The cross border mobility of health workers in an enlarged Europe: a multiscalar approach

Abstract

This article looks at the structural, institutional and agency drivers of migration in an enlarged Europe by focusing on the labour market for health workers. Demographic changes leading to an increase in the demand for health care and health care workers coupled with the accession of countries from Central and Eastern Europe with significantly lower wage levels has increased the cross border mobility of workers in the sector. Drawing on questionnaires from across the European Union and case studies in one receiver country (the United Kingdom) and two sender countries (Romania and Poland), a multiscalar framework is posited. While the level of the European Union and nation state are the main focus, the sub-national dimension is identified as a site where migration in conjunction with other factors is contributing further to uneven development. The findings are that 'push' 'pull' factors associated with differential wages are only part of the picture, and poor working conditions and life/work balance also influenced the decisions of workers. The data suggested that institutional factors such as language barriers and the slow process of harmonising qualifications are inhibiting and constraining the movement of workers. The novelty of the article lies not only in the sectoral focus, but also the sender country perspective and the identification of a regional aspect in a multiscalar framework. Further, the collective agency of workers in the form of professional organisations and trade unions is emphasised as important in mediating processes associated with labour mobility.

Keywords

Labour mobility, migration, health workers, trade unions, embeddedness

Introduction

The study of migration draws on multiple disciplines, blurring the boundaries between them and resulting in little consensus regarding the causes and impacts of the movement of workers. In geography research in migration has drawn on anthropological approaches to study the experience of migrant communities or has been focused on the impacts of migrants in particular cities, localities or regions (Wills *et al*, 2009; Stenning and Dawley, 2009; Mingione, 2009). Furthermore, the emphasis has tended to be on labour mobility in sectors that are low skilled, poorly paid and 'grease the wheels' of flexible labour markets (Ruhs, 2006; Wills *et al*, 2009).

The global migration of health workers from low to high income economies from the end of World War Two is a well-documented phenomena (Valiani, 2012; Yeates, 2009; Bach, 2010; Connell, 2012). However, within the European Union a number of economic, political and social developments are in the process of changing the labour market for health workers and the patterns and drivers of inter-country mobility. This mobility in the European Union needs to be understood in the context of demographic changes, the integration of the market for health care and its growing marketization and the enlargements of 2004 and 2007 to include New Member States (NMS) with significantly lower levels of incomes and salaries.[i]

The health care sector in the European Union is of growing social and economic significance. Employment in this sector has risen to account for, on average, ten per cent of employment across OECD countries by 2009 (OECD, 2011). An increasingly ageing population coupled with a reduced working age population

present a challenge regarding both the funding and recruitment of workers in this sector. The growing demand for health and care workers, projected staff shortages and differential pay and working conditions has led to an increase in the mobility of labour across national boundaries in the sector. Pressures on health budgets have intensified as governments have implemented austerity measures since the financial crisis of 2007/08 and in response to the ongoing sovereign debt crisis in Europe, while the increased marketisation and privatization of health care provide additional challenges.

Drawing on primary research data, which comprises EU-wide questionnaires and interviews, and case studies of two sender countries (Poland and Romania) and one receiver country (the United Kingdom), this article focuses on the case of workers in the health sector. Here we argue that although the primary interplay of factors is at the EU and national level, there are ramifications for sub-national spaces and localities, and we therefore posit a multiscalar framework of labour mobility in the European Union. The conceptual framework that informs the investigation is socioeconomic, locating economic relations as being embedded in institutional and social processes and structures. This approach provides an integrated approach whereby economic, political and social factors are not discrete processes, but interrelated and mutually constitutive. The approach synthesises; structural complexities that go beyond the simple 'push' 'pull' dichotomy; the role of formal and informal institutions that shape the opportunities for mobility; and the individual and collective agency of workers.

The framework aims to enrich the literature on labour mobility by emphasising the importance of the interrelationship between different scalar levels; European, national and regional (sub national). In particular, the novel contribution of this article lies first through interrogating labour mobility through the lens of a sectoral perspective by focusing on health workers as a broad category. Second, by drawing extensively on interviews conducted in Poland and Romania we emphasise the sender country perspective and exacerbation of national and regional inequalities (Perrons, 2009). Third we emphasise the role of trade unions and professional associations as important agents in mediating the migration process.

The structure of the article is as follows; the first section draws on structure, institutions and agency to outline a socio-economic conceptual framework. The second section discusses definitional problems in investigating the mobility of health workers and outlines the methodology used in this study. The third section reports the emerging trends and new divisions of labour emerging in the health care sector. The following three sections continue with a discussion regarding the drivers and inhibitors of mobility from a structural, institutional and agency perspective. Before concluding, the paper draws out a distinct regional aspect arising from the study.

A socioeconomic framework

Centring on the notion that economic relations are embedded in and structured by existing social relations the approach taken is socioeconomic (Polyanyi, 1944; Granovetter, 1985; Smelser and Swedberg, 1994). This eschews both neoclassical accounts, which view migrant workers as rational agents

responding to economic incentives (see Hodgson, 2008) and crude Marxist accounts where migrant workers are simply a reserve army of labour (Castles and Kosack, 1973). The conceptual approach taken in the article draws on three analytical strands; the structural dimensions of unevenness and the underpinnings of markets and their mutual constitution and reconstitution through socio-political processes; the role of formal and informal institutions, and the state in particular, in controlling and mediating labour mobility; and the individual and collective action of workers in negotiating, accommodating to and contesting the first two elements. These elements are summarised in Table 1.

Table 1 about here

First, the structural underpinnings of labour mobility locate the analysis at a meta- level in the global integration of health labour markets, contextualised in the dynamics of capitalist restructuring (Sassen, 1988; Valiani, 2012). This is manifest in marked unevenness and disparities between the GDP, incomes and salaries (and specifically those that pertain in the health sector) of different economies and within regions in individual economies. This unevenness is replicated within the Europe Union more acutely since the accession of the (mainly) post-communist economies (2004 and 2007) at significantly lower levels of development. At a basic level these provide the 'push and pull' factors for labour mobility.

However, an important premise of the socioeconomic approach is that an integrated market for health is not exogenously determined, but socially and

politically constructed (Myrdal, 1957); this is manifest in the case of the European Union through a drive to smooth the terrain for the movement of capital and labour. There has been a series of directives and court rulings by EU institutions that have furthered the neoliberal drive to disembed national health care systems and reembed them in a single European market (Morton, 2011).

Second, the mobility of health workers needs to be understood as being shaped, controlled and mediated by formal and informal institutions and the state in particular. Global health care chains involve skilled (doctors and nurses) and less (formally) skilled (care workers) workers with varying degrees of regulation in institutional (and home) settings employed in a matrix of public and private provision. Individual states constantly intervene to recast the rules of the game relating to the mobility of workers. Nation states face the dilemma of balancing the requirement of ensuring a flow of workers with differentiated skills and the costs of reproducing and training labour; inward migration enables receiver countries to externalise the renewal costs of labour (Burawoy, 1976; Harvey, 1982; Sassen, 1988). Immigration rules are not a neutral framework of legislation, but create categories of worker, impose employment arrangements and may institutionalise uncertainty (Anderson, 2010).

Yeates (2009) points to a complex institutional architecture of educational recruitment strategies, national and international governance and professional and employer organisations. In some cases 'sender' countries (notably the Philippines and India) have treated the production of health workers for the global market as part of a national development strategy, where the export of labour is actively promoted (Yeates, 2009; Phillips, 2009), be it for national

workforce skill acquisition or for remittance earnings contribution to national GDP. This panoply of institutions and arrangements ranging from transnational employment agencies to bilateral governments agreements broker the movement from sender to receiver economies. States are not undifferentiated in their approaches to labour and Menz (2009) suggests a 'varieties of capitalism' approach where the constellation of institutions will inform distinct types of labour recruitment strategies. Therefore health care provision in general, and care regimes in particular, are embedded in different national employment models (Simonazzi, 2010), as well as different modes of public provision.

However, nationally embedded health care systems with disparate governance arrangements are incompatible with the single market and the mobility of labour. Therefore efforts have been made to overcome these 'market distorting' obstacles through the EU Directive on the Recognition of Professional Qualifications established in 2005 and revised in 2011 which sets the rules for mutual recognition of professional qualifications between member states (EC 2005 and 2012).[ii]

The third element of this conceptual framework points to the importance of the individual and collective agency of workers in processes of mobility and migration. Workers are not simply units of labour, but the subjects and authors of their own mobility 'always struggling, often with some success, to better their lot' (Harvey, 1982: 380). Collectively trade unions and professional associations, in receiver countries in particular, are important agents in migration processes (see Fitzgerald and Hardy, 2010; Yeates, 2009). In the first instance unions have a choice of whether to resist migration, for example by demanding quotas, or to

engage with it by trying to influence policies. With the arrival of migrant workers trade unions and professional organisations face the dilemma of whether to seek to recruit and organise them or simply ignore their presence. If immigrants are recruited, questions are raised as to how far additional resources should be used to integrate these workers into union and professional association structures and support their special needs (Penninx and Roosblad, 2000). Further, most EU member states have specific regulations through professional body registration requirements, requiring health professionals to demonstrate that they are up to date and fit to practice. [iii] Therefore collectively trade unions and professional organisations in sender countries intervene in mobility processes by trying to ameliorate conditions and reduce disparities (voice) while on an individual basis workers may decide to migrate (exit).

The key relationship discussed in this section has been at the level of the European Union and national economies. However, the local and regional level will contribute to the complexity of structural factors that shape migration and, as a consequence will be subject to some of the impacts of and trends in labour mobility. With specific reference to the EU NMS, since the beginning of transformation to market oriented economies in 1990, regional disparities have increased in terms of GDP and employment, with a growing concentration of economic opportunities concentrated in urban areas and big cities. The existence of local differences in the demands on and working conditions in the health service, as well as regional variations in wages, could serve either to attract workers or act as a catalyst for them to seek employment either in a different locality within the country or in another country. Furthermore, the location of a

region in terms of proximity to a higher income economy may be an incentive for increased cross border mobility.

Definitional issues and methodology

The health and care sectors cover a wide range of services and occupations[iv]. This study will focus on three broad categories each of which is governed by a different set of dynamics; doctors (highly skilled workers), nurses (skilled workers) and health and care workers (skilled, semi-skilled and unskilled).

There are significant problems in gauging the migration of health personnel due to the limitations of available statistical data (Dussault et al, 2009). Most countries have reliable data neither on the stock of health care professionals, nor on the proportion of them who are active and in particular information on the private sector is generally scarce. Further difficulties with international comparisons emanate from a lack of homogeneity with definitions of occupational categories and because data are rarely available for the same year or the same period. Most countries do not systematically collect information on migratory flows and it is inconsistently measured; in some cases being measured by health workers' country of birth and in others on their country of training (either can be used as a proxy). With regard to migrants who work as carers in the informal sector the difficulties of estimating stocks and flows of incoming workers is exacerbated, as a significant proportion of these are undocumented workers. No data is available on intra country mobility.

An additional complication in gauging the migration flows of health workers is that the literature has not been clear as to whether this represents temporary migration. In the past highly skilled workers migrated to gain experience and

access to training and then returned to their countries of origin, while some groups of less skilled workers exhibited a tendency to migrate and settle in the destination country. More recently, new forms of temporary migration appear to have developed, with some workers maintaining family and work in separate countries, either migrating for successive periods or working abroad for a few days while retaining positions in their own countries. Therefore the classification of countries as either source or destination countries can be difficult as observed patterns are complex with the emergence and increased tendency towards circular or pendular migration and for varying lengths of time.

The primary empirical research which informs this study comprises three elements. First, we report the data from a questionnaire undertaken with affilitates of the European Federation of Public Service Unions (EPSU). Twenty one returns were received from seventeen countries. Questions were answered by research departments, departments that specifically dealt with migration or senior officials. Quantitative and qualitative answers informed broad patterns of migration between countries and drivers of and inhibitors to labour mobility. Second, face-to-face interviews were undertaken in the following countries; Belgium, Germany, Italy, Ireland, Netherlands, Poland, Romania, Sweden and the United Kingdom. These countries were selected on the basis of being sender and receiver countries and core and peripheral economies with different institutional configurations. Third, three countries were developed as case studies; Poland and Romania (sender countries), the United Kingdom (primarily a receiver country) where multiple interviews with professional associations, trade unions and employers were undertaken. Interviews took place with both national and

regional level actors, which enabled insights into regional dynamics and impacts of labour mobility.

Health worker mobility and emerging divisions of labour

This section reports the findings of the questionnaires in order to identify new and complex patterns of migration and emerging divisions of labour. Tables 2 and 3 summarise the responses to the questionnaires regarding patterns of immigration and emigration and the motivating and inhibiting factors. Four notable features that characterise the movement of health workers within the European Union from 2004 were identified. The first feature is the outward migration from New Member States (NMS) to higher income European economies. This has to be set in the context of significant general outward migration since their entry to the EU in 2004 and 2007. In the case of Poland this is particularly marked as an estimated one million people left to work in other parts of the European Union and the UK, Sweden and Ireland in particular, which had fully opened their labour markets.

Within this general picture there has been significant outward migration of health workers from NMS (Bulgaria, Latvia, Romania, Slovakia). In all cases Germany and the UK are the most cited destinations. Other destinations are influenced by language (Romanians to countries that speak Latin based languages) or proximity (for example Slovakians to Austria and the Czech Republic; Latvians to Norway and Sweden; Russians and Estonians to Finland; nurses from Western Poland commuting to Germany[v]). In general mobility and outward migration was highest for doctors and lowest for care workers. NMS reported low or very low levels of inward migration to replace the outflow of

doctors and nurses. Inward migrants tended to be from developing countries (Africa, South America) or neighbouring non-EU countries with relatively lower salaries (Ukraine, Moldova).

The second feature of post-2004 mobility was a strong continuation of the mobility between Nordic countries (Norway, Sweden and Denmark) that reported low or negligible levels of outward labour mobility. For example, Swedish nurses living on the border with Norway, commute to do overtime. The exception to this pattern of Nordic cross border mobility is Finland, where high levels of outward and inward migration by doctors and nurses were reported. Motivated by higher salaries elsewhere Norway, Sweden and England were the main destination countries. Doctors and nurses were recruited mostly from the geographically proximate countries of Russia and Estonia, but also from Somalia and other EU countries.

The third feature, specific to the UK, was a shift from recruiting non-EU to EU health workers showing a marked discontinuity in terms of the pattern of the immigration of health workers. In the early part of the 1990s between 10,000 and 16,000 international nurses were added to the UK register. By 2010 this figure had fallen to 2,500 (Buchan and Seccombe, 2011). International recruitment of nurses to the UK from non-EU countries has practically collapsed, in part because of reduced UK demand and in part because entry to the UK for non-EU nurses has become more challenging and costly.[vi] In 2009/2010, 78 per cent of international registrants were from the EU, compared with less than 7 per cent in 2001/2. Although similar figures are not available for care workers, it was reported by a trade union interviewee that difficulties with obtaining or

renewing work permits from non-EU countries has led to a growing number of workers from NMS in this sector[vii]. In addition, there has been a decrease in the reliance on non-EU doctors.

The fourth feature was the invisibility of care workers in the replies to the surveys. However, there is an extensive academic literature documenting the importance of migrant workers in the care sector (see Table 4, Simonazzi, 2010) and the increasing cross border mobility of this group. The research identifies a growing trend of circulatory migration between NMS and their higher wage neighbours; Poland to Germany, Slovakia to Austria and Romania/Bulgaria to Italy (Bettio, *et al*, 2004; Di Rosa *et al,* 2012; Döhner *et al*, 2008; Elrick and Lewandowska, 2008 ; Lamura et al, 2008; Leon, 2010; Metz-Göckel *et al*, 2010; Neuhaus *et al*, 2009; Walsh and O'Shea, 2009).

Having outlined broad movements in health workers across national boundaries, a much more detailed micro and 'fine grained' picture can be observed within these general macro patterns of migration, particularly in relation to skills, public sector to private sector and rural to urban movements, and duration of stay. In the case of skill, although in Poland 10 per cent of doctors were estimated to have migrated by 2011, this was much higher in particular specialisms, with anaesthetists being the most numerous group that migrated (18.3 per cent), followed by plastic surgeons (17 per cent) and chest specialists (15.5 per cent). A similar pattern was manifest in Romania with the highest outward migration from specialist doctors and nurses in anaesthetics, radiology, obstetrics, gynaecology, intensive care services and psychiatry.

The questionnaire findings indicated a growing private sector in health, with staff mobility from public to private sector becoming increasingly common at sub-national level as the private sector grows in urban areas and for particular health specialisms. These issues appear to be fuelling a trend of rural to urban migration. In addition, information gathered here indicates that regional disparities are affecting all countries in some form or other. For example, in Germany and France (receiver countries) vacancy levels for health workers are higher in rural areas than in urban areas and this drives demand in a targeted way for migrants from NMS, through incentives such as housing for migrants to locate to fill these rural vacancies. We focus more deeply on the regional dynamics of sender countries through our case studies of Romania and Poland later in this paper.

Patterns of duration of stay were very mixed and hard data is not available. Doctors and nurses were cited as having more of a tendency to migrate permanently. Although alongside this 'move and settle' model doctors (from Germany and Poland) were flying in to cover shifts in the UK in addition to employment in the home country. Care workers exhibited the highest incidence of circulatory migration, for example from Bulgaria to Italy and Slovakia to Austria. In Romania, for example, nurses are likely to return to employment in Romania, perhaps after three to five years away, although they may return to the private rather than the public sector; however, doctors would appear to return less commonly.

We now turn to looking at the drivers and inhibitors of labour market mobility through the themes of structural underpinnings, institutional frameworks and the agency of workers.

Structural underpinnings

Table 2 shows that, with the exception of the UK, Germany and the Netherlands perceived low salaries were the most common reason given in the questionnaires for outward migration. Table 5 shows average wages in the EU and reveals significant disparities between high, middle and low wages economies, with NMS belonging exclusively to the latter.

Table 5 about here

However, it is not only comparative remuneration between countries that is is important, but also the salaries of health workers in comparison to the average salary pertaining within a particular economy. The ratio of the salary of a general practitioner doctor to the average salary was lower in NMS. This ratio was 1.4 in Hungary and 1.7 in Estonia - compared with 3.6 in the UK and 3.7 in Germany. Table 6 reveals significant disparities in the remuneration of nurses. In the old member states remuneration ranges from 37,000 to 80,000 (USD) and is equal to or above the average wage. In the NMS (with the exception of Slovenia) remuneration ranges from 17,000 to 22,000 USD with wages at or below the average wage.

Table 6 about here

Beyond poor relative salaries low spending on health and deteriorating working conditions were the second most cited reasons for outward migration, and from NMS in particular. Table 7 shows that NMS are at the bottom of the table in terms of expenditure on health per capita. In old member states health expenditure per capita ranged from 2,703 USD (Portugal) to 4,242 USD (Austria), while in the NMS it ranged from 773 USD (Romania) to 1,924 USD (Czech Republic).

Table 7 about here

Table 7 also mirrors disparities between old and NMS in total health expenditure as percentage of GDP. This ranges from 9.5 per cent (Italy and Spain) to 11.8 per cent (Germany) of GDP in old member states to 5.6 per cent (Romania) to 7.9 per cent (Czech Republic) in NMS.

Low spending and under-investment have been exacerbated by privatisation and chaotic restructuring, which has led to demoralisation and deteriorating working conditions in NMS. In the case of Romania, Vladescu *et al* (2008) describe "poor administrative capacity, lack of accountability mechanisms at the local level, inadequate communication… and insufficient management skills" (p.xx) as exacerbating the frustrating experience of working in the sector. At a wider level,

themes of political unrest and of corruption emerge as contributory causes of health worker migration problems.

It can also be noted that relative differences in wages and working conditions were not only important in explaining the movement of workers from NMS to higher wage economies. The questionnaires showed that doctors and nurses in higher income countries also move between countries to take advantage of better labour markets in terms of working conditions and work/life balance. Vårdförbundet (Sweden) registered temporary outward migration among nurses. According to the respondent the lack of investment in the Swedish health sector tends to encourage nurses to move to countries where working conditions are perceived to be better such as in Norway. It was reported that nurses can earn up to a third more in Norway, have much better working conditions and uncapped hours. The German doctors' organisation suggested that working conditions in France were better than in Germany with more holidays and better pay, while in Switzerland doctors were not only paid better but unlike in Germany, they were also paid for their 'on call' time. With regards to leaving the profession, on finishing training doctors in Germany are now moving into industry, in particular the pharmaceutical industry, where the pay and working conditions are more favourable. In the United Kingdom work/life balance was cited as the important reason for doctors emigrating.

Institutional facilitators and inhibitors

The previous section established the existence of marked disparities in wages and working conditions, particularly between pre-2004 EU member countries and NMS. These structural underpinnings provide a foundation of strong

incentives for health workers to migrate on a temporary or a permanent basis. Further, EU directives on freedom of movement, the harmonisation of qualifications and the end of transitional arrangements[viii] provide the institutional framework for the mobility of labour. However, while the questionnaires established the general direction and pattern of movement, the scale of migration has been modest.

In Poland the Ministry of Health and Doctors Council estimate that between eight and ten per cent of doctors migrated between 2004 and 2007. However, despite predictions of substantial migration the outward labour mobility of nurses has been relatively low; between 2004 and 2007, 158 Polish nurses registered in Ireland, 1,013 in the UK and 830 in Italy (Leśniowska 2008). Evidence from Estonia echoed this lower than expected mobility. In 2011 709 doctors and 605 nurses were reported as having migrated with the main destination country being Finland accounting for 74 per cent and 61 per cent of total outward migration respectively. In Romania it is estimated that around three per cent of doctors migrate, however the outward migration on nurses is substantial with between five and ten per cent of nurses leaving the country each year.

Although the direction of both EU policy and discourse is to disembed national healthcare systems and re-embed them in a Single European Market, barriers to mobility are substantial. The main inhibitors of movements across national boundaries were qualifications and language skills (see Table 3). The lack of requisite language skills was particularly applicable to nurses, and the necessity to be fluent in the destination country language was a barrier to taking up

employment. Doctors were more likely to have linguistic skills and in the case of care workers these were less important.

Despite EU directives there is as yet no uniform acceptance of professional qualifications across EU states, particularly in nursing. In Sweden, it is relatively easy to transfer a general nursing registration from within the EU. However, problems arise when it comes to migrant specialist nurses wanting to work in Sweden with a foreign training as there are no clear guidelines on equivalences of training for specialists. All health care workers whether professional or not, wanting to work in Sweden must speak Swedish to a sufficiently high standard. While the Swedish government provides Swedish language courses for those migrants coming to settle permanently in the country (mainly from outside the EU), temporary migrants need to have sufficient knowledge of Swedish if they wish to register as a health care professional. As Swedish is not a common language, this effectively acts as a barrier to migration.

Whereas in some developing countries there was an extensive machinery of arrangements and intermediaries to 'export' nurses, there was no evidence of such systematic structures in the EU. According to the questionnaires employers, employment agencies and the initiative of individuals were cited as equally important in mediating and facilitating migration. There were examples of bilateral initiatives such as a Swedish agency in Poland which provides free language courses for doctors so that they can work on the Swedish labour market. They are particularly oriented to recruiting in shortage areas such as radiologists, gynaecologists, psychiatrists and general practitioners and dentists. In the UK there was evidence that some private health care firms or NHS

(National Health Service) Trusts targeted countries for recruitment, and in particular regions where there were local airports to ease travel.

'Exit or voice' the individual and collective agency of workers

'Voice' was manifest in discontent with wages and working conditions evident in the industrial disputes among health workers in NMS. In Slovakia in March 2011 there were protests by the Slovak Union of Medical Specialists (SLUS) regarding the non-payment for some interventions, poor infrastructure and inadequate wages. In May 2011 the Slovak Medical Trade Union Association (LOZ), following a lack of progress in negotiations threatened to follow the mass resignations of Czech colleagues to pressurise the government (Eurofound, 2011a). Also in May 2011 the Slovak Chamber of Nurses (SKAPSA) protested outside parliament is support of their demand for an earlier retirement age (60 to 58) and minimum hourly wage of Euro 4.50 (Eurofound, 2011c). In the Czech Republic the Doctors Union (LOK), organized the mass resignation of 4,000 doctors in January 2011 in protest against poor working conditions and wages and underinvestment in the health care system (Holt, 2011). Protests also had a regional dimension. In Latvia in August 2011 demonstrations by the health union (LVSASA – Latvian Health and Social Care Workers) in three regional hospitals protested about underfunding and employees not being paid for increased workloads (Eurofound, 2011b).

In Poland in 2007 protests by nurses established a camp, 'white city' outside the Prime Minister's office in protest against low pay. In March 2011 there was an occupation of the *Sejm* (parliament) by the Union of Nurses and Midwives and a hunger strike in protest against making it easier for hospitals to hire staff on

temporary contracts. In January 2012 there were a series of protests on the streets of Bucharest and other Romanian cities, ostensibly against a Bill to extensively privatise the health sector, which had been presented to parliament for only ten days consultation and over which a popular health leader had resigned in protest. Protests may be successful in changing relative differentials which may affect the motivation for migration. For example, in Poland in 2007 as a result of the doctors' protests (Grzymski, 2008) the improvement in doctors' wages reduced the material incentive to migrate. The success or otherwise of 'voice' is important in that it has some potential for changing the incentives that underpin migration and therefore the dynamics of labour mobility.

The European Federation of Public Service Unions (EPSU) that represents workers in health unions tries to support both the 'voice' and 'exit' of workers by adopting policies to ensure labour mobility, but also prevent social dumping (Hardy *et al*, 2012). However, different returns across space stemming from uneven development potentially leads to differentiated interests between trade unions in high and low wage economies.

At national level trade unions and professional associations in receiver countries play a key role in contesting the entry of, ignoring or integrating migrant workers. The case study country, the United Kingdom is (mainly) a receiver country and has substantial experience of immigrant health workers. The most significant organisations that represent them, the British Medical Association (BMA), the Royal College of Nurses (RCN) and Unison (care workers and nurses), all subscribe to the principle of freedom of movement and play a critical

role in relation to migrant workers through lobbying and advocating, collective and individual support and shaping workplace spaces.

First, all three organizations collectively represent the health care professions at a global (World Health Organisation), European (EPSU) and national level (advisory bodies – the Nursing and Midwifery Council for example) and lobby on the impact on the home countries of migrant health care workers (WHO), language requirements of migrant workers (EU level), the impacts of point based immigration (national level). Second, the BMA, RCN and Unison provide extensive, collective and individual advice "to make sure that they [migrant workers] know their rights and are not exploited". The RCN, for example, has intervened to prevent 'sharp practices' whereby agencies or employers made disproportionate deductions for travel and accommodation and took away passports. Third, these professional organisations and trade unions significantly shape workplace spaces. The RCN provide guidance to employers and local representatives on good practice and working with different cultures. Unison employed an organiser seconded from a sister trade union in Poland. In particular, Unison has tried to shift discourses on migration by producing materials to dissemble the 'myths of migration' promulgated by some sections of the popular press in the United Kingdom.

A regional perspective

If national statistics for migration are partial and inconsistent, sub-national regional data on the movement of workers in general and health workers in particular, are non-existent. While the structural and institutional underpinnings of inter-EU migration are relatively transparent, the regional perspective and

impacts are much harder to unpick. The migration of health workers, and the movement of doctors in particular, are one of a number of factors interrelated in complex ways that contribute to virtuous or downward cumulative causation in the provision of health care and wider quality of life of regions. Here we provide a deeper analysis of regional dynamics based on the case studies undertaken in the two 'sender' countries Romania and Poland.

The most critical factors shaping the provision of health care in regions are the mutually reinforcing mechanisms of decentralization and marketization, and the interplay between these and an existing but deepening level of rural poverty. In Romania and Poland decentralization is leading to larger regional differences in health care, related to the relative wealth of regions. In one part of Romania which generates county and municipal income from industry, local governance allows local politicians to invest in hospitals. In Poland individual branches of the National Health Fund (NFZ)[ix] have different amounts to spend on health services per insured person. In 2008 for example the Mazowieckie NFZ branch spent almost 14.1 per cent more per insured person than the poorest branch (Podkarpackie) (GUS 2012).

In Romania, although constrained by national controls on staff budgets, regions are able to fund equipment and other facilities (imaging equipment, medicines, training) in such a way that benefits health care locally and provides some incentive to staff to prevent them leaving. Hospitals in more wealthy urban regions are able to raise additional income more easily by charging patients, their families and communities for additional services, such as overnight accommodation, health checks for employment, and out-patient services for non-

referred patients. These are in contrast to other regions which are poorer, typically more rural and less industrialised.

In both Poland and Romania local differences in income and decentralised bargaining enable the use of maximum pay scales for specialist staff. Migration is easier and more common for staff with specialisms (such as anaesthetics, radiology, obstetrics, gynaecology, other intensive care and surgery expertise, family medicine and psychiatry) (Galan *et al*, 2011), and specialist occupations are more numerous in larger urban centres of population. The implications are that the larger clinical hospitals based in major urban areas are suffering from migration loss through specialist staff loss. By contrast, smaller municipal hospitals have more stable staffing due their generalist functions. However, small towns and more rural regions are more exposed to the effects of loss of a small number of specialists, both through inter-regional, rural to urban, and national migration. In smaller cities in Poland higher wages are paid to retain specialists squeezing the total wage bill and leading to increased disparities with occupational groups in the health sector.

In both countries there is a shift toward health being provided in private rather than public space (Vladescu and Olsavsky, 2009; WHO, 2011). In Poland for example, between 2000 and 2009, the number of public hospitals decreased substantially while the number of private and non-public hospitals increased (largely the result of the commercialization of hospitals). The total number of private hospitals increased from 38 in 2000 to 228 in 2009, partially as a result of the transformation of public hospitals into Commercial Code; between 1999 and 2009 local government privatized 77 public hospitals (GUS, 2012).

Although currently relatively small in scale, a regional impact is felt because of the effect of the concentration of private sector establishments in urban-based locations. These are typically mono-speciality clinics in gynaecology, dermatology and some surgeries which are seen to be more profitable (CMAJ, 2010). This specialist occupational and city-based private sector exacerbates regional effects, reinforcing the vulnerability of urban regions to loss of specialist staff out of the public sector, and the attractiveness of urban regions over more rural ones.

There is thus a cumulative effect, caused by a combination of restructuring, decentralisation, and urban concentration of specialist occupations and private work with migration as a contributory factor. In Romania 86 per cent of physicians practice in urban areas, with only 14 per cent in rural areas where they serve 47 per cent of the population (Wiskow, 2006). Rural and deprived areas have been persistently under-staffed due to lack of incentives to work there (Galan, 2006; Wiskow, 2006). Ninety eight villages are without a health professional and a third of the country is lacking 30 per cent of the medical specialisms found elsewhere in the country (Vladescu and Olsavsky, 2009). For doctors, three-quarters of Romanian districts are staffed below the national average (Wiskow, 2006) with two-thirds of the doctors concentrated in six centres (CMAJ, 2010). A 2009 survey in Poland found a shortage of health workers, which included 4,113 unfilled posts for doctors (mostly anaesthesiologist and other specialisms) and 3,229 for nurses (WHO, 2011), again with regional differentials.

In Romania there are regional pay differentials of up to 15 per cent between urban and rural regions because, despite a national pay scale, lower grading of status of hospitals in more rural areas constrains hospital managers in the use of these scales. The poor rural living conditions (with for example a significant proportion of rural homes without running water, and roads being unpaved) make living in these spaces unattractive to health workers. Some choose to commute to poorer regions to work, but at their own cost as they take lower salaries and pay travel costs. There are also strong indicators that the role of informal payments, common through Romania and other NMS, has a regional effect, as a poorer rural population is unable to provide the same level of informal payments as other regions, and health workers are unable to make up a shortfall in their salary by this means.

In this context, 'exit' by workers in regions – either out of the country, from the public to the private sector or from rural regions and small town to larger cities – contributes to a process whereby regions are locked into a downward spiral of cumulative causation. The outward migration of health professionals compounds this situation and leaves staff that remain with considerably higher workloads and more difficult working conditions providing an incentive to migrate spatially or occupationally. This is compounded by the fact that outward migrants tend to be the younger workers and those who have acquired valuable specialist skills. For the inhabitants of less wealthy regions this leads to a diminished health service, with the loss of specialist services and a deteriorating quality of life.

Conclusion

The research has established some general patterns regarding the direction of migration in the European Union, and in particular identified a trend in health care workers moving from NMS to higher wage economies. However, the findings caution against a simple 'push' 'pull' analysis on several counts. For example, relative wages within economies, working conditions and work/life balance mediated individual decisions. In addition, Nordic countries (taken broadly) exhibited path dependency with very modest labour mobility.

Accurate data relating to the overall scale of mobility is not available, but the research points to relatively modest flows of health workers. Nevertheless even small outward movements of health care specialists can have a disproportionate effect on sender countries and the poorer regions within them. A multiscalar analysis points to the interrelationship between the spatial levels of the EU, nation state and regions, the complexity of which is increased by the opening up of new spaces of governance and employment; namely decentralisation and an increasing private sector. In other words financial incentives not only induce the migration of health workers from low to high income economies, but there are much more nuanced divisions of labour as workers move from weak to strong core economies and from weak to strong peripheral economies. Patterns of migration are further complicated by internal migration from rural to urban areas, and with an increasing drive to privatisation from the public to the private sector.

What emerged strongly was a contradiction between the legislation and discourses of the EU to disembed national systems of health care and to promote the mobility of labour, and the persistence of national institutions of languages

and qualification which constitute a significant barrier to the movement of health workers. In the longer run the importance of these factors may diminish in terms of their role in inhibiting labour mobility. Labour organisations have a significant role to play in exercising 'voice' in sender countries in order to improve wages and working conditions, thereby reducing the differentials with non-NMS economies. Through their collective agency health workers disputes are able to alter domestic conditions in such a way that, on the margin at least, decisions to migrate or to stay may be influenced – this is especially true of more powerful groups such as doctors. Further, trade unions and professional organisations, at EU, national and regional level, play a critical role in shaping spaces of work in receiver countries in terms of influencing policy, mitigating exploitation and promoting cultural sensitivity.

Looking ahead a new set of challenges are presented as legislation increases patient mobility, which opens up the possibility of arbitraging labour costs in different ways – namely that of the movement of capital and patients rather than health care workers. This highlights the important of the agency of communities and trade unions in assessing the outcomes and implications of such market driven initiatives and intervening in such a way as to maximise the benefits for the majority of people.

Notes

[i] The following countries acceded in 2004: Cyprus, the Czech Republic, Estonia, Latvia, Lithuania, Hungary, Malta, Poland, Slovenia and Slovakia (omitting Malta and Cyprus referred to as A8). Romania and Bulgaria joined the EU in 2007 (A2).

[ii] Taken together these include the introduction of a European Professional Card, better access to information on the recognition of professional qualifications, updating minimal training requirements, the introduction of an alert mechanism for health professionals benefitting from automatic recognition, the introduction of common training frameworks and common training tests, and a mutual evaluation exercise on regulated professions (EC, 2012).

[iii] Examples include, the General Medical Council (GMC) for doctors in the UK, the Royal College of Nurses (RCN) in the UK and, in Sweden Svenska Barnmorskeforbundet (SBF – the Swedish Society of Midwives) and Svensk sjukskoerskeforening (the Swedish Society of Nursing).

[iv] Employment in the health and social sectors includes people working in the following groups of the International Standard Industrial Classification (ISIC) Rev.3.1: 851 (human health activities) and 853 (social work activities).

[v] It should be noted, however, that there was already an established trend from 1990 to 2004 of cross border circulatory migration from the Visegrad countries (Czech Republic, Hungary, Poland and Slovakia) on the German border to Germany.

[vi] Increases in registration requirements from the Nursing and Midwifery Council (NMC) and a shift to a points based permit system has reinforced the government's policy of making international recruitment a more difficult option for employers.

[vii] This was because of the United Kingdom's Point Based Immigration System.

[viii] After the 2004 and 2007 enlargements states were allowed to temporarily restrict the free mobility of workers from acceding countries for a period of 5 years in general, and up to 7 years under certain circumstances. These transitionalarrangements are intended to smooth the shock to labour markets of the enlargementprocess.

[ix] Narodowy Fundusz Zdrowia

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Table 1

A multiscalar conceptual framework for the migration of health workers

	European Union	National level	Regional level
Structural factors	Workforce demographics Demands for health services Differential wages Integrated market for health	Comparative wage with other European economies Comparative working conditions with other European economies Wages in relation to national average (all sectors) Marketisation/privatisation Labour shortages	Wage in relation to national average in sector Working conditions in relation to national average in sector
Institutional factors	<u>Formal</u> Directives on labour mobility Directive on qualifications <u>Informal</u> Discourses	Modes of health and care provision Qualifications and training Bilateral agreements Employment agencies Employer recruitment strategies <u>Informal</u> Language Cultural specificities	Employer recruitment strategies <u>Informal</u> Local patterns of migration Social networks
Individual and collective agency	European Federation Public Service Unions	Trade unions Professional Associations Employers bodies	Local trade unions Local employers bodies

Table 2

Cross border mobility of health care workers by country and group: emigration

Country	Destination for outward migration	Jobs affected (High/low levels of migration)	Drivers	Permanence
Austria	No information	No information	No information	No information
Belgium	France, UK, Switzerland, Nordic countries	Doctors (high) Nurses (high) Care workers (high)	Low pay Poor working conditions Other	Usually circulatory or permanent
Bulgaria	Germany, UK, France, Italy	Doctors (high) Nurses (high) Care workers (low)	Low pay	Usually permanent, occasionally temporary or circulatory
Cyprus	No information	Nurses (high)	Lack of job opportunities	Temporary/circulatory
Finland	Norway, Sweden, UK	Doctors (high) Nurses (high) Care workers (low)	Low Pay Getting experience	Usually permanent, occasionally temporary
France	Mainly Switzerland, Spain, Belgium and Italy. Also humanitarian medicine in Africa	Doctors (low) Nurses (low) Care workers (low)	Low pay Lack of job opportunities	Usually circulatory. Occasionally temporary.
Germany	UK, US, Switzerland, Austria, France	Doctors (high) Nurses (not known) Care workers (low)	Better working conditions, work/life balance (doctors)	Temporary, circulatory, permanent (doctors)
Italy	Various EU destinations	Doctors (high) Nurses (low) Care workers (low)	Lack of job opportunities (doctors)	Permanent (doctors)

Table 3 Cross border mobility of health care workers by country and group: immigration

Country	Source of inward migration	Jobs affected (High/low levels of migration	Barriers to Immigration	Permanence
Austria	Germany, Turkey, Herzegovina, Hungary	Care workers (high)	Qualifications Language	Permanent care workers
Belgium	Portugal, Africa, Russia, South America	Nurses (high) Care workers (high)	Qualifications Language Poor wages Other	Permanent
Bulgaria	Macedonia, Lebanon and Syria (although all at a low level)	Doctors (low) Nurses (low) Care workers (low)	Language Poor wages	Usually permanent
Cyprus	No information	Doctors (low) Nurses (high) Care workers (high)	Qualifications Language	Permanent
Finland	Estonia, Russia, Somalia, EU	Doctors (high) Nurses (high) Care workers (low)	Qualifications Language	No information
France	Maghreb (13.7%) Europe (13.7%) Africa (12.3%) Asia (6.9%)	Doctors (30,000) (low)	Language Accommodation	Occasionally circulatory or permanent
Germany	Poland and NMS (care workers)	Doctors (moderate) Nurses (not known) Care workers (high)	Qualifications	Circulatory (care workers) Temporary, circulatory, permanent (doctors)
Italy	Poland, Bulgaria, Romania (only 2% of registered nurses) Romania (care workers)	Doctors (low) Nurses (low) Care workers (high	Qualifications (nurses) Language (nurses) Oversupply domestically (doctors)	Permanent (nurses) Circulatory (care workers)

Table 4

Total employment in the elder care sector (selected countries)

	Home care	**Nursing home/Residential care**	**Irregular workers (estimated)**	**Total (including estimated number of irregular workers where available)**
Austria (2002)	3,400	16,963	(40,000)	60,636
England (2003/4)	163,000	(462,000)		625,000
France (no year given)	800,000	134,000		934,000
Germany (2003)	200,897	510,857	(100,000)	811,754
Greece (2001)				21,325
Italy (2004)	30,000	125,000	(500,000)	655,000
Spain (2003)			(50,000)	200,000
Sweden (2004)				239,500

Source: Simonazzi (2010, p.44)

Table 5

Average monthly salary 2005 and 2009 (in Euros)

Country	2005	2009
High salary countries		
United Kingdom	42, 866	38,047
Germany	47,529	56,044
Austria	36,032	33,384
Sweden	34,027	34,746
Middle salary countries		
Italy	22,657	23,406
Spain	20,333	26,316
Portugal	14,042	17,129
Low salary countries		
Bulgaria	1,978	4,085
Czech Republic	7,405	10,663
Hungary	7,798	9,603
Poland	6,270	10,787
Romania	3,155	5,450
Slovakia	6,374	10,387

Source: Eurostat, 2011: 76

Table 6

Remuneration of hospital nurses, USD PPP and ratio to average wage, 2009

Country	USD PPP	Ratio to average wage
Luxembourg	80,000	1.4
Ireland	54,000	1.0
Denmark	52,000	1.1
United Kingdom	52,000	1.1
Norway	49,000	1.0
Spain	48,000	1.3
Netherlands	44,000	1.0
Finland	38,000	1.0
Italy	37,000	1.1
Slovenia	35,000	0.9
Czech Republic	22,000	1.0
Estonia	20,000	1.0
Slovakia	18,000	0.9
Hungary	17,000	0.8

Source: Adapted from OECD report 2011, p.77

Table 7

Total health expenditure per capita and as a percentage of GDP, 2010

World Health Organisation estimates

Country	USD Purchasing Power Parity [1]	Health expenditure percentage of GDP [2]
Norway	5,394	9.5
Austria	4,242	11.0
Germany	4,128	11.6
Ireland	4,004	9.2
France	3,934	11.9
Sweden	3,690	9.6
UK	3,399	9.6
Finland	3,357	8.9
Spain	3,150	9.5
Italy	3,027	9.5
Greece	3,025	10.2
Portugal	2,703	11.0
Slovenia	2,475	9.4
Czech Republic	1,924	7.9
Slovakia	1,897	n/a
Hungary	1,440	7.3
Poland	1,358	7.5
Estonia	1,372	6.0
Lithuania	1,096	7.0
Latvia	995	6.5
Bulgaria	985	6.9
Romania	773	5.6

[1] Source: WHO Global health Expenditure Database

http://data.euro.who.int/hfadb/tables/tableA.php?w=1024&h=640

[2] Source: OECD (2011, p. 151)
WHO Global Health Expenditure Database
http://data.euro.who.int/hfadb/tables/tableA.php?w=1280&h=1024