

Euro Observer

**The Health Policy Bulletin
of the European Observatory on Health Systems and Policies**

Summer 2011
Volume 13, Number 2

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Health professional mobility and health systems: evidence from 17 European countries

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Health professionals move between countries in search of higher salaries, better working conditions, training and career opportunities, or new professional and personal experiences. When crossing borders, they change the composition of the workforce in both sending and receiving countries, affecting the size, skill-mix, geographical distribution and demographic profile. This can have consequence on the workforce's contribution to the performance of the health system by mitigating or aggravating workforce shortages, the lack of specific skills, or the situation in underserved areas.

With 12 Member States acceding to the European Union (EU) in 2004 and 2007 a new impetus for health professional mobility was expected. As the EU became more diverse in socio-economic terms, with larger salary differentials, incentives to seek employment in another Member State have increased. The threshold to move across borders is relatively low in the EU, due to the mutual recognition of professional qualifications¹ in the European free movement area; this provides an automatic procedure for the 'regulated professions', among which are medical doctors, nurses, dentists, midwives and pharmacists.

Increasing health professional mobility and its growing impact on health systems have moved the issue up the political agenda. Concerns have been voiced about brain-drain, and the accessibility, quality and safety of services in both sending and receiving countries. Some

Member States imposed, for a transitional period, labour market restrictions on the new Member States while others actively invited health professionals from abroad.

Evidence from European countries

Despite the growing political attention health professional mobility has received in Europe, relatively little is known about its magnitude, the dynamics resulting from the process of enlargement, the balance of losing and receiving health professionals between old and new Member States, the drivers of mobility and the impacts on health systems. To shed more light on the phenomenon, the PROMeTHEUS project has documented and analyzed health professional mobility in Europe (Box 1).

Scale of mobility: significant but diverse

The scale of mobility is significant for a number of European countries in terms of reliance on foreign health professionals and in proportion to new entrants to the health workforce.

Figures from 2008 show that foreign health professionals make up over 10% of doctors in Belgium, Portugal, Spain, Austria, Norway, Sweden, Switzerland, Slovenia, Ireland and the United Kingdom (Figure 1). Reliance on foreign health professionals exceeds 10% of the nursing workforce in Italy, the United Kingdom, Austria and Ireland.

This article is based on the volume *Health Professional Mobility and Health Systems: Evidence from 17 European Countries* edited by Wismar M, Maier CB, Glinos IA, Dussault G and Figueras J (2011). World Health Organization, on behalf of the European Observatory on Health systems and Policies.

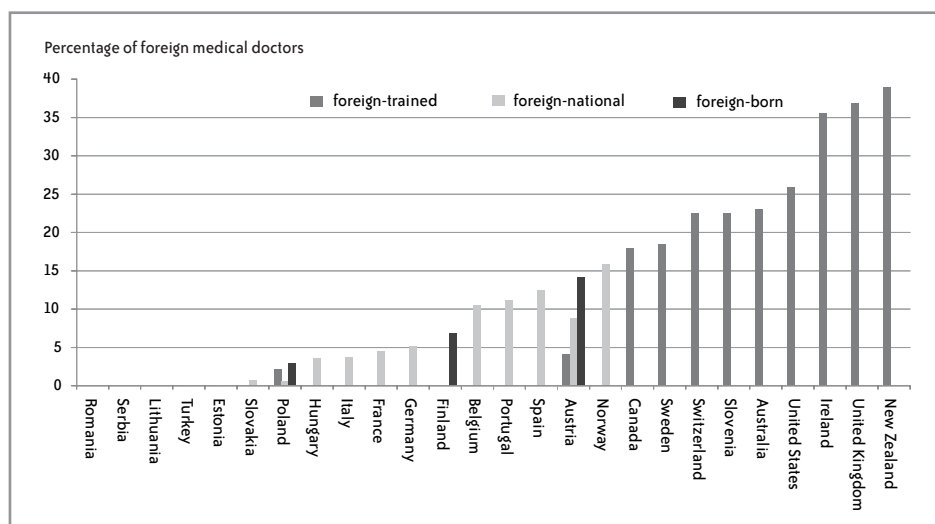
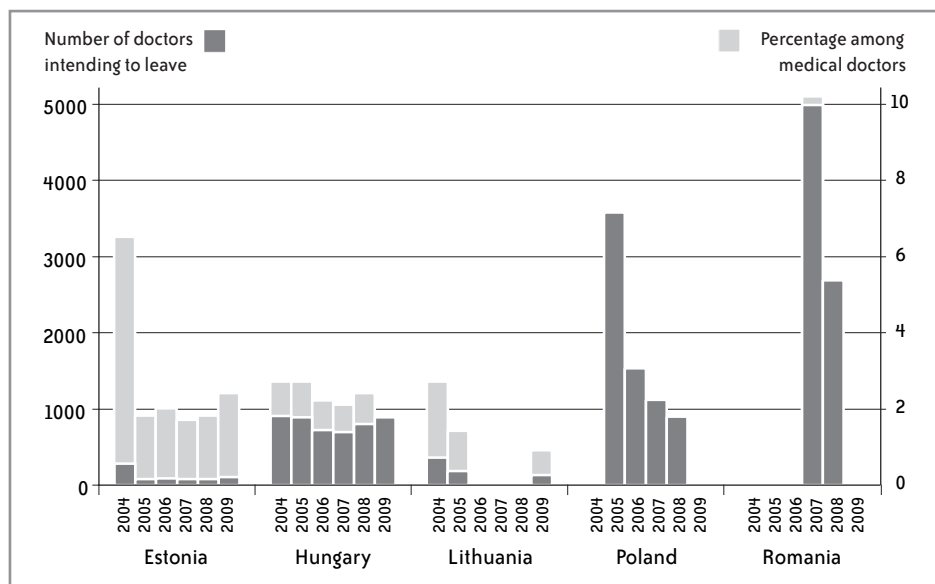
The Observatory is a partnership between the WHO Regional Office for Europe, the Governments of Belgium, Finland, Ireland, the Netherlands, Norway, Slovenia, Spain, Sweden and the Veneto Region of Italy, the European Commission, the European Investment Bank, the World Bank, UNCAM (French National Union of Health Insurance Funds), the London School of Economics and Political Science and the London School of Hygiene & Tropical Medicine.

Box 1: PROMeTHEUS – Health Professional Mobility in the European Union Study

The issue of health professional mobility was discussed during the informal meeting of health ministers organized by the Hungarian Presidency of the Council of the European Union in Gödöll (Hungary) on 4–5 April 2011. On this occasion, a new study, on which this Euro Observer issue is based, was presented by the European Observatory on Health Systems and Policies, in partnership with the WHO Regional Office for Europe. This volume, *Health Professional Mobility and Health Systems: evidence from 17 European countries*, draws on the first results of a research project funded by the EU (grant agreement 223383) on health professional mobility in the EU (PROMeTHEUS) that started in 2009. The countries covered include Austria, Belgium, Estonia, Finland, France, Germany, Hungary, Italy, Lithuania, Poland, Romania, Serbia, Slovakia, Slovenia, Spain, Turkey and the United Kingdom. Based on evidence provided by the 17 country case studies, the book looks into the scope of health professional migration in the EU, both in terms of the flows and the reliance on foreign health professionals. The study also provides a better understanding of the underlying push and pull factors influencing health professional mobility, the impact on health systems, the broader domestic workforce issues and the policies to address the related challenges.

Reliance on foreign health professionals has accumulated over decades, and for many countries inflows remain significant. In 2008, the proportion of foreigners within all new health workforce entrants was particularly high for medical doctors in the United Kingdom (42.6%), Belgium (25.3%) and Austria (13.5%); for nurses in Italy (28%), the United Kingdom (14.7%) and Belgium (13.5%); and for dentists in Austria (40.8%), the United Kingdom (33.7%), Belgium, (19.3%) and Hungary (9.7%). In Finland, 43.2% of newly licensed dentists from 2006 to 2008 were foreign trained.

While some countries rely heavily on foreign health professionals, Figure 1 shows the diversity across Europe, with several countries showing little or no reliance on foreign health professionals.

Figure 1: Reliance on foreign medical doctors 2008, or latest available year**Figure 2: Yearly outflow intentions of medical doctors from selected 2004 and 2007 enlargement countries**

Effects of EU enlargement: less than expected

EU enlargement since 2004 has generated a new impetus for mobility, although it did not generate outflows as large as initially expected – with mobility intentions, as expressed by the number of requests for conformity certificates, in the EU-12 hovering at around 3% of health professionals (see Figure 2) and actual migration being even lower since not all requests are followed by emigration.

Recent data from Estonia, Hungary and Romania (see case study in this issue) seem to suggest a new surge in outflows, presumably related to the economic downturn since 2008. However, a reverse trend has also been observed, with Polish medical doctors returning to Poland.

East-West asymmetries worsened

The new mobility triggered by the EU enlargement in 2004 and 2007 has further emphasized East-West asymmetries in terms of in and outflows of health professionals with the EU-15 as the main destination for migrants from the then new Member States. The asymmetry does not lie in the outflows per se. Many of the EU-15 have considerable outflows of the same magnitude as the EU 12. However, unlike the EU-15, the EU-12 countries have only negligible inflows.

Outflows from Eastern Europe started well before accession, following the political transitions of the late 1980s and early 1990s. For example, high numbers of health professionals from Bosnia and Herzegovina, Croatia and Serbia in Germany's workforce in 2003, reflect decades of out-migration from the former Yugoslav Republic (see case study on Germany).

Money: a main driver for mobility

The enlargements of 2004 and 2007 have increased the economic diversity of the EU and salary differentials. An Estonian medical doctor can earn six times more in Finland, and a Romanian general practitioner can earn ten times more in France. Income is the most cited factor in deciding to migrate, and influences leavers, returnees and those who remain.

In Lithuania, annual salary increases of 20% for medical doctors and nurses between 2005 and 2008 (see case study in this issue) helped to reverse high dropout rates from medical studies as well as attrition and emigration. In Poland, better remuneration is reported to have diminished outflows and motivated returns (see case study in this issue). In Slovenia, increases in salaries arguably contributed to a smaller than expected loss of health professionals. Conversely, a 25% cut in the salary of health professionals in Romania may have contributed to higher outflow numbers in 2009.

Money is not the only factor influencing mobility patterns; it is less important between countries where the salary differentials are slight. Working conditions, working environments and work contents also have an important influence on decisions by health professionals to move.

Impacts on health systems' performance: subtle but significant

In spite of intense debates in some countries, there is surprisingly little evidence on the impact of health professional mobility and there appear to have been no systematic studies in the countries. Impacts on the performance of health systems are subtle in the sense that they are often indirect and hard to

discern but there are evident impacts on their functioning. Although some may be insignificant at country-level they may be substantial at regional or hospital level.

Some receiving countries' health systems have benefited substantially: inflows of medical doctors, nurses and dentists have increased service capacities in the United Kingdom, Spain, Austria and Italy. Unfilled positions in the less affluent eastern parts of Germany are increasingly filled by foreign medical doctors – their numbers tripled between 2000 and 2008. In France, medical doctors from non-EU countries fill gaps in public hospitals, and in socioeconomically disadvantaged or isolated areas.

Other countries have faced losses. Slovakia lost a reported 3243 health professionals between January 2005 and December 2006. In Romania, rural areas with the lowest coverage of medical doctors report some of the highest emigration rates of medical doctors and nurses. Impacts are not always related to the size of flows. Hungary, Estonia and Lithuania noted that the departure of even a few specialists can upset service provision. Certain specialties appear to be more vulnerable. In Poland, most vacant posts concern anaesthetists and emergency doctors – specialists that show greatest intention to leave. In Belgium, the emigration of child psychiatrists has been reported as problematic given important shortages in the profession.

Data are still limited

Policy makers, workforce planners and healthcare managers need to understand the mobility trends as they occur in order to react adequately. However, the data situation in many countries is far from satisfactory. In 13 of the 17 country case-studies (Belgium, France, Germany, Hungary, Italy, Lithuania, Poland, Romania, Serbia, Slovakia, Spain, Turkey, United Kingdom) insufficient availability of updated, comprehensive and reliable data on migration was reported. Many countries worried about significant losses of health professionals have used 'intention-to-leave' data, based on certificates issued when applying in another Member State for the recognition of diplomas.

But intentions do not equal factual movement; rather this data represents a proxy for movements with several limitations. An emigration study conducted in Romania showed that the actual outflow was more than three times lower than the intention-to-leave data suggested. On the other hand, certificate data does not always overestimate mobility, since some countries waive the need to produce certificates and some forms of mobility do not require these documents.

Measuring inflows is a tricky business, since the three indicators available show different aspects of mobility with large variations – see Austria and Poland in Figure 1. Data on nurses suffer from greater limitations and inaccuracies than data for medical doctors in most countries. Even where data are available, the professions and qualifications included vary widely between countries. Time series data is only available for a few countries in Europe, making the monitoring of trends particularly challenging.

Policy implications

When considering whether health professional mobility is an issue important enough to take action, policy makers will want to understand future trends and possible scenarios. However, grasping the phenomenon and taking the right decisions is made more difficult by a series of factors.

First, there are uncertainties surrounding the impact of the economic crisis. In some countries public budgets were slashed, including those for health care and for the training of health professionals, while in others budgets remained relatively unaffected. Health workers worried about their professional future may decide to seek work or training abroad and with it contribute to health professional mobility. A new economic environment changes opportunities and incentives, adding to the unpredictable nature of flows.

Another source of uncertainty is the health workforce development in Europe. According to a recent forecast by the European Commission, a shortage of around 1 million health professionals is expected by 2020. Vacancies in the more affluent

Member States may attract health professionals from the poorer parts of the EU, thus aggravating existing asymmetries.

To compensate for workforce shortages by recruiting from third countries is increasingly restricted by ethical constraints. The World Health Assembly adopted in 2010 a Code of Practice for the International Recruitment of Health Personnel. The code provides ethical guidance on international recruitment and discourages recruitment from countries facing workforce shortages. Therefore, countries with a high demand for health professionals will face increasing difficulties to fill vacancies with health professionals from other countries.

The overarching implication of our findings is that health professional mobility should be addressed in the first place within countries. This includes improvements in data, intelligence and evidence; a focus on general workforce strategies, including good-quality education and measures for retention; the further development of workforce forecasting and planning; and to complement this, the use of international frameworks to manage health professional mobility.

The first set of policy implications focuses on data, intelligence and evidence. Due to the unavailability or unreliability of outflow data, policy makers and health workforce planners cannot factor in current out-migration. It is also crucial that inflow data becomes available on a timely basis. The lack of robust and comparable nursing data will need to be addressed too. However, the need to be better informed goes beyond the data issue. With the free-mobility framework, shortages and changes in workforce policies have almost immediate effects on other countries, especially if there are large differences in the level of income. Changes of recruitment policies in the United Kingdom and the increasing inflow from EU-12 countries provide an example of how important it is to have timely intelligence available on the sustainability of the workforce, including workforce policies and training capacities. And finally, it will be essential to better understand the effectiveness of measures to retain, integrate or re-integrate health professionals.

A second set of policy implications is related to the strengthening of general workforce strategies. Health professional mobility is mostly the consequence of underlying domestic workforce issues related to the working conditions, working environment, skill-mix supply and training opportunities available. Salary differentials also play an important role.

A third policy implication is to sustain the re-emerging interest in workforce planning methods and techniques, that go beyond extrapolating past staffing trends but rather taking into account the changing demands for, and needs of, the health workforce of the future. That includes the feminization and aging of the workforce.

Finally, there are international frameworks that can help to manage health professional mobility, including the WHO code. According to the experiences from the United Kingdom with their code, the timely monitoring of inflows, the existence of accountability frameworks and national workforce strategies can help. Bi-lateral agreements between consenting countries can structure or exclude, international recruitment. They can also facilitate recognition of diplomas from third countries. There are other international mechanisms which can contribute to the management of health professional mobility on the organizational level; for example, twinning schemes and joint training programmes.

The way forward

It is now time to lay the foundations for future actions. The policy implications listed here should provide guidance. Furthermore, the role of the EU vis-à-vis the Member States needs to be clarified. Health care is a competence of Member States, but it is clear that mobility, which is a competence of the European Union, interacts with service provision.

Aware of this issue of competence, Member States, the European Commission and the European Parliament have fostered discussion and collaboration on workforce issues, including health professional mobility. Under the Belgian Presidency in 2010 the Member States adopted Council Conclusions on the health workforce,² encouraging exchange of good practices but also the development of an action plan and a joint action, a method which allows the Commission to collaborate with Member States. This was further endorsed by the Hungarian Presidency in 2011, which put health professional mobility on the agenda of the Council (see Box 1). The initiatives of the Member states were preceded by a Commission Green Paper and a consultation process on the European Workforce for Health.³ In parallel, the European Parliament adopted a declaration on the EU Workforce for Health.⁴ This may constitute a splendid window of opportunity to address the challenges ahead.

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A destination and a source country: Germany

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Mobility profile

Germany is both a destination and a source country for migration in the health care sector. Foreign health professionals have long had a presence within Germany's health services and nearly half of these hold EU citizenship. However, the EU enlargements of 2004 and 2007 have not produced the expected strong effect on the migration inflows of health professionals. In 2008, foreign national health professionals still represented a relatively small percentage (about 6%) of the total health workforce in the country. At the same time, a number of German health professionals are leaving the country to work abroad, attracted by better working conditions and higher pay.

Inflows

Medical doctors: The numbers of registered and active (practising) foreign-national doctors have increased since 2000, as have the percentages of total numbers.¹ At the end of 2008 there were 21 784 registered doctors of foreign nationality in Germany (approx. 5.2%) and 18 105 active foreign doctors (approx. 5.7%).

This growth has been considerably higher in eastern Germany: from 2000 to 2008 the number of active foreign doctors in the states of the former West Germany rose by 40% while the corresponding figure for the former East Germany was roughly 309%. Only 6% of all active foreign doctors were practising in eastern Germany in 2000 but this proportion had reached 15% by 2008.² While the number of foreign doctors from the new Member States working in Germany has increased constantly since 2000, the highest growth rate (around 21%) occurred in 2003, when demand was first diagnosed to be high but the restrictive immigration

policy for non-EU nationals still applied to these countries.

It is quite rare for foreign doctors to become self-employed. In 2008 only 3534 foreign doctors ran private practices – 2.8% of all practice-based doctors. The absolute number and share of foreign doctors is considerably higher in the hospital sector – 13 207 (8.6%).¹ In 2008, the main source countries for foreign doctors were Austria, Greece, the Russian Federation/former USSR, Poland, the Islamic Republic of Iran and Romania.

Nurses: The share of foreign-national nurses and midwives subject to social insurance contributions has been declining, from 3.7% in 2003 to 3.4% in 2008.* The numbers with foreign EU nationality show only a slight decrease (3%) while there were more pronounced decreases in the numbers from Asia (30%), Europe (excluding the EU, 7%) and Africa (5%). The share of nursing assistants also decreased from 7.6% in 2003 to 7.0% in 2008.³ The main source countries for legally employed nurses are Croatia, Turkey and Poland, followed by Serbia/the former Federal Republic of Yugoslavia, Bosnia and Herzegovina and Austria.

While the number and share of foreign nurses and midwives subject to social insurance contributions is declining, other forms of employment, such as self-employment and illegal employment, offer eastern European nurses the possibility to work in Germany, mainly as home-care workers for elderly people.

Dentists: Data on foreign dentists are only partially available. Federal Chamber of Dentists figures for 2007 give a total of 1573 dentists with foreign EU nationality, representing around 2% of all den-

tists in the country. Microcensus data show that the number of dentists of foreign nationality in Germany hovered around 2000 (3% of all dentists) between 2003 and 2006 and increased to 3000 (5% of all dentists) in 2008.

Outflows

Data on the annual outflows of health professionals from Germany are partially available. Data compiled by the regional chambers of physicians show that in 2008 a total of 3065 medical doctors who originally practised in Germany (approximately 1% of all active medical doctors) moved abroad; 67% of these held German nationality. The most popular destination countries were the German-speaking countries of Switzerland (729) and Austria (237), followed by the United States (168), the United Kingdom (95) and Sweden (86).

Data on the outflow of nurses is not available but according to German Nursing Association estimates, the annual outflow does not exceed 1000. An important destination country is Switzerland which offers better training opportunities, higher incomes and flatter workplace hierarchies.

Health system impacts

The scale of health professional migration to and from Germany is relatively limited in comparison to major destination and source countries and therefore there has been little research on its impact on the country's health care system. While the decentralized and corporatist health care system in Germany hampers active nationwide recruitment of health professionals, mainly in the less affluent and sparsely settled regions of eastern Germany, federal states and hospitals affected by a shortage of medical doctors are increasingly recruiting personnel from abroad. Demand for nurses is expected to rise as a result of demographic changes

* Data from the Federal Employment Agency. No registry data is available as nurses and midwives are organized through voluntary membership of a variety of professional organizations and are not required to register with a particular organization or chambers.

and the declining appeal of the profession, especially in times of economic upturn. The health system's dependence on foreign-trained health personnel is already noticeable in areas such as elderly care and is likely to increase.

Policy responses

Germany lacks a comprehensive national health workforce strategy that takes into account the inflows and outflows of health professionals. There is also no explicit national self-sufficiency policy. The country's federal and corporatist system, in which healthcare goals are fixed and implemented within a complex set of institutional mechanisms acting at different levels, impedes adequate planning. Some ad hoc responses to workforce shortages, typically implemented at state or hospital level, include recruitment of medical doctors from the new EU Member States by hospitals in eastern Germany; easing of bureaucratic hurdles concerning work permits and legal occupational regulations by regional authorities, particularly in eastern Germany; retraining schemes for foreign trained doctors in the state of Brandenburg; and offering extra bonuses (such as cheap loans, low rent and mortgages) by some hospitals to attract young doctors.

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A source country: Lithuania

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Mobility profile

EU accession has not produced the anticipated outflows of health professionals from Lithuania. The most likely reasons for this include improved working conditions within the country (enabled by EU structural funds for the health care system) and increasing salaries. However, Lithuania is still best described as a source country for medical personnel, with pull factors that include better working conditions abroad, better quality of life, higher prestige and higher pay. The main destination countries for Lithuanian health professionals are the United Kingdom, followed by the Scandinavian countries.

Outflows

Medical doctors: During the first year of EU membership (1 May 2004 to 30 April 2005) 357 (2.7%) Lithuanian doctors obtained certificates of good standing (CGSs) which are issued by the Ministry of Health to health professionals wishing to practise abroad.* That number almost halved to 186 (1.4%) in the following year and fell to 132 (0.9%) in 2009.

Nurses: Nurses show a different pattern to doctors – 107 (0.4%) nurses were issued with CGSs in 2004–2005, with increases to 166 (0.7%) in 2005–2006 and 267 (1.1%) in 2009.

Dentists: Dentists show fluctuating numbers of CGSs – 81 (3.6%) dentists were issued with certificates during 2004–2005. These numbers fell to 42 (1.7%) in 2005–2006 but rose to 72 (3.1%) in 2009.

Inflows

Ministry of Health data indicate that only 10 basic medical degrees, 12 medical

specialty degrees, 10 nursing degrees and 11 dentistry degrees from countries outside the EEA (Armenia, Belarus, Russian Federation, Ukraine and Uzbekistan) were accredited between 2005 and 2008. Three dentistry degrees (from Norway and Poland) were recognized through European Directive 2005/36/EC. Thus, the numbers represented by these accreditations remain very low in comparison to the total economically active health workforce in 2008 (13 403 medical doctors, 24 908 nurses and 2287 dentists).

Stock data on foreign health professionals practising in Lithuania is more problematic as it is not systematically collected. The only data available are the number of work permits issued to foreign nationals. During 2005–2008 15 medical doctors, 6 nurses and 2 dentists were issued with permits. Lithuanian Labour Exchange data show that foreign health professionals mainly come from third countries (Belarus, China, Israel, Lebanon, Pakistan, Russian Federation, Syria and Ukraine); only three came from EEA countries (Latvia and Norway).

Health system impacts

While domestic data sources indicate an unmet demand for medical doctors, nurses and dentists, this does not indicate a general shortage. Rather, certain specialties and sectors experience recruitment problems; for example, a study from 2006¹ shows that the demand for psychiatrists was 24 times higher than supply; demand for other medical doctors (surgeons, ophthalmologist) was higher by 3–10 times. Another study² revealed that gynaecologists, paediatricians, anaesthetists, surgeons, internists, doctors of laboratory medicine, general practitioners

* While the number of certificates issued does not reflect the real migratory flows – as the holders may choose not to leave the country or may leave for a short while – other evidence, such as listings of Lithuanian health professionals in foreign registries, shows that certificate holders have serious migration intentions.

and medical doctors with basic training migrated most often in 2004–2006. The magnitude of vacant positions might have adverse consequences for health service delivery, especially when the mobility of particular specialties is taken into account.

At the current rate of migration, the health care system is not dependent on foreign health professionals but vigilance is required as the country is dependent on the health workforce situation in wealthier EU and EEA countries that actively recruit foreign medical personnel, such as Ireland, Norway and the United Kingdom. Moreover, the current unfavourable economic situation may significantly accelerate outflow rates, which are unlikely to be remedied by an inflow of professionals from EU-15 countries; any shortages are more likely to be met by professionals from Commonwealth of Independent States countries.

Policy responses

Health professional mobility began with Lithuanian independence, but it was only after EU accession that politicians started discussions on its possible negative effects on the health system and initiated planning processes at governmental, regional and local levels to determine the future supply and needs. The Strategic Planning of Health Human Resources in Lithuania 2003–2020 programme is a primary example.

The domestic health workforce outflows have not led to the development of explicit policies to attract a foreign workforce to supplement the domestic stock. Rather the Ministry of Health has concentrated on reform and restructuring to retain and motivate Lithuanian health professionals to practise in Lithuania. Also, in 2005 the Ministry of Health and the medical associations signed a memorandum on salary increases (20% annually for doctors and nurses in 2005–2008).

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Opportunities in an expanding health service: Spain

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Mobility profile

Market forces have made Spain a corridor for health professional mobility between Latin America and Europe. In particular, doctors from Latin America have responded to shortages by immigrating to work as general medical doctors and to train as specialists. In turn, Spanish doctors and nurses have been leaving for other EU countries, presumably attracted by better working conditions, but this trend has been in decline since the mid-2000s.

Inflows

Medical doctors: In 2001, 7.5% of doctors working in Spain were foreigners.¹ The Organization of Medical Colleges (OMC) estimates that in 2007 about 12.5% of the 203 305 doctors registered in Spain were of foreign origin, with wide geographical variations ranging from 0.2% of doctors in the Basque Country to 15.5% in the Balearic Islands.

Between 1998 and 2002, 4318 degrees in general medicine (licenciaturas) from countries outside the EU were recognized, most from Latin America. Between 2003 and 2008 the number jumped almost six-fold to 24 330.

The number of medical degrees recognized through European Directive 2005/36/EC averaged 230 per year between 1998 and 2004 but the trend has been upward ever since. Far fewer specialty decrees are recognized – 702 in 2007 or 13% of the specialist medical resident slots in 2007.

Nurses: Data for 2004–2008 show that around 1% of nurses working in Spain are foreign nationals, around 48% of whom come from Latin America, 39% from the EU, 10% from Africa and 3% from other parts of the world.² The inflows of Latin American nurses have increased since 2000.

In 2007, recognized or homologated foreign nursing degrees represented the equivalent of 20% of new nursing graduates, up from 3% in 2002. Among the 1195 degrees of EU nurses and midwives recognized during 2002–2007, 23% were from the United Kingdom, 20% from Germany and 18% from Portugal.

Dentists: The number of registered dentists has increased threefold in Spain from 7471 in 1988 to 24 515 in 2007.³ There are significant proportions of foreign dentists with foreign degrees – for example, 20% of all dentists in Madrid, Catalonia and

Valencia – and in tourist areas. There are also a large number of Spanish dentists with foreign degrees, mainly obtained in Latin America or the EU; in 2007 these represented 37% of Spanish dental school graduates.

Outflows

Doctors: In 2001, 5.9% of practising Spanish doctors were registered in other countries. Of these, just under half were practising in the EU and most of the rest were in the United States.¹ Within the EU, most migrating Spanish doctors go to Portugal, France and the United Kingdom, with a considerable number continuing to live in Spain while commuting to work in neighbouring Portugal. Since 2008 there has been a trend towards returning to Spain, with returnees attracted by a domestic labour market that moved from a surplus to a shortage of doctors in the mid 2000s.* In 2007, 650 Spanish doctors requested a certificate from the OMC in order to work abroad, equivalent to only 0.34% of practising registered doctors.**

Nurses: The number of Spanish nurses who validated their degrees to work in the EU increased sharply in 2002, equivalent to 19% of that year's nursing school graduates. However, the increase in internal demand has led numbers to decline sharply since 2003, falling to only 3% of nursing graduates in 2007.

Dentists: The main destination for Spanish dentists is the United Kingdom, following a bilateral agreement in 2001. The number of dental degrees recognized for practise in the EU grew significantly from 2002 to 2005 (from 25 to 177) and has been decreasing since (to 125 in 2007).

Health system impacts

The inflow of foreign professionals, particularly medical doctors, relieved the acute shortages in 2000–2005 and added

flexibility to the market; but it also led to public debate about the quality of some foreign professionals. In recent years, regional health services have compensated for shortages of doctors in some specialties by hiring non-EU doctors whose specialty degrees have not yet been recognized by the Ministry of Education.⁴ The OMC estimates that between 10 000 and 12 000 medical doctors are working in Spain under these irregular conditions.⁵

Despite medical salaries increasing considerably over the past five years, they have not risen to the levels that would be expected. This is due to foreign professionals, mainly from Latin America, who are willing to accept lower salaries and poorer working conditions. From this perspective, since 70% of health financing is funded by taxes, foreign professionals have produced savings for Spanish taxpayers.

Policy responses

There is no defined national strategy for health in Spain and therefore recruitment and training of foreign professionals is improvised and reactive rather than planned. Despite the need for more systematic planning, measures that have been implemented include:

- In 2005 a formal planning process for doctors (based on analysis of needs and supply with a temporal horizon to 2025) was established;
- A simulation model to estimate the shortages and surpluses of medical specialists is being used to set adequate enrolment limits in medical schools and to establish individual specialty numbers in the annual residency competition based on need;
- A register of health professionals, funded by the Ministry of Health, is being set up with the participation of Spain's regional governments; and

- A royal decree for the professional recognition of health specialist from outside the EU was published in May 2010.

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* Shortages were due to three demand shocks: (i) regional governments became responsible for health care and they invested in new hospitals and clinics; (ii) a buoyant economy supported a flourishing private sector in medical services; and (iii) Spanish doctors were attracted by other European countries with doctor shortages and strong demand.

** Such certificates indicate an intention to emigrate but do not represent actual migration to another country.

A major destination country: the United Kingdom

Ruth Young

Mobility profile

The United Kingdom has a long history as a destination country for health professionals. In areas such as hospital services, the National Health Service (NHS) has consistently depended on immigrants, while in areas such as nursing and general practice, the reliance has fluctuated with domestic shortages. Today, more than a third of medical doctors and every tenth nurse registered in the UK are internationally trained.

Inflows

Medical doctors: Foreign trained doctors accounted for 34.5% of all registered doctors in 1988 (or 57 575 in absolute numbers), growing to 36.8% (or 91 064) in 2008. Around one quarter came from the EEA and three quarters from the rest of the world. Overall, EEA-qualified medical doctors accounted for 6% of those registered in 1988, 7.6% in 2003 and 9% in 2008. Overall, Germany is the most significant EU-15 source country with 3201 more medical doctors registered in 2008 than in 1988. Ireland remains a major migration source but numbers are declining. Moreover, numbers from the newer EU Member States (the EU-12) are catching up to those from the EU-15. In 2008, the EU-15 and EU-12 accounted for 1166 and 970 new registrant medical doctors respectively.¹

Nurses: In 2008, 86 947 foreign-trained nurses and midwives were registered in the UK, equivalent to 12.9% of all registered nurses and midwives. The main countries of origin lie outside the EU, namely India, the Philippines, Australia, South Africa, Nigeria, Zimbabwe, New Zealand and the West Indies; 1.3% of all nurses and midwives came from the EEA countries compared to 11.6% for the rest of the world. However, the relatively small share of health professionals from the European region has been growing

since 2003, particularly from the newer EU Member States. For example, in 2008, among newly registered nurses and midwives, 437 were from the EU-15 while 932 came from the EU-12 countries.^{2,3}

Reliance on mobile health professionals from different sources differs across professional groups. For example, it appears that certain professions (eg. dentistry, midwifery, general practice) are proportionally more reliant on European migrants, especially following the 2006 introduction of restrictions on other sources. The relative increase in EU/EEA-qualified health professionals registered in the last ten years is noteworthy, although the numbers remain lower than for non-EEA sources.

The most important drivers for migration to the UK are the potential economic and professional/career opportunities in comparison to source countries. This applies to differing degrees to individuals from developing and CEE countries and to richer nations such as the EU-15. The interaction of economic and family circumstances also appear to be important – whether to generate remittances to the country of origin or the perception that the family will have a better life in the UK. Linguistic and cultural ties, as well as shared traditions in educational curricula and professional practice, also play a role in attracting migrants to the UK.

Outflows

The numbers of health professionals leaving the UK appear to be significantly lower than inflows but data are scarce. Verification of qualification requests and Certificates of Good Standing (CGSs) can only give an approximation of outflows as they indicate an intention to leave the country rather than actual migrations.

In this respect, between November 2007 and May 2009 a total of 9820 CGSs were issued to medical doctors to work

abroad.¹ For nurses and midwives, data show that 8070 applications for qualification validation were received in 2002/2003, increasing to 11 178 in 2007/2009. For both doctors and nurses, approximately ten times more verifications are issued for Ireland than for any other EU country, followed by Spain and France. Outside Europe, Australia is the main destination country, with New Zealand, the United States, Canada and the Middle East also featuring strongly in the rankings. Several African countries are also destination countries for doctors.

However, it is not known how much of this is due to emigrating UK nationals or to foreign-qualified professionals returning home or moving onto a third country for which the UK was a stepping stone.

Health system impacts

While the benefits and challenges of health professional mobility have not been systematically quantified, certain observations can be made.⁴ First, the UK's recent openness to mobility fulfilled its purpose of improving staff coverage rates. In turn, this is perceived to have contributed to reductions in waiting times for NHS treatment. Second, NHS organizations were able to make financial savings on agency fees for temporary staff and greater workforce stability also enabled increases in the UK's training capacity. More generally, mobility clearly has resource benefits for the health system in that it reduces domestic spending on health professionals' education and post-graduate training.

Policy responses

The British government began a policy of massive NHS investment and workforce expansion across all health professions from 1998 to 2006, and increased domestic training capacity alone was not sufficient for the timescale required. Thus, targeted international recruitment of health professionals was a central element of this process. At the same time, many health professionals were recruited into private sector hospitals, nursing homes and social care. The policy of active international recruitment was reversed in 2006 and more restrictive immigration rules

were introduced as earlier expansion in the UK training numbers came on stream. Within the European region, the British Government also signed recruitment agreements targeting (for instance) general practitioners, nurses and pharmacists in Spain; nurses in Greece; nurses and GPs in Germany; hospital doctors and GPs in Italy and Austria; and GPs in France. Scandinavian countries were the other main sources targeted.

It is noteworthy that policy-makers have used internationally recruited health personnel as an approach to influence absolute numbers in the workforce rather than channelling migrants specifically to address geographical imbalances. Moreover, workforce planning has not eliminated cyclical shortages/surpluses and the recruitment/retention problems of less popular specialties and geographical areas. A centre of excellence for workforce planning has been established to provide intelligence and develop planning capacity at all levels. Nationally, the Workforce Review Team provides annual evidence to the Home Office Migration Advisory Committee that reviews the shortage occupation list. This arrangement is intended to enable clearer links between health professional mobility and NHS workforce analysis and planning.

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Emerging challenges after EU accession: Romania

Adriana Galan, Victor Olsavszky, Cristian Vladescu

Mobility profile

Romania is predominantly a source country for health professionals and professional mobility represents an emergent challenge for policy-makers. This situation is the result of EU accession in 2007 and (probably more importantly) other dynamics related to demographics and poor planning and management of the workforce. The scale of migration in 2007 was high but also, since the end of 2009, the economic crisis has begun to impact deeply on Romanian society, including the health system.

Romania has no accurate information on international inflows or outflows of health professionals, particularly for nurses, and data is based on estimates or proxies. Diploma verification certificates issued by the Ministry of Health and the certificates of good standing (CGSs) issued by the Romanian College of Physicians provide an indication of intentions to leave the country but are not an accurate measure of mobility as not all actually emigrate. For example, in 2007 only 28% of doctors who requested verification certificates actually emigrated.

Outflows

Medical doctors: Official data on diploma verification certificates show that in 2007 about 4990 (10%) active doctors had the intention of leaving the country. In the two years following accession, the total number of applications (2683) showed a clear decrease to just over half the 2007 figure.^{*1} Nevertheless, unofficial data show substantial increases in requests for verification certificates in 2010 – with applications averaging over 300 per month.² CGSs are considered to be better proxies than verification certificates. About 3% (1421) of the total number of practising

doctors left Romania in 2007 and more than 90% of these requested CGSs for other EU Member States.³ The majority of medical doctors applying for CGSs came from the Iasi district situated in the country's most economically deprived region. The most common medical specialties of applicants were family medicine, intensive care and psychiatry.

Nurses: The extent of nurse emigration is underestimated by the existing data sources which are of insufficient quality and do not cover all nurses leaving the country. After accession, official data show that 2896 nurses and midwives applied for diploma verification certificates in 2007, equivalent to 3.4% of the workforce, with a fall in the applications in subsequent years.¹ Data from destination countries such as Italy, Germany and the United Kingdom show considerable numbers of newly registered Romanian nurses, and that out-migration is considerably higher than that suggested by diploma verification data. In particular, data from Italy shows that 25% (or 8497) of all foreign nurses registered in that country in 2008 are from Romania.

France, Germany, Italy and the UK appear to be the favoured destination countries for migrating health personnel. The main push factors are low salaries, unsatisfactory social status, difficult working conditions and limited opportunities for career development. In 2010, disincentives for health professionals, such as a 25% cut in salaries and staff reductions in health care institutions, were introduced.

Inflows

There are almost no data on foreign medical doctors or nurses working in Romania but it is likely that the constant high numbers of immigrants from the Republic of Moldova include medical doctors and nurses.

* Data for 2009 includes only January–May.

Health system impacts

Overall the high annual loss of health professionals is a major issue; while there are various reasons for leaving the health system, the total loss is estimated to be 10–30% of the workforce. While there is little evidence of its direct impact on the health care system, there is a general problem of access to primary care services. Given that family medicine is one of the most demanded specialties in some EU countries (e.g. France) it is likely access problems will increase in Romania if the emigration of family doctors continues or increases. Another possible effect of doctor migration is long-term scarcity of some specialties and skills in hospitals.

Increased emigration of doctors and nurses in 2010 is jeopardizing the proper running of many facilities, especially in small municipal hospitals. Large district hospitals are also facing staffing problems, with many vacancies unfilled. This situation is compounded by the government-imposed freeze on all new recruitment in the public system since January 2010.

Policy responses

To date, there is no comprehensive health workforce policy in Romania. The drafting of a national strategy, commissioned in 2007 has seen several delays and does not seem to be a priority. Evidence from other EU countries shows that thousands of Romanian doctors and (especially) nurses have migrated. Hence, it is vital for Romania to develop (i) good monitoring and control systems for cross-border mobility and other factors related to entries and exits from the health workforce; and (ii) better tools to manage the flows of health professionals to minimise any losses for the national health care system.

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When the grass is greener at home: Poland

Marcin Kautsch and Katarzyna Czabanowska

Mobility profile

Although commonplace before EU accession, health workforce mobility escalated significantly in 2004 with the removal of barriers hindering those seeking job placements abroad. After reaching a peak in 2006, recent years have seen considerable changes to migration patterns, probably largely due to substantial increases in the income levels of health professionals, particularly doctors, in Poland.

The main destination countries are the United Kingdom, Ireland, Germany, Sweden and Denmark. The main push factors are low salaries, difficult working conditions and limited possibilities for professional development.

Outflows

Medical doctors: 3% of doctors are estimated to have considered emigrating in 2004.¹ After accession (2005–2008) over 7000 (6.1%) doctors obtained professional qualification certificates issued by the professional chambers and associations to allow them to work abroad.* While certification requests initially increased rapidly following accession, the rate slowed from mid-2007. The majority of doctors applying for certification were anaesthetists and intensive care specialists, followed by thoracic surgeons, plastic surgeons and specialists in emergency

care. This may be because these groups have rather limited contact with patients and so do not need the degree of language fluency that is normally required for non-surgical specialties. Moreover, it appears that younger specialists, having just gained their qualifications, are willing to migrate permanently to other European countries while more senior doctors with long experience and families prefer short duties abroad rather than complete relocation.² Other evidence from professional chambers also suggests that most doctors work abroad for a set period of time before returning home or work part-time in another country (for example, weekend work) to earn extra money.

Nurses: 1.2% of nurses are estimated to have considered emigrating in 2004.¹ A relatively low number of nurses and midwives applied for certification during 2004–2006, approximately 1.9% of registered or 3% of practising nurses and midwives.** This may be because employers (such as long-term care providers) did not require documents or because they were employed to perform care activities that did not require professional qualifications.

Dentists: 3.6% of dentists are estimated to have considered emigrating in 2004.¹ Around 2000 (6.7%) dentists obtained professional qualification certificates in 2005–2008.

* Not all those who obtain a certificate actually migrate. Also, some doctors leave Poland without certification – although it is unclear how these individuals are employed abroad.

** While there are more than 300 000 registered nurses in Poland, nurse organizations estimate that around 200 000 actually work as nurses.

Inflows

Only a limited number of health professionals choose Poland as their target country, mainly due to the language barrier and the lack of a proactive recruitment policy – it can take up to 18 months to obtain a work permit and recognition of professional diplomas.³ Estimates for 2009 put the share of foreign doctors and dentists to be less than 1% of registered personnel. Those who do come are mostly from countries in which GDP is lower than in Poland, mainly Ukraine. There are also indications that Poland may be attracting individuals from the Polish community abroad, especially from the countries of the former USSR, who were born and trained overseas.

Health system impacts

It is difficult to evaluate the exact impact of health professional mobility due to the absence of data or studies. However, while it is not so large that it poses a significant threat to the health care system in the short-term, it is a noticeable phenomenon. It can be argued that emigration contributes to staff shortages in general and in certain specialties. Smaller towns and hospitals are particularly affected. The data indicate that the specialties first affected are those where relatively high proportions of doctors are applying for certification, particularly anaesthetics, intensive care and emergency medicine.

Policy responses

Health policy concerning the health workforce and mobility is not well developed and government activities are limited to general declarations about the need to keep health professionals at home. Market mechanisms of compensation levels, demand levels and exchange rates determine the behaviour of health professionals by influencing whether or not they perceive working abroad as attractive. Thus, *ad hoc* policy interventions have included:

- In 2001, the salaries of all fully contracted health professionals in public health institutions were raised by

203 PLN (€56) per month, whatever their positions, years of experience, qualifications or implications for their health care institutions;

- Preferred loans were offered to health professionals to start their own private business/practice, thus providing financial, career-related and entrepreneurial incentives to promote domestic opportunities for professional development;
- Recruitment of new candidates for health and health-related studies have been instigated, particularly in priority areas which attract higher salaries for medical interns; and
- Managers of health care institutions are offering changes in employment status, from full-time employment to fee-for-service self employment agreements (with smaller obligatory insurance contributions). These will allow self-employed doctors to increase their working hours (beyond the limits of the EU working time directive) and increase income.

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Design and production by
Westminster European

ISSN: 1020-7481



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