Migration patterns of Polish doctors within the EU

Joanna Leśniowska

The accession of Poland to the European Union (EU) has brought with it many challenges as well as benefits. These challenges inevitably include the migration of health care professionals. The principle of the free movement of labour implies that health professionals, as a part of the European workforce, can move across borders and work in other Member States. Free movement of health care personnel within the EU is permitted by European Council Directive 2005/36/EEC, subject to the mutual recognition of professional qualifications. Under this legislation doctors, dentists and nurses are entitled to full registration in any EU Member State. As the living standards in most of the old EU countries continue to exceed those seen in Poland, the economic incentive to move is often high.

Verification certificates
Despite these economic pressures, there remains little information on the migration patterns of doctors. The principal source of information is the Polish Chamber of Physicians and Dentists which issues professional verification certificates, allowing Polish doctors to apply for jobs in other EU countries. Data from this organisation indicates that between January 2004 and April 2007 more than 6,000 doctors received such certificates. Most were issued to doctors specialising in anaesthesiology and intensive care (17.54%), plastic surgery (14.97%) and chest surgery (13.18%).

By far the most popular destination was Great Britain (England, Scotland and Wales), which registered 1,633 doctors post accession, compared with just fifty-three between 2000 and 2003 (Figure 2). Substantial levels of migration were also seen in Sweden, Germany (where migration had been longstanding), Ireland, Denmark and the Netherlands.

Conclusions
Clearly, the accession of Poland to the EU has had a considerable impact on the escalation of the migration process for doctors. This is most notable in Great Britain where prior to accession there were just 335 Polish doctors registered compared with 1,968 by 2007. Although it is also the case that a much lower number of doctors migrate compared to those who obtain the necessary professional validation certificates (6,007 versus 2,961), it must be stressed that the number of migrant doctors shown here is conservative. There are gaps in registration data from several EU-15 countries which if plugged would increase the number of migrant doctors. Other doctors have also migrated to the principal European Economic Area coun-

Verification certificates should be perceived only as an indicator of the interest of medical personnel in taking up work abroad. A better sense of the scale of migration can be obtained from the competent authorities in other EU countries responsible for the registration of the medical workforce.

Migration patterns
As Figure 1 indicates, between January 2004 and March 2007 2,961 doctors were newly registered to practice in the EU-15 countries. This represented a dramatic increase on registration rates in the pre accession period. Most of these migrant doctors were specialists in the fields of anaesthesiology (327), internal medicine (213) and general surgery (129).

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Figure 1. New Polish doctor registrations in the EU-15 2000–2007

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No data were available from Austria and Greece; only partial data available from Germany (1 regional medical office ‘Landesärztekammer’ out of 17 existing), Ireland (registration of specialists not compulsory), Italy (26 of 69 regional medical offices ‘Ordine Provinciale dei Medici Chirurghi e degli Odontoiatri’), Sweden (data from 2004–2007 only), Spain (8 of 40 regional medical offices ‘Colegio Oficial de Medicos’).
Restructuring municipalities and municipal health services in Finland

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Public responsibilities for health care services have been decentralised more in Finland than in any other country. In Finland, 415 municipalities, with a median of about 5,000 inhabitants, hold legislative responsibility for organising and funding health services for their residents. In addition to health services, municipalities are also responsible for organising social services and primary education. Municipalities have a significant degree of freedom to plan and organise these services as they see fit and state-level steering is quite weak. Municipal services are funded mainly by municipal income tax, state subsidies and user fees.

The municipal health care system provides the largest share of health care services in Finland (for example about 70% of outpatient physician visits, about 60% of outpatient dentists visits and about 95% of inpatient care periods). In addition to the municipal system, health care services are also delivered by occupational health care and private health care providers; these are partly reimbursed by the statutory National Health Insurance.

National legislation stipulates that every municipality must have a health centre that organises primary health services. The survey recorded the number of vacancies on 30 May 2006. The ensuing data indicated that there were 4,113 unfilled posts. The greatest number of vacancies were for anaesthesiologists (398) and internists (312). These deficits in personnel may just be a foretaste of problems to come; migration rates continue to increase, with 1,167 doctors obtaining the necessary certification to pursue professional opportunities elsewhere in the EU in 2006, compared with 862 in 2005 and 461 in 2004.

REFERENCES

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