been introduced to increase the wages of doctors in general. Wages of health professionals, however, have not been increased substantially since 2002–2004. In addition, during the current climate of budget cuts, it is doubtful whether the doctors' wage demands could be met; the Hungarian Chamber of Doctors has asked that their wages be set at three times that of the average wage.

As already mentioned, the health system in Hungary also suffers from staff shortages in certain rural and deprived areas. In order to remedy this situation, wage increases have been differentiated, depending on where the service is provided. Similarly, wage increases could be higher in certain specialist areas of medicine, where shortages are acute.

Inward migration

Similar to most other countries, the inflow of third-country nationals is now sporadic and small. Previously, ethnic Hungarians provided additional supply and eased shortages: between 1990 and 2005, six thousand ethnic Hungarian doctors came back, mainly from Romania (Makara, 2012). The most recent data from the OHAAP show that 620 doctors from third countries were registered on 1 September 2012. No further large inflow is expected.

Lithuania

There was a lot of public discussion on the migration of healthcare staff in 2011. There were assumptions in the media that actual migration may be higher than the official figures. The debate has focused predominantly on doctors, not nurses or care workers.

In a national acknowledgement of the problem, in 2011, the National Science Programme financed research into the career development of doctors, and the Ministry of Healthcare commissioned research on human resources in the healthcare sector (some of their findings are referred to below). Lithuania has also been included in the sample of country case studies by the EU-funded MoHProf project.

The impact of the current outflow of workers may not yet be fully evident in terms of the shortage of healthcare professionals due to a number of factors:

- a rise in the number of available places for medical students (introduced in the early 2000s);
- doctors working overtime;
- many doctors continuing to practise medicine even after reaching retirement age (LSMU, 2011).

Apart from the outflow to other countries, current assessments show that the present numbers of healthcare workers will be severely affected by ageing. Many current practitioners will have retired by 2025:

- 58% of current surgeons;
- 38% of ophthalmologists;

- 25% of general practitioners;
- 50% of obstetricians;
- 25% of nurses.

The prospects of completely replacing current healthcare professionals with those who are training is by no means certain as only two-thirds of first-year medical students go on to practise medicine in the country after graduation (LSMU, 2011).

Outward migration

As a proxy for the outflow of medical professionals, the data on certificates of good practice can be used (see the annex, Figure A1). While the standard stipulations apply (for example, not all of those who got certificates may have left; some may have left without any certificates and quit the profession), some estimates point out that, since the accession to the EU (2004–2011), 3% of healthcare professionals have left. Certain specialisations were particularly affected by outward migration:

- surgeons – 8.5%;
- obstetricians – 6%;
- obstetricians/gynaecologists – 4.7% (Taljunaitė, 2012, p. 155).

Some discussions in the media suggest that these figures may not be comprehensive and that the true scale of migration is larger.

In order to see how many people act upon their intention to migrate, the Lithuanian University of Health Sciences (LSMU) looked into the number of those getting good practice certificates, but who continued to work in Lithuania. They found the highest actual outflow among obstetricians, nurses and general practitioners (LSMU, 2011).

In terms of destinations, the UK, Germany and Norway prevail. There have been cases of active recruitment measures that affected the outflow of healthcare workers, such as the offer of free language courses in Norwegian to Lithuanian doctors and nurses.

Inward migration

Regardless of publicly voiced concerns about the outflow of medical professionals, the replacement of medical staff by an immigrant labour force is not explicitly a part of policy concerns. Lithuania regularly reviews the list which specifies occupations in demand and for which those who are qualified can obtain work permits more easily – but doctors have not yet appeared on this list.

The numbers of medical professionals migrating to Lithuania are minimal in terms of the issued work permits:

- 9 permits in 2009;
- 6 in 2010;
- 13 in 2011;
- 2 in 2012.¹⁰

¹⁰ Data mainly refer to doctors, yet there were two nurses included in the 2009 figure, and two dentists included in the 2011 figure. The data for 2012 are preliminary.

However, these figures cannot be directly interpreted as a reflection of a low demand for staff in healthcare services: the International Organisation for Migration (IOM) in Lithuania characterises Lithuania's labour migration policy as passive and conservative (IOM and EMN, 2010, p. 58).

While Lithuania does not seem to be experiencing any significant inflow and it does not explicitly develop measures to attract specialists in healthcare, the contextual factors and increasingly acknowledged issues of staff replacement, suboptimal workload and relatively low pay suggest that changes in the composition of the healthcare workforce may occur.

Apart from the differences in pay and working conditions, the regulatory framework has not been well researched. For instance, a factor hindering immigration, return migration and overall dynamics in the labour market of medical professionals is a lack of opportunities for individual private practice: one has to be employed by a legal body – therefore, one needs to register one's own establishment or become an employee of an existing body. The market for potential clients is limited by certain constraints for private medical service providers (such as a client's ability to use the compulsory state health insurance system to cover the costs of private services). Lack of transparency about financing medical services leads to a lack of clarity about prospects in both the private and public sector.

There are no obvious professional factors that would encourage the return migration of medical professionals or that would make Lithuania's environment for medical practice more attractive than other countries of the region. Most problems, related to working conditions, have not yet changed. They include:

- excessive workload;
- relatively low pay;
- a high administrative burden;
- limited career prospects;
- issues around informal payments and corruption.¹¹

The status, funding and remuneration for medical staff were debated in 2010–2011 by junior doctors, and this subject was then taken up by society in general but the discussion did not spark any changes and eventually faded.¹²

There are several aspects to be considered in regard to potential mobility of healthcare professionals in Lithuania.

- The number of medical professionals leaving Lithuania could increase due to the ease of moving around within the EU and because those who have already left become part of a migration network that facilitates information and opportunities for those planning to leave.
- The assumption that those who have migrated may choose to return for a private career in Lithuania may be dashed by the lack of opportunity to do so.

¹¹ Problems in the Lithuanian healthcare system, particularly with regard to the practice of doctors, are identified by the MoHProf project's national report for Lithuania (Szulecka and Valavičienė, 2012, p. 35); see also Taljunaitė (2012).

¹² See the Junior Doctors Association website: <http://www.jga.lt/>

- At present, 85% of healthcare and social care practitioners in Lithuania work in the public sector. While the number of doctors and dentists, as well as the number of private healthcare establishments, increased in 2004–2010, any future growth may depend on structural reforms in the sector, and legal and financial reforms at national level (Taljunaitė, 2012 p. 162).

Policy responses to the challenge of increased mobility of health professionals

The process of increased mobility of health professionals has been continuing, to a considerable extent, for quite some time now. The phenomenon seems highly responsive to the general economic climate. For example, based on a Greek media review at the end of 2012, over 2,000 Greek doctors have left the country recently in order to work, both inside and outside the EU. It should be noted that it is mainly specialised doctors with long experience who leave.¹³ There has also been a recent surge in migration from Latvia and Lithuania. However, these high numbers have led to a focus on problems that the health systems in these countries have been suffering for decades:

- underresourced hospitals;
- management problems;
- rundown equipment and buildings;
- overloaded staff with high administrative burdens;
- low status of nurses;
- underpaid doctors.

At the same time, there are labour shortages in the EU15 countries because of their ageing populations, their ageing health workforce and also internal structural problems within their own health systems. Therefore, there is a high demand for new staff (for example, to replace retired health professionals). The conclusion by the MoHProf study that ‘large and persistent structural differences between sending and receiving countries’ lead to continuing flows of workers can be confirmed (Tjadens et al, 2012). It remains to be seen how the EU10 countries would be able to cope with such challenges, since in most of them (with the exception of Slovenia) there is no replacement for their ageing health workforce, and no strategic preparation for this can be foreseen at present. Moreover, current cutbacks in health and education could lead to deteriorating imbalances across health professions (such as an even greater lack of specialist doctors). Even in the long term, it seems unlikely that health expenditure in these countries could be increased.

Measures taken in the EU10 Member States

Wage increases

Due to increasing tension, governments of the most affected countries have already tried to introduce several measures. One of the most common and important of these was wage increases, for example, in Estonia, Lithuania, Poland and to some extent also in Hungary. In some countries (especially in the Baltic states), these measures seemed initially to be effective, but as a consequence of the economic crisis, outward migration increased again. In order to ease regional imbalances in the distribution of medical personnel, there have been some efforts, for example, in Romania and Hungary, to give incentives for doctors to work in remote areas and small villages. In these areas the problem is quite acute (partly as a consequence of emigration). In some countries (for example, Hungary), tension has been rising seriously due to the low salaries of young doctors, resulting in public demonstrations. The government has responded with wage increases (mainly in the form of a grant – see the Hungary case study in the previous section). It remains to be seen, however, whether these measures are able to reverse the increasing trend of emigration.

¹³ Ad hoc media review conducted by Eurofound between October 2012 and January 2013.

System reform attempts

Measures include various reform attempts. In Hungary, for example, a centralisation process is occurring, with the state taking over hospitals from municipal authorities in order to run them more efficiently. Governments in other EU10 countries have introduced various other restructuring measures. Recurrent restructuring waves, however, could be counter-productive, since the uncertainty they imply could be another reason why people decide to leave, as is the case in Lithuania (Matrix Insight and Centre for Workforce Intelligence, 2012a).

Retaining graduates

Specifically referring to the migration of health professionals, the ‘brain drain’ argument is often mentioned, and the issue of lost investment into education of health professionals is high on the agenda. For example, Fotakis presented data on the educational attainment of mobile EU15 nationals and showed that it is higher than that of EU10 nationals. He added: ‘This does not preclude brain-drain effects in specific sectors, i.e. health’ (Fotakis, 2011). According to Maier et al, ‘in an effort to offset such financial losses, programmes in Slovakia require compulsory postgraduate service or monetary compensation if graduates migrate’ (2011, p. 50).

Similar developments can be observed in Hungary, where the minister for education plans to conclude a contract with publicly financed students. The contract would stipulate that, after graduating, they either stay on in the country for at least twice as long as their studies lasted (not more than 20 years) or repay their tuition fees.

The option of attracting foreign nationals is not on the agenda as yet, although previous spontaneous movements and even current, sporadic trends in some countries point in this direction. Nevertheless, the migration of health professionals is an increasing concern in EU10 countries, which are beginning to look for ways of retaining and recruiting healthcare workers.

Policy initiatives at European level

In its Employment Package, the European Commission recognises how significant the role of health and social care sectors is in expanding employment opportunities. It is also clear from its Communication ‘Towards a job-rich recovery’ that both policymakers at EU level and those in the Member States are well aware of those key problems (European Commission, 2012a). It states:

The size and fast growth of these sectors (twice the employment growth overall) suggests they will remain a key driver in providing new jobs in the years to come. To exploit this job creation potential, the sectors have to overcome several challenges [including labour shortages and an ageing health workforce].

Therefore, the Commission has initiated an ‘Action Plan for the EU Health Workforce’ (European Commission, 2012b). Its key objectives are:

- enhanced European cooperation ‘to support and complement national efforts to tackle the challenges facing the EU workforce’;
- consultations between the European Commission and stakeholders in order to exchange best practices, to develop European networks and to improve European data on the healthcare workforce.

The action plan has four key areas:

- workforce planning (with the objective of improving planning and forecasting of needs);
- recruitment and retention;
- anticipating skills needs;
- international ethical recruitment.

As regards the first area, it has already been concluded by several case studies, as well as summaries of major projects such as PROMeTHEUS and MoHProf, that better planning is needed in the healthcare sector. For this, more reliable data are necessary, requiring their systematic collection. Because of the extent of the mobility of health professionals across countries, not only does each country need to gather data, but there is a need for much more efficient international comparison, requiring coordination at European level. Recognising this, the EU Joint Action on Health Workforce Planning and Forecasting has been established (implementation started in 2012), with seven work packages, three of which are horizontal (coordination, evaluation and dissemination), and the rest are:

- data for health workforce planning (WP4);
- exchange of good practice in planning methodologies (WP5);
- horizon scanning (WP6);
- sustainability of the results of the joint action.

For more efficient planning, more detailed data are also needed on the inward migration of third-country nationals (specifically of those working in the healthcare sector). The introduction of the Blue Card Directive (2009/50/EC) will mean that data will be collected on those who arrived under this scheme from 2013. From 2014, the application of the Blue Card Directive will also be monitored (OECD, 2012, p. 114).

Efforts to establish a unified database at EU level, in the form of the Action Plan, seem quite ambitious. The feasibility report by Matrix Insight and the Centre for Workforce Intelligence (2012a, p. 91), however, recognised that:

collating and assessing mobility across countries continues to be challenging. The data collected on this often does not reflect the complexity of migration and it does not effectively capture the different types of migration/mobility (e.g. temporary workers) as well as change in status of the professionals. There is an identified need in the European region to improve comparability of health workforce data as one prerequisite for monitoring the demand and supply of health labour across countries.

In addition, as the PROMeTHEUS study highlighted, problems with definitions of ‘foreign-trained’, ‘foreign-born’ or ‘foreign national’ make cross-country comparison difficult. Inaccuracy of stock indicators, such as licensed/active or full-time/part-time, and different types of mobility (return migration, short-term mobility, weekend work and dual practice, commuting, undocumented work and training abroad) pose further challenges. Other issues include a lack of time series data, such as trends or fluctuations, and a lack of accurate data on outward migration (Tjadens et al, 2012).

Conclusions and issues for further research

As the Matrix Insight and Centre for Workforce Intelligence feasibility study concluded, ‘migration of [the] health workforce across European countries appears to be a solution to shortages in western European countries’ (2012a, p. 91). However, the question is, what could be a solution for the 10 central and eastern European Member States – that is, Bulgaria, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, Slovakia and Slovenia (referred to here as the EU10)? This is all the more relevant since other countries expecting to join the EU within the foreseeable future may face similar challenges to those of the EU10 countries. One can see the migration accumulated over the decades in the high number of health professionals from Croatia, Bosnia and Herzegovina, and Serbia already present in Germany in 2003 (Glinos et al, 2011, p. 75).

The data presented in this study have shown that the migration of third-country nationals to most of the EU10 countries is marginal. The case studies of the three selected EU10 countries, with the most recent data, also confirmed this. Despite the large outflow and the already visible shortages of labour, there are no policies in place aiming at attracting health professionals from third countries. The reason is partly political and partly economic; amid deteriorating living conditions, a shrinking economy and high unemployment, policymakers are reluctant to opt for this solution. This is all the more understandable since there is a general perception that problems in the healthcare sector could be solved by other means, such as wage increases, improved working conditions and training. Indeed, some attempts to solve the problem by introducing wage increases can be seen in the case studies of Poland, Hungary and Lithuania. In addition, labour shortages nowadays are found in specific professions only, not across the board.

At the same time, experts, making forecasts from current trends, emphasise that more serious shortages could develop, mainly as a consequence of ageing both among health professionals and in the general population (a phenomenon that has been identified in all three country case studies). It is highly doubtful, however, that measures for attracting third-country nationals to the sector would be a viable option. They would hardly make sense due to those structural differences that exist between the EU15 and EU10 countries (such as the great disparity in income and in living and working conditions, especially in the healthcare sector). It is clear that, under these circumstances, potential migrants would rather go to the EU15.

As regards return migration, this cannot be expected on a large scale. Although there is some evidence of mobile health professionals taking up positions at a lower level than they are qualified for, the better living and working conditions in the receiving countries seem to offset this negative phenomenon (even if, in specific cases, it could be a motivation to return, as the Polish case study confirms). The phenomenon, however, could be an interesting topic for further analysis, since it appears that not much research has been conducted so far on this ‘brain waste’ (for example, even in the case of doctors, anecdotal evidence shows that they are often employed in a lower position than in their home countries). As a general remedy for this, better and more efficient recognition of certificates and diplomas is usually suggested. In the case of health professionals, this seems less relevant because three categories of workers, medical doctors, nurses and dentists, fall under the automatic diploma recognition procedure specified in Directive 2005/36/EC on the recognition of professional qualifications. Therefore, in this case, more focus on integration measures would also be needed (such as language courses). None of the two types of inward migration (either of third-country nationals or of return migrants) could be a general solution to labour shortages in the healthcare sector. The countries concerned have no choice but to rely on a long-term strategy with, possibly, the support of the EU; this is crucial if further, deeper division across the EU is to be avoided. Such a strategy should obviously be based on sound data, and, as seen in this study, there are substantial EU-wide problems with this. This is why the Joint Action on Health Workforce Planning and Forecasting, initiated by the European Commission, is of great significance, and its implementation could be an essential step towards elaborating any long-term strategy.

Apart from the joint action, however, more research is needed. For example, a deeper analysis of the mobility of nurses could provide substantially more information. Although available data show that Europe is less reliant on third-country nurses than doctors, there may be doubts about this because few countries have exact data on the issue; indeed, the report

from the EU-funded Health Professional Mobility in the European Union Study (PROMeTHEUS) admits ‘it may be that the real scale of nurses’ migratory flows has been considerably underestimated because of the lack of good-quality data in several countries, including Poland, Romania and Slovakia’ (Maier et al, 2011, p. 42). There is also the problem that available data do not take into account nurses employed in social or private care.

Various types of mobility, such as circular, short-term, commuting or weekend work, needs further investigation in order to understand the factors and patterns in health professionals’ mobility.

After identifying sources of current inefficiencies within the healthcare sector, one of the key objectives of any strategy should be to identify the sources of the problems and then find the most appropriate means of dealing with them. It would be worthwhile, for example, to conduct a thorough analysis of the reasons for the high level of differences in total qualifications required in the health and social work sector across the EU. For the sector as a whole, a higher level of requirements is found more often in the EU10 than in EU15. Although this may be attributed to a lower share of social work activities (where the quality requirements are lower than in the other subsectors) in the EU10 group, there could be other reasons, related to inefficiencies of the health systems in these countries (Cedefop, 2013, p. 102).

Another issue to be addressed by a long-term strategy is the role of private schemes. It remains to be seen to what extent private schemes in the healthcare sector are to be extended. No doubt, an accelerated extension may slow down emigration; this could, however, lead to widening social inequalities, which have already been a source of tension in these countries. Therefore, long-term strategies should be designed within the context of wider societal implications. There would also be the need for a clearer picture on the combined existence of private and public health schemes and the implications of this for health systems as a whole. Therefore, this issue, including the relationship between the two schemes – ‘production for the market versus production for the public services’ – should be the subject of further research (see summary report from the EU-funded project on Mobility of Health Professionals (MoHProf): Tjadens et al, 2012, p. 159).

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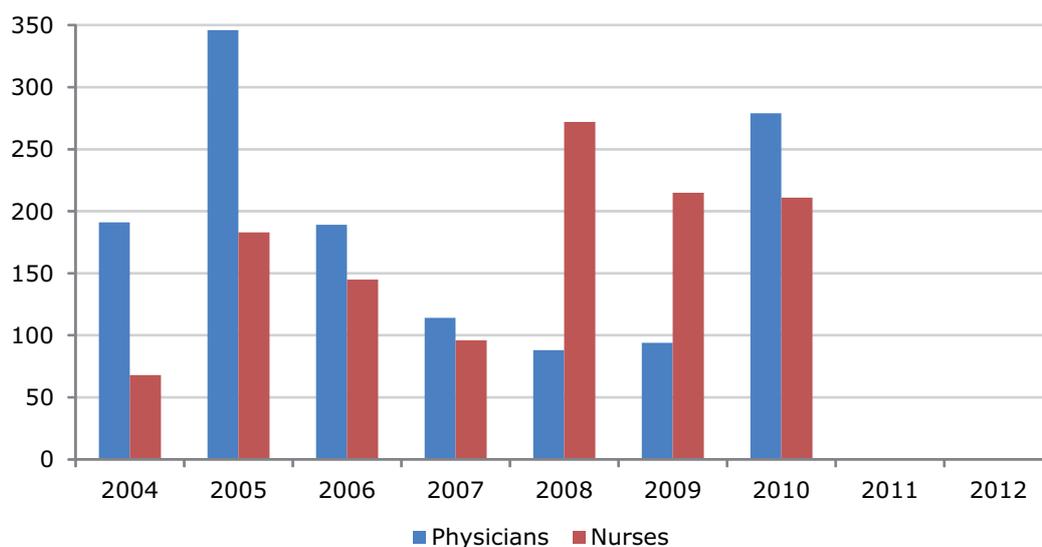
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Table A1: Number and proportion of health and care workers from EU10 in Ireland

Nationality	Number of health professionals	Number of health and social care associate professionals	Number of caring personal service professionals	Total number of health and care professionals	Proportion of health and care professionals in all occupational groups by nationality (%)	
					Female	Total
Bulgarian	17	3	29	49	6.6	4.0
Czech	45	10	117	172	8.2	4.2
Estonian	14	7	44	65	5.5	3.7
Hungarian	120	35	166	321	9.4	5.2
Latvian	40	26	159	225	2.7	1.6
Lithuanian	135	36	393	564	4.0	2.2
Polish	685	271	1,844	2,800	6.1	3.2
Romanian	174	44	262	480	7.9	4.3
Slovak	82	32	217	331	7.1	3.9
Slovenian	11	2	7	20	21.5	14.1

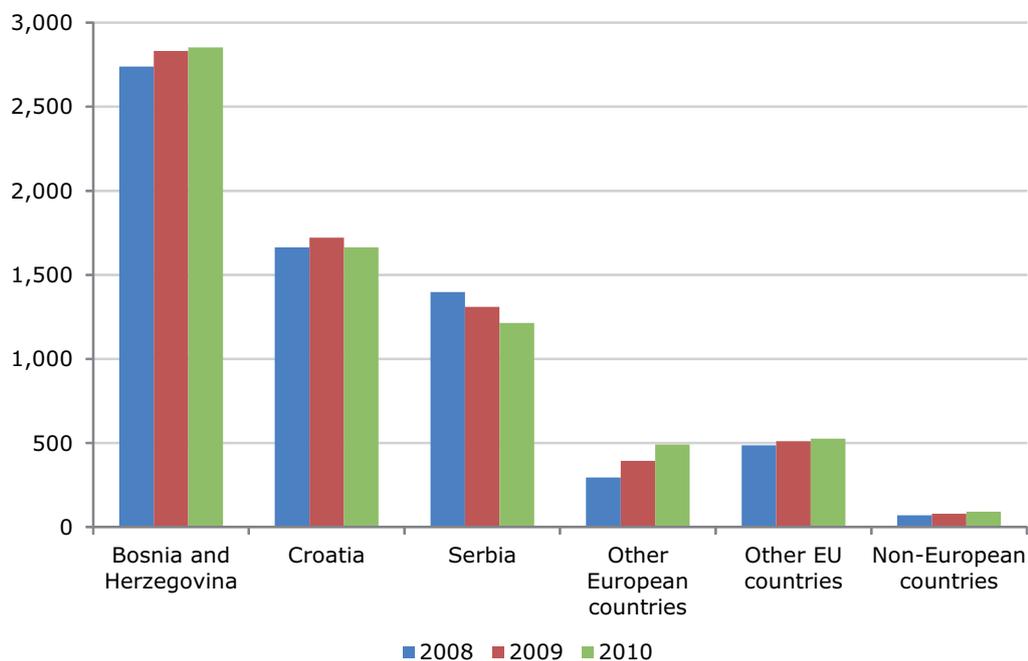
Source: Central Statistics Office (CSO) Ireland, Census 2011

Figure A1: Number of certificates of good practice issued in Lithuania to medical professionals



Source: Statistical office of Slovenia (Zavratnik, 2012)

Figure A2: Foreign-born workers in health and social work in Slovenia



Source: Statistical office of Slovenia (Zavratnik, 2012)

Table A2: Number of Polish nurses working in other EU countries

Destination country	Number of registered nurses	Comments
Greece	44	Majority of them are secondary school graduates
UK	1,722	This number does not reflect the true scale of nurses employed in the UK.
Portugal	16	Data from December 2009
Sweden	24	
Denmark	160	

Source: National Chamber of Nurses and Midwives, Poland

Topics covered during interviews in Poland, Hungary and Lithuania

- Data on outflow from the sector (emigration), including time trends
- Data on commuting, temporary work
- Data on labour shortages and consequences
- Data on the number of third-country nationals employed in the sector
- Is there a ‘replacement effect’? (ladder, or chain migration)
- Strategies/steps to deal with labour shortages – (re)training and related measures, wage increases, improving working conditions of domestic health professionals, attracting third-country nationals
- Changes in education system (for example, legislation and/or proposals for it) as a response for increased outflow (aiming to prevent it)

- Impacts of austerity measures in the sector – decreased labour demand, decreased labour shortages? Also, wider consequences on well-being – that is, unmet effective demand.
- Impacts of cutbacks on private health and care institutions. Increased labour flow from public service institutions (internal mobility?). Presence of third-country nationals there? Data about this?
- Key destination countries – is there a different pattern than for other workers, leaving the country?
- Role of languages
- Role of geographical proximity (in commuting, short-term mobility)
- Any experience of return migration (helping to alleviate labour shortages)
- Personal opinion (of the expert) for solution – could more inflow of third-country nationals help?

Interview partners

Interviews by Tadas Leončikas in Vilnius, 22 October 2012:

Ministry of Healthcare of the Republic of Lithuania – Jonas Barlingas, Audronė Dragūnienė

Ministry of Social Protection and Labour of the Republic of Lithuania – Daiva Buivydyaitė, Almira Gecevičiūtė

Thanks to Karolis Zibas (Lithuanian Centre for Social Research) for facilitation of access to relevant information sources.

Interviews by Klára Fóti in Budapest, September 2012

Ministry of National Human Resources – Zoltán Cserhádi, Head of Department

Chamber of Hungarian Health Professionals – Zoltán Balogh, President

Health Services Management Training Centre, Semmelweis University of Budapest – Edmond Girasek, Assistant Lecturer

Office of Health Authorisation and Administrative Procedures, Department of Migration and Monitoring – Nándor Rikker, Acting Head of Department

Interviews by Anna Ludwinek in Warsaw, September 2012

National Chamber of Doctors

National Chamber of Nurses

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EF/13/35/EN

