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ЕВРОПЕЙСКА АСОЦИАЦИЯ НА СТАРШИТЕ БОЛНИЧНИ ЛЕКАРИ
ASOCIATIA EUROPEANA A MEDICILOR DIN SPITALE

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Main Draft Conclusions and Recommendations

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Content

Introduction

The Project MoHProf project team has analysed the current situation of and trends and developments in international migration of health workers in 25 countries around the world with a focus on migration within, to and from the EU. The following recommendations are based on the main research findings, which have been summarized by country (MoHProf National Profiles). The several research activities (mainly based on available data, context analysis and qualtitative research at macro and micro level) carried out under the umbrella of the MoHProf project leads to the following conclusions and recommendations.

The sampling of countries was based on high absolute figures and/or high rates of foreign or expatriated health professionals in the health systems of – mainly – receiving or – mainly – source countries, respectively. Research was conducted in EU receiving countries (Austria, France, Germany, Ireland, Netherlands, Portugal, Sweden, United Kingdom), source countries within the EU (Bulgaria, Lithuania, Poland, Romania) source countries to the EU Russia, Ukraine [Europe]), (Angola, Egypt, Ghana, Kenya, Morocco, South Africa [Africa], India, The Philippines [Asia], and destination countries for health professionals from EU Member States (Australia, Canada and United States of America).

Acknowledgments

1 Background and challenges

The MoHProf project, in its aims to gather information about migration of health workers to, within and from the European Union, has identified a number of health system related challenges that do not only apply to EU Member States, but also to other countries. These challenges are:

- Health care systems need to adopt their policies and services to an aging population and an aging health workforce, both resulting in tremendous increases of needs for human resources for health. Without significant counterbalancing it is, for instance, It is estimated that the EU by the year 2020 will be lacking many health workers. However, its ageing is to peak around 2050, while potential recruitment reservoirs will shrink due to low birth rates and increased labor market participation of women. This suggests that shortages may well increase rapidly beyond 2020. Integrated efforts are therefore urgently required to not only reduce demand but also to better balance demand with supply of health and care workers.
- Moreover countries' populations are changing in character and background, with migration of health workers being part of a wider picture of migration. This leads to other questions requiring attention, amongst which health and care provision to migrants, and to those foreign-born.
- Similarly health workforce characteristics in the EU are changing in terms of working hours, gender typologies, work-life balances and specificities of medical work across Europe requiring adjustments in the health systems to cope.
- The current and ongoing financial and economic crises is already impacting on countries' capacities to develop and maintain their health systems and may have severe impact on resources and the allocation thereof to and within health systems. These events are likely to affect health workers' opportunities as well as migratory waves. In and by itself, value for money is an important topic for ever growing health expenditures. However, with the crises in mind It is urgently required to develop and implement strategies and experiments that can lead to high value for scarce money in health and care.
- Competition (between countries, regions, sectors, public and private employers) on the market for human resources for health is increasing and long term strategies are needed on a global market.
- Data and information on stock, flows and trends of health workers at national and EU level is limited, difficult to compare and currently insufficient in terms of long term strategic planning.
- Source countries (inside and outside the EU) loose significant investments in health worker education, which further weakens their health systems.
- EU Enlargement did not lead to overall massive outflows of health professionals, but in some of the new MS it has led to critical shortages, in particular of medical doctors, thus endangering the sustainability of the respective health systems.
- Currently there is a lack of strategic planning to address the above challenges at Member State level.

2 Main features and particularities of migration of health professionals

2.1 Fundamental political assumption: sustainable health systems

There is a general need for countries to become, to a greater extent, self-sufficient in their health systems and human resources for health. Policies addressing self-sufficiency and strategies need to be formulated and implemented in order to reduce unequal distribution of health workforce around the globe.

This does not imply that either the migration of health workers per se or the freedom of individuals to move between countries should be restricted, but the mobility of health professionals across source and receiving / destination countries should become mutually beneficial for both systems and as well as for the migrants themselves through managed migration policies, meaningful human resource management policies at (sub-)country level, better information sharing through monitoring and tracking systems and further research, inter alia, into the effectiveness of human resources for health management strategies.

These arguments are not always fully shared by actors within health systems, for several reasons. Professional bodies may gain power by shortages – and may be assisting certain professionals to high remuneration - and shortages may also lead to reduced demand and thus to limited expenditures. In some cases employers may utilize shortages to recruit cheaper labor from abroad, thus reinforcing an unattractive image to the work for 'domestic' workers.

Thus the sustainability of health care within national health systems and within those of the source countries in particular as overarching goal needs to be kept in mind by all actors.

2.2 The rural-remote / urban split is crucial in managing health care workforces

In all countries included in the MoHProf project, the distinction between urban areas and rural areas in terms of health provision was crucial, with shortages appearing first in rural/remote areas. Whether in source or receiving countries, this is one of the most shared experiences. This implies that shortages in rural areas of receiving countries tend to exacerbate shortages in source countries and thus aggravating already critical shortages in their remote areas. Thus, whatever approach or strategy is formulated to innovate in strategies addressing health services in source countries as well as receiving countries, innovation of health services in rural and remote areas should be considered an absolute first priority.

2.3 Health professionals and other migrants: different pathways and consequences?

A major question is to what extent migration of health workers differs from migration of other professions. There are several related issues here: It remains unclear whether emigration or immigration processes for health professionals follow general pathways of migration, or that special routes and factors play a role. Specific attention for health workers is required because more often than not, they are trained by a public system (or trained with at least partly public funding)for the purpose of providing services in the source country.

Emigration of health workers can deplete a country's health resources in terms of loss-of-investment for the common good, loss of practitioners and thus negative impact on public health care delivery in the source country. Furthermore, migrating health workers – like other often high skilled professionals - require recognition of qualifications, more than other migrants, to be allowed to practice in the receiving / destination country.

The combined existence of public and private educational systems for health professionals or a combined existence of public and private health systems in one country can lead to imbalances where production for the market versus production for the public services can contribute to imbalances.

2.4 National policies can have multiple and international effects

Policy actions implemented in one country can have major effects on the health workforce in another one, thus the supranational impacts of workforce related methods applied at national or even regional level have to be taken into consideration.

Some policies may also have double faces and undesired effects. Several countries mention the desirable policy of fast-tracking recognition procedures with the aim to limit personal frustration for the migrant as well as increasing their productivity in the receiving / destination country health system. A rough estimate is that this would – on a global scale – limit the global shortage of health workers with hundreds of thousands of workers. However such policies, while attractive, can have as a side effect that the transaction costs for migration decrease. Thus, the net effect may be that migration is enhanced, leading to more outflow from countries with already substantial shortages. Moreover, such policies can also enhance global competition in the market between 'domestic' and 'foreign' workers. Furthermore, such policies can also affect patient safety as language and culture issues may affect health provision in receiving countries, while shortages enhanced by or due to *emigration* may affect safety of patients in the source countries. Thus the development of workforce management policies and strategies should be discussed taking potential untoward side-effects into account.

2.5 Push-, pull-, stick- and stay- factors, perceived transaction costs and benefits jointly lead to migration

International migration of health workers is a complex phenomenon and part of a wider international migratory movement. International migration occurs by a combination of push- and pull factors and the perceived associated transaction costs and benefits, both at individual and collective level.

To balance the impacts of health worker migration on the global market therefore requires:

- Reduction of push factors
- Reduction of pulls factors
- Decrease of transaction costs and increase transaction benefits.

Examples of the major general push-factors are:

- Frail states and conflict
- Human rights violations
- Standards of living
- Culture of out-migration

Examples of the major health system related push factors are:

- Corruption within the health system
- lack of options related to practice or professional and personal growth (especially for medical professionals)
- lack of options to earn decent wages (for both medical and nursing professionals)

Examples of the major general pull-factors are:

- Undersupply with health workers
- Better remuneration and living conditions
- Easy recognition of qualification

Examples of the major health system related pull factors are:

- undersupply
- developed health systems
- (easy) recognition and valuation of health and care workers
- earning opportunities

Examples of transaction costs are

- Personal: psychological, social and material costs of the entry in to a receiving / destination countries' health system
- Health systems: requirement to adjust to incoming workers

Examples of transaction benefits are

- Personal: (perceived) better future, professionally or economically; adventure
- Health systems: more hands and heads to provide care, without most of the cost for training locally.

3 General strategic planning at EU and Member State level

Encouraging Member States as well as third countries to articulate policy targets for self-sufficiency of their health workforce is vital to address human resources for health needs of the future. In the long term Member States should aim at self-sufficiency in terms of production of their health workforce based on rational analysis, planning and forecast of the demand and developments within their health systems and regions.

For the time being, those countries which still rely on foreign trained workforce have agreed to and should strictly implement principles of ethical recruitment[1], apply appropriate strategies to integrate foreign trained health workers into the receiving / destination workforce and receiving / destination society and aim at faster tracking of acknowledgement of certificates. One such strategy could be the development of an EU-wide portal (linked to health workforce monitoring bodies) for comparing non-EU qualifications, enabling registrars to verify qualifications.

Since across the EU health and care needs are changing, strategic rethinking of health and care systems is required to be able to meet changing demands in particular in a post-crisis period. Such a rethink should include health and care literacy, widespread introduction and implementation of self-management tools and techniques, including ICT, new job-descriptions and responsibilities of health professionals and substantial support to both family caregivers and volunteers as well as to those unlicensed or non-formal care workers that may be providing care on 24/7 basis.

EU Member States need to adjust education and training to the current and forthcoming health care labour market needs and this means for most of the countries that they have to prepare for increasing their domestically trained health workers.

4 Monitoring and managing health workforces

Since there is an urgent need to improve the monitoring (as prerequisite for informed management of migration flows of health workers) it is recommended to establish centralized EU wide data and information collection mechanisms such as currently being developed under the Joint Action. This coincides inter alia with the conclusions of the Green Paper on the European Workforce for Health[2], the Council conclusions on investing in Europe´s health workforce of tomorrow[3] and OECD communications[4].

This recommendation has already been expressed for a long time by researchers and policy makers at national and international level, but the fact that efforts towards improvements and harmonization of data and information to support decision making in terms of workforce planning are developing, but slowly, leads to the conclusion that there is a need for stronger support and coordination at EU level and for further investments in monitoring and management of mobility of health workers to, from and within Europe, where – under an EU

[1] WHO Global Code of practice on the International Recruitment of Health Personnel, http://www.who.int/hrh/migration/code/code_en.pdf

[2] Green Paper on the European Workforce for health http://ec.europa.eu/health/ph_systems/docs/workforce_gp_en.pdf

[3] Council conclusions on investing in Europe´s health workforce of tomorrow, http://www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/en/lsa/118280.pdf

[4] OECD Policy Brief: International Migration of Health workers, p. 7, http://www.oecd.org/dataoecd/8/1/44783473.pdf, accessed 08/11/2011

umbrella - workforce planning has to be based on actual current and future needs which requires reliable data and information. Among others this will require the following tasks:

a. Develop common key indicators on stocks, flows and trends in collaboration with other international bodies which are involved in monitoring
b. Increase comparability of definitions of health professionals, migrants, migratory processes etc.
c. Collect, analyse and report clear and specific quantitative data to be complemented with qualitative information on
    i. Stock of health professionals according to profession, main specialization (differentiating between country of original health professional training and country of additional health professional training, country of birth and nationality)
    ii. Flows of health workers to, within and out of the EU, short term/long term migration
    iii. Internal flows including mobility between subsectors of the health system as well as to other sectors
    iv. Different types of mobility like short-, mid- and long-term temporary, circular and return migration, weekend shifts abroad, dual employment etc.)
d. Collect, analyse and report information about HP education and training and compare education/training and demand in order to adjust education and training to the current and forthcoming labour market needs
e. Improve dialogue, data quality and sharing (in particular registration bodies) between source and receiving countries
f. Facilitate data and information exchange and dissemination and build up links with other source and receiving countries outside the European Union
g. Develop policy options and recommendations for action at global, EU, country and regional level
h. Publish and disseminate examples of good practice in health professionals workforce policy, strategies and planning
i. Analyse the effectiveness of specific workforce management strategies
j. Develop and adapt (existing) common guidelines for recognition of licenses from non EU MS, facilitate recognition of licenses and establish training equivalency recognition
k. Contribute to the development of strategic plans to address the health worker shortages in the EU MS
l. Formulate priorities for further research into the mobility of health workers and health workforce management
m. Support initiatives that support and enable global data consistency.

5 Assist countries to build and maintain sustainable health systems and strengthen international cooperation

Challenges relating to health workforce management need to be reflected in wider European policies. Among these are Commission policy areas such as DG EuropeAid Development and Cooperation, DG Health and Consumers, DG Research and Innovation, DG Information Society and Media, DG Employment Social Affairs and Inclusion, DG Internal Market and Services, DG Education and Culture, DG Enterprise and Industry, DG Home Affairs and DG Eurostat. Preferably a horizontal approach by and between these and other EU institutions is required to achieve the goals mentioned.

The importance of international cooperation to address the global shortage of health workers should in particular be reflected and incorporated in the EU development and cooperation strategic planning. DG Development and Cooperation has a clear case of reducing push factors by supporting health systems in low

and middle income countries. Financial and policy assistance for global health workforce capacity development need to be taken into account when agreement with low and middle income countries are negotiated.

The EU and in particular the main destination countries of non-EU trained health workers should invest in strengthening health systems and health care strategies in source countries. These investments should focus primarily on innovative workforce approaches, health workforce training, retention policies, health systems and information improvements and address health care needs in rural areas.

Where international cooperation is required to reduce general global pushes for health worker migration, concerted actions are needed, well beyond the scope of the management of human resources for health. Issues relate to supporting frail states, defending human rights (of health professionals), and the fight against corruption (in health systems).

6 Other suggested strategies at EU level

EU member states need to learn from each other's experiences and those gained in third countries in building and maintaining sustainable health systems and related workforces. OECD work, for example, is of great value. However, the EU has a wide array of instruments available to enhance such exchange of knowledge and experiences, which can be used beyond 'mere' data gathering and monitoring (reported under 4). For instance EU PROGRESS funding, including the Open Method of Co-ordination could be assistive in knowledge development and exchange on research, stakeholder and (sub-national) government level. Moreover, instruments such as Twinning and TAIEX have been and are used to assist acceding states and neighborhood countries to implement and discuss consequences of – amongst others – EU-Directives, including Directive 2005/36/EC. These instruments could also be used for a wider exchange and development of knowledge. Similarly EU Educational funds such as Erasmus could be specifically used for wider knowledge development and exchange on this issue.

6.1 Learning by doing: knowledge development and exchange

Overall, it is urgently required for the EU to stimulate, facilitate, evaluate and endorse (cost and quality effective) workforce management strategies related to its Member States. This would require to stimulate, identify, publish and disseminate examples of good practice and cost-effectiveness in health professionals workforce policy, strategies and planning including health workforce management. Such examples could include issues such as:

- Innovative use of recruitment pools and re-recruiting
- Professional education and profiles, professional (continued) training
- Bridging the gap between education and health employment
- Improving productivity with at least same quality health care delivery
- Innovation on the job, in the job and between the jobs including adjustment of skill mixes (medical extenders, nursing extenders)

- Retention strategies (amongst which: policies adjusting workplace stress, age-related worker policies, worker oriented management and patient oriented organisation, E-health, task shifting, work-life balance)
- integration of foreign trained health workers

6.2 Other possible EU initiatives and concerns

Furthermore a number of initiatives could be taken at EU-level:

- Regulate rights and duties of international health worker recruiters to protect the health workers, and make employers accountable for not using regulated recruiters
- Work towards an EU knowledge base of third-country qualifications/certificates that could assist and could be approached by registrars from across the EU
- Develop common guidelines for recognition of licenses from non EU MS, facilitate recognition of licenses and establish training equivalency recognition
- Analyse options to, while protecting basic human rights of health professionals under investigation of misconduct, stimulate governments to discuss the issue of 'pending cases' and/or to reduce the length of time required between first investigation and verdict by a (professional) court and subsequent registry measures.
- Stimulate member states to develop policies geared to prevent parallel grey markets in health care.

7 Wider areas of research and innovation

Further analyses of short-, medium- and long-term factors behind and consequences of mobility of health professionals for the individual migrant, the social networks (e.g. in terms of remittances and social costs), the health systems and economies of the source and receiving countries are urgently needed at national and global level as well as sound research into the effectiveness and consequences of health workforce management approaches.

Policies and health systems

- Further research into the global market of health workers to increase better understanding of global developments beyond national strategies in order to better respond to and manage national and local human resources for health
- Examine implications of the financial crisis on health care systems at regional, national and EU level in terms of workload and burden, career opportunities, wages and working conditions, management, system innovation etc.)
- Further analyse pull push stick stay factors, focusing primarily on the stick factors, i.e. factors that effectively prevent migratory waves which harm health systems in source countries
- Identify potential areas of harm and benefits due to health worker migration including financial cost, social costs and returns
- Assess the impact of international agreements, codes of practice and other health workforce management strategies (like twinning, bilateral agreements etc.) on health worker migration and their effects on health systems
- Analyse different forms of migration of health workers on patient safety

- Analyse the issue of nurse migration from wider perspectives, amongst which that of female migration in general and that of the grey care market at home including the impact of legislation on social home care services and protection of the rights of migrants

Migrants / individuals

- Qualitative research into emigrating populations: profile, motives, career plans, intentions regarding temporary/permanent stay, relevance of family bonds and other social factors in relation to economic factors
- Channels of foreign trained health workers entering the systems and in particular the role of recruitment agencies
- Tracking of health science graduates from education, to employment and deployment, including those receiving bursaries from destination countries
- Analysis of experiences (expectations and reality, job satisfaction, career, etc.) of emigrated health workers from different types of source countries in terms of integration/discrimination in different types of receiving countries in term of policies(migration, integration, health system, insurances (job satisfaction, career development etc.)
- Further analysis of stick and retention factors as well as motives and incentives for return migration
- Further analyse cases of migrant health workers ending up in receiving / destination countries in a) different sectors b) same sectors, lower qualified jobs or c) illegal labour arrangements