Cross-border recruitment of hospital professionals

Final report to HOSPEEM and EPSU

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1.0 Introduction

1.1 Overview of the study

This study charts the migration profile of the hospital sector workforce in Europe and identifies and analyses initiatives within the hospital sector that have addressed the issues arising from a mobile workforce. The European Federation of Public Service Unions (EPSU) and the European Hospital Employers' Association (HOSPEEM) commissioned the study to inform the development of a social dialogue in the hospital sector, which received support from the European Commission under budget line 04.03.03.01.

The development of European level social dialogue in the hospital sector started with a conference in May 2000. A second conference took place in 2002, which underlined the importance of developing dialogue in the light of enlargement. The conference also highlighted three key issues for the sectoral social dialogue; issues around free movement of workers, skills shortages faced by hospitals in numerous Western European countries, and the problems presented by an ever increasing workforce.

The HOSPEEM / EPSU conference on 16-17 March 2006 was the fourth pan-European meeting with the core aim of formalising the social dialogue in the hospital sector in the EU. The initial findings of this study were presented at the conference. This final report presents the research findings and takes into consideration comments and views from conference participants. More specifically this report attempts to provide an overview of migration patterns amongst the hospital sector workforce in the EU (EU-25) and to assess ways in which sectoral social dialogue at the European level can help to address the issues presented by migration and mobility among the hospital workforce.

1.2 Migration in Europe

The mobility of workers has been a central issue in European policy in recent years not only as a result of the discussions regarding freedom of movement for workers from the "new" Member States. Indeed, freedom of movement of persons is one of the fundamental rights guaranteed by Community law, including the right to live and work in another member state. Despite these provisions, enshrined in the early EC Treaties, the number of workers moving between (and indeed even within) Member States is relatively small, as a result of cultural, language and personal barriers. This apparent overall reluctance to exploit the possibilities of freedom of movement poses difficulties in resolving skills gaps and labour shortages in certain regions and occupations. Not least for this reason, the European Commission has declared 2006 the European Year of Mobility, with a range of initiatives implemented to encourage worker movement throughout Europe.

1.2.1 General legislation governing mobility of workers

For workers, freedom of movement has existed since the foundation of the European Community, as laid down in Article 39 of the EC Treaty. While the term "worker" has not been defined in the Treaty, it has been interpreted by the Court as covering any person who (i) undertakes genuine and effective work, (ii) under the direction of someone else (iii) for which he is paid., hence covering anyone working ten hours a week and trainees. It does not apply to self employed persons, students, retired or non-active persons, who are covered by other provisions of Community law.

EC legislation on the free movement of workers (article 3(1c), 14 and 29-42 EC Treaty) establishes that nationals of a Member State are entitled to seek employment within the territory of another Member State on the same terms as national workers. Community workers must consequently be treated in the same way as national workers in respect to conditions of employment, benefits not directly connected with employment, (i.e. social and tax advantages, vocational training, housing benefits, aid intended to ensure a minimum subsistence level and family allowances) and trade union representation.

The Agreement creating the European Economic Area, uniting the Community and the European Free Trade Association (EFTA), likewise confirmed that the nationals of the latter enjoy the same rights as the EU nationals in relation to the free movement of workers.

The accession of the 10 new member states to the EU on 1st May 2004 generated a debate on the free movement of workers from these member states. A transitional period of up to seven years was agreed (Treaty of Accession 2003), to deal with the fears of some EU 15 Member States that a massive and sudden mobility would take place and harm their labour markets. The transitional period is based on the "two plus three plus two" formula and is applicable to nationals of the Czech Republic, Estonia, Latvia, Lithuania, Hungary, Poland, Slovenia, Slovak Republic. Nationals from Malta and Cyprus are exempted.

The formula implies that the EU-15 Member States may restrict access to their labour market, initially for a period of two years. These restrictions will be reviewed by the European Commission by the end of the two-year period, after which the EU 15 Member States can decide to apply the Community rules on the movement of workers to nationals from the new Member States or to continue with their national rules for a further three-year period. Five years after accession nationals of the new member states should fully benefit from rights to free movement, unless an EU 15 member state experiences serious disturbances on its labour market, or the threat thereof in which case it can apply its national rules for another two years. The Treaty of Accession requires that by the end of these seven years, in May 2011, labour markets are open to all EU 25 citizens.

1.2.2 Access to social benefits

The establishment of access to social benefits is important with regards to the free movement of workers. There are many attempts (mainly based on case law) to ensure that the workers enjoy full benefits. Regulation 1408/71 set out the basic principles regarding social security schemes and the free movement of persons. The social benefits covered by the regulation include sickness and maternity benefits, invalidity benefits, old age benefits, survivor's benefits, benefits in respect of accidents at wok and occupational diseases, unemployment benefits, family benefits and death grants.

The main issue regarding migrant workers is that they may be either insured twice or not insured at all or that because they may be insured in a member state for a less than the minimum required period they may lose out on benefits. To deal with this situation, European Community law establishes the following basic principles regarding social benefits and the free movement of workers.

- Workers must be subject to the legislation of only one member state at a time and insured only in the country of occupational activity;
- There are temporary exceptions for short-term posting abroad, during which the migrant worker remains insured in the country where s/he used to exercise his/her occupation activity;

- There are also special categories of workers, like mariners or workers in international transport, in which case workers could be insured in countries other than the ones where they exercise their occupation activities; and
- Special cases have been implemented, for example for persons working regularly in more than one member state. In such cases workers are insured in the country they reside in.

It is important to note that while it is up to the member states to design their social insurance and social benefit system, Community provisions on social security determine which country has to pay these benefits. The basic principle remains the same: migrant workers have to enjoy equal treatment with national workers.

Regulation 1408/71 and the subsequent amendments provide technical details on the provisions of these social benefits. While it is not the purpose of this section to analyse technical information, we analyse the provision of some of the most important benefits in order to present the problems that arise and the rationale of the solutions.

1.2.2.1 *Sickness benefits*

Workers need to know who is responsible for their sickness benefits, in kind or cash, when working in another country. The main principle regarding these benefits is that whenever certain conditions have to be fulfilled before a migrant worker becomes entitled to benefits (i.e. certain years of insurance) the competent institution must take into account periods of insurance, residence or employment completed under the legislation of another Member State (*principle of aggregation*).

Sickness benefits in cash, benefits that replace income (wages, salaries), which are suspended because of sickness, are paid according to the legislation of the country of insurance. However, sickness benefits in kind, like medical and dental treatment, medicines or hospitalisation, are provided according to the legislation of the country the migrant worker resides.

1.2.2.2 *Pensions*

This is one of the most complex issues regarding the free movement of workers in the EU, especially regarding the recognition of the periods a worker has been insured in other member states. Migrant workers retain their insurance record in every member state they have worked in until they reach pensionable age. Every country in which they have worked for at least a year will have to pay an old-age pension when they reach pensionable age. Whether this will be a “high” or “low” pension will depend on their insurance record in the country.

This means that migrant workers does not lose any of their pension rights and that rather than one big pension they receive many small ones. Migrant workers do not lose from shorter periods – i.e. less than 12 months – since the last member state worked in has to bear the responsibility to incorporate such periods.

Some technical issues regarding exchange rates and postal bank charges remain problematic. However, the main problem arises from the differences in the pension age around Europe which means that the migrant may be entitled to a pension in one country but may need to wait for a pension from another country.

The European Commission is currently seeking to take action in order to improve the portability of supplementary pension rights.

1.2.2.3 *Unemployment*

The basic rule regarding rights to unemployment benefit is that they should be claimed in the country where the migrant worker was lastly active, under the same conditions as national workers. If calculations are based on previous wage or salary only those received in that country should be taken into account. Community law has also tried to facilitate the search for jobs in other member states while unemployed by specifying periods that an unemployed individual will be entitled to these benefits even when job hunting in other member states, albeit under specific conditions.

1.2.3 Legislation for third country nationals

Access to European labour markets for third country nationals is subject to national-level legislation. However, family members of workers enjoy special privileges regardless of their nationality and have the right to live with the worker in the host Member State and have the right to equal treatment as regards for example education and social benefits. Some members of the family have also the right to employment.

Whereas access of third country nationals to work is a highly sensitive issue and relies on national sovereignty, the EC has proposed to determine common definitions, criteria and procedures regarding the conditions of entry and residence of third country national for the purpose of paid economic activities, aiming to establish a single national application procedure, whilst still respecting member states' discretion to limit economic migration[I].

The European Council has recently decided to extend Regulation (EEC) No 1408/71 to third-country nationals legally resident in an EU Member State. Council Regulation (EC) No 859/2003 of 14 May 2003 on this subject entered into force on 1 June 2003. As a result, third-country nationals and their family members and survivors can benefit from the European provisions on the coordination of social security schemes as long as they are legally resident in a Member State and in situations which involve more than a single Member State (e.g. a worker who is working in Belgium and whose children are studying in France may apply for family benefits even though the children do not live in Belgium). Specific provisions on family benefits apply in the case of Austria and Germany.

In the UK there are a number of schemes available to non-EU/EEA citizens which aim both to facilitate and control the access of migrants to the UK labour market. There are also some special initiatives in place for the Commonwealth countries.

1.2.4 Frontier workers

A frontier worker is an employed or self employed person who pursues his employment in a different states from the one he resides in and to which he returns at least once a week [II]. Due to geography and languages, there is a great potential for frontier workers in some countries in the EU, especially in Central Europe.

Frontier workers generally enjoy the same benefits as migrant workers, for example with regards to insurance, family benefits and pensions. However they have different provisions regarding sickness benefits and unemployment benefits.

With regards to benefits in kind for sickness and accidents at work, frontier worker may choose where to obtain benefits from. However with regards to unemployment benefits, a

[I] Proposal for a Council directive, Com (2001) 386

[II] As defined in the regulation 1408/71

frontier worker can claim these benefits from the country he resides in. (These have been improved by the reform of the Regulation 1408/71 and the Regulation 883/04).

Issues regarding taxation are more complicated and are mainly dealt with through bilateral agreements, although the general rule of equal treatment applies for income tax. Rules applied call for a frontier worker not to pay more tax than a person living and working in the same country as the one of his employment. In addition, rules that make it more beneficial to be taxed as a couple rather than as a single person should not be conditional on both, frontier worker and spouse be residing in the same country.[I]

There is a lack of uniform national data and hence no reliable statistical information regarding the situation of frontier workers in EU. There is, however, an estimate that such workers make up less than 0.5% of employed workers in the European Union[II], with Luxembourg and Switzerland receiving most frontier workers[III].

1.3 Legislation governing the mobility of hospital workers

The EU's position in relation to health policy has traditionally been rather diffuse as responsibility for health was, in 2000, spread across 13 of the 24 DGs, and generally focused on public health rather than health services specifically. The 1997 Amsterdam Treaty emphasised that the responsibility for health services should fall to individual Member States, although certain articles of the Treaty (the Health Policy Mandate) did allocate some responsibilities to the Commission such as health promotion. In recent years, it has been the role of the Social Protection Committee to monitor and benchmark developments in relation to health and social care as part of the open method of co-ordination in this field. The White Paper on Services of General Interest published in May 2004[IV] announced a more systematic approach to the treatment of social and health services of general interest at EU level. A Communication on this issue is expected in 2006.

While the European Commission's role in health has been traditionally fragmented, the Commission has demonstrated support for the mobility of hospital professionals for many years. The Treaty of Rome laid the initial foundations for the mobility and movement of workers throughout the EU, and further European Directives were passed in 1975 (75/362/EEC and 75/363/EEC) which focused specifically on facilitating the entry of doctors into Member States by means of ensuring that professional qualifications were recognised and equally acceptable across all Member States. These two directives were consolidated in 1993 into directive 93/16/EEC ("The Doctor's Directive"), which, in accordance with citizenship and completion of training, essentially allowed doctors to register in any other Member State. In recent years, this directive was amended several times, and eventually was replaced by 2005/36/EC in October 2005. Alongside the Doctor's Directive sit eleven other sectoral directives, all based on minimum training standards. A proposed reform of the recognition of qualifications envisages consolidation of three general system directives[V] with

[I] Communication from the Commission, Free movement of workers-achieving the full benefits and potential, 2002.

[II] Opinion of the Committee of the Regions on Frontier workers: Assessment of the situation after ten years of the Internal Market: Problems and Perspectives (2005/C 43/02)

[III] Frontier Workers in the European Union, Directorate General for Research , WORKING PAPER Social Affairs Series - W 16A - Summary

[IV] http://europa.eu.int/eur-lex/en/com/wpr/2004/com2004_0374en01.pdf

[V] Council Directives 89/48/EEC and 92/51/EEC and European Parliament and Council Directive 1999/42/EC

twelve sectoral directives[I] covering the seven professions of doctor, nurse, dental practitioner, veterinary surgeon, midwife, pharmacist and architect[II]. These pieces of legislation were merged into a single text, namely the Directive 2005/36/EC[III]. The new Directive will be effective as of 20 October 2007.

While EU/EEA nationals are afforded the ability to move freely around Europe, restrictions are in place on a country-by-country basis for those originating outside the EEA as discussed above. In most countries regulations differ for third country nationals who are trained and qualified medical professionals. For example, the UK's Highly Skilled Migrant Programme has in place conditions which encourage qualified hospital personnel to move to the UK to take up employment in the Health Service. However, new immigration rules which come into force in mid-2007 mean that third country hospital professionals will need work permits to practice in the UK and permits will only be awarded where there are genuine skills gaps and where posts cannot be filled by a UK or EU national. The new points-based system will ensure that doctors can enter the UK without a firm job offer, while nurses will be allowed entry only with a firm job offer in a "shortage area". In Ireland, non-EU/EEA doctors are entitled to temporary registration which requires the passing of a language test and the passing of the Temporary Registration Assessment Scheme (TRAS) which involves further training and development. Temporary registration can be held for a maximum of seven years.

1.3.1 Patterns of mobility in the hospital sector

Over the past decade there has been a general trend of increased mobility in the hospital sector within Europe, from third countries into Europe and from Europe to other third countries. This report seeks to establish patterns of worker migration in the sector, what motivates workers to migrate, what challenges increased migration brings and what social dialogue can do to address these challenges.

When trying to establish a picture of mobility in the sector difficulties arise around the data which is available. Currently, there is no comparable data collected for the EU-25. While DG Internal Market surveys and the Labour Force Survey have both sought to establish levels of migration, there are significant gaps in their statistics over time, and for many countries data is unavailable. Using national registry data can prove to be a useful measurement tool and can provide more consistent data, although this method is not without flaws either. Registry data is collected differently in each country and so the data is far from comparable, and furthermore, this method only provides data for those professions which legally require registration; namely physicians and related professions, and nurses and midwives. This means it becomes almost impossible to monitor the level of migration amongst lower-skilled and management-level workers at an EU level. Finally, registration data only measures the intention to work in a certain country and not actual employment.

However, by examining the available data and legislation imposed across the EU, it becomes possible to draw together a picture, albeit fragmented, of migration in the hospital sector. While some countries have restrictions on migration in the sector, such as Italy, others allow completely free movement. For example, EU citizens are entitled to apply for healthcare

[I] Council Directives 93/16/EEC, 77/452/EEC, 77/453/EEC, 78/686/EEC, 78/687/EEC, 78/1026/EEC, 78/1027/EEC, 80/154/EEC, 80/155/EEC, 85/432/EEC, 85/433/EEC, and 85/384/EEC

[II] For more information on the reform of the system see: Reform of the system for the recognition of professional qualifications on SCADPlus at: http://europa.eu.int/scadplus/leg/en/cha/c11065.htm

[III] Directive 2005/36/EC of the European Parliament and of the Council of 7 September 2005 on the recognition of professional qualifications, OJ L 255, 30.9.2005, p.22-142

posts in Italy and subject to passing a public exam will be granted access. However, limitations are imposed on upper-level posts; public manager vacancies must be filled by Italian citizens and thus the movement of doctors and high level health professionals is restricted[I]. Further illustration comes from examining mobility between neighbouring countries: movement between the Nordic countries has been traditionally high since the 1960s, and in 2001, around half of the non-Danish trained physicians in Denmark were Norwegian.

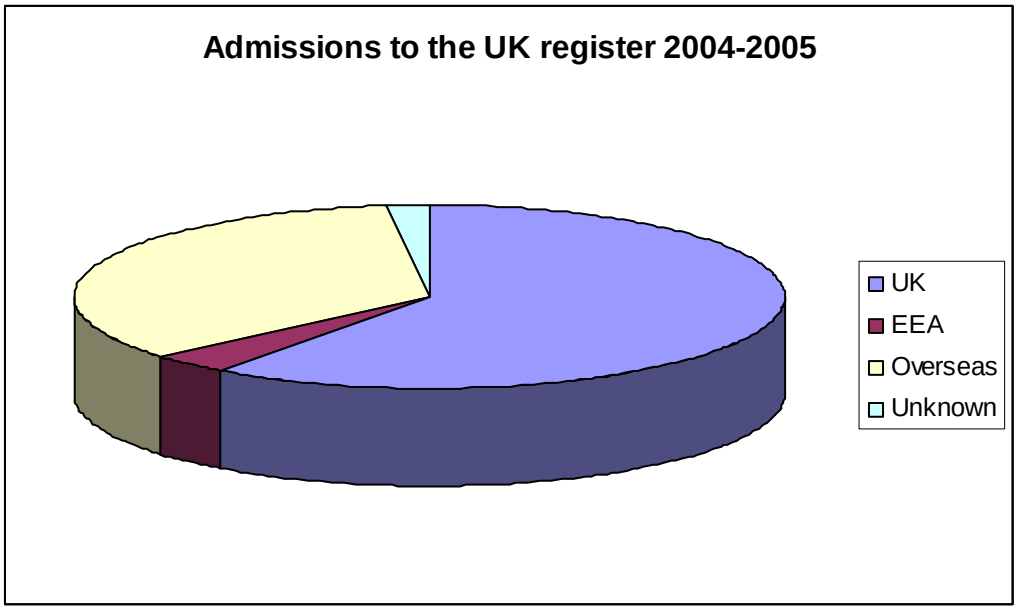
By using a combination of registry data, LFS data and other surveys, a general overview of patterns of migration in selected countries can be found in the annex to this report. This chapter provides a more in depth analysis of movement to the UK and Ireland, both countries for which data is readily available.

1.3.2 Mobility in the hospital sector – the case in the UK and Ireland

The UK has seen a 290% increase in overseas nurses in 8 years with the level of Internationally Recruited Nurses (IRNs) standing at 4.9% of the total nursing workforce. While this figure is relatively small, when considering the level of new admissions to the register over recent years it is possible to see how the increase in IRNs has affected the structure of the nursing workforce. Here, the level of overseas registration forms a far larger percentage of registrations than the 4.9% which is true for the wider workforce.

Figure 1.1 demonstrates the percentage of initial registrations in 2004-2005 to the UK Nursing and Midwifery Council register from the UK, the EEA and Overseas (third countries). The extent to which the EEA has acted as a supplier of nurses to the UK hospital sector is minimal when compared to the number of admissions from third countries. The register data shows that for 2004-05, the EEA supplied only 1,193 (3.6%) initial registrants of a total 33,257. UK admissions make up the highest percentage by far (60%), although admissions from third countries made up 34.5% of the new registrants for the year.

Figure 1.1 Source countries for admission to the UK nursing register 2004-2005



NMC Register Analysis, 2005

[I] Silvana Dragonetti, The National Health Service in Italy: (http://www.eurocarenet.org/IMG/doc/The_italian_situation_about_the_recruitment_of_nurses.doc)

Furthermore, the concern with regards to immigration as a result of accession would also appear to be unfounded when the initial registration data for the EU10 is analysed. Table 1.1 illustrates the number of admissions to the UK nursing and midwifery register in the year following accession. The EU10 admissions to the register form only 0.69% of total registrations, 19% of EEA registrations and 1.8% of all international registrations. Registrations from Poland constituted the majority of EU10 nurse registrations. Unfortunately data for the EU10 is not readily available for previous years, and so it is difficult to establish whether there was a change as a result of the accession process.

Table 1.1 Admissions to UK nursing register from EU10 – 2004/2005

Country	Number of admissions
Poland	133
Czech Republic	23
Hungary	22
Slovakia	22
Lithuania	17
Malta	7
Estonia	5
Cyprus	2
Latvia	0
Slovenia	0
TOTAL	231

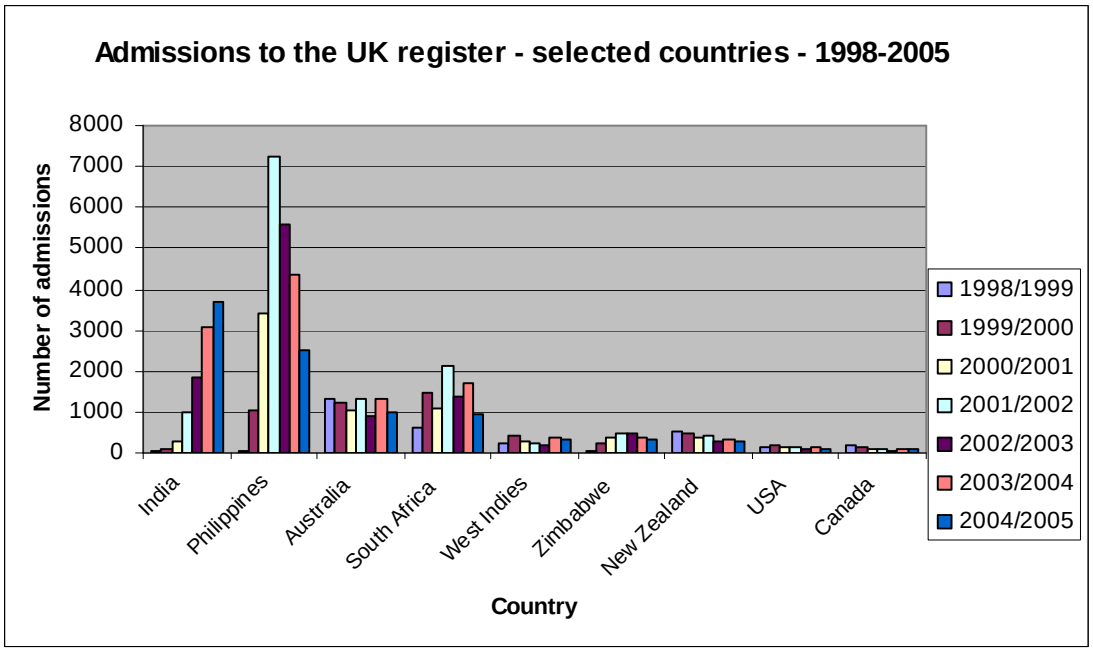
NMC Register Analysis, 2005

When comparing the numbers of initial registrations to the UK register over recent years the data show that from the previous year, 2003-2004, registrations from the EEA increased slightly. UK registrations broadly maintained a similar level, while overseas registrations dropped by 2,600. The largest growth in overseas registrations occurred between 2000 and 2002, when the level increased from 8,403 to 15,064. This increased level of recruitment was largely a response to the publication of the NHS Plan[I] in 2001, a policy document for the NHS which held as a central aim a target to increase the nursing staff by 20,000.

Figure 1.2 illustrates the changes in the level of overseas recruitment in the UK. India is the only country which has shown a year on year increase in initial nursing registrations. The "poorer" countries such as the Philippines and South Africa have seen an overall increase over the eight year period, while the levels of registration from wealthier countries such as Australia and the USA have remained fairly consistent.

[I] Department of Health, 2001 The NHS Plan: a plan for investment, a plan for reform

Figure 1.2 Changes in admission to the UK nursing register

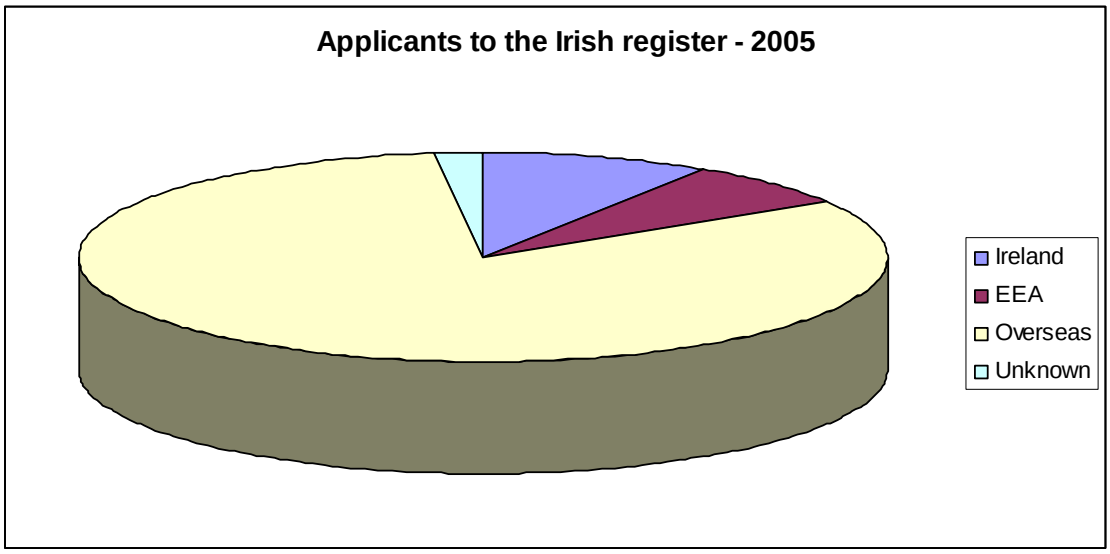


NMC Register Analysis, 2005

An important factor to consider when interpreting the statistics for the UK is that the majority of IRNs are recruited to the private sector and so are not subject to the same guidelines on recruitment and good practice as those in the NHS (see section 4.2.1 on ethical recruitment practices).

Ireland has experienced similar patterns in its admissions to the nursing register as the UK. Figure 1.3 illustrates the extremely large number of overseas applications for registration received by An Bord Altranais (Irish Nursing Board) in 2005 – 2,438 of a total of 2,982 applications. However, due to changes in the nursing qualification structure, no Irish nursing students completed their training in 2005 and so employers compensated for the shortfall by recruiting overseas nurses. Of all the applicants to the Irish nursing register from the EEA, the UK was the biggest supplier with 117 nurses, while Poland was the second largest with 34 applicants. India was by far and away the largest supplier of nursing staff to Ireland in 2005, with over half of the total number of applicants (1,709) being of Indian nationality. Registration data for 2001 and 2002 shows that the majority of registrations were made by Irish nurses while the Philippines supplied the second largest number of first-time registrants across both years. India supplied very few registrants in 2001 and 2002, indicating that this number has risen dramatically in recent years.

Figure 1.3 Source countries for admission to the Irish nursing register 2005



An Bord Altranais

Finally, it is equally important to remember that there has also been a significant level of outward migration from both the UK and Ireland. Table 1.2 illustrates the level of migration amongst UK nurses to the ten most popular destinations, with the figures showing those who are registered with the NMC but are resident in another country. Australia has remained the most common destination country for UK nurses for the past five years at least, with the highest number of verification requests to the NMC since 2000. It is interesting to note that the number of verification requests from Australia has more than doubled to 4,393 in the period 2000 to 2005. Similarly, the number of requests from the USA has quadrupled to 2190 in 2005, while the number of requests from the EEA increased from 827 to 1284.

Table 1.2 UK-trained nurses resident and registered abroad

Country	Number of nurses
Australia	5,415
Ireland	4,472
South Africa	2,197
USA	2,076
New Zealand	1,971
Channel Islands	1,484
Canada	961
Isle of Man	852
Hong Kong	766

NMC Register Analysis 2005

The annex to this report provides further details on the level of outward migration for selected countries.

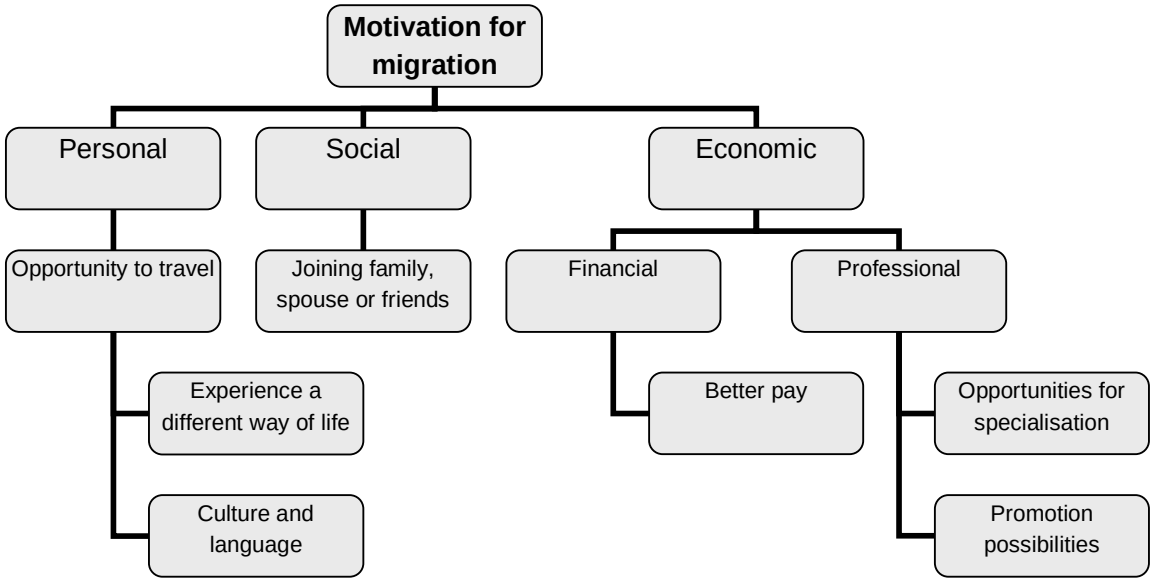
2.0 Exploring migration in the sector

2.1 Motivation for migration: personal and social migration versus economic migration

By understanding the motivation behind worker migration in the hospital sector it becomes more possible for employers and social partners to develop approaches which attempt to address the reasons highlighted and therefore improve worker retention in the country of training or nationality or indeed to encourage ethical migration from countries of oversupply to those of skilled labour shortage. There are two key categories of reasons offered for migration by those who move between countries in the hospital sector: those which can be classed as personal or social migration, and those which can be classed as economic migration. These factors are explored in more depth below.

Figure 2.1 provides a categorisation of the key motivations for migration which were offered in two surveys of internationally recruited health professionals in the UK and France[I].

Figure 2.1 Motivation for migration – personal, social and economic



Three studies have attempted to establish the reasons for migration amongst health professionals, two of which were conducted in the UK[II] and one was conducted in France. The studies concluded that the reasons for migration vary greatly depending on the destination country of the staff in question. Amongst third country nurses in the UK, financial motivations were most common amongst nurses from the Philippines and South Africa, although financial incentives were not cited by one single respondent from Australia. Other

[I] J Buchan et al. *Internationally recruited nurses in London: profile and implications for policy*, 2005, Kings Fund and C Thayer, *Survey of European doctors working in France*, presentation to La Conférence Européenne des Ordres et des Organismes d'attribution similaire (CEOM).

[II] J Buchan et al. *Internationally recruited nurses in London: profile and implications for policy*, 2005, Kings Fund and C Jinks et al, *Mobile medics? The mobility of doctors in the EEA*. Health Policy, 2000, 54 p45-64

studies of EEA nationals working in France and the UK however found that financial motivations were very low; only 19% of EEA doctors surveyed in France cited economic gain as a motivation for moving – of these the biggest number were from Poland.

Table 2.1 Finance as a motivator for doctors migrating to France

Better off financially in France				
Country	**No**	**%**	**Yes**	**%**
UK	21	95%	-	-
Netherlands	34	92%	-	-
Germany	147	75%	33	17%
Italy	67	66%	11	11%
Greece	17	65%	4	15%
Belgium	234	65%	93	26%
Poland	21	54%	11	28%
Spain	36	51%	13	19%
All doctors	637	67%	186	19%

C Thayer, European doctors working in France

When considering the movement of EU/EEA professionals, reasons associated with career progression are commonplace; a study conducted in the UK in 2000 showed that the two greatest reasons for migration were a lack of jobs and specialisation in the source country, and better opportunities for training in the destination country. This was corroborated by the study conducted in France which showed that 30% of Spanish doctors and 28% of Belgian doctors felt that they would have more career flexibility in France.

Movement for personal reasons was most commonly attributed to nurses from Australia, New Zealand and the USA. In this group, no other type of reason for migration was offered in response to the survey. Again, this was shown in the survey in France, in which 48% of respondents noted they had desired a “change of scene” when they moved. Social reasons such as joining family were uncommon amongst the respondents but occurred most frequently amongst those from Africa and India.

Finally, and perhaps most interestingly, the survey carried out amongst doctors in France showed that language skills were the most influential factor in the decision-making process in moving. 73% of respondents cited knowledge of the French language as being a factor favouring migration. This response was most common amongst doctors of UK and Belgian nationality.

2.2 Targeted and active recruitment

It is true that the majority of health services across the world are suffering from shortages of health professionals. While it is noted that there are huge difficulties in defining and measuring staff shortages - the USA, with a reported nurse to population ratio of 773 nurses to 100,000 population, is reporting nursing shortages, and so is Uganda, with a reported nurse:population ratio of approximately 6 nurses per 100,000 population – the World Health

Organisation noted in 2003 that "most critical issue facing health care systems is the shortage of people who make them work"[I].

At the most basic level, it would be fair to summarise that a shortage of hospital professionals exists where there is an imbalance between the level of skills required (the number of doctors and nurses for example) and the actual availability of these staff. Growing and ageing populations have globally increased the demands placed on healthcare systems and thus increased the need for trained and qualified staff.

The above-mentioned difficulties with measuring staff shortages mean that it is difficult to compile a comprehensive picture of the situation in Europe. In the UK, shortages are measured in terms of the number of NHS posts vacant for more than three months for example. A lack of data for the EU10 makes it difficult to establish whether health professional shortages are in effect, however assumptions can be made when monitoring the number of doctors and nurses employed in different countries over time, bearing in mind the general increasing need for services. Self-reported figures show that the number of nurses employed in Poland has dropped significantly over recent years (a reduction of over 30,000 between 1995 and 2003). However, it should be borne in mind that there are high levels of variation between countries; for example Spain has a well-documented oversupply of trained medical personnel.

Further information and data on reported staff shortages in selected European countries is provided in Annex One of this report.

As a response to staff shortages, many health services have employed programmes of targeted and active recruitment in other countries. Targeted recruitment is taking place on a large scale throughout Europe and drives much migration throughout the continent, by means of programmes coordinated nationally by Ministries of Health, at a local level by hospital trusts and individual employers and independently via recruitment agencies. Bilateral agreements between governments are relatively commonplace and exist both within Europe (UK and Spain, the Netherlands and Portugal) and also between third countries and EU Member States. For example, the South African government has established bilateral agreements with Germany and Cuba, and the UK has agreements in place with the Philippines and India.

However, recruitment through agencies has remained the primary route for most mobility in the sector, in the UK at least. A study of internationally recruited nurses in London showed that over 60% of nurses involved in the survey had involved an agency in their move to the UK, and this was the case for almost 100% of Filipino nurses and over 80% of South African nurses. In the UK alone, there are 46 agencies involved with international recruitment on the list of approved contractors assembled by NHS Employers – these agencies have received two references from NHS trusts which state they comply with ethical codes of practice. There are many more who only provide one reference and 150 agencies with no NHS references at all.

[I] Buchan & Calman, 2005, The global shortage of registered nurses – a report for the global nursing review initiative

2.2.1 Example: the bilateral agreement between the UK and Spain

A bilateral agreement was established between the UK and Spanish governments in 2001 to formalise the supply of nurses, general practitioners, consultants, pharmacists and dentists to the English labour market. While relatively informal in terms of the conditions it set out, the agreement concluded that the UK was free to recruit actively from the Spanish health sector.

The agreement was initiated by the Spanish Minister for Health as a response to the NHS Plan[I], a central aim of which was a target to increase the UK nursing staff by 20,000. The Spanish authorities agreed that a possible action to contribute to meeting the staffing target would be to encourage the migration of nurses from Spain to the UK, thereby also providing employment for the large number of unemployed nurses in Spain as a result of the oversupply of trained staff in the country. Recruitment from Spain provided further advantages for the UK in that as an EU Member State free movement was possible between the two countries, and that both healthcare systems function on similar working practices.

In practice, for the most part recruitment is initiated by individual NHS Trusts who have vacancies which they wish to fill with Spanish staff. The British Embassy in Spain is the first port of call for those who wish to move to the UK through the agreement; the Embassy liaises between applicants and employers to arrange the first round of selection by coordinating applications which are passed on to the recruiting Trusts. Most of the recruitment process takes place in Spain – recruiters visit the country and carry out interviews there. A language ability test is involved for applicants; while for nurses the test is not the formal IELTS test (International English Language Testing System) other methods are used including being interviewed in English. Once positions have been filled, staff are offered a minimum contract of two years.

On arrival in the UK, the type of induction process nurses, consultants and pharmacists undertake is left to the decision of the recruiting trust. While core guidance has been developed by the Department of Health which recommends an induction period of 4-6 weeks including further language training where necessary, it is not mandatory to offer the level of training which is suggested. Each nurse recruited should be allocated a mentor and a member of staff in each Trust should act as an International Staff Support Officer who will be responsible for providing social and pastoral support. Finally, the recruiting Trust is also responsible for arranging accommodation as close to the hospital as possible for the new staff member to move into on arrival.

The project has to date recruited over 1,200 nurses to the UK. The Department of Health admits that due to the large numbers of nurses involved in the project it is more difficult to provide the same level of support to nurses as is provided to consultants or general practitioners on their arrival in the UK. Despite this, it is thought that retention is good and while a number of nurses do return to Spain after the two-year contract period is completed, many of these nurses return to work in the UK after a short time. The approach which was initially developed for nurses has now been applied to hospital consultants, general practitioners and pharmacists and has proved so successful that it is now being applied in a non-medical setting to social workers. In a recent pilot 16 social workers were recruited to three local authorities in the north-west of England.

The Department of Health in the UK maintains that the success of the project rests on the fact that the programme was fully piloted and tested prior to full implementation and the rigorous approach it takes to recruitment from Spain.

[I] Department of Health, 2001 The NHS Plan: a plan for investment, a plan for reform

2.2.2 Example: targeted recruitment in Denmark; Storstroem County

While Denmark does not have an agreement in place with Poland, some targeted recruitment does take place. In 2003, four Danish counties came together to actively recruit doctors from Poland through a Swedish agency. Storstroem County was looking to fill general vacancies in smaller hospitals and was also seeking to recruit specialist radiologists; of the 40 doctors which were recruited, 12 were employed in Storstroem. Prior to leaving Poland, the doctors selected were engaged in six months of intensive language and skills training, learning about the Danish healthcare system and law. It was also arranged for the doctors to visit the departments in which they would be employed.

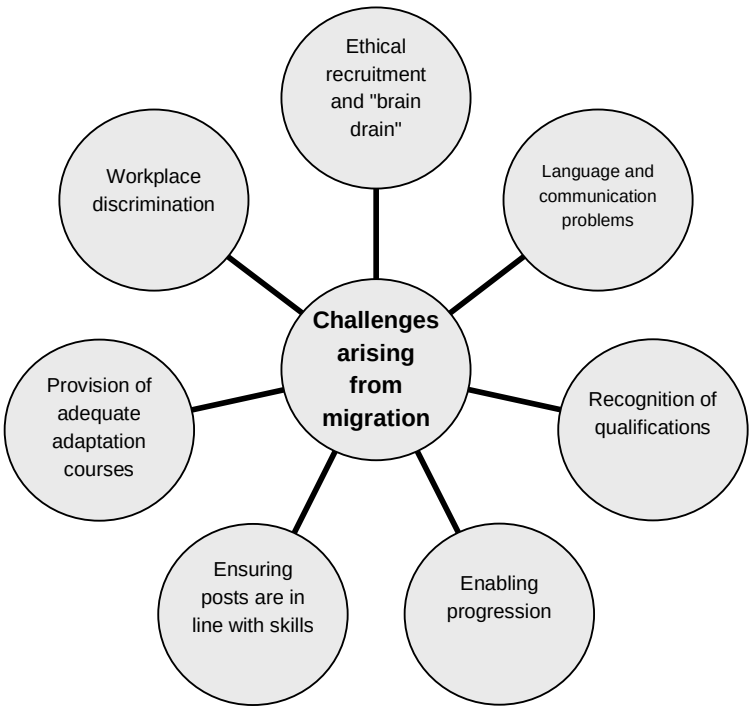
It was found that on arrival, the doctors generally needed further language training and further development. There were also difficulties in terms of the transferability of skills; generally, the Polish doctors were more specialised in their experience then their posts in Denmark required. For positions in the small hospitals, it was deemed more important that the doctors had good management skills and were able to deal with a range of cases.

While there have been some problems, recent statistics provided by the Swedish agency showed that a large number of the doctors were still employed in the Danish hospital sector 11 months after taking up their post. While some had changed the area in which they worked, the majority were still based in the same county.

3.0 Challenges presented by migration of hospital professionals

An ever increasing level of mobility in the hospital sector brings with it new challenges for both the source and the destination countries. Besides the impact that migration has on health systems worldwide, there are implications for the migrants themselves. Figure 3.1 summarises the key challenges which arise with professional migration, and these are further explored in this chapter.

Figure 3.1 Challenges presented by migration of hospital workers



3.1 Ethical issues related to migration

A global study of the shortage of nurses showed that there are vast differences in the availability and supply of nurses between countries and continents. At country level, the reported nurse to population ratio varies from less than 10 nurses per 100,000 population in areas such as the Central African Republic, Uganda and Liberia to more than 1,000 nurses per 100,000 in countries such as Finland and Norway, a variation of more than one hundredfold. The average ratio in Europe, the region with the highest ratios of nurses to population, is 10 times that of the lowest regions - Africa and South East Asia. On average, the nurse to population ratio in high-income countries is almost eight times greater than in low-income countries. One recent estimate is that sub-Saharan African countries have a shortfall of more than 600,000 nurses needed to meet the Millennium Development Goals [I].

[I] Buchan & Calman, 2005, The global shortage of registered nurses – a report for the global nursing review initiative

Clearly then, it is vital that developed and "richer" countries take an ethical stance on recruitment in order to prevent "brain drain" in countries which can ill-afford to lose already scarce hospital staff.

3.2 Difficulties on arrival in the destination country

3.2.1 Recruitment agencies

As noted, recruitment agencies play a role in the vast majority of migration in the hospital sector, especially in third country recruitment into the EEA. Two-thirds of international nurses surveyed in London had involved recruitment agencies in their move. In the case of nurses from the Philippines, the recruitment agencies were primarily based in their own country, while nurses from most other countries had used UK-based or international agencies.

Worryingly, there are definite inconsistencies with regards to payment for the services of recruitment agencies. While most nurses from Australia, New Zealand and the USA had not paid for any of the services provided by their agency while 74% of those from the Philippines and most respondents from India had paid for some or all of the services they received (including services such as registration and flights to the UK). From the results of this survey it would appear that nurses originating from poorer countries are more vulnerable to paying for migration services.

3.2.2 Adaptation and communication

Current EU legislation does not require that hospital professionals moving around Europe undertake any language tests for proficiency. Tests are only compulsory for those moving to Europe from third countries, in which case staff are required to pass the IELTS test. Similarly, adaptation courses to accustom staff to both the new country and new job are not required. While most social partners and governments recommend that language and adaptation training are delivered to all internationally-recruited staff, provision is at best patchy and leaves much room for development and improvement. A study conducted by the RCN found that most nurses recruited internationally to the independent sector had problems accessing adaptation training and so had difficulties in gaining registration. Furthermore, anecdotal evidence shows that language training is often not adequate, especially when provided in the source country. This training does not account for local colloquial phrases and dialect, which can often leave internationally recruited staff with communication problems.

3.2.3 Recognition of qualifications and capacity for progression

While the EC Directives go some way towards ensuring that professional qualifications are recognised across Europe there is some anecdotal evidence suggesting that some workers, particularly those from the EU10, still struggle to have their training and skills recognised. This has especially been the case for those who completed their training at a pre-university level – in some countries four-year nurse education courses are available to 14-year olds and these courses are not recognised under the EC Directive.

Further problems which arise in the area of recognition of professional training were highlighted in a study of around 100 internationally recruited nurses in the UK which was undertaken by the RCN. The study found that 57% of the nurses involved did not feel their position in the UK reflected that which they had held in their own country. However, this was especially a problem for those employed in the private sector than in the NHS, 54% of those in the NHS felt that their job was at the correct level while 70% of those in the private sector

felt that their job was not adequate for their experience and training. Furthermore, progression was very difficult for the nurses, with very few being offered promotion (18%) regardless of whether they worked in the public or independent sector. This study has unfortunately been unable to establish if this has been a problem in other EU Member States however. This points to a lack of data across the EU with regards to nursing and healthcare workers and the posts in which they are employed; it is difficult to understand the full scale of qualified staff working in healthcare assistant posts across Europe without sufficient research and data in place.

3.2.4 Discrimination in the workplace

As set out above, the RCN research shows that internationally recruited nurses face discrimination in the work place in terms of the recognition of their skills and reduced likelihood of promotion and progression. However, a study carried out by the European Institute of Health and Medical Sciences[I] into the experiences of internationally recruited nurses in the UK found that many nurses also suffer from issues around bullying, management, racism and exploitation in the workplace; for example many of the nurses surveyed had experienced a very bad reception from their employer, while experiences were mixed regarding the support from the workplace. In terms of management issues, IRN's in the independent hospital sector had significant problems with bullying from care assistants, and feeling as though they were policed by management. Others experienced exploitation in various ways, but particularly from their managers who used them to cover undesirable shifts. In some cases, IRNs reported frequent experiences of discrimination. In some cases this appeared as crude racism and, in other cases, white IRNs explained how they, also, felt discriminated against because they were foreign.

Many of the nurses surveyed noted that they had received support and had positive experiences when they had involved their union to help with problems in their workplace. However, whilst all internationally recruited staff in the UK are entitled to the same legal protection as 'home' staff, many may be reluctant to access these services, or indeed may not understand how to.

[I] "We need respect": experiences of internationally recruited nurses in the UK, 2003, European Institute of Health and Medical Sciences

4.0 Implications for social dialogue

4.1 How can the challenges of mobility be addressed?

The challenges presented by the mobility of workers present many possible areas of action for the social partners across Europe. Historically, bilateral agreements have been implemented to monitor and govern the levels of mobility in the hospital sector. Furthermore, factoring in time limits on residency for workers and capping the level of recruitment from EU countries could both be suggested as methods of solving some of the challenges mobility brings. However, free movement of workers remains a central aim of the European Union and is actively encouraged by the Commission and national-level policy makers through initiatives such as EURES and the European Year of Mobility. As a result, moral and ethical questions would be raised were social dialogue to attempt to restrict the level of mobility in the hospital sector around Europe.

Therefore, as it is impossible to curb migration within the EU it becomes more important to ensure that mobile workers are treated fairly in their destination countries and that adequate support is provided to both those who employ internationally recruited staff and to the staff themselves.

In recent years, various reports have suggested a range of policy actions which could address the problems which arise through higher levels of mobility in the sector. Table 4.1 provides examples of policy developments which could be taken; some of these suggestions are discussed in more detail in this chapter.

Table 4.1 Possible policy actions to address migration in the hospital sector

Level	Characteristics / Examples
Organisational	
Twinning	Hospitals in source and destination countries develop links, based on staff exchanges, staff support and flow of resources to source country.
Staff exchange	Structured temporary move of staff to other organisation, based on career and personal development opportunities/organisational development.
Educational support	Educators and/or educational resources and/or funding in temporary move from destination to source organisation.
Bilateral agreement	Employer(s) in destination country develop agreement with employer(s) or educator(s) in source country to contribute to, or underwrite costs of, training additional staff, or to recruit staff for fixed period, linked to training and development prior to return to source country.
National	
Government-to-government bilateral agreement	Destination country develops agreement with source country to underwrite costs of training additional staff, and/or to recruit staff for fixed period, linked to training and development prior to staff returning to source country, or to recruit surplus staff in source country.
Ethical recruitment code	Destination country introduces code that places restrictions on employers – which source countries can be targeted, and/or length of stay. Coverage, content and compliance issues all need to be clear and explicit.
Compensation	Much discussed, but not much evidence in practice: destination country

Level	Characteristics / Examples
	pays compensation (in cash or other resources) to source country. Possibly some type of sliding scale of compensation related to length of stay and/or cost of training, or cost of employment in destination country; possibly brokered via international agency?
Managed migration (can also be regional)	Country (or region) with staff-outflow initiates programme to stem unplanned out-migration, partly by attempting to reduce impact of push factors, partly by supporting other organisational or national interventions that encourage planned migration.
Train for export (Can be a subset of managed migration)	Government or private sector makes explicit decision to develop training infrastructure to train health professionals for export market to generate remittances or up-front fees.
International	
International code	As above, but covering a range of countries; its relevance will depend on content, coverage, and compliance. The Commonwealth Code is an example.
Multilateral agreements	Similar to bilateral (above), but covering a number of countries (EU?). Possible brokering/monitoring role for international agency.

Buchan and Dovlo (2004), in Human Resources for Health in Europe, European Observatory on Health Systems and Policies series, 2006

4.2 Actions for "destination" countries

4.2.1 Ethical recruitment practices

As discussed in point 3.1 of this report, international recruitment can place a huge strain on healthcare systems in developing countries which can ill-afford to lose already scarce staff. While migration may not be a major issue for all countries in the EU/EEA, all countries still need to apply ethical recruitment approaches. The World Health Assembly drew up a resolution (57.19) which urges member states to "develop strategies to mitigate the adverse effects of migration of health personnel and minimise its negative impact on health systems." In the main, this resolution called on countries to adopt ethical codes of practice in recruitment. In the UK, the Department of Health has developed an ethical code of practice; this is described further in point 4.2.1.1 below. Social partners can take action to encourage the development and implementation of ethical guidelines for recruitment in their own member states. Furthermore, there is possible scope to develop a European-wide legislation which would encapsulate movement around European States and migration into Europe from third countries.

The WHA resolution also calls for the development of inter-governmental agreements to manage international healthcare recruitment. This call has been backed by many experts in the field, as shown in the table above, as well as many European governments (for further information on the agreement between the UK and Spain, see point 2.2.1). This ideology includes the possibility for those participating in migration through bilateral agreements to be able "give something back" to their home country on return, by means of being more experienced or more highly trained for example. As noted in this report, it is difficult to regulate the level of movement between EU States but government-government agreements definitely offer possibilities for better-managed migration between third countries and Europe. Social partners could potentially play an influential role in establishing and developing agreements between EU Member States and third countries.

Finally, it is important that social partners take a role in monitoring the actions of recruitment agencies and the independent healthcare sector. Current codes of practice on ethical recruitment are not mandatory for the public sector although generally they are encouraged; however agencies and independent sector recruiters are not under the same pressure.

4.2.1.1 *Example: Department of Health ethical guidelines for international recruitment*

In 2004, the UK Department of Health launched a revised Code of Practice to govern international recruitment into the UK. As noted in the introduction to the document, "[the code of practice] is underpinned by the principle that any international recruitment of healthcare professionals should not prejudice the healthcare systems of developing countries. Therefore a key component of the Code of Practice is to preclude the active recruitment of healthcare professionals from developing countries, unless there exists a government-to-government agreement to support recruitment activities."

The code operates under seven guiding principles which, while emphasising the role international staff can play in the UK health service, ensure that recruitment is conducted in a fair way which does not deplete the staffing resources of countries who can ill afford it. A list of countries from which recruitment is not advised, compiled with the help of the Department for International Development, is publicly available on the Department of Health's website. The guidelines set out that international recruits should have a good proficiency in English and a comparable level of training to that which is supplied in the UK, but also emphasises that international employees should be protected by the same employment law that governs UK nationals and that international professionals should have the same opportunities for training and development. These guidelines have been translated into best practice benchmarks.

While the code is not legislation or compulsory practice in the UK, it is strongly recommended that all employers, both public and independent, adhere to the benchmarks set out in the code, and it also applies to recruitment agencies and temporary/locum agencies. All healthcare staff, regardless of their contract status or level of expertise, should be included in the terms, although the code does not extend to the independent healthcare sector. The code has the full support of NHS Employers, who have taken actions to provide advice on the code and the benchmarks to NHS Trusts.

4.2.2 Support for employers of internationally recruited staff

NHS Employers, the employer organisation for the hospital sector in the UK, has developed a programme of support for hospital employers who are considering undertaking international recruitment. The programme includes the provision of advice on ethical recruitment, work permit applications, registration issues, service of recruits and dealing with regulatory bodies. Furthermore, the organisation has facilitated international recruitment networks for employers. The intention of the programme is to ensure that recruitment is handled properly and responsibly, making the experience good for the employer and the employee. Throughout, the emphasis is placed on comprehensive induction programmes and continuing professional development for all internationally recruited staff. Similarly, the RCN has developed a good practice guide for healthcare employers to be used when recruiting international nurses.

This approach could usefully be translated to other hospital sector social partners across Europe. By ensuring that employers are aware of legislatory issues and ethical considerations, the first hurdle in achieving good practice in international recruitment can be

crossed. Other challenges faced by employers include ensuring that internationally recruited staff have same access to support by trade unions. In the UK, union membership rates show that most NHS staff, either national or international, are affiliated, but this may not be the case in other Member States. Social partners must work together to ensure that international staff receive equal treatment in terms of affiliation, pay, progression, development and terms and conditions that 'national' staff receive.

4.2.3 Support for internationally recruited staff

The issues outlined in point 3.2 show that internationally recruited hospital staff face many difficulties on their arrival in destination countries. Sufficient and thorough adaptation training can influence an IRNs experience in a new country significantly, and both unions and employers should work together to ensure that support is provided to internationally recruited staff both on arrival and for the duration of their employment. To address issues such as bullying and discrimination in the workplace, a joined up approach is needed, which could also include adaptation for 'home' staff who will be working with internationally recruited staff.

In the UK at least, most IRNs do have union representation; however it must be made clear to staff what this representation means and how they can access the support that they need.

4.2.4 Development and retention of "home" staff

In order to avoid the need to recruit from abroad to meet skills gaps which have arisen through non-retention of staff and the lack of new entrants, it is important that national agencies look towards ways of attracting more people to train as hospital professionals and also attempt to uncover ways to make the professions more attractive in order to retain staff.

Social partners could be actively involved in developing policies encouraging recruitment and retention in the sector. Active attempts to encourage staff who are currently not practicing to "return to work" through re-training and up-skilling; targeted recruitment from disadvantaged groups; and the development of flexible working packages could all contribute to raising the level of "home-grown" staff in the hospital sector.

4.2.4.1 *Example: The Improving Working Lives initiative*

The UK Department of Health has introduced the "Improving Working Lives" initiative with the aim of helping National Health Service organisations develop exemplary HR practice, increase staff involvement and therefore improve the recruitment and retention of staff. The NHS Plan introduced the Standard which makes it clear that every member of staff in the NHS is entitled to work in an organisation which can demonstrate its commitment to more flexible working conditions which gives staff more control over their own time. The Standard also requires NHS employers to prove that they are investing in improving diversity and tackling discrimination and harassment. Improving Working Lives aims to support organisational cultural change to embed good HR practices at the heart of service delivery. NHS organisations were required to achieve accreditation against the Standard by April 2003.

4.2.5 Recognition of qualifications

As discussed, there are many well-trained staff who struggle to have their qualifications recognised in Europe despite the Directives implemented by the European Commission. European social partners could work together to lobby for the inclusion of those qualifications gained at pre-university level in the EU Directive. However, this is an issue which has raised

much debate amongst some parties who feel that there could be potential implications for both patient care and employers. As a result, a more suitable approach could be for the social partners to debate this subject at an EU level in order to identify the best way forward. At the same time, cooperation is vital in helping hospital workers - in the independent sector especially - to gain employment in positions for which they are qualified.

4.3 Actions for "source" countries

4.3.1 Pay equity

Much as destination countries need to develop strategies for retaining "home" staff and developing new hospital sector professionals, source countries also need to address the issues which are causing their staff to migrate. Removing the incentives for economic migration through developing strategies of pay equity for women for example, and also developing more competitive salary packages, should go some way towards improving staff retention.

However, the effect of mobility on salaries Europe-wide, and in both the sending and receiving countries, has been a contentious issue. Some commentators expect that competition will develop throughout Europe on the basis of pay - countries with higher pay scales will find it easier to attract specialists, while countries with low pay scales may lose those specialists. If low-pay countries wish to keep their specialists, then they will have to pay the "going market rate", which will effectively be the highest pay scales within the European Union[I]. The fears amount to the ability to maintain good domestic rates of pay in countries importing workers from areas with lower standards of living.

Social partners could usefully play a role in negotiations around pay and terms and conditions in traditional "sending" countries. Where it is not possible for countries to compete with the higher European pay-scales, employers need to look towards more innovative ways to retain staff.

4.3.2 Example: Pre-departure training in Sri Lanka[II]

Looking outside the specific sphere of the hospital sector, Sri Lanka provides a good example of how migrant workers can be helped to prepare to take employment outside their own country. Since 1996, pre-departure training has been compulsory for all Sri Lankans moving abroad for work. The Sri Lankan Bureau of Foreign Employment (SLBFE) provides the training along with residential facilities free of charge for all who participate, and the training lasts between 12 and 21 days depending on the destination country. The programme of training includes tuition on financial management, health issues, personality development, counselling, cultural adaptation skills, basic language skills, family arrangements and home management.

The Migrant Service Centre which is affiliated with the All Ceylon Federation of Free Trade Unions provides information to prospective migrant workers to prepare them for migration and to raise their awareness of illegal practices and other hardships they may face. The

[I] Philip Berman, Mobility of Health Professionals conference paper, December 2001

[II] Nimalka Feranando, Covenor of the Sri Lankan National Campaign for the Rights of Migrant Workers, quoted in *An information guide: preventing discrimination, exploitation and abuse of women workers*, ILO, 2003. Taken from *An introductory guide to international migration in the health sector for workers and trade unionists*, PSI, 2003.

Centre provides information on health status, age requirements and medical certification of needs, passport requirements, visas, tickets and registration with the SLBFE.

4.4 Better data collection

The main problem with monitoring migration in the sector and the further development of policies in this area is the lack of comparable information available within the EU. Section 1.2.1 of this report highlights the difficulties associated with the data which is currently available and many have called for better data collection to aid progress.

A study conducted on behalf of the WHO, the International Council of Nurses and the Royal College of Nurses in the UK has set out the parameters for the data which would be most beneficial to support policy analysis and development in nurse migration. Table 4.2 outlines this in detail below. Useful actions from the social partners in this respect would be to lobby for better and more complete data collection across Europe, providing a source of comparable information for analysts.

Table 4.2 Additional data needed across the EU

Analysis	Data needed		
	Minimum	Additional	Attitudes
Inflow or outflow	No. leaving the country (by destination)	Work location of nurses leaving the country	Reasons for leaving the country; or
	No. entering (by source)	Year first qualified as a nurse	Reasons for coming to the country
	Qualifications		
	Sex		
	Race or ethnicity		
	Age		
Stock	Total no. of nurses	Geographical distribution of nurses	Career plans
	No. working in nursing	No. of nurses by work location	Career history
	Qualifications	Length of stay	Cultural adaptation issues
	Sex	No. of qualified nurses working as unqualified healthcare staff	Job satisfaction
	Race or ethnicity		
	Age		

Buchan & Sochalski, Migration of nurses: trends and policies. Bulletin of the World Health Organisation, August 2004 82(8), with author's additions

4.5 Conclusions

While some solutions to the ever-increasing level of migration in the hospital sector propose restricting the levels of migration by means of the imposition of limits on mobility through capping levels of admission, such policies mean infringements on the rights of European citizens to move freely around Europe. Meanwhile, it is helpful to consider that aspects of the ethical recruitment policies implemented for citizens of third countries perhaps could usefully be implemented in respect to the EU10.

As it becomes increasingly difficult to impede movement and mobility in the sector, it is important that mobility and international recruitment is dealt with in an effective manner. Partnership working and collaboration between employers, employee representatives and stakeholders at national, European and international levels could lead to a common protocol on international recruitment which might help to address aggressive recruitment policies and make the experience a positive one for all involved.

Annex One

Overview of migration data for selected countries

Country	Nurses	Physicians
Belgium	No information available	*Overseas doctors* LFS data for 2001 shows that Belgium had 7.77% non-Belgian national physicians. Of these, 28% were Dutch, with a large percentage of the remainder also originating from EU countries.
Denmark	No information available	*Overseas doctors* Of the total number of physicians in Denmark, 7.79% are non-Danish nationals according to LFS data for 2001. Of these, 50% are Norwegian. Most other nationalities registered are also primarily European, with a majority originating from Spain and Germany. A small percentage of overseas doctors (5.2%) are from the USA.
Estonia	*Nursing shortages* Estonia has reported a shortage of nurses. *Overseas nurses* No overseas nurses were registered in Estonia in the period 2001-2005. *Migration of nurses* In the latter half of 2004, 115 certificates of conformity were issued to Estonian nurses to enable them to work abroad. This figure dropped to 52 in the first half of 2005, and it is thought that this may be as a result of a new pay agreement which was reached in January 2005. While the number of certificates issued to both nurses and doctors equates to 3% of the total medical workforce, the Estonian authorities have noted that 32% of nurses in possession of a certificate are still working in Estonia. Finland is the most popular destination for Estonian nurses, with Sweden, the UK, Norway and Ireland all attracting nurses too.	*Doctor shortages* There is a reported shortage of some specialist physicians including anaesthetists, psychiatrists, pathologists and gynaecologists. *Overseas doctors* In the period 2001-2005, Estonia registered 17 doctors from EU countries and 7 from third countries. Four were registered from Russia and four from Finland, with Germany, Belarus, Latvia and Jordan supplying the remainder. *Migration of doctors* Between the months of May and December 2004, 271 certificates were issued to Estonian doctors to allow them to work abroad. This decreased significantly in early 2005 to 108, and again it is thought that this was because of the pay deal agreed in January 2005. 47% of doctors who have been awarded the certificate are still working in Estonia, although some doctors remain resident in Estonia during the week and travel to other countries to practice medicine on a weekend. Finland is the most popular destination for doctors, with the UK, Sweden, Germany and Norway also attracting doctors.
Hungary	*Nursing shortages* Hungary has an overall shortage of nurses although some regions, such as those in the east and north, do have	*Specialist shortages* There are concerns about the sustainability of the Hungarian healthcare system due to a lack of personnel, namely regional

Country	Nurses	Physicians
	satisfactory levels. *Overseas Nurses* In the period 2001-2005, only 20 nurses who undertook their training elsewhere in the EU were registered in Hungary. Almost all (19) were from Slovakia, and one was from Sweden. However, during the same period 800 nurses registered from Romania (approx. 750), Serbia and the Ukraine. However, most of these are from the Hungarian minorities in these countries and so have a link with the country. *Migration of nurses* Approximately 250 nurses requested certificates of conformity from the Hungarian authorities between May 2004 and July 2005. The most popular destinations for these nurses include the UK, Germany, Sweden and Austria.	shortages of specialists. There are an increasing number of medical graduates who never enter clinical practice. *Overseas doctors* In the four years between 2001 and 2005, 562 overseas doctors were registered to practice in Hungary. Only 44 were from EU Member States, the majority of whom (29) were from Slovakia. The other EU supplicant countries included Germany, Poland, Italy, the Netherlands and Sweden. Those from non-EU Member States included citizens of the former Yugoslavia, Romania and the Ukraine. *Migration of doctors* From Accession in May 2004 to July 2005, approximately 1,000 Hungarian doctors requested certificates of conformity to practice abroad. As for nurses, their most popular destinations were the UK, Germany, Sweden and Austria.
Ireland	See section 1.2.2 for more information	*Overseas doctors* LFS data for Ireland shows that a large percentage of physicians (8.91%) were of non-Irish nationality. Of these, the largest number came from the UK
Italy	*Nursing shortages* With 200,000 nurses in the country, Italy has a nursing shortage of around 20%. The problem is at its peak in the Northern and Central areas of Italy. *Overseas nurses* Between 2002 and 2005, the number of overseas nurses working in public hospitals, rose from 2,612 to 6,730. Seven out of ten are from European Countries (with the majority of these from either Poland or Romania). There has also been an increase in nurses from Asia (from 4 per cent to 12.2 per cent) however the number of African nurses has decreased. In all, the number of non European nurses is 4,741.	*Surplus of doctors* Currently Italy is experiencing an overall surplus of hospital physicians, with one doctor for every 172 inhabitants. However, there are some shortages in specialist areas such as anaesthetics and radiology

Country	Nurses	Physicians
Poland	*Nursing shortages* Poland has reported no significant shortage of nurses. *Migration of nurses* 2,830 Polish nurses have received recognition certificates to work abroad, which equates to 1.07% of all nurses in Poland.	*Doctor shortages* There is no reported shortage of physicians in Poland. However, through the late 1990s and early 2000s, Poland did see a decrease in the number of both doctors and nurses. *Overseas doctors* In 2004-2005, only 13 non-Polish trained doctors applied for registration to practice in Poland. Of these, 7 were Polish citizens who had trained abroad. The rest were from Germany (2), Lithuania, Austria, the Netherlands and Sweden. *Migration of doctors* Since Accession, over 2,500 certificates have been issued to Polish doctors to allow them to practice abroad, which equates to 2.3% of all doctors in Poland. In terms of specialisms, the highest number of certificates was awarded to anaesthetists, along with specialists in internal medicine and general surgery.
Sweden	*Overseas Nurses* A study of Swedish registration data in relation to five EU Member States (Belgium, Estonia, Hungary, Poland and the UK) established that in the period up to 2003 registration of nurses from the study countries had traditionally been low, with no registrations from the EU10. However, in 2004 there was a dramatic increase in such registrations, with 175 nurses from Poland, 57 from Hungary and 19 from Estonia taking up residency and registration to practice.	*Overseas doctors* The same study showed that year on year, there has been an increase in overseas registration applications between 1999 and 2004. Of the five countries, the UK has been the biggest supplier of doctors to Sweden. However, in 2004 15 doctors from Estonia took up registration and residency in Sweden, which was the first time the country had recruited from Estonia. Registrations from Hungary and Poland remained very low.
Switzerland	*Overseas Nurses* According to LFS data for 2001, Switzerland has a very high level of overseas nurses (23.11%). Of these, the majority (22.5%) are German, with a further 14% originating from Bosnia Herzegovina. Compared to other EEA members, Switzerland has a much higher supply from the EEA than other countries which are primarily supplied by third	No information available

Country	Nurses	Physicians
	countries.	
UK	*Unfilled vacancies* Using the data on nursing vacancies which remained unfilled for more than three months, the number of vacant nursing posts halved between 2000 and 2005. In some speciality areas of nursing, vacancies were higher than others. *Overseas Nurses* LFS data seems to contradict that of the UK national register of nurses and midwives. According to the LFS data, only 8.34% of nurses were non-UK nationals in 2001, and the largest numbers of overseas nurses were Irish (30.5%). However, data from the 2001 UK nursing and midwifery register shows that admissions to the register were substantially higher for non-EU countries than for EEA countries, including Ireland. However, it must be considered that the register data do not take into account those nurses already registered in the UK, and it could be that there were a large number of Irish nurses already practicing in the UK. As noted in the report, the register data does have some drawbacks in terms of accuracy and it is difficult to draw a conclusive picture from the existing sources. *Migration of nurses* There was a general increase in requests for verification for British nurses between 2000 and 2003 which has since reached a plateau. Australia is the only country which has seen a consistent increase in verification requests over the five year period. According to NMC register statistics, the majority of UK-registered nurses living abroad are located in Australia, Ireland, South Africa and the USA.	*Unfilled vacancies* Generally, there was a drop in unfilled vacancy rates for hospital doctors across the UK between 2004 and 2005. However, some specialities such as accident and emergency medicine had significantly higher vacancies (9% in 2005) than others, such as surgery, which had vacancies of 1.1% in the same year. *Overseas doctors* According to LFS data, of all UK physicians 12.6% were not of UK nationality. Of these, most (23.3%) were from the African continent, with other large numbers originating from India and Ireland. GMC registration data was analysed for the EC working group study on mobility in six Member States. For the countries involved, the level of registration in the UK had remained fairly consistent until 2004, when there was a dramatic increase in applications from the New Member States, and especially so from Poland. Here, the applications increased from 19 in 2003 to 140 in 2004. However, this number did decline in 2005 to 104. Furthermore, the data shows that applications from Sweden increased by more than half between 2004 and 2005, from 46 registrations to 104. Applications from Estonia and Hungary remain relatively low. GMC data showed that 14,736 doctors registered for the first time in 2004. Of this total, 10,005 were foreign nationals with the largest number (3,644) being Indian, around 1,000 being Pakistani and over 700 being of German nationality.