OPPORTUNITIES AND CHALLENGES RELATED TO CROSS BORDER MOBILITY AND RECRUITMENT OF THE HEALTH SECTOR WORKFORCE

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Abbreviations

ABVAKABO	(NL) acronym for the largest public sector union in The Netherlands, made up of two composites: *Algemene Bond Van Ambtenaren* (ABVA) + *Katholieke Bond van Overheidspersoneel* (KABO)
AMSI	(I) Italian Foreign Doctors Organisation *(Associazione Medici di Origine Straniera*)
ASS	(I) Italian Health and Social Assistants (*Assistenti Socio Sanitari*)
BMA	(GB) British Medical Assocation
CEE	Central and Eastern Europe
CFDT	(F) French Democratic Confederation of Labour (*Confédération française démocratique du travail)*
CGIL	(I) Italian General Labour Confederation (*Confederazione Generale Italiana del Lavoro*)
CISL	(I) Italian Confederation of Laboratories Trade Unions (*Confederazione Italiana Sindacati Lavoratori*)
CJ	Court of Justice of the European Union
CPD	Continuing Professional Development
CSC	(B) Confederation of Christian Trade Unions (*Confédération des Syndicats Chrétiens*)
CGSP	(B) General Confederation of Public Services Unions (*Centrale Générale des Services Publics*)
EC	European Commission
ECTS	European Credit Transfer and Accumulation System
EEA	European Economic Area
EOHSP	European Observatory on Health Systems and Policies (part of WHO)
EPSU	European Public Service Union
EU	European Union
EU8	Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovenia, Slovakia
EU2	Bulgaria and Romania
EURES	The European Job Mobility Portal
GDP	Gross Domestic Product
GMC	General Medical Council
GP	General Practitioner
HCA	Health Care Assistant
HSMCTU	(GEO) Health, Social Care, Medical and Chemical Industry Workers' Independent Trade Union
HOSPEEM	European Hospital and Healthcare Employers' Association
ILO	International Labour Organization

IPASVI	(I) Italian Professional Nurses, Health Assistants and Childcare Workers (*Federazione Nazionale Collegi Infermieri professionali, Assistenti sanitari, Vigilatrici d'infanzia*)
ISIC	International Standard Industrial Classification
IMF	International Monetary Fund
IMI	Internal Market Information System
IMPACT	(IRL) Public Sector Trade Union
JHL	(FIN) Trade Union for the Public and Welfare Sectors (*Julkisten ja hyvinvointialojen liitto*)
LOZ	(SK) Medical Trade Union Association/Labour Union of Physicians (*Lekárske odborové združenie*)
LSADPS	(LT) Lithuanian Trade Union of Health Care Employees (*Lietuvos sveikatos apsaugos darbuotojų profesinė sąjunga*)
LVSADA	(LV) Latvian Health and Social Care Workers (*Latvijas Veselības un sociālās aprūpes darbinieku arodbiedrība*)
MEP	Member of the European Parliament
MOH	Ministry of Health
NGO	Non-governmental Organisations
NHS	(GB) National Health Service
NMC	(GB) Nursing and Midwifery Council
NMS	New Member states
NSF	(N) *Norwegian* Nurses Organisation (*Norsk Sykepleierforbund*)
OECD	Organisation for Economic Co-operation and Development
OPZZ	(PL) All-Polish Alliance of Trade Unions (*Ogólnopolskie Porozumienie Związków Zawodowych*)
OSS	(I) Health and Social Operations (*Operatori Socio-sanitari*)
OSZSP ČR	(CZ) Trade Union of the Health Service and Social Care of the Czech Republic (*Odborový svaz zdravotnictví a sociální péče ČR*)
PASYDY	(CY) Pancyprian Public Employees Trade Union
PPP	Purchasing Power Parity
RCN	(GB) Royal College of Nursing
SALAR	(S) Swedish Association of Local Authorities and Regions (*Sveriges Kommuner och Landsting*)
SBF	(S) Swedish Society of Midwives (*Svenska Barnmorskeförbundet*)
SKSAPS	(SK) Slovakian Chamber of Nurses and Midwives (*Slovenská komora sestier a pôrodných asistentiek*)
SLUS	(SK) Slovak Medical Union of the Specialists (*Slovenská lekárska únia špecialistov*)
SOZZaSS	Slovak Trade Union of Employees in Health and Social Services (*Slovenský odborový zväz zdravotníctva a sociálnych služieb*)
TFEU	Treaty on the Functioning of the European Union

TU	Trade Union
UIL	(I) Union of Italian Workers (*Unione Italiana del Lavoro*)
USD	US Dollar
WHO	World Health Organization

Executive Summary

Background, aims and methodology

The health and care sector in the European Union (EU) is of growing social and economic significance. Employment in the health and care sector has risen and, in 2009, on average, accounted for 10 per cent of employment across OECD (Organisation for Economic Co-operation and Development) countries. Demographic changes of an increasingly ageing population coupled with a reduced working age population presents a challenge regarding funding and the 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. The accession of New Member states (NMS) in 2004 (Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovenia, Slovakia – EU8) and 2007 (Bulgaria and Romania – EU2) further increased the potential for migration. Pressures on health budgets have intensified as governments have implemented austerity measures since the financial crisis of 2007/2008 and in response to the ongoing sovereign debt crisis in Europe. Increased marketisation and privatisation provide additional challenges.

This study will focus on three broad categories: doctors (highly skilled workers), nurses (skilled workers) and care workers (skilled, semi-skilled and unskilled). Each of these groups is governed by a different set of dynamics. The study will cover hospitals, residential and home care in the public sector, and the for-profit and not-for-profit sectors.

The aims of the report are to:

- outline the EU legal and qualifications frameworks related to cross-border mobility
- identify patterns of migration between countries
- investigate the 'push' and 'pull' factors driving migration
- examine the role of trade unions (TUs) in this process.
- identify key challenges and make recommendations.

The research comprises three elements. First, we report the data from a survey of European Public Services Union (EPSU) affiliates. Second, we report on primary data in the form of face-to-face interviews that were undertaken in the following countries: Belgium, Germany, Ireland, Italy, The Netherlands, Poland, Romania, Sweden and the United Kingdom. Six countries were selected and developed as case studies (Germany, Italy, Poland, Romania, Sweden and the United Kingdom). These were selected on the basis of including sender and receiver countries from a labour perspective, which broadly correspond to established EU members and New Member states (NMS). Third, the report draws on secondary data from reports, academic literature and databases.

Legal and institutional frameworks

EU law establishes a broad legal framework that enables the free movement of workers across all member states. From 2011, complete freedom of movement for workers from the member states that joined in May 2004 was guaranteed. However, most member states still limit access for Romanian and Bulgarian workers. Special rules apply to workers who are employed in one member state, but are sent, for a temporary period, to work in another member state while maintaining their original employment relationship. Such posted workers are a frequent occurrence in the health care sector. This poses a potential problem if they are posted from a member state with, for example, low wages, to a member state with higher

wages. Unless this is regulated, posted workers could thus be used to undercut wages in the host country. EU law provides some protection for migrants coming from countries that are not members of the European Union. However, it is largely up to member states to regulate migration from outside the European Union based on their national laws. *The Charter of Fundamental Rights of the European Union* (December 2009) gives third-country nationals some rights and is based on the principle that 'every worker has the right to working conditions that respect his or her health, safety and dignity'.

The mobility of health professionals is enabled by the Directive on the Recognition of Professional Qualifications (EC, 2005), which sets the rules for mutual recognition of professional qualifications between member states. The Directive provides for automatic recognition of qualifications based on a set of harmonised minimum conditions of training for seven sectoral professions. New legislative proposals were announced in December 2011. This includes: 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 benefiting from automatic recognition; the introduction of common training frameworks and common training tests; and a mutual evaluation exercise on regulated professions. In addition, it should be noted that many member states also have specific regulations through professional body registration requirements, requiring health professionals to demonstrate that they are up to date and fit to practice.

Findings

Patterns of mobility

- Outward migration from New Member states to higher-income European economies has to be set in the context of significant general outward migration since their entry to the EU in 2004 and 2007. Within this general picture there has been significant outward migration of health workers from NMS. In all cases Germany and the UK are the most cited destinations. Other destinations are influenced by language and/or proximity. In general, mobility and outward migration was highest for doctors and lowest for care workers.
- The situation regarding the mobility of health workers is complex and ambiguous, involving different patterns of mobility – public to private, rural to urban, outward migration and circular migration.
- All NMS countries reported low or very low inward migration to replace the outflows of doctors and nurses. Inward migrants tended to be from developing countries or neighbouring non-EU countries with relatively lower salaries.
- Nordic countries (and The Netherlands) reported low or negligible levels of outward migration. There is strong continuity with the pre-2004 trend of mobility of health workers between Nordic countries (Denmark, Norway and Sweden).The exception to this pattern is Finland, where high levels of outward and inward migration by doctors and nurses were reported.
- The UK showed a marked discontinuity in terms of the pattern of the immigration of health workers. There has been a significant overall reduction in overall immigration, and a marked switch from non-EU to EU entrants.
- The questionnaire shed little light on the migration trends of care workers. However, there is an academic literature that shows a growing trend of circulatory migration between NMS and their higher-wage neighbours; from Poland to Germany, Slovakia to Austria and Romania/Bulgaria to Italy.

- Within general patterns of migration a much more detailed and 'fine grained' picture can be observed in relation to skills and private sector employment. Highest outward migration is from specialist doctors and nurses in anaesthetics, radiology, obstetrics, gynaecology, intensive care services and psychiatry.
- The questionnaire responses suggested that patterns of duration of stay (temporary, permanent, circulatory) were very mixed and hard data is not available.

Factors driving or inhibiting health workforce migration

- Poor salaries were the most common reason given in the surveys for outward migration of health workers in general and from the NMS in particular.
- Poor working conditions were the second most cited reason for migration, in NMS in particular. NMS are at the bottom of the table in terms of total expenditure on health per capita and total health expenditure as percentage of Gross Domestic Product (GDP). Low spending and under-investment have been exacerbated by privatisation and chaotic restructuring, which has led to demoralisation and deteriorating working conditions in NMS.
- There is evidence that doctors and nurses in higher-income countries also move between countries to take advantage of better labour markets in terms of pay. Also better working conditions and/or work–life balance was cited as important.
- Employers, employment agencies and the initiative of individuals were cited as equally important in mediating and facilitating migration. No clear pattern of agents of recruitment emerges. There was no evidence of the large-scale systematic recruitment strategies that are present in the migration of health workers from developing to developed countries (with the exception of the UK).
- The factors that were specifically and most frequently cited as barriers to the mobility of health care workers were those of language and the lack of recognition of qualifications. The lack of requisite language skill 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.
- There is as yet no uniform acceptance of professional qualifications across EU states.

It was clear from the questionnaire responses that differentials in wages and working conditions, both between NMS and old EU member states and between higher-income economies, provide some explanation for migration and cross-border mobility in the EU. However, this mobility is complicated by internal migration within countries from rural to urban areas and from the public to the private sector. Labour shortages within the health sector, particularly in nursing, are compounded by its perceived lack of attractiveness as a career by young people.

The care sector

- Ageing populations, demographic change and changing work and family patterns across Europe mean that the care labour market is one of the most dynamic in the EU and its expansion is projected to continue into the future. The demand for long-term care services has not been matched by a sufficient supply of care workers. The characterisation of this sector as low paid and low status means is perceived as an obstacle to creating an adequate supply of workers.
- Although this varies between countries of the EU, there is a significant and increasing dependence on migrant labour working in this sector. It is estimated that workers

from NMS constitute an increasing share of the workforce; 7 per cent of EU8 workers are employed in the care sector in the UK; in Germany 19 per cent of those that work in elderly care are foreign born; and in Norway 7.4 per cent of those in health care are migrant workers.

- In Austria, migrant care work provided in private homes, for both older people and those with disabilities, has been subject to major reforms. In 2006 the government established a new care profession: 'the personal carer'. The benefits of regularisation are mixed. It comes with some social protection coverage, but other benefits are linked to residence in Austria.
- In Italy, immigrant care workers meet much of the home care demand from the elderly and the disabled, hiring private live-in or hourly carers. The 2002 Bossi-Fini Act regularised domestic work and care work. Efforts were made to integrate care workers through training and language provision with mixed success.
- There are a number of specific difficulties for trade unions in organising care workers, including: the gendered nature of the job; isolation in the home; the uncertain legal status of many migrant care workers; the fragmented provision between the private, public and charity sectors; and the self-employed status of many care workers.
- There are a number of countries (for example, among others, Germany, Italy, The Netherlands and the UK) in which trade unions have worked very successfully with both EU and non-documented migrant workers. This has included initiatives with regard to recruitment and orientation, legal support, liaising with local communities, combating xenophobia in the wider union, campaigning for a living wage (as opposed to a minimum wage), special advisory centres and campaigning for labour clauses in public contracts to prevent dumping.

The role of trade unions

- Where social dialogue and corporatist arrangements were entrenched (Norway, Sweden and Finland, for example), discussions on migration were embedded in this process. In countries without corporatist arrangements there is discussion with the government or government bodies on migration (Bulgaria, Slovakia and the UK).
- Most respondents to the questionnaire reported that no special efforts were made to recruit migrant workers. However, interviews in the UK, Germany, Italy and The Netherlands revealed a range of initiatives to support and give advice to migrant workers and to facilitate their integration.
- Marburger Bund, the union representing doctors in Germany, encourages migrant doctors to join the union and offers services such as the checking of contracts; they also encourage migrating doctors to join the union in their destination country. The UK has the most developed strategies for recruiting and integrating migrant workers. The Royal College of Nursing (RCN) has a dedicated immigration section to provide information.
- There was some limited evidence of cross-border collaboration, particularly in the Nordic network of countries. In the UK, a Polish worker has been seconded from the OPZZ trade union to work with Polish and other migrants from NMS. In Germany, Marburger Bund has a reciprocal agreement with unions in the Czech Republic, The Netherlands and Switzerland.
- Norway has signed up to the EPSU-HOSPEEM (European Public Services Union-European Hospital and Healthcare Employers' Association) code of conduct, the World Health Organization (WHO) Global Code of Practice on the international recruitment of health personnel and employment of migrant workers. In the UK, there is a Code of Practice for International Recruitment of Healthcare Professionals (2004) issued by the Department of Health. In Finland, Sweden and The Netherlands, employers and unions are signed up to the EPSU-HOSPEEM code.

Respondents from many other countries did not confirm that the EPSU-HOSPEEM code had been actually made use of, neither in the context of social dialogue nor towards relevant ministries or regional or local authorities – and this for a number of reasons.

Impacts of health worker migration

- The impacts of health worker migration were experienced by individuals who benefited from employment opportunities that may not be available in the home country. Other possible benefits include: training and experience; better promotion opportunities; and superior working conditions in relation to hours, holidays and workload.
- The problems of losing skilled health workers are being replicated within some parts of Europe and in some specialisms. This is the case particularly in relation to NMS, albeit on a smaller scale than that which exists between developed and developing countries.
- At a general level, outward migration reduces the pool of potential workers for the health service. Within sender countries impacts may be greater in rural areas than in cities. However, it is very important to emphasise that the scale and the impact differ between NMS. While Romania has shortages in specific health workers skills, this was less reported in other countries. The available figures showed that Polish nurses working outside the country were very small.
- One source of resentment in sender countries is that the training and education of health workers is financed by the public purse and that the skills of these workers are then 'exported' to receiver countries without any compensation. The reverse is true for receiver countries, which are able to fill shortages in their labour force of health workers with people who were recruited without any investment in their cost of educating and training.

Challenges

- The cost and transparency of recognising of cross-border qualifications
- the cross-border sharing of information by professional bodies and trade unions on salaries and contractual rights and obligations for doctors, nurses and care workers
- lack of language skills 1) as a barrier to mobility leading to 2) employment below level of qualifications
- promotion, use and monitoring of EPSU-HOSPEEM Code of Conduct on Ethical Cross-Border Recruitment and Retention (2008) and of the WHO Code of Practice on the International Recruitment of Health Personnel (2010) monitoring of recruitment procedures of employers or recruitment agencies and putting on a black list recruitment agencies not complying with the principles of ethical recruitment
- representation of migrant workers in professional organisations and trade unions
- prevention of social dumping in the private (not-for-profit and for-profit/commercial) sector
- invisibility and isolation of (migrant) care workers
- discriminatory treatment for non-EU migrant workers in the health sector
- improving/facilitating access of undocumented workers to citizenship rights
- problems experienced by sender countries for both their health care systems and in view of the pay and employment conditions for health workers staying when a considerable number of other health workers (in a specific profession or region) migrate

In addition, the research team would suggest that there is a need for the improved collection and availability of statistics. Further, we would underline the importance of the challenges identified in the research in the context of the austerity measures being implemented across most of Europe and the implications for the scapegoating of migrant workers and the growth of the Far Right.

Recommendations

The following recommendations have been drawn up in response to the challenges identified in the study, but have also been elaborated jointly by the research team in conjunction with the EPSU Secretariat.

- To improve the transparency of processes and the effectiveness of the actual cross-border recognition of qualifications and provide information on administrative procedures for the recognition of qualifications.
- To identify where information exists on salaries and the contractual rights and obligations of doctors, nurses and care workers; to review the accessibility of information (languages, format); and to explore if there are initiatives to set up a point of information-collecting of this type of information.
- For EPSU affiliates to investigate the possibility of including into their range of services offered for migrant care workers (of a specific profession) the checking of work contracts and/or employment conditions.
- Free and appropriate ongoing language support by employers and/or public authorities in receiver countries, and for language support to be provided both as part of vocational training and as stand-alone language classes.
- For EPSU affiliates to continue with awareness-raising about the contents and potential of the EPSU-HOSPEEM Code of Conduct on Ethical Cross-Border Recruitment and Retention and to monitor its use, based on the joint EPSU-HOSPEEM Evaluation Report (2012).
- To explore the possibility of reciprocal agreements for temporary membership in trade unions.
- Where there are substantial numbers of unorganised migrant workers, to explore strategies for organising, recruiting and integrating migrant workers, and to review the outcomes of any related campaigns.
- Inclusion of social/labour clauses on wages as agreed in collective agreements or legislation and other working and pay conditions in public contracts for private (not-for-profit and for-profit/commercial) providers in the context of public procurement procedures to support the principle ‘Equal pay for equal work’ on a given territory.
- Training care workers and certification of their skills and qualifications and comparability of both across Europe, the integration of home-care workers into local public service networks; and to identify and work with community groups and non-governmental organisations (NGOs).
- For trade unions to promote the International Labour Organization (ILO) convention on domestic workers.
- To review any existing compensatory arrangements between sender and receiver countries and to consider the elaboration of compensation mechanisms/agreements, involving employers’ associations, the institutions administering health care systems (social insurances or national health services), relevant national ministries and, where appropriate, EU institutions.
- To promote fair treatment for non-EU health workers through, for example, the right to vote in local elections in the host country after four years of residency (consistent

with the practise in most EU countries) and facilitating access to naturalisation/citizenship in the host country.

- Giving support to or affiliation to appropriate organisations committed to promoting anti-racism and anti-xenophobia and to consider producing materials that set out the value of migrant workers in particular to health and social services and to combat myths of migration.

1.0 Introduction

1.1 Aims of report

The health and care sector in the European Union is of growing social and economic significance. Employment in the health and care sectors has risen and in 2009, on average, accounted for ten percent of employment across OECD countries (OECD, 2011). Demographic changes of an increasingly ageing population coupled with a reduced working age population presents a challenge regarding funding and the recruitment of workers in this sector. For example, in 2009 on average across OECD countries 30 percent of doctors were over 55 years of age. (ibid). 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. The accession of New Member States (2004 and 2007)[1] further increased the potential for migration. Pressures on health budgets have intensified as governments have implemented austerity measures since the financial crisis of 2007/2008 and in response to the ongoing sovereign debt crisis in Europe. Increased marketisation and privatisation provide additional challenges.

The health and care sectors cover a wide range of services and occupations[2]. This study will focus on three broad categories; doctors (highly skilled workers), nurses (skilled workers) and health and care workers (skilled, semi-skilled and unskilled). Each of these groups is governed by a different set of dynamics. The study will cover hospitals, residential and home care in the public sector, and the for-profit and not-for-profit sectors.

There have been many studies related to the mobility of health and care workers between developing and developed countries (Yeates, 2009; Valiani, 2012; Connell, 2012). However little has been written regarding the mobility of these workers within Europe. Therefore the general aims of the report are to;

- Outline the EU legal and qualifications frameworks related to cross border mobility
- Identify patterns of migration between countries
- Investigate the 'push' and 'pull' factors driving migration
- Examine the role of trade unions in this process.
- Identify key challenges and make recommendations

1.2 Research Methodology

The research comprises three elements. First, we report the data from a survey of EPSU affiliates (see Appendix 1 for questionnaire and Appendix 2 for respondents). Second, face-to-face interviews were undertaken in the following countries; Belgium, Germany, Italy, Ireland, Netherlands, Poland, Romania and the United Kingdom (see Appendix 3 for list of interviewees). Six countries were selected and developed as case studies (Germany, Italy, Poland, Romania, Sweden and the United Kingdom). These were selected on the basis of including sender and receiver countries from a labour perspective, which broadly correspond to established EU members and New Member States (NMS). In addition, we include countries with a range of different institutional frameworks. These case studies can be found in Section 11 of the report. Third, the report draws on secondary data from reports, academic literature and data bases.

[1] The following countries acceded in 2004: the Cyprus, Czech Republic, Estonia, Latvia, Lithuania, Hungary, Malta, Poland, Slovenia and Slovakia. Romania and Bulgaria joined the EU in 2007. Workers from the countries that joined in 2004 with the exception of Cyprus and Malta are referred to as "EU8" workers, and Romanian and Bulgarian workers are described as "EU2" workers throughout this report.

[2] 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).

1.3 Health care sector context and trends

Eurofound (2011a) identifies three key trends in the health sector across Europe. First, there has been a trend towards the decentralisation of provision and financial responsibility to individual hospitals or local authorities. This has been the case in Norway, the UK, Slovakia, Romania and Poland. Although the justification has been to devolve decision making, increase accountability and responsiveness, the outcomes have not always been positive. Second, there has been a marked shift towards the liberalization and privatization of health care services. This has included Belgium, Cyprus, the Czech Republic, France, Germany, Greece, Italy the Netherlands, Norway, Poland, Romania, Slovenia and Spain. Third, there has been a trend towards allowing people to access health and care support in their own homes. This is a particularly increasing trend for elderly care, but it is also true of some primary services and mental health care. This reflects a general trend towards increased life expectancy, but conditions suffered in older age are more complex and often require assistance with living independently rather than in institutions.
Taken together these trends pose challenges for health care workers as they are leading to fragmentation in bargaining and increased competition between institutions, which puts downward pressure on the wages and working conditions of employees. Therefore the mobility of health care workers has to be understood in the context of an increasingly complex and dyamic framework.

2. EU Legal Frameworks

EU law establishes a broad legal framework which enables the free movement of workers across all member states. Sections 2.1 and 2.2 outline the general legal framework applicable to workers moving from one member state to another. Section 2.3 outlines the rules relating to social security. Special rules apply to certain categories of workers which are frequently used in the health care sector. Section 2.4 and 2.5 thus outline the rules applicable to posted workers and temporary agency workers. As EU competence is largely limited to legislation for EU citizens, third country nationals are afforded limited protection. This is discussed in Section 2.6. EU rules are also being developed to cover workers in intra-company transfers. At present, this legal structure is not being used in the health care sector; however there is a possibility that employers may avail themselves of this form of employment in the future. An overview of the applicable legal framework is thus contained in the annexe (See Appendix 4, point 6).

2.1 The principle of intra-EU mobility of health care workers

The mobility of health care workers within the EU is governed by the free movement provisions contained in the Treaty on the Functioning of the European Union (TFEU), the case law of the Court of Justice of the European Union (CJ) as well as secondary legislation. The provisions apply to workers who are nationals of an EU or EEA state (See Appendix 4, points 1 and 2).

In 2004, Directive 2004/38/EC on the rights of citizens of the Union and their family members to move and reside freely within the territory of the Member States brought together all EU secondary legislation on the right of entry and residence of EU citizens and their family members. Directive 2004/38 is broader than previous legislation in that it applies to EU citizens and not just workers. It gives EU citizens and their family members (regardless of their nationality) rights of entry and residence in another member state as long as they do not become an unreasonable burden on the social assistance system of the host member state. The legal framework for workers remains unchanged from that in existence prior to adoption of the Directive. Thus, the Directive did not change the legal framework applicable to health care workers, but it extended rights to free movement and non-discrimination to EU citizens who can move freely from one country to another without having to show that they are workers.

2.2 Freedom of movement after enlargement

Following the enlargements of the European Union to 27 member states in 2004 and 2007 (see Footnote 1), member states were given the right to restrict free movement for workers from the New Member States with the exception of Cyprus and Malta. The legal basis for the restriction can be found in the transitional arrangements in the Accession Treaties of 16 April 2003 regarding the accession of the Czech Republic, Cyprus, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovenia and Slovakia, and of 25 April 2005 regarding the accession of Bulgaria and Romania. The Accession Treaties initially allowed member states to enact national measures which restricted access to their labour markets for the first two years following accession (see Appendix 4, point 3).

From 2011, complete freedom of movement for workers from the Member States which joined in May 2004 was guaranteed. Similar measures were put in place by member states for workers from Bulgaria and Romania. All EU-15 member states with the exception of Finland and Sweden limited access for Bulgarian and Romanian workers from the date of the enlargement. Since 2009, some member states with measures in place have progressively lifted the restrictions. However, most member states still limit access for Romanian and Bulgarian workers.

Individuals moving as service providers are not affected by the transitional measures. They may avail themselves of their rights under EU law from the date of accession of their home country. Thus, self-employed individuals working in the health care sector as service providers (rather than employed as workers) are not restricted in their ability to move from a new to an old member state. Equally, 'posted workers', i.e. workers who are sent from one Member State to another for a limited period of time, may avail of their rights under EU law. The legislative framework regulating posted work is examined in more detail below (see 2.4.1). Despite the transitional arrangements for workers, all EU citizens moving across borders benefit from a right to non-discrimination granted to EU citizens under article 18 TFEU.

2.3 Social Security Coordination

Article 48 TFEU on the coordination of social security systems allows the European institutions to adopt measures in the field of social security which are necessary to enable and facilitate the free movement of workers within the EU. To this end, they can make arrangements for employed and self-employed migrant workers and their dependants in the following areas:

(a) aggregation, for the purpose of acquiring and retaining the right to benefit and of calculating the amount of benefit, of all periods taken into account under the laws of the several member states; and
(b) payments of benefits to persons resident in the territories of member states.

Regulation 883/2004 (Appendix 4 point 4a) applies to nationals of an EU member state, stateless persons and refugees who are or who have been covered by the social security legislation of one or more member states, as well as their family members and their survivors regardless of their nationality. The Regulation enshrines the principle of equal treatment for those caught by the Regulation within local social security schemes. The provisions of the Regulation cover the following areas: sickness, maternity, accidents at work, occupational diseases, invalidity benefits, unemployment benefits, family benefits, retirement and pre-retirement benefits, and death grants.

The Regulation also recognises the principle of the aggregation of periods of insurance. This means that periods of insurance, employment or residence in an EU country are taken into account in all other EU countries. As a general rule, the insured person is subject to the legislation of a single member state only, usually the one in which he or she pursues a

gainful activity (see Appendix 4 point 4b for Social Security rules applicable to special categories of workers).

2.4 Posted workers

Special rules apply to workers who are employed in one member state, but are sent, for a temporary period, to work in another member state while maintaining their original employment relationship. Such posted workers are a frequent occurrence in the health care sector. This poses a potential problem if they are posted from a member state with, for example, low wages to a member state with higher wages as we can see from the *Laval* and *Rüffert cases*. Unless this is regulated, posted workers could thus be used to undercut wages in the host country.

Posted workers are thus granted certain minimum rights under EU law as a result of Directive 96/71/EC concerning the posting of workers in the framework of the provision of services. It defines a posted worker as (art. 2(1)):

> a worker [as defined by the law of the of the Member State to whose territory the worker is posted] who, for a limited period, carries out his work in the territory of a Member State other than the State in which he normally works."

The Directive prescribes minimum standards of core working conditions which should apply equally to national and posted workers in the following areas:
(a) maximum work periods and minimum rest periods;
(b) minimum paid annual holidays;
(c) minimum rates of pay, including overtime rates; this point does not apply to supplementary occupational retirement pension schemes;
(d) conditions of hiring-out of workers, in particular the supply of workers by temporary employment undertakings;
(e) health, safety and hygiene at work;
(f) protective measures regarding the terms and conditions of employment of pregnant women or recent mothers, children and young people;
(g) equality of treatment between men and women and other provisions on non discrimination.

Member states may choose to lay down these rules either by law or by collective agreements which have been declared universally applicable (art. 3(10)) meaning that they must be observed by all undertakings in the geographical area concerned (art. 3(8)). Should a member state not have a system by which collective agreements can be declared universally applicable then they can base themselves on collective agreements which are generally applicable to all similar undertakings in the geographical area and in the profession or industry concerned, and/or collective agreements which have been concluded by the most representative employers' and labour organisations at national level and which are applied throughout the national territory (art. 3(8)).

There has been much debate on how to interpret the Directive particularly following a number of recent controversial judgments of the Court of Justice of the European Union (see also Appendix 4 point 5).

C-341/05 Laval un Partneri Ltd and C-346/06 Dirk Rüffert.
These two cases are worth a specific discussion because of their far reaching implications.
In the *Laval* and *Rüffert* judgments[3], the social partners in Sweden and Germany were permitted to determine rates of pay for posted workers through collective bargaining. Neither system had a fixed minimum wage to determine a basic rate of pay for posted workers. The

[3] C-341/05 *Laval un Partneri Ltd v Svenska Byggnadsarbetareförbundet, Svenska Byggnadsarbetareförbundets avd. 1, Byggettan, Svenska Elektrikerförbundet* judgment of 18 December 2007 and C-346/06 *Dirk Rüffert, in his capacity as liquidator of the assets of Objekt und Bauregie GmbH & Co. KG v Land Niedersachsen* judgment of 3 April 2008.

collective agreements which fixed the rate of pay were not declared universally applicable across the industry at issue but were agreed on a case-by-case basis.
The CJ ruled in both cases that negotiation at the place of work, when minimum rates of pay are not determined in accordance with one of the means provided for by the Posted Workers' Directive, are not permissible under the Directive.

The implications of this are that the Directive now seems to limit the levels of protection guaranteed to posted workers. The social partners are unable to ask for more favourable conditions which go beyond the mandatory rules for minimum protection in the Directive. Thus, employers cannot be forced through collective bargaining to pay posted workers more than the minimum wage unless collective agreements which cover rates of pay are extended so as to be universally applicable.
As a result of the controversy surrounding the Directive, the European Commission has issued a roadmap for reform of the legal framework applicable to posted workers[4] and, in March 2012 put forward a proposal for a Directive and Regulation to clarify the Posted Workers' Directive scope and application.[5]

Posted workers make up a significant proportion of migrant workers in the health care sector and it is important to ensure that applicable rules and standards in the host country comply with the CJ's rulings in *Laval* and *Rüffert* as otherwise they will not be enforceable.

2.5 Temporary agency workers

EU wide rules on temporary agency workers were only adopted in 2008 after a decade of attempts at reaching an agreement failed. The deadline for implementation of Directive 2008/104/EC on temporary agency work in the member states was on 5th December 2011. The Directive defines (art. 3(1)(c)) a "temporary agency worker" as "a worker with a contract of employment or an employment relationship with a temporary-work agency with a view to being assigned to a user undertaking to work temporarily under its supervision and direction." In article 5, the Directive enshrines the principle of equal treatment in relation to employment and working conditions between agency workers and non-agency workers from the first day of the agency worker's employment unless a derogation has been negotiated by the social partners. Pay has been specifically included as a condition of employment to which the principle of equal treatment applies. The Directive also provides for the right to representation by trade unions in article 7. Member states are required to review and justify any existing restrictions in their territory on the use of agency work. The Directive is important as it limits the extent to which temporary agency workers can be treated differently from traditional workers and increases the levels of protection afforded to these workers.

2.6 Third country migration

EU law provides some protection for migrants coming from countries that are not members of the European Union. However, EU competence in this area is limited so the legal framework is derived from those rules applying to EU workers and it is largely up to member states to regulate migration from outside the European Union based on their national laws. Article 79 TFEU only allows the European institutions to adopt measures to allow the EU to develop a common immigration policy aimed at ensuring the efficient management of migration flows, fair treatment of third-country nationals residing legally in member states, and the prevention of, and enhanced measures to combat, illegal immigration and trafficking in human beings.

[4] European Commission, *New legislative initiative for Posting of Workers*, 25th October 2010.
[5] Proposal for a Directive of the European Parliament and of the Council on the enforcement of Directive 96/71/EC concerning the posting of workers in the framework of the provision of services and Proposal for a Council Regulation on the exercise of the right to take collective action within the context of the freedom of establishment and the freedom to provide services.

The Charter of Fundamental Rights of the European Union which came into force on 1 December 2009 following the entry into force of the Lisbon Treaty, gives third-country nationals some rights. Art. 31 provides that, 'every worker has the right to working conditions that respect his or her health, safety and dignity'. This applies to third-country nationals as well as nationals of the EU member states. Art. 15(3) establishes a principle of equal treatment as regards working conditions between non-EU nationals and EU citizens, a principle not evident in the Treaties. However, art. 15(3) does not modify the legal position of third-country nationals in terms of access to national labour markets or free movement within the EU.

Directive 2000/43/EC and Directive 2000/78, both discussed above (at 2.1), cover equal treatment in 'employment and working conditions, including dismissals and pay' of workers regardless of their nationality. Council Regulation 859/2003 of 14 May 2003 also extends certain social security provisions to third-country nationals who are legally residing in the EU and want to move from one member state to another.

3. EU Directives on Qualifications

3.1 Professional qualifications

The mobility of health professionals is enabled by the EU Directive on the Recognition of Professional Qualifications (EC, 2005) which sets the rules for mutual recognition of professional qualifications between member states. It provides for automatic recognition of qualifications based on a set of harmonised minimum conditions of training for seven sectoral professions, of which doctors, dentists, nurses, midwives and pharmacists are relevant to the health sector in this paper.

The Directive has been the subject of review and consultation through a Green paper consultation which took place between June 2011 and September 2011 (EC, 2012). The proposals place more onus on the 'issuing' member state rather than the 'receiving' member state and are mainly designed to enable easier movement, although a few proposals will also act to tighten requirements. As a result of the consultations, the key elements of the legislative proposal were announced in December 2011 as follows. The introduction of a European Professional Card would include; 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).

The proposal for a European Professional Card is to be enabled by technology using the Internal Market Information System (IMI) to facilitate much faster co-operation between the issuing and receiving Member States. Currently the receiving Member State is responsible for verification of qualifications, which can lead to delay due to translation requirements. The European Professional Card would be issued by the issuing Member State and would speed up the process. This would be a voluntary activity and the design of the card is still to be finalised in consultation with all stakeholders.

With regard to training and experience, currently in the case of movement from Member States who do not have a regulating professional body which is comparable across all Member States to those which do, migrating professionals are required to demonstrate two years' professional experience or 'regulated education and training'. The consultation proposed a broadening of the interpretation of 'regulated education and training' to 'all training recognised by the Member State which is relevant to a profession'. There may also be various other improvements in how equivalent content of training and experience is assessed, and in how it is measured, whether in terms of minimum training periods and the consistent use of measures of time (whether hours, or days), or a move from a system of training hours to the use of the European Credit Transfer and Accumulation System (ECTS).

For nurses and midwives, it proposes raising the admission criteria for entry to nursing training courses to be after a minimum of 12 years general education rather than the current minimum requirement of 10 years general education.
Member States currently have different practices on the recognition and regulation of specialised sub-professions (such as paediatric nurses or 'Altenpfegerin/Altenpfleger' for the care of elderly persons in Germany and The Netherlands) that do not exist as such in other Member States and therefore where they are not recognised and regulated in the same way. The proposals to introduce common training frameworks and for a mutual evaluation exercise of regulated professions appear to give an opportunity to extend the recognition of health-related professions beyond the specified sectoral professions, although this needs to be further clarified.
The 2005 Directive states that professionals must have language knowledge necessary to perform their duties in the host Member State. In determining this, the host Member State must take account of the principle of proportionality, which excludes the systematic use of language tests. The Green paper acknowledged that "a public debate on language requirements for health professionals is ongoing in a few Member States. The issue of language skills of health professionals is gaining more importance as migration of health professionals increases, and is particularly acute in the case of health professionals benefitting from automatic recognition who come into contact with patients" (EC, 2011, p.15). The December 2011 proposal clarifies that the checking of language requirements for health professionals is to take place after the host Member State has recognised the worker's qualification. In the case of health professionals, it also specifies that this is up to the national health care systems and patients' organisations to check whether competent authorities should carry out language controls where strictly necessary (EC, 2012). Ultimately the main responsibility for ensuring all necessary professional language skills are acquired lies with the employer. Simply because a professional is free to travel and practice in another EU Member State does not guarantee them automatic employment.

3.2 Regulation and professional body registration requirements

Many Member States also have specific regulations through professional body registration requirements, requiring health professionals to demonstrate that they are up to date and fit to practice. 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) and examples in other Member States. In the UK the GMC is currently revalidating the process for doctors' registration from 2012, to include further capability appraisal measures; clinical audit, clinical review, clinical outcomes review processes, and evidence of Continuing Professional Development (CPD) (GMC, 2011). In Sweden, the trade union Vårdförbundet, provides advice to nurses and midwives on gaining and maintaining registration. Again, however, it should be stated that while national regulatory bodies do have a role in registering and licensing for practice in that country, decisions to employ, and suitability for employment are made at employer level.
Processes of interaction between regulatory bodies and employers have been have been highlighted for review by the European Observatory on Health Systems and Policies (EOHSP), aiming to enable easier movement and to further standardise CPD and what employers should be doing in their policies to enable CPD to take place in the workplace. To encourage employers to be more effective in enabling CPD, in 'Investing in Europe's Health Workforce', EOHSP (2010) highlight four areas of dialogue, of which two are most relevant here.

One area of discussion is how to create the best conditions for adapting skills to new needs and for lifelong learning, enabling skill adaptation and the redistribution of tasks through education and training. As a general requirement, health professionals are expected to remain current in their practice through: knowledge and management practices (evidence-based practice); and through self-directed learning strategies (lifelong learning), with CPD to be shared between the individual and the employer.

The second area of dialogue is how to create an attractive and supportive working environment for health professional. Here there are a common set of themes. The first theme relates to employment, income, working time, safety and health, professional development and work organisation. The second theme relates to the quality dimension of work, including: employment quality (relationship between employer and employee – type of contract, working hours, social benefits, training and skills development); work quality (material aspects i.e. risk of accidents, health variables); and with both these influencing job quality.

4. Problems of statistics and measurement

4.1 General problems

A report for the World Health Organisation on the migration of health personnel in the European Area outlines the limitations of available statistical data (Dussault, 2009).

- Most countries have no reliable data on the stock of health care professionals, nor on the proportion of them who are active.
- Information on the private sector is generally scarce.
- International comparisons are difficult because definitions of occupational categories are not homogenous and because data are rarely available for the same year or the same period.
- Most countries do not systematically collect information on migratory flows.
- Some countries collect information on health workers' country of birth and 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 are even greater, as a significant proportion of these are undocumented workers.

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 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 circulatory migration and for varying lengths of time.

4.2 Romania: An example

Romania is illustrative of some of these problems of measurement in that information available is partial and contradictory (Galan, 2006). The Ministry of Health should keep data on the numbers of doctors and nurses who request certificates for mutual recognition of their qualifications within the EU. However, these are requests, and do not necessarily mean that the worker does actually emigrate. Vladescu and Olsavsky (2009) had obtained this Ministry of Health data for nurses in 2007 to 2008. However, subsequent data has not been published, and published figures for doctors do not seem available at all.
A further difficulty is that mobility is enabled by the contractual right for public sector health workers to request up to two years unpaid leave of absence. This enables staff to be circumspect about their intentions without divulging what they are doing, to try out the

options of working abroad, to take short overseas contracts, and ultimately to resign if they find a successful longer term job abroad.

5. Patterns of European cross border mobility

This section begins with outlining previous trends in the migration patterns of health workers based on secondary data. Section 5.2 in based on the survey responses of EPSU affiliates and identifies the emergence of new macro and micro patterns of migration.

5.1 Previous trends in the migration of health workers

There have been two broad trends in the migration patterns of health workers since the end of World War Two;

- Movements from low to high income countries, specifically the migration of doctors and nurses from Commonwealth countries to the UK since the 1960s and 1970s; of nurses from the Philippines, India and South Africa to the United Kingdom since the late 1980s; and of doctors, nurses and midwives from sub-Saharan Africa to the OECD countries (UK, US, Canada, Denmark, Finland, Ireland and Portugal)

- Movements between high income countries – specifically the migration of doctors and nurses from Australia and New Zealand to the UK and Ireland, and from the UK and Ireland to Australia, New Zealand, the US and Canada; of doctors among Germany, France, the Netherlands, Sweden and Norway; of workers in general among Nordic countries (after the creation of a Nordic labour market in 1954).

5.2 Macro patterns of European cross border mobility from 2004 onwards

Appendices 5 and 6 summarise the broad directions of the inward and outward migration of health workers in the EU. There are four notable features of these movements;

5.2.1 Outward migration from New Member States to higher income European economies

The outward migration of health workers from NMS has to be set in the context of significant general outward migration since their entry to the EU in 2004 and 2007. This is particularly marked in the case of Poland where 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. 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.

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). In general mobility and outward migration was highest for doctors and lowest for care workers. In Poland the Ministry of Health and Doctors Council estimate that between eight and ten percent of doctors have migrated. However, despite predictions the migration of nurses has been modest; between 2004 and 2007, 158 Polish nurses registered in Ireland, 1,013 in the UK and 830 in Italy. However, Romania was something of an exception where it is estimated that around three percent of doctors and somewhere between five and ten percent of nurses

leave the country each year; and they tend to be the younger workers and those who have acquired valuable specialist skills (this is discussed further in Section 11.4).

Although there is undoubtedly a straightforward story of Romania as a 'sender' country of health workers to Western Europe, the situation regarding mobility of health is complex and ambiguous, involving different patterns of mobility - public to private, rural to urban, outward migration and circular migration.

All NMS countries reported low or very low inward migration to replace the outflows of doctors and nurses. Inward migrants tended to be from developing countries or neighbouring non-EU countries with relatively lower salaries.

5.2.2 The continuity of mobility between Nordic countries

The pattern of mobility between Nordic countries continues. Nordic countries (and the Netherlands) reported low or negligible levels of outward migration. There is strong continuity with the pre-2004 trend of mobility of health workers between Nordic countries (Norway, Sweden and Denmark).

The exception to this pattern 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.

5.2.3 From non-EU to EU immigration to the UK

The UK showed 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. 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. 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. Therefore there have been two notable features in the pattern of inflows, first a significant overall reduction, and a marked switch to EU entrants. In 2009/2010, 78 percent of international registrants were from the EU, compared with less than 7 percent in 2001/2. Although similar figures are not available for care workers, it was reported 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. In addition, there has been a decrease in the reliance on non-EU doctors.

5.2.4 The increasing cross border mobility of care workers

The questionnaire shed little light on the migration trends of care workers as respondents relied on anecdotal evidence. However, there is an academic literature that shows a growing trend of circulatory migration between NMS and their higher wage neighbours; from Poland to Germany, Slovakia to Austria and Romania/Bulgaria to Italy. This will be discussed in more detail in Section 8.

5.3 Micro patterns of European cross border mobility

Within general patterns of migration a much more detailed and 'fine grained' picture can be observed in relation to skills and private sector employment.

In Poland 10 percent of doctors were estimated to have migrated by 2011, however, this was much higher in particular specialisms. Anaesthetists were the first and most numerous group

that migrated (18.3 percent), followed by plastic surgeons (17 percent) and chest specialists (15.5 percent).

A similar pattern was exhibited in Romania with the highest outward migration from specialist doctors and nurses in anaesthetics, radiology, obstetrics, gynaecology, intensive care services and psychiatry. In addition to outward migration, there is increasingly a movement of staff within the country from the public to the private sector. This particularly applies to nurses with specialist experience such as gynaecology moving to private clinics.

5.4 Duration of stay

The questionnaire responses suggested that 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 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.

6. Factors driving or inhibiting health workforce migration

This section of the report discusses the reasons given in the survey completed by EPSU affiliates regarding motives for and drivers of migration and those factors which prevent or inhibit migration. Contextual secondary data is given to support the survey responses.

6.1 Poor wages and working conditions in New Member States

6.1.1 Poor wages

Poor salaries were the most common reason given in the surveys for outward migration from the NMS. Average wages are a general indicator of the disparity between wages in high, middle and low income economies (see Appendix 7) with NMS belonging exclusively to the category of low wage economies.

More specifically the OECD present data on the remuneration of health workers in two ways. First, the remuneration level in each country is converted into a common currency, the US dollar (USD) and then adjusted for purchasing power parity (PPP) to provide an indication of the relative well being of health care workers compared to their counterparts in other countries[6]. Second, remuneration is compared with the average wage of all workers in each country, providing some indication of the relative financial attractiveness of nursing compared to other occupations.
With regard to doctors Appendix 8 shows that the ratio of remuneration for general practitioners to the average wage in 2009 was lower in the NMS – Hungary 1.4 and Estonia 1.7 – compared with 3.6 in the UK and 3.7 in Germany for example. Appendix 9 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

[6] Purchasing power parity (PPP) is an economic theory and a technique used to determine the relative value of currencies, estimating the amount of adjustment needed on the exchange rate between countries in order for the exchange to be equivalent to (or on par with) each currency's purchasing power. It asks how much money would be needed to purchase the same goods and services in two countries, and uses that to calculate an implicit foreign exchange rate. For a good explanation for the non-economist see The Economists Big Mac Index http://www.economist.com/blogs/freeexchange/2012/06/purchasing-power-parity

(with the exception of Slovenia) remuneration ranges from 17,000 to 22,000 USD with wages at or below the average wage.

6.1.2 Low spending on health and deteriorating working conditions

Poor working conditions were the second most cited reason for migration, in NMS in particular. Appendix 10 shows that NMS are at the bottom of the table in terms of total expenditure on health per capita. In old member states health expenditure per capita ranged from 2,703 (Portugal) to 6,526 (Luxembourg), while in the NMS it ranged from 773 Romania to 1,924 Czech Republic.

Appendix 11 also mirrors disparities between old and NMS in total health expenditure as percentage of GDP. This ranges from 9.3 percent (UK) to 11.8 percent (Belgium) in old member states compared with a range of 5.4 percent (Romania) to 7.6 (Czech Republic) in the NMS.

Low spending and under-investment have been exacerbated by privatisation[7] 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.

In the case of Romania there was a recruitment freeze as part of the austerity measures and therefore the outward migration of health professionals compounds this situation and leaves those staff who remain with considerably higher workloads and difficult working conditions.

6.1.3 Discontent and disputes

Discontent with wages and working conditions are evident in the industrial disputes among health workers in these economies.

- In Latvia in August 2011 demonstrations by health union (LVSASA – Latvian Health and Social Care Workers) in three regional hospitals protesting about underfunding and employees not being paid for increased workloads (Eurofound, 2011b).

- 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 Medical Trade Union Association (LOZ), following a lack of progress in negotiations suggesting following the mass resignations of Czech colleagues to pressurise the government. Also in May 2011 the Chamber of Nurses (SKSAPS) protested outside parliament is support of their demand for an earlier retirement age (60 to 58) and minimum wage of Euro 4.50 (Eurofound, 2011c). The doctors' campaign had been supported by the EPSU affiliate and health workers' union SOZZaSS, which has been calling for higher pay for all workers in the sector.

- In the Czech Republic, organised by Czech Doctors Union (LOK), 4,000 doctors resigned *en masse* in January 2011 in protest against poor working conditions and wages and underinvestment in the health care system (Holt, 2011).

- In Poland in 2007 protests by doctors and 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

[7] In Romania under the privatisation bill introduced in December 2011, it is proposed that hospitals will be free to set up as Foundation hospitals, free from some government Ministry of Health controls and able to raise money in different ways.

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.

However, it should be emphasised that these factors can change and the relative differentials can increase and decrease affecting the motivation for migration. For example, in Poland in 2007 as a result of the doctors' protests (Grzymski, 2007) the improvement in doctors' wages reduced the material incentive to migrate.

6.2 Relative differences in wages and working conditions in higher income countries

There is evidence that doctors and nurses in higher income countries also move between countries to take advantage of better labour markets in terms of pay and working conditions. Although remuneration varies in relation to the average wage, nevertheless the average wage gives a proxy of the disparity of wages between countries (see Appendix 7)

- Vårdförbundet (Sweden) registered a high level of 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 better such as in Norway. In the past, nurses moved temporarily and/or permanently to Denmark however there is no evidence that this is still happening due to the assimilation of working and living conditions between Sweden and Denmark in recent years. There is however evidence that nurses who live on the border to Norway work overtime in Sweden, take the overtime as leave and then travel to Norway to work as many hours as possible before returning to their regular employment in Sweden. Nurses can earn up to a third more in Norway, have much better working conditions and uncapped hours.

- In France the working conditions were cited as being 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 (Interview Marburger Bund Representative 2012; Interview with German doctor 2012).

6.3 Institutional factors and active recruitment

Employers, employment agencies and the initiative of individuals were cited as equally important in mediating and facilitating migration. No clear pattern of agents of recruitment emerges. There was no evidence of the large scale systematic recruitment strategies that are present in the migration of health workers from developing to developed countries.

The exception to this is the UK where the previous large scale recruitment of overseas health workers (non-EU) was undertaken by a combination of employers and recruitment agencies.

6.4 Barriers to mobility: qualifications and language skills

The factors that were specifically and most cited as barriers to the mobility of health care workers were those of language and the lack of recognition of qualifications. The lack of

requisite language skill 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.

6.4.1 Qualifications

As was discussed in section 3, there is as yet no uniform acceptance of professional qualifications across EU states, particularly between those where there is not yet unrestricted movement of labour. While the nursing diploma from Romania was acceptable in most EU countries, there was some ambiguity with regard to the UK (Bach, 2010). Generalist nurses found it difficult to obtain employment at an equivalent level, because they were not entitled to work permits. Specialist nurses would be able to obtain employment if their specific skill was designated as being in a shortage area.

In Sweden, it is fairly easy to transfer a general nursing registration from within the EU. However, problems frequently arise when it comes to specialist nurses wanting to work in Sweden with a foreign training. There are no clear guidelines on equivalences of training for specialists.

One interviewee suggested that it was difficult to quantify how much of a barrier lack of recognition of qualifications is as there is no record of the number of applications that are refused on these grounds.

6.4.2 Language

In the case of Romanian workers moving to the UK, work permits require linguistic and cultural skills appropriate for the type of job, particularly for work involving direct contact with patients (Bach, 2010). This limits the possibilities for Romanian workers, although this situation is changing as increasingly English is being learnt as the language of choice in schools.

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), trade unions do not offer such kind of courses for professionals in its areas. Those coming as temporary migrants need to have sufficient knowledge of Swedish if they wish to register as a health care professional in order to gain employment. As Swedish is not a common language, this effectively acts as a barrier to migration.

6.5 Complex ‘push’ and ‘pull’ factors

It was clear from the questionnaire responses that differentials in wages and working conditions, both between NMS and old EU member states and between higher income economies, provide some explanation for migration and cross border mobility in the EU. However, this mobility is complicated by internal migration within countries from rural to urban areas and from the public to the private sector. Labour shortages within the health sector, particularly in nursing, are compounded by its perceived lack of attractiveness by young people as a career.

7. The Care Sector

Ageing populations, demographic change and changing work and family patterns across Europe mean that the care labour market is one of the most dynamic in the EU and its expansion is projected to continue into the future. However, this sharp increase in the demand for long-term care services has not been matched by a sufficient supply of care workers. The characterisation of this sector as low paid and low status means that it is

perceived as an obstacle to creating an adequate supply of workers. Although this varies between countries of the EU, there is a significant and increasing dependence on migrant labour working in this sector.
Care workers are an integral part of health care regimes, and academics and NGOs have produced much research in this area. However, the trade union questionnaires captured very little about care workers in general and their mobility in particular. This section begins by examining problems in defining and capturing the extent of this sector before identifying broad trends. It then goes on to focus on the case studies of Austria and Italy. The specific challenges for trade unions are examined before discussing examples of trade union practices and strategies.

7.1 Definitional problems

There are four main issues and problems in considering the labour market for care workers (Österle *et al*, 2011).
First, the long term care of looking after the elderly, frail and those with disabilities or chronic illnesses are often grouped with those that take care of children or do domestic work. Therefore there are difficulties in estimating numbers of employees in the sector as there is no separate category which captures care workers specifically.[8]
Second, whereas doctors and nurses are subject to the same broad institutional and legal frameworks within countries and this is being steadily harmonised across the EU with regard to qualifications, care regimes are subject to a different mix of providers. It can be the family, the state, the market or community which provides care services and these can be in the public or private sectors, publicly or privately paid for or unpaid, and organised informally or formally.

Third, there are different forms of state intervention and provision in the sector. These include:

- the (conditional) entitlement to cash payments or tax deductions to compensate for the provision or the cost of care;
- the supply of services to provide direct care;
- the introduction of employment related measures such as paid and unpaid leave to compensate for time and money lost in the provision of care;
- vouchers which can be used to buy care services from accredited professionals.

Fourth, different employment regimes arise from the specific type of organisation and financing of care. Simonazzi (2010) concludes that where there is a formal market for care services with institutionalised provision for the elderly (for example in Scandinavian countries and France) there are more stable employment conditions. In contrast, home-care based and largely informal care arrangements provided by the family or paid 'help' can be found in countries where cash benefits are built into public care policies. Appendix 7 combines the key dimensions of migrant care work and care regimes including the level of commodification, formalisation and compliance and associated patterns of work.

7.2 The growth of migrant workers in the care sector

According to Di Rosa *et al* (2012) there is a growth in the employment of migrant care workers, especially, but not only in Southern European countries. Migrant care arrangements in private households have primarily emerged in countries with a preference for cash benefits rather than social service provision; these would include Germany (Neuhaus *et al*, 2009), Ireland (Walsh and O'Shea, 2009), England (Cangiano *et al,* 2009), Spain (Leon, 2010), Italy (Lamura *et al*, 2010) and Austria (Osterle and Bauer, 2010). From the 1990s onwards, Central and Eastern Europe became a major source region and has led to a large outward migration of women providing care work in Western and Southern

[8] International Standard industrial Classification (ISIC) Rev.3.1: 853 [social work activities].

Europe. Hardy *et al* (2013) estimate that workers from NMS constitute an increasing share of the workforce; 7 percent of EU8 workers are employed in the care sector in the UK, in Germany 19 percent of those that work in elderly care are foreign born and in Norway 7.4 percent of those in health care are migrant workers.

Although the figures are historic Appendix 12 indicates the scale of domestic workers. Some of those in the table will now be documented wither because of the 2004 and 2006 accessions or due to regularisations.

Therefore migration patterns have been driven by public cash for care schemes providing benefits for dependent persons. These have attracted large numbers of unskilled, mainly live-in domestic workers, primarily women, employed by families in a grey economy characterised by illegal immigration and/or work status. In Mediterranean countries the private employment of migrant workers by families has become the normal solution for caring for the elderly. Despite the limitations of official statistics in Greece Kavounidi (2004) estimates that 25 percent of all migrants are employed in personal care/household services (and 80 percent of those are migrant women); in Spain, the number of work permits rose from 33,000 in 1999 to almost 230,000 in 2006 (INE, 2008).

Lutz and Palenga-Mollenbeck (2010) claim that in Germany, without undocumented care workers from abroad, the care system would collapse (p.349). They quote the German daily Süddeutsche Zeitung;

> The system is illegal, but it works. If it were not for Hungarian, Polish, Czech or Romanian women, most of whom are working illegally, domestic care would collapse completely. Therefore it is tolerated, more or less tacitly (Kastner, 2008, p.41).

Lutz and Palenga-Mollenbeck (2010) point to a contradiction whereby the government turn a blind eye to undocumented elderly carers while officially combating undocumented work. Although the legal situation of transnational placement agencies is still unclear, their research shows that they seem to fill a gap in the structure of the German care system. Functioning as the formal counterpart of informal social networks, it could be argued that transnational agencies benefit family employers because the workers are flexible and affordable, and for migrant workers they provide (legal) contracts, including the payment of fees to agencies.

Alongside these foreign born workers in the informal sector migrant workers are increasingly employed in the formal care sector. This appears to be highest in the UK, Sweden and Norway, where the majority of them are employed in community services, and are more likely to be represented by long settled migrants. However, in the UK it was reported that non-EU migrants are finding increasing difficulties in getting their visa renewed and there are growing numbers of EU workers from the NMS employed in the sector. This is due to the Points Based Immigration system where only specific categories of workers (usually determined by shortages) are granted visas.

7.3 Case studies; Austria and Italy

These case studies have been selected on the basis that care workers in these countries have benefitted from the regularisation of their status which raises important policy issues that trade unions need to consider.

7.3.1 Austria

In Austria migrant care work provided to older people and those with disabilities in their private homes has been subject to major reforms since 2007. There was a substantial growth of migrant 24 hour care[9] from the 1990s and until 2006 the phenomena developed as

[9] Personal care is defined as a live-in arrangement involving 24-hour availability usually based on a self employment arrangement organised as bi-weekly or monthly shifts.

a ‘grey area’ of care (Österle, 2000). According to Schmid (2009) the number of care workers was estimated to be between 30,000 and 40,000 providing help and support to people in need of care in about 15,000 households. In 2006 the government reacted to a media driven debate about the growth of 24 hour care with legislation that established a new care profession: ‘the personal carer’. As a result by 2010 32,000 people were registered as personal carers (Österle et al, 2011). Personal carers so far almost exclusively originate from neighbouring (Slovakia) and increasingly from more distant CEE countries (Bulgaria and Romania).

Following a biweekly shift, the monthly income of a carer is about 900 Euros, which compares very favourably with wages in the health sector in Slovakia (652 Euros) or gross average earning in Bulgaria (531 Euros). Therefore it can be seen that there is a considerable financial incentive for migrant workers to seek employment in this sector by moving across national boundaries.

The benefits of regularisation are mixed. On the one hand it comes with full social protection coverage including health, accident and retirement insurance, but other benefits are linked to residence in Austria. Self employment is the predominant and often only possible mode of employment provided by transnational employment agencies. However, self employment is excluded from working time regulations, collective agreements and extra remuneration for Christmas and sick leave (Schön *et al*, 2008).

In terms of qualifications there are a large number of qualified nurses and care workers working in the domestic sphere (Metz-Gockel *et al*, 2010). As a result of problems in accessing employment in the regular health and social care sectors, qualified workers, sometimes with university degrees, work in the 24-hour care sector in private households. While EU membership has facilitated (or is in the process of establishing) the mutual recognition of qualifications, lack of language skills often limits this option. Regarding qualification requirements for personal care jobs, a 2008 reform set out some general provisions which involved personal carers having to do a basic course in nursing (168 hours) or have six months experience.

This regularisation of 24-hour care has been a success story in terms of the take-up of this new scheme as 30,000 migrant care workers are registered as personal carers. This may be a stepping stone to them being able to gain access to institutionalised care work through contacts with placement agencies or providers in social care. This status change from individualised, precarious or non-compliant work into compliant, more institutionalised and stable work could lead to better participation rights of workers, collective networking within a team of carers or even the establishment of a works council. However, Karl-Trummer *et al (*2010) suggest that this ‘success story’ has to be offset against migrant workers being viewed detrimentally by some in terms of contributing to dequalification processes and lacking language skills. Trade unions have been critical of this development for fears that it increases competition between migrant care workers from CEE and regular social service provision (Osterle, 2000).

7.3.2 Italy

In Italy Chaloff (2008) refers to the ‘overwhelming role played by immigrant care workers, who meet much of the home care demand from the elderly and from the disabled’ (p.19). Many Italian families hire private live-in or hourly caretakers, with some surveys showing that 2.4 percent of those over 65 have a live-in carer – almost always a recent immigrant.

Most of these workers have been invisible in the past, either being without a work permit or working off-the-books (see Appendix 8). The 2002 Bossi-Fini Act tightened the criteria for legal entry and expanded the possibilities for detaining and expelling illegal immigrants, however at the same time the legislation regularised three different categories of applicants; dependent contract work, domestic work and care work. This resulted in 316,000 domestic

workers being regularised. Citizens from Ukraine and Romania accounted for nearly half of this figure, followed by Ecuador, Poland, Moldova and Peru. In 2007 61 percent of all registered foreign domestic workers came from Eastern Europe (van Hooren, 2010). Estimates of the legal population of foreign elder-care workers in (?) reach 500,000 representing about 1 percent of the total population. In 2006 quotas included a set-aside for domestic workers and personal care assistants. In 2007 140,000 potential employers asked for one of the 65,000 available home care authorisations.

Care workers include *Assistenti Socio-sanitari* (ASS) and *Operatori Socio-sanitari* (OSS) whose profiles vary from region to region. There are two main obstacles to foreign workers – the confusing certification system and precarious employment. In part this is due to the role of cooperatives in the provision of low-skilled care. Social assistance is means tested and provided by municipalities. Both health services and municipalities tender these services to third-sector cooperatives. However, one issue is that most of these predominantly women workers, especially from CEE do not have a background in the health professions. Those that do have some medical training have great difficulty in achieving recognition for their training. In some cases, local authorities have tried to create a role in the mediation for support of these women, even integrating private home care into the public employment mediation system.

Chaloff (2008) cites three examples of action taken to address this challenge.

- The first model is in the municipality of Rome and offers a 130 hour course to about 230-250 care workers annually. The programme provides a substitute worker to the family which employs the care worker, enrols graduates in a municipal care worker registry and provides mediation with families. However, the course is not recognised by the region and does not count towards certification as an OSS.

- The second example, an EU funded project in Reggio Emilia, is more ambitious. Public social services attempted to draw private care workers into an integrated network, offering tutoring home visits and support from trained care workers in local cooperatives. The objective was to improve the quality of care and to offer care workers themselves a social centre as a break from long working hours and isolation.

- The International Organisation of Migration with the local authorities of Tuscany and the Italian Ministry of Labour ran a pilot project for international recruitment from Sri Lanka for care work in Tuscan families. Candidates received Italian language training in Sri Lanka and about 60 were supported in this initial period. Obstacles included finding families willing to take in strangers with insufficient language skills. Compared to the informal matching of supply and demand, the pilot project had much higher costs and longer term difficulties.

7.4 Organising challenges

Long term care workers share many of the same features across European countries (European Foundation, 2006). The majority of care workers are women over 45 and in general these workers suffer problems in relation to pay, hours, training and status. The coverage of collective agreements, however, varies between countries and between public and private providers. Common features in all countries includes a lack of representation across different skills and tasks and the decentralisation and fragmentation of bargaining encouraged by the diversity of employers, which includes public and private sub-contractors in the for-profit and non-profit sectors (Simonazzi, 2010). Atypical contracts are common and turnover rates are high.

Beyond these common features, wide country differences can be observed and according to Simonazzi (2010) these reflect and mirror national employment models. Systems relying on in-kind provision (Sweden), contracting-out (UK) and ‘tied’ cash allowances to be used to

hire private carers can be classified as a formal market grouping. Systems that rely on unconditional cash allowances and monetary transfers (Austria, Germany and Mediterranean countries) fall into the informal or mixed categories.

There are a number of specific difficulties for trade unions in organising care workers;

- First, the way in which 'caring' is gendered and thus associated with and often seen as an extension of the role of women in the family makes it more difficult to delineate it as 'work'.
- Second, the work itself is in the home and isolated with carers having an intimate relationship with their employers, that is the family of the individual for whom they work. This makes these workers a 'hard to reach' group for trade unions and may make agreements difficult to enforce.
- Third, the uncertain legal status of many migrant care workers who may be undocumented means that there may be a reluctance to challenge the wages and conditions of work.
- Fourth, the fragmented provision between the private, public and charity sector means there may be many employers which is problematic for collective bargaining.
- Fifth, the self-employed status of many workers.

7.5 Case studies of trade union strategies in the care sector: Germany, Netherlands and the UK

This section looks at the strategies towards migrant workers employed by trade unions in three countries.

7.5.1 Germany

The political priority of the United Services Union (ver.di) was the introduction of a minimum wage for all care workers in Germany on the basis of the German Posted Workers Law (Steffen, 2009). The preconditions for a sectoral minimum wage were complicated by a fragmented collective bargaining landscape with care workers in the public sector and private sectors and church related companies all subject to different agreements. Only workers in public enterprises are covered by the collective agreements. In March 2010 a special commission established by the German Ministry of Labour presented a compromise for sector-wide minimum wages according to which all workers in the care sector should receive at least an hourly minimum wage of 8.50 Euro in West Germany and 7.50 in East Germany (BMAS, 2010). However, as many migrants are hired by households, not as household help, but rather as professional care workers, there already seems to be a way of circumventing minimum wage regulation (Eckhorst, 2010).

Beyond campaigning for a sectoral minimum wage, ver.di is still at the beginning of developing a special policy for migrant care workers (Steffen, 2009). In 2007, ver.di gave migrant workers the status of a 'special group', which allowed the establishment of special working committees of migrant workers within ver.di at national and regional level. To date, these groups have dealt mainly with issues of general migration policy rather than with the needs of migrants in specific sectors. With regard to irregular work, ver.di has recently opened special advisory bureaus for irregular workers in Hamburg and Berlin as a pilot project.

7.5.2 The Netherlands

FNV Bondgenoten is the largest trade union in the Netherlands with a membership of approximately 470,000; it is a general union representing the retail, services, industrial, metal, agricultural, temporary agency work and transport sectors. There is union organiser for domestic workers (including home workers). The health care sector has gone through processes of privatisation and deregulation which has led to many care workers no longer having contracts, access to training, trade union membership and collective agreements.

This has opened up a 'huge space for an informal economy for domestic workers'. Domestic workers do cleaning work, however, this is intertwined with other care services provided at home.

The FNV campaigns for the recognition of domestic work. Domestic workers are not fully recognised as workers in the Netherlands and therefore do not have minimum labour standards or access to social security and pensions. There are a huge number of undocumented workers with no work permits Workers started to self-organise amongst community groups and then approached NGOs (Respect) and then eventually FNV.

Domestic workers self-organise in the FNV in groups by language (Philipino; Latino; African) and sub-groups within these by political tendencies. These groups then come together in an Organising Committee that is elected from the various groups and meets approximately once a month. Every city has organising committee of workers made up of leaders from within the city communities.

According to the FNV organiser this group of workers is isolated and hard to organise; often do not speak the language; have been criminalised; are misunderstood and fearful. They are in a very precarious situation, but want to be legitimate saying to the government

> 'we do want to pay taxes, we do want to have a work permit, we do want our rights and our responsibilities. We know that it is possible because we have seen it in other European countries and the Netherlands are behind on this.

They see the trade union as giving them a 'voice' inside the system as well as support. The FNV helps members get access to support (migration lawyers; healthcare); works in partnership with NGOs and other organisations; provides opportunity for organising and raises profile of the trade union; and gets issues raised in Parliament about domestic workers. Trade union membership helps social cohesion for migrant workers and issues of integration and migration 'takes the union to places we haven't been before and that is good'. However, there is resistance from some union members – 'old club' with rules of behaviour.

Successes of the FNV include developing a support network of (unpaid) lawyers who advise workers; better relationship with police, involving domestic workers involved in strike and dialogue with the public. The biggest success is establishing an organising committee with power and an input into the FNV.

7.5.3 United Kingdom

Unison, the trade union that represents this sector along with the GMB, started a migrant workers project in late 2007 when large numbers of non-European members in care homes were having difficulties renewing their visas. Requirements with regard to qualifications, minimum earnings threshold (which were above the minimum wage paid) and length of service with one employer made it impossible for some migrants to meet the new criteria. According to the Unison interviewee the primary recruitment of non-European workers was stopped as workers from EU8 countries were viewed as the new source of labour that could fill shortages in the sector.

Unison's strategy for engaging with migrant workers had three strands. First, an organising approach which provides a detailed strategy for regional and local branches in engaging with and including migrant workers. Nationally there is a *Migrant Organising Knowledge Bank*, to collect and disseminate good practice and successes in organising. Second, there is a servicing strand which provides specific information for migrant workers on welfare and tax. Third, there is an element of mainstreaming the issue of migrant workers through campaigning on issues relevant to indigenous and migrant workers such as the *Living Wage* campaign and also issues related to immigration. Further, there is a section which specifically combats the myths of migration and immigration to give all activists the tools for countering xenophobic or racist arguments. In addition, a young Polish trade unionist from OPZZ[6] has been seconded to Unison to engage with Polish communities as a way of raising the profile of trade unions and trying to recruit to UNISON.

8. Trade Union Strategies

This section discusses the strategies reported in the questionnaires regarding mobility and health and care migrant workers. The themes include consultation with government and employers, recruitment of and orientation to migrant workers; cross border collaboration; agreement to and implementation of the EPSU-HOSPEEM code of conduct (see Appendix 13 for a summary).

8.1 Consultation with government and employers

Where social dialogue and corporatist arrangements were entrenched, discussions on migration were embedded in this process. In Norway, there are bilateral consultation meetings with the government including the Ministries of Health and Social Welfare, Labour, Education and Research and Internal Affairs. Consultative meetings are also held with the Directorate of Health and the Norwegian Registration Authority for Health Personnel. These meetings discuss developments in the work force and issues related to inward migration. These issues are also discussed with employers' organisations. In Sweden, there are discussions with the Swedish Association of Local Authorities and Regions (SALAR - the biggest employer) and relevant national public agencies. In Finland, there was continuous dialogue between trade unions and the government.

In the absence of more formal corporatist arrangement some trade unions engaged in social dialogue. The Bulgarian trade union also discussed inward migration with the Minister of Health in the context of a statutory committee. Slovakia reported discussions with the government, but gave no details. In the UK, the Royal College of Nursing (RCN) was consulted by the government's Migration Advisory Committee and had regular meeting with the Department of Health. Belgium, Cyprus and the Netherlands reported that there are no discussions with government or employers and in Romania structures for bargaining and social dialogue are fragmented and becoming marginalised.

8.2 Recruitment of and orientation to migrant workers

Most country respondents reported that no special efforts were made to recruit migrant workers. Only one respondent suggested that there was a need to develop this. Another respondent suggested that such an approach was unnecessary given the small percentage of migrant health care workers. It was stated 'Our opinion is that we should solve our labour market problems within our own country as much as possible. In addition of that, in the past we experienced that recruitment abroad is complicated, costly and not always successful.'

Norway and Sweden have contact with migrant workers through social dialogue structures and through induction programmes. In Norway, for example, union stewards participate in mandatory classes for migrant workers seeking a licence to work as nurses in Norway. The purpose of their contribution is;

'...to give an understanding of the strong role that unions play in the Norwegian workplace and that there are three parties involved in workforce discussions: government, employers, workers. Many migrants are fearful of union membership because union members are often persecuted in their country. This is also a major barrier to migrant workers becoming members. However, we do recruit members through participation at these classes. Also our union stewards in the workplace actively recruit new members among migrant workers'.

There is also an office in Oslo which has established a specialist network where Norwegian nurses and migrant workers meet on a regular basis for support, exchange of culture and friendship.

Marburger Bund, the union representing doctors in Germany, encourages migrant doctors to join the union and offers services such as the checking of contracts; they also encourage migrating doctors to join the union in their destination country.

In Sweden, neither Kommunal nor Vårdförbundet adopt any special strategies to recruit migrant workers. Although occasionally, a local branch may provide special assistance to a migrant worker (for example help with translation or housing), this depends very much on the personal relationship that exists between the local branch and the migrant.

The UK has the most developed strategies for recruiting and integrating migrant workers. The Royal College of Nursing has an international section to provide information and support for immigrant nurses and care workers. Unison which represents some nurses and care workers has a range of initiatives, which were discussed in the previous section (7.5).

In the UK many cases of non-EU workers who were having difficulties in getting their work permit renewed due to a more points-based immigration system were taken up by Unison. In Sweden, local interventions had been made to help members in the process of getting their legitimation (documentation). There have been wider discussions in the context of the Zuwinbat project to help Slovakian citizens work in Austria after labour markets were fully open.[10]

8.3 Cross border collaboration

The practice of Swedish nurses working overtime in Norway is actively discouraged by Vårdförbundet as it means that nurses are undercutting Norwegian nurses and return to work in Sweden. The sharing of information and best practice between trade unions in the Nordic countries is facilitated by their similar healthcare systems, high trade union participation and similarity of language. Apart from cooperating with Norwegian colleagues, Vårdförbundet is very active in a 'Nordic Network' of trade unions. There is regular exchange of information and best practice between trade unions in the Nordic countries. Kommunal also coordinates policies with other Nordic trade unions as and when necessary.

In the UK a Polish worker has been seconded from the OPZZ trade union to work with Polish and other migrants from NMS.

In Germany, Marburger Bund has a reciprocal agreement with unions in the Czech Republic the Netherlands and Switzerland whereby while living in these countries their members can join the host country union for free for a period of approximately six months, and vice-versa.

8.4 Agreement to and implementation of EPSU-HOSPEEM code of conduct

Norway has signed up to the EPSU-HOSPEEM code of conduct, the WHO Global Code of Practice on the international recruitment of health personnel. Further, the Norwegian government has adopted a set of principles for ethical recruitment and employment of migrant workers.

In the UK, there is a Code of Practice for International Recruitment of Healthcare Professionals (2004) issued by the Department of Health. NHS employers manage the list of recruitment agencies which have signed up to the Code. In Finland, Sweden and the Netherlands employers and unions are signed up to the EPSU-HOSPEEM code. In Sweden it was suggested that the low level of migrant workers means that it has had little impact. Respondents from other countries did not confirm that the EPSU-HOSPEEM code had been agreed.

[10] ZUWINBAT is an international project 'Space for the Future Vienna – Lower Austria – Bratislava – Trnava which was research to examine projection of and status of commuting and migration behaviour.

8.5 Comparative pay and working conditions of migrant workers in health care sector

The questionnaires reported that branch or national collective agreements allow migrant workers in health care to have the same wages and working conditions as indigenous workers (Bulgaria, Belgium, Latvia, the Netherlands and the UK). In Sweden where there is 90 percent union density among healthcare professionals, sectoral agreements apply to union and non-union members. However, in some countries collective agreements are only valid in workplaces where trade unions operate: 'Where a collective agreement is lacking, there is a risk of wage dumping for inward migrant workers'. The Norwegian Nurses Association (Sykepleierforbundeten) reported that the disparity between the pay and working conditions for migrant workers was a major issue for them. In France differences between the salaries of indigenous and migrant doctors was reported.

In some cases there are disparities between private and public sector wages and conditions. The pay and conditions of care workers employed in the home are particularly difficult to monitor.

9. Impacts of health worker migration

This section discusses some of the impacts of health and care worker mobility and migration. We focus on the impact on individuals and both sender and receiver countries. The information is drawn from the questionnaires, interviews and secondary sources.

9.1 Individual impacts

The individual moving to another country benefits from employment opportunities that may not be available in the home country. However, as discussed earlier, the primary reason given for health workers migrating, both within higher income economies and from those with a significant variation between the sender and receiver country, was the possibility of better remuneration. There is also a range of benefits which include training and experience, better promotion opportunities and superior working conditions in relation to hours, holidays and workload. In the case of Germany achieving a good 'work-life' balance was cited as an important motive for the outward migration of doctors.

There are also personal costs and challenges to moving between countries which include moving up the learning curve of a new environment and possible discrimination. In the case of care workers there was evidence of migrant workers from NMS often working well below their qualifications.

Because of the benefits to the individual and general acceptance of the principal of free movement, unions have generally been very supportive of the principle of intra-EU mobility, although views on non-EU immigration were more varied.

9.2 Sender country impacts

The problem of 'brain drain' in relation to developing countries has been well documented (Yeates, 2009; Connell, 2012). However, the questionnaires and interviews showed that these problems are being replicated within Europe and particularly in relation to countries of the NMS, albeit on a smaller scale. At a general level outward migration reduces the pool of potential workers for the health service. For example, the huge exodus from Poland after 2004 was young (81 percent between the age of 18 and 34) and female (50 percent by 2008) (Clark and Hardy, 2011). In this way the labour force is not being replenished. More

specifically, migration might lead to the loss of key health specialisms. In the case of Sweden there was a shortage of specialist nurses. In Romania at one hospital surgery had been particularly badly hit because of a shortage of anaesthetists, which had reduced from seven to three.
Within sender countries impacts may be greater in rural areas than in cities. In Romania, rural and deprived areas have been persistently under-staffed, attributed by Galan (2006) to lack of incentives to work there. 98 villages are without a health professional and a third of the country is lacking 30 percent of the medical specialisms found elsewhere in the country (Vladescu and Olsavsky, 2009). Further, the Prahova County President of the Doctors' Federation reported that the County had a deficit of 500 doctors, including 90 family doctors and 150 doctors in diagnostics treatment centres. Shortages may not be directly caused by migration, but this exacerbates a situation where there is a freeze on recruitment as part of the austerity measures in 2011/12.
In Poland, workers in the health service face similar problems with regard to increasing workloads and what was perceived as a deteriorating service. However, this was much more attributable to restricted budgets, commercialisation, the extensive outsourcing of ancillary jobs and unattractiveness of nursing as a profession rather than outward migration.

One source of resentment in sender countries is that the training and education of health workers is financed by the public purse and that the skills of these workers are then 'exported' to receiver countries without any compensation.

Sender countries may benefit in the short term by exporting unemployment and reducing staff surpluses, however, there is no evidence for this. Neither is there any current evidence to suggest that migrating health professionals transfer knowledge back to the sending country through collaborative training or research programmes.

9.3 Receiver country impacts

The advantages for the receiver country are first that they are able to fill shortages in their labour force of health workers. In the UK, doctors and nurses were recruited very heavily until recently from outside the EU to fill shortages in the sector. A further advantage is that this workforce can be recruited without any investment in the cost of educating or training health workers. Migrant workers may be willing to accept work in regions or specialisms that find it difficult to recruit. Those that are prepared to migrate are likely to be those that are young and display the most initiative. In the case of the UK the points-based immigration system for non-EU citizens is a very flexible and specific tool for targeting those workers whose skills are in demand. There may be costs to the receiver country, which are associated with the recruitment of migrant workers. These relate to the integration of these workers who come from different cultural backgrounds generally and different cultural and institutional practices that frame medical and care practices.

10. CASE STUDY COUNTRIES

10.1 Germany

10.1.1 Background

Germany has a population of approximately 81.7 million of which approximately 6.7 million are 'foreign-born' nationals (OECD 2011); the main nationalities are Turkish (approx. 1.7 million), Italian (approx. 0.5 million) and Polish (approx. 0.3 million) (Miera, 2008). These figures relate to official documented workers and although non-documented workers and 'illegal residency' is apparent (German Red Cross, 2011) there are no accurate figures available. According to Miera (2008) more stringent immigration controls have resulted in an

increase in the number of undocumented migrants. For undocumented workers there is a paucity of access to social services and fear of disclosure to the authorities is forcing parents to fail to register the birth of their children with the result that health care and education are unavailable to them (German Red Cross, 2011).
Ver.di, the United Services Union, is engaged in supporting illegal migrant workers. In May 2008 the union opened a drop-in centre, Migrar, in Hamburg which is staffed by volunteers; this was later followed by a centre in Berlin. Migrar offers advice on employment and social rights, in ten different languages, to migrants who are residing in Germany illegally but find themselves in an employment situation. The union will take cases on behalf of these workers trying, as far as possible, to protect their identity and place of residence to prevent their deportation. Migrants who use Migrar to enforce their rights are required to become members of ver.di.
There is little available data on the migration of health care workers out of Germany. A report for the World Health Organisation suggests that outflow is low and that overall there is a net gain in health care workers as 'in-flow is markedly higher than out-flow' (Buchan and Perfilieva, 2006:14). There is some evidence of movement of health care workers between Germany, Austria and Switzerland (Rutten, 2009). Although there is currently an in-flow of doctors, Germany is also seen as an important source of doctors for other countries (Rutten 2009); more recently there has been some focus on recruiting highly skilled workers, such as doctors, into the country (Lutz and Palenga- Möllenbeck, 2010).

10.1.2 Health care workers (excluding doctors)

It is predicted that the number of people in need of long-term care in Germany will increase to 3.4 million by 2030 while at the same time hospital patients will increase to 19 million (Statistische Ämter des Bundes und der Länder 2008 in Schulten); this will inevitably put pressure on the provision of professional care. Alongside this, Eurofound (2011) report that around 80 percent of care workers leave their jobs within five years and many women with parental care do not return to employment due to difficulties in reconciling work and family responsibilities. These factors have contributed to a widespread view in Germany that the gap in current and potential care workers will need to be provided by migrant workers. In some cases such as nurses (Williams, 2008) and home care workers (Döhner *et al,* 2008) this is already taking place.
As in most countries, care work in Germany is highly feminised with around 85 percent of all care workers being female (Statistisches Bundesamt, 2010). A large minority of nurses (approximately 16 percent) and elderly care workers (approximately 18 percent) are from a migrant background (ibid) with an estimated 70,000 to 100,000 female migrants, many of them non-registered, providing health care in private households (Döhner *et al,* 2008). Many of these workers originate from Eastern Europe (Lutz and Palenga- Möllenbeck, 2010). Due to a high demand from households for elder-care workers it appears that the government has not only 'turned a blind eye' to the existence of undocumented care workers but these workers are now becoming integral to the welfare system as a whole and without them 'domestic care would collapse completely' (Lutz and Palenga- Möllenbeck 2010:10).
Due to the difficulty in gaining official permission to work in the country, many workers in the care sector follow a system of circulatory migration whereby they enter the country as tourists, work for a period of time in a private residence, go back to their own country and then return at a later date to re-start the cycle. More recently, and following a court judgment in 2007 forbidding private households to employ migrant care workers, these workers are employed by agencies who work closely with counterparts in Germany who place them in positions (Elrick and Lewandowska, 2008). There is evidence to suggest that migrant workers are employed under less favourable terms and conditions than their German counterparts (Döhner *et al,* 2008).

10.1.3 Doctors

Germany has moved from a historic surplus of doctors to a shortage; many young doctors are either not entering the profession once they have finished training (going into industry) or leaving the country altogether (Kopetsch, 2009). This is due to inadequate remuneration, inability to attain a good work-life balance and increasing bureaucracy and administration

(Interview, Marburger Bund Representative 2012). There is currently a net migration with the main receiving countries being the USA and UK, both popular for post-graduate training and financial reasons and more recently Switzerland and Austria (Kopetsch, 2009; Interview Marburger Bund Representative 2012). Both Switzerland and France are seen as offering better working conditions (Interview with German doctor 2012). Although the USA offers good training and research opportunities and is seen as a good career move for doctors wishing to return to Germany at a later date the stringent examination requirements can be seen as a barrier. Overall, there are generally fewer doctors seeking advice on migration than there were in the mid 2000s (Interview Marburger Bund Representative 2012).

The Marbuger Bund subscription fee covers advice for migrating doctors. The union also liaises with doctors' unions in other countries and provides limited information to doctors seeking work in Germany. There are some reciprocal agreements with unions across Europe regarding union membership and Marburger Bund advises migrating doctors to join the union in their destination country. Some doctors remain as 'resting' members of Marburger Bund while working abroad.

To fill the current doctor shortfall, the government is currently recruiting doctors at all levels, however it is generally junior doctors who are responding. Special agencies have been commissioned to recruit from other countries with doctors coming mainly from Poland, Czech Republic, Slovakia, Ukraine (Kopetsch, 2009) Bulgaria and Romania (Interview Marburger Bund Representative 2012). Recruitment from these countries is particularly for hospitals in East Germany (Kopetsch, 2009). All doctors entering Germany are required to have an adequate command of the German language and alongside this are strict regulations covering qualifications. The recognition process is straight forward for doctors who hold a basic medical diploma from another EEA country or Switzerland. For doctors coming from outside the EEA/Switzerland the process for recognition of qualifications is complicated with a lack of published criteria on the equivalence exam; also, there are twenty three different regional authorities, each with different rules and regulations (Interview Marburger Bund Representative 2012). Recognition of qualifications has been a barrier to migration into Germany. On 1 April 2012, however, a new law came into force to make it easier for doctors with foreign diplomas from outside the EEA/Switzerland to have these recognised in Germany (Interview Marburger Bund Representative 2012). For example, from that date, if the doctor's diploma is deemed to differ significantly from the German curricula, but the doctor is deemed to possess adequate work experience, then he or she may be granted full registration as a doctor in Germany (as long as they fulfil other requirements such as good health and no criminal record).With regards to providing help and advice for doctors migrating to Germany, Marburger Bund encourages doctors to join the union and will then check their employment contracts for them. There are two reasons for this: firstly it helps with recruiting the migrant doctors into the union and secondly it helps Marburger Bund ensure that the migrant doctors are not working for less favourable terms and conditions and therefore being treated less favourably or undercutting the terms and conditions of doctors as a whole.

10.2 Italy

Italy's health care system is a regionally based national health service funded through taxation that provides universal coverage free of charge at the point of service. The system is organized at three levels: national, regional and local. The Italian healthcare system is under increasing pressure from an ageing population.

10.2.1 Nurses

As the nursing profession is not highly regarded in Italy and is badly paid with long working hours, it is not an attractive profession for students to go into. The figures for nurses are from 2006 when the National Federation of IPASVI (Professional Nurses, Health Assistants and Childcare Workers) estimated a national shortfall of 60,000 nurses. Faced with a choice, most students prefer to study medicine (Interview, CISL representatives 2012). There is also some evidence that Italian nurses emigrate to Switzerland where the working conditions and pay are better (Interview, CISL representatives 2012). There have been attempts to recruit

nurses from abroad however complex national regulations make this very difficult and there is no systematic recruitment of nurses from abroad (OECD 2008; Interview, CISL representatives 2012). Language was also noted by CISL as a barrier to immigration. Nurses must speak Italian in order to work as nurses. This language barrier also forces many qualified foreign nurses to work as care workers where language is not so important. There is also evidence that a lot of Central and Eastern European immigrants, although trained as nurses, become care workers in order to avoid trying to get their qualifications recognised (Interview, CISL representatives 2012). According to CISL, about 90 percent of Central and Eastern European nurses are in Italy on a temporary basis and want to return home once they have earned enough money. Immigrants from outside the EU stay more permanently. The reaction to the inflow of nurses from abroad has been largely positive and has not raised major concern among trade unions. Some concern persists over poor language skills, on the one hand, and over the fact that these nurses also require the support of an experienced Italian nurse during their initial period on the job. This mentoring and supervision responsibility falls on nursing departments which are already understaffed and overburdened (OECD 2008).

10.2.2 Doctors

While there is a nursing shortage, there is a surplus of doctors as Italy trains too many physicians. According to the 2008 OECD report, Italy had the world's highest rate of medical doctors to population in 2005. The surplus of doctors had not changed by 2008. As a result, Italy suffers from a noteworthy brain drain and is, with Spain, the only EU-15 country to suffer a net loss of university graduates. The Italian Ministry of Health notes that a major obstacle for foreign doctors is the language barrier, since Italian is not widely spoken abroad. Yet most foreign and foreign-born doctors have trained in Italy rather than immigrating after studying abroad, and given the use of oral exams can be considered to have mastered the language. 80 percent of the members of AMSI (Associazione Medici di Origine Straniera in Italia, the main association of foreign doctors, were trained in Italy. The recognition of non-EU medical degrees is a lengthy and cumbersome process, and while the Ministry of Health certifies degrees within a year of filing a complete application, it often takes applicants 5 years to assemble the appropriate documents. The exam for foreign-trained doctors is held every 6 months. An alternative is to enrol in the 6th year of medicine, take 7 exams and receive an Italian degree, converting the non-EU degree into an Italian degree (OECD 2008).

10.2.3 Home care sector

By way of contrast, the home care sector whether formal or informal is haphazardly regulated and, as a result, there is no shortage of human resources in this sector and it is relatively easy to recruit affordable home care assistants, even if they are of unproven quality (OECD 2008).The Italian public health system provides needs-tested home care for the non-self sufficient within the limits of its local staff resources, which are usually chronically overstretched in this field. Faced with limited public supply, many Italian families have hired private live-in or hourly caretakers. Most of these workers have been invisible, either because they are in Italy without a work permit or because they are working off the books although there are sporadic regularisation programmes conducted by the Italian government.

Most home care workers – predominantly women, especially from East Europe – do not have a background in the health professions (OECD 2008). Those who do have medical training face enormous difficulties in achieving recognition for their training and as a result, there is evidence that they de-skill and work as care workers, resulting in some displacement for Italian care workers (Interview, CISL representatives 2012). For non-qualified migrant home care workers access to training is difficult as there is no legislation requiring private agencies to provide this; this leaves patients vulnerable and exposed (Interview, CISL representatives 2012). Migrant care workers are frequently underpaid, with even those highly qualified paid less than the minimum wage whilst they are in their 'training' period; this also puts a downward pressure on pay for the indigenous workforce (Interview, CISL representatives 2012). There is also a conflict for families who employ illegal carers between

wanting them to become legal and the higher costs (tax, insurance, regulated wages, etc.) that are associated with employing a legal worker (Interview, CISL representatives 2012).
A large proportion of the migrant workers from Eastern Europe are believed to be temporary workers who are working to meet financial needs and once these needs are met they return to their home country (Interview, CISL representatives 2012). Migrant workers are deemed to be less stable and it was reported that following the earthquake in Modena in the Emilia Romagna region in May 2012 many migrant care workers left to return home (Interviews, CGIL and CISL representatives 2012).

10.2.4 The Trade Unions and Migrant Workers

There are three main trade union confederations in Italy; the General Confederation of Italian Workers (Confederazione Generale Italiana del Lavoro – CGIL); the Italian Confederation of Workers' Trade Unions (Confederazione Italiana Sindacati Lavoratori – CISL); and the Union of Italian Workers (Unione Italiana del Lavoro – Uil). The confederations represent different political orientations. CGIL is traditionally associated with moderate and radical left-wing political parties. CISL, who split from the CGIL in 1950 in order to be politically independent (Interview, CISL representatives 2012), is closer to the former Christian Democratic Party but also includes members who sympathise with parties of the centre-left and left of the political spectrum (Eurofund 2010). Uil is mainly associated with the non-communist, reformist left (Eurofund 2010). Trade unions represent 35.6 percent of workers in Italy (Eurostat 2008).
Both CGIL and CISL actively recruit migrant workers (Interviews, CGIL and CISL representatives 2012). Both unions have advice centres which provide help and support to migrant workers with work and immigration issues in general; CISL also help migrant workers to access welfare services such as disability allowances. In Bologna, CGIL's advice centre has existed for over 20 years; CISL's centre was set up approximately 5 years ago. CGIL uses the personal contacts established through the centre in order to recruit migrant workers into the trade union. CISL also has contacts in relevant communities in order to find out the needs of individual immigrant workers and they actively promote cultural intervention. CISL tries to act as a link between the immigrant and state institutions (e.g. the police). CISL helps legal and illegal workers and places emphasis on helping illegal workers become legal. It is estimated that there are roughly 4.5 million legal and 4.5 million illegal workers in Italy (Interview, CISL representatives 2012).
CISL report many home health care workers in the informal economy and they have helped families to obtain regularisation for their carers under the Government's amnesty programme. They have also found themselves in the uncomfortable position of a conflict between, on the one hand, migrant workers seeking regularisation and on the other retired members not wanting to pay the additional costs associated with the regularisation of the worker.

10.3 Poland

10.3.1 Background

After accession to the EU in 2004 there was a massive migration of (often young) Polish workers to other parts of Europe. By contrast inward migration to Poland is relatively low.

Doctors and nurses and midwives are obliged to register with the self-government councils. These councils collect statistics on occupational activity and provide confirmation of qualifications for people planning to migrate, according to EU Directive 2005/36WE. The councils' statistics are the only estimate of the scale of outward migration. Their credibility varies since not all people who collect certificates migrate afterwards and not every migrant in health care obtains permission. Some nurses take up employment in domestic care or in the private sector where individual employers do not require such documents. Some doctors work in Poland and abroad at the same time, combining working Monday to Friday in Polish hospitals and weekends on duty abroad. Nurses in western Poland in the cities near the Polish-German border commute to work in Germany while living in Poland. Although

migration in the health care is not currently a massive issue - it may become problematic for employee ratios in Poland in the future.

10.3.2 Doctors

Polish doctors were one of the most significant groups that migrated to other countries after EU accession. According to national statistics, there are 79,000 doctors in health care system (GUS, 2011). Based on the numbers of qualifications certificates issued by the Council the Ministry of Health and the Doctors' Council estimate that between 8 and 10 percent of registered doctors migrated. Further, the council estimates that anesthetists were the first and most numerous group of specialist health workers that migrated (18 percent), followed by plastic surgeons (17 percent) and chest surgeons.

The common reasons for migration decisions were very low wages, the intensification of work, lack of proper technology and career opportunities, especially for young doctors (Katrynisz, 2007). The most common destinations were Ireland, United Kingdom, Germany and Sweden. Young doctors emigrated to undertake apprenticeship at hospitals which is an obligatory part of their training. The situation started to change after 2006 and opt-out clause. The EU directive introduced restrictions on doctors' working time and posed a situation when hospitals directors had three options: to contract out doctors' services, to introduce shifts or to introduce opt-out clause. Since there were insufficient numbers of doctors, they could dictate financial demands and in effect work more than 48 hours per week but for significantly higher wages. In 2007 as a result of doctors protests (Grzymski, 2007), their wages improved further and since then the material reason for migration was reduced (Doctors' Council, 2010). Currently, there are new patterns of economic migration – including the sharing of contracts abroad between several doctors and weekend mobility to other country.

10.3.3 Nurses

The intensification and poor organization of work, the lack of technological support for physical work, and low wages are the push factor for the migration of nurses. Polish nurses usually migrate to UK, Ireland, Germany (as care workers), Italy, Spain, Belgium and Norway. However, despite previous predictions the migration of nurses and midwives did not turn out not to be such a massive phenomenon (Zajac, 2004; Inoue, 2010). Between 2004 and 2007, only 158 Polish nurses registered in Ireland, 1,013 in UK and 820 in Italy (Leśniowska, 2008).

Outward migration increased continuously after EU accession and then decreased in 2007 and 2008, when after a massive protest of nurses and midwives (camping in front of Prime Minister Office) those they received pay rises (Briskin, 2011, Kubisa: 2010, Grzymski 2007). However, since 2010 the numbers of health workers migration have risen again.

10.3.4 The care deficit

The deficit in care workers was supposed to be filled by immigrant nurses. The theme of 'Ukrainian nurses' was present in the public debate and this was present in negotiations between trade unions and employers in the health care sector for many years as the argument of possible social dumping was repeated in the years after the health care system reform (early 2000s). However, Ukrainian nurses never arrived in significant numbers. In 2011 only nine people from Ukraine, Belarus and Lithuania wanted to confirm their nursing qualifications. This indirectly confirmed arguments made by Polish nurses that low wages combined with relatively high living costs would not attract migrant workers

This does not mean that there are no immigrants in the care sector. There is a growing need for domestic care, especially for elderly people as this service is not fully covered by the state. Ukrainian care workers live in the houses of their clients and work, usually without legal contract, or are employed by private care work agencies. In both cases, trade unions cannot organize them because of the legal reasons. Trade unions only organize members only with contracts, usually in larger companies. The Polish industrial relations system is

based on plant-level organizations with a minimum of 10 people which makes organizing in work-agencies almost impossible.

10.3.5 Government policy

Outward migration process is neither supported nor discouraged by the government. Until recently the only and most recognized case of inter-governmental agreement about health care workers was signed between Poland and Norway in 2001 (Isaksen, 2009). The Norwegian government agency recruited Polish nurses and doctors who spoke English and graduated university and offered them work at hospitals and care homes. After the EU accession Finnish health care ministry undertook similar action, informed Polish ministry about plans to recruit several dozens of nurses but they were not successful in recruiting.

Government support for migration is evident in changes to the training of nurses. A university education is needed to obtain confirmation of qualifications and permission to work abroad. This system was introduced before EU accession. Nurses with secondary education are offered 'bridging studies' financed by the European Social Fund. The officials at the Ministry reported that it was also introduced as a way of supporting nurses who wanted to migrate.

Trade unions and ministry officials held a common view about the flow of information suggesting that estimates of outward migration are insufficient and that there is a lack of information regarding more practical issues. First of all, definitions of occupations vary between countries and the range of duties is different. In effect Polish nurses, doctors and physiotherapists often take jobs below their qualifications, either because of the country differences or because of individual decisions made by country administration officers who question certificates of qualifications. Trade unions point out that information about wages in receiving country should be available with estimates of living costs to avoid social dumping and unfair competition with local employees. The Ministry of Health cooperates with the Solvit – international agency helping migrants with everyday life issues.

There are cases cooperation between union, for example between Polish OPZZ and British UNISON. For several years a Polish delegated employee worked for UNISON to organize Polish workers in UK and information about UNISON activity was on OPZZ website.

10.4 Romania

10.4.1 Background

The public sector in Romania is undergoing dramatic change as the state continues to come to terms with the post-Communist era, liberalisation encouraged further by accession to the European Union in 2007, and the impact of austerity measures implemented as a result of IMF loans in 2010. In this context Romania may be thought of as predominantly a 'sender' country of migrant health workers to Western Europe. Although this is undoubtedly so, the situation regarding mobility of health workers in Romania is highly complex, involving multiple patterns of mobility.

Studies of the Romanian health care system show poor health outcomes and chronic under-investment. The country has an increasing mortality rate, with average life expectancy six years shorter than the EU average and infant and maternal mortality among the highest in Europe (Vladescu *et al*, 2008). It has one of the lowest densities of health professionals to population in Europe (Vladescu and Olsavsky, 2009) and low government spend on health compared to other European countries (Ovidiu *et al*, 2008).

A potent mix of contributory factors, including economic austerity measures, a public sector salary cut of 25 percent, a recruitment freeze, a limit on hospitals' staff budgets yet, despite these centralised controls, a decentralisation that has meant the cessation of national coordination and workforce planning, all contribute to a negative situation for the sector. This is all the more of a problem given the country's ageing but declining population (Cismas and

Maghear, 2010), the increasing demand for health care, but the loss of health care workforce through migration.

Obtaining accurate data on migration is highly problematic, with official data limited to pre-arranged EURES work contracts and recruitment agency contracts, and to numbers of requests for qualification verification certificates although these requests do not necessarily mean that the worker emigrates. A further complication is the legal right to request up to two years unpaid leave of absence with no obligation to divulge purpose or destination. Nevertheless, reviewing previously published figures (Vladescu and Olsavsky, 2009; Galan et al, 2011), official ministry data, and information gathered first hand during the study visit to Romania, a realistic estimate is that 3 percent of doctors and 5 to 10 percent of nurses leave the country each year, although this may be an under-estimate of the real number leaving as between 20 and 40 percent express a desire to work abroad.

Prior to EU accession in 2007, migration was limited by the need to obtain work permits. Nurse migration was enabled by the Ministry of Labour arranging bi-lateral agreements with other European countries, although this practice appears to have now all but ceased. Since 2007, although migration to traditional destination countries is still strong (particularly Italy for nurses and France and Spain for doctors, both drawn by traditionally strong cultural links and language similarities), this is now being over-taken by the popularity of the UK and Nordic countries as destinations.

10.4.2 Multiple causes of migration

There are multiple causes of migration. The most frequently cited are pay and income, and working conditions. Public health sector pay is around 15 percent of the levels typically paid in western European countries and even when cost of living differences are taken into account, migration provides an attractive financial gain. The unitary national pay scale affords little flexibility and slow incremental progression and the 25 percent pay cut had a major effect on absolute pay levels and on ability to progress because the pay scale maximum was reduced, so halving the difference between the maximum and minimum. The national recruitment freeze and resultant staff shortages cause worsening conditions in the form of work overload, with reports of around half of posts being unfilled and very high nurse to patient ratios.

Other contributory factors are perceived lack of autonomy and respect for nurses, training and qualification equivalence now enabling more free movement, an over-supply of qualified staff and the lack of effective workforce planning, the opportunity to gain further education and to use new equipment and procedures (both for personal career gain and to bring back new expertise to the Romanian system), the activity of recruitment agencies, and specific regional differences and cultural links. The right to two year's absence may also speed up the rate that staff leave, as hospital managers are keen for staff to take this up rather than resign, because they can at least recruit temporary replacements against leave of absence rather than risk vacancies being blocked. In addition, a tradition of informal 'under-the-table' payments by patients to doctors and nurses has been highlighted in the media as a way of vilifying the profession and this bad press is seen by some as a further reason for disenchantment and leaving. Perversely, such payments are seen by some workers as more important than ever, given the reduction in formal pay.

Although there is a clear story of Romania as a 'sender' country of health workers to Western Europe (and there is very little immigration – limited mainly to doctors from Moldova), the situation is complex and involves different patterns of mobility - public to private, rural to urban, outward migration and circular migration. Workers move on a succession of temporary contracts, between countries and between sectors (public to private), primarily for calculated financial reasons, to invest in their future (often to build a house) or futures of others (their children). This applies particularly to younger workers and those with specialisms and skills that are in demand, such as anaesthetics, radiology, obstetrics, gynaecology, other intensive care and surgery expertise, family medicine and psychiatry. However, the temporary and circulatory nature is emphasised here with workers likely to return once they have earned enough money. Nurses particularly 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. The gendered nature of the work, uncertainties surrounding employment of

spouses, and the draw of friendship, family and cultural links, all seem to reinforce the need to return. Some circulatory migration also occurs around times when workers return to Romania for professional updating. Such training is mandatory in order to retain a Romanian license to practice and it seems that the vast majority wish to do so.
Outward migration is more likely to be a problem from large urban areas where there is a concentration of specialist and surgical fields. In addition, movement out of the public to the private sector is becoming increasingly common in urban areas and for particular specialisms, enabled by the growth of mono-clinics and likely to be enabled further by new legislation. There are great problems with lack of health staff in rural and deprived areas, not necessarily attributable to regional or national migration but due to lack of incentives, good working conditions and infrastructure. However, decentralised control means that different regions and hospitals that have different purposes and governance structures, experience different circumstances. General work, and smaller municipal and county hospitals may face less of a problem of staff loss, but this depends on the affluence of their region or city and how they are able to leverage additional funding.
The adverse staffing situation in the Romanian health sector is one of great concern, with numerous stories of surgical wards unable to operate due to a lack of specialist staff, poor levels of care in hospitals due to high staff to patient ratios, and some rural areas with no health professionals. Furthermore, the mobility of health workers to migrate, and the growth in the temporary contract culture, raises serious longer term concerns about staffing capability and skill acquisition across the range of medical service provision in the future.
At national level the collective bargaining and social partnership structures appear ill-equipped to address these issues, with both government employers and trade unions resigned to being unable to prevent workers leaving. Four trade unions represent workers for collective bargaining in the health sector (Eurofound, 2011), although Federatia Sanitas is by far the biggest, and although there is a joint negotiation body, the unions appear to have competing interests, both for membership and politically as Sanitas feels that the government gives the smaller unions equal bargaining recognition in return for blocking Sanitas' moves. National bargaining is further limited in scope to a pay and core conditions remit, both of which are frozen by central government control, and by a fragmented health system, with the one sector-specific employers' organisation representing only hospitals which are under direct government control. Other local and regional hospitals are not included in national bargaining, but are nevertheless subject to national government pay and recruitment controls. A broader social dialogue structure at national level appears to have broken down. Further pressure is put on the health system due to what Vladescu et al (2008) describe as "poor administrative capacity, lack of accountability mechanisms, insufficient communication and insufficient management skills" (ibid, p.xx). There is some creativity in management and trade union initiatives at local hospital level, with managers and unions working constructively to find pragmatic solutions such as the creation of role payment allowances, training on new equipment and promotion to pay maxima, albeit the room for manoeuvre appears very limited here. Overall the employment relations system is struggling to cope with the challenges of migration.

10.5 Sweden

10.5.1 Background

The Swedish case study was conducted in February 2012 and consisted of interviews with representatives of the Swedish Association of Health Professionals (Vårdförbundet) and the Swedish Municipal Workers' Union (Kommunal) in their offices in Stockholm. Vårdförbundet is the only trade union dedicated to health care workers in the health care sector. It is a non-partisan organisation with 110,000 members of whom 94,600 are nurses, 7,000 biomedical scientists, 5,600 midwives and 2,800 radiographers. Kommunal has 570,000 members and is the largest trade union in Sweden. In the health care sector, 110,000 members are assistant nurses, 70,000 are care assistants, 1500 are ambulance paramedics, 13,000 are mental care assistants, and 20,000 work as personal attendants for disabled people. The Swedish health care system is primarily funded through taxation. However, since 2009 the

government has pushed for the liberalisation of primary health care services by allowing members of the public to choose between public and private primary health care providers. The reform drew mixed reactions from the relevant trade unions. Kommunal's vice president dismissed the reform because it would take away the counties' right to determine and distribute the tax funding for care services. It was also argued that the form, range or concentration of care services should be controlled by democratic and public institutions, not by profit seeking private companies (Kommunal webarticle). Vårdförbundet stated that it is important for care-seekers to have a large and diverse supply of care providers to choose from so that care can be given according to the needs of the patients. In this context, the liberalisation was considered a good reform for the patients. The union however still argues that the reform has not dealt with the issue of diversity and providing care according to needs (Eurofund 2009).

10.5.2 Trade unions and migration

The Swedish trade unions interviewed did not report a noticeable rise in migration among health care workers or health care professionals. In particular, there is no evidence of an increase in inward migration following European enlargement in 2004 and 2007. There seem to be two main barriers to inward migration. First, in order to work as a nurse, midwife, biomedical scientist or radiographer in Sweden, the candidate needs to be registered with the relevant professional organisation. This deters many migrants from coming. However, for those that do come Vårdförbundet provides substantial information on its website in Swedish and English on how to register. The union also offers help and advice during the registration process to migrants. Within the EU, it is fairly easy to transfer a general nursing registration. However, problems frequently arise when it comes to specialist nurses wanting to work in Sweden with a foreign training. There are no clear guidelines on equivalences of training for specialists.

Second, 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), the trade union does not offer such kind of courses for professionals in its areas. Those coming as temporary migrants need to have sufficient knowledge of Swedish if they wish to register as a health care professional in order to gain employment.

Although there is no noticeable rise in levels of inward migration, Vårdförbundet has noticed higher levels of temporary outward migration. There is evidence that nurses who live on the border to Norway work overtime in Sweden, take the overtime as leave and then travel to Norway to work as many hours as possible before returning to their regular employment in Sweden. Nurses can earn a higher wage in Norway; they have much better working conditions and benefit from uncapped hours. This practice is actively discouraged by Vårdförbundet as it means that nurses are not only undercutting Norwegian nurses but they return to work in Sweden without having had any rest periods or holidays. Vårdförbundet cooperates with Norwegian trade unions to try to provide some level of protection for their members who engage in this practice and come across difficulties in Norway thereby needing union protection. However, Vårdförbundet recognises that this practice can only be stopped if working conditions in Sweden improve. In particular, there is a shortage of specialist nurses and the patient-nurse ratio is not as good as in Norway. The Swedish government does not support or restrict this temporary migration. Their lack of investment in the health sector tends to encourage nurses to move to countries where working conditions are much better such as in Norway. This lack of investment has also led to a shortage of specialist nurses in Sweden as a whole.

Neither Kommunal nor Vårdförbundet adopt any special strategies to recruit migrant workers. Although occasionally, a local branch may provide special assistance to a migrant worker (e.g. help with translation or housing), this depends very much on the personal relationship that exists between the local branch and the migrant. Apart from cooperating with Norwegian colleagues, Vårdförbundet is very active in a 'Nordic Network' of trade

unions. There is regular exchange of information and best practice between trade unions in the Nordic countries which is facilitated by their similar healthcare systems, high trade union participation and similarity of language. Kommunal also coordinates policies with other Nordic trade unions as and when necessary.

10.6 United Kingdom

10.6.1 Background

The general trend has been one of decreasing employment of migrant workers in the UK National Health Service (NHS), which in the past was heavily reliant on internationally trained and recruited health workers. Further, there has been a shift in the recruitment of personnel from non-EU to EU countries. Health workers are represented by a number of organisations. The British Medical Association (BMA) is an independent trade union and voluntary professional association that represents doctors from all branches of medicine throughout the UK. It has a membership of 141,000. The professional organisation for nurses is the Royal College of Nurses (RCN) (representing 400,000 members), but they may also choose to be in the Unison trade union. Care workers and health assistants will be represented by the Unison trade union, but those that work in care institutions may also be represented by the GMB trade union.

10.6.2 Doctors

In April 2012 only 61.7 percent of doctors registered with the General Medical Council (GMC) were trained in the UK with the remainder being trained in and drawn from the EEA (European Economic Association) (9.9 percent) and outside the EU (27.2 percent) (GMC, 2012). Historically the UK has been heavily dependent on recruiting doctors from outside the country. For example, in 2003 12,000 international doctors were added to the GMC register, while the corresponding figure from the UK (7,000) and the EEA (2,500) was considerably lower (ibid). This trend reversed after 2006 and by 2012 7,000 doctors from the UK were added to the register while the corresponding figures from the EEA and non-EU were 2,500 from each category. In the past decade a number of medical schools have been established in the UK which has resulted in reduced reliance on doctors from outside the EEA. In fact, the UK by 2012 was more than self-sufficient in doctors and a report from the Department of Health Centre for Intelligence warned that the NHS will struggle financially to employ the current pipeline of student doctors as consultants. It is projected that by 2020 there will be an oversupply of 20,000 doctors (Gainsbury and Neville, 2012).

10.6.3 Nurses

In the mid-1990s the international recruitment of nurses was a major strategy for addressing shortages of staff. In the early part of the 1990s between 10,000 and 16,000 international nurses were added to the UK register of nurses and midwives (Buchan and Seccombe, 2011). By 2010 this figure had fallen to 2,500. The majority of these nurses came from countries in the EU, notably Ireland, Poland, Portugal and Romania. International recruitment of nurses to the UK from non-EU countries has become more difficult because; in 2005 the professional body – the Nurses and Midwives Council instigated a much tougher and more costly registration programme for overseas nurses; in 2006 the main entry clinical grades were removed from the Home Office shortage occupation list; the NMC raised the English language test requirements; and in 2008 the shift to a points-based immigration system reinforced the government policy of making international recruitment a more difficult option for employers[11] (RCN, 2010; Buchan and Seccombe, 2011).

The last full report from the Migration Advisory Committee in March 2011 recommends retaining only a small number of nursing specialities on the shortage occupation list. In the ten years between 1999/2000 and 2009/2010 the UK shifted from low level international

[11] Only some specialities of experienced nurses, such as critical care and theatre nursing are likely to qualify for entry.

recruitment in the late 1990s to very high levels of recruitment in the early part of this decade, then back to low levels of activity in recent years (Buchan and Seccombe, 2011).

Therefore there have been two notable features in the pattern of inflow of nurses, first a significant overall reduction, and a marked switch to EU entrants. In 2009/2010, 78 percent of international registrants were from the EU, compared with less than 7 percent in 2001/2. With regard to outflows of nurses in 2009/2010 6,357 UK nurses requested that their registration be verified as part of applying for a job in another country. 87 percent of all verification requests from UK based nurses were for four destination countries: Australia, New Zealand, Canada and the USA. The overall trend has shifted from one where the UK is a net beneficiary of international flows in the early part of the decade to the situation in recent years where there has been a marked outflow of nurses.

The RCN International Department offers a welfare rights and guidance service to migrant nurses. It has an Immigration Advice Service which provides free and confidential advice and representation services to overseas nurses, nursing students and health care assistants (HCAs)

10.6.4 Care workers[12]

In the provision of care the extensive privatisation of the sector has posed increasing problems for trade union organising and membership has dwindled. This is compounded by the difficulty of a fragmented sector with a large number of workplaces, which are geographically dispersed and employ relatively small numbers of people who work shifts. Unison, the trade union that represents this sector along with the GMB, started a migrant workers project in late 2007 when large numbers of non-European members in care homes were having difficulties in renewing their visas. Requirements with regard to qualifications, minimum earnings threshold (which were above the minimum wage paid) and length of service with one employer made it impossible for some migrants to meet the new criteria. According to the Unison interviewee the primary recruitment of non-European workers was stopped as workers from EU8 countries were viewed as the new source of labour that could fill shortages in the sector. At present only senior care workers fulfil the Tier 2 entry requirement.[13] Between 1998 and 2008 the number of foreign born care workers increased from 8 percent to 18 percent of the work force. By 2010 7 percent of the care workforce were from the NMS/EU8 countries.

Unison's strategy for engaging with migrant workers had three strands. First, an organising approach which provides a detailed strategy for regional and local branches in engaging with and including migrant workers. Nationally there is a *Migrant Organising Knowledge Bank*, to collect and disseminate good practice and successes in organising. Second, there is a servicing strand which provides specific information for migrant workers on welfare and tax. Third, there is an element of mainstreaming the issue of migrant workers through campaigning on issues relevant to indigenous and migrant workers such as the *Living Wage* campaign and also issues related to immigration. Further, there is a section which specifically combats the myths of migration and immigration to give all activists the tools for countering xenophobic or racist arguments (Unite, 2009). In addition, a young Polish trade unionist from OPZZ[14] has been seconded to engage with Polish communities as a way of raising the profile of trade unions and trying to recruit to UNISON.

[12] The information on care workers is drawn from a project undertaken with Line Eldring and Thorsten Schulten which is reported in Hardy *et al* 2013.

[13] Tier 2 is the route by which 'skilled' migrants with a job offer come to the UK to fill gaps in the UK labour force. Employers must first apply to the UK Border Agency for a sponsor licence.

[14] Ogólnopolskie Porozumienie Związków Zawodowych (OPZZ) translates as the All-Polish Alliance of Trade Unions. It is a federalist organisation made up of 86 trade union organisation.

10.6.5 Perspectives on mobility

In response to the proposed changes to the Recognition of Professional Qualifications Directive (2005/36/EC) there was an Inquiry by the House of Lords which took evidence from organisations and professional groups which represented health workers. The main recommendations were that;

- regulatory bodies should be allowed to test the language skills of all non-UK applicants
- an alert mechanism should be in place so that fitness to practice information can be shared with an exchange of information about practitioners subject to disciplinary hearings
- qualifications and skills recognised by the EU directive must be updated (Hospital Management, 2012)

Shortcomings to current regulations were highlighted by the case of a German locum doctor who accidentally killed his 70 year old patient in 2008 by giving him a fatal dose of a drug that he was not familiar with (NHS Employers, 2012).

11 Challenges

The following issues emerged from the questionnaires and interviews as the challenges of cross border mobility for EPSU affiliates and European trade unions in general;

- Duration, cost and transparency of cross-border recognition of cross border qualifications
- The cross border sharing of information by professional bodies and trade unions on salaries and contractual rights and obligations for doctors, nurses and care workers.
- Lack of language skills 1) as a barrier to mobility 2) leading to employment below level of qualifications
- Promotion, use and monitoring of EPSU-HOSPEEM Code of Conduct on Ethical Cross-Border Recruitment and Retention (2008) (see http://www.epsu.org/a/3715) and of the WHO Code of Practice on the International Recruitment of Health Personnel (2010) (see http://www.who.int/hrh/migration/code/code_en.pdf)
- Representation of migrant workers in professional organisations and trade unions
- Prevention of social dumping in the private (not-for-profit and for-profit/commercial) sector
- Invisibility and isolation of (migrant) care workers
- Discriminatory treatment for non-EU migrant workers in the health sector
- Improving/Facilitating access of undocumented workers to citizenship rights
- Problems experienced by sender countries when health workers migrate

In addition, the research team would suggest that there is a need for the improved collection and availability of statistics. Further, we would underline the importance of the challenges identified in the research in the context of the austerity measures being implemented across most of Europe and the implications for the scapegoating of migrant workers and growth of far right (see summary in Appendix x).

12 Recommendations

The following recommendations (also summarised in Appendix x) have been drawn up in response to the challenges identified in the study, but have also been elaborated jointly by the research team in conjunction with the EPSU secretariat.

- To improve the transparency of processes and the effectiveness of the actual cross-border recognition of qualifications and provide information on administrative procedures for the recognition of qualifications.
- Training care workers and certification of their skills and qualifications and comparability of both across Europe, the integration of home-care workers into local public service networks; and to identify and work with community groups and non-governmental organisations (NGOs).
- To identify where information exists on salaries and the contractual rights and obligations of doctors, nurses and care workers; to review the accessibility of information (languages, format); and to explore if there are initiatives to set up a point of information-collecting of this type of information.
- For EPSU affiliates to investigate the possibility of including into their range of services offered for migrant care workers (of a specific profession) the checking of work contracts and/or employment conditions.
- To explore the possibility of reciprocal agreements for temporary membership in trade unions.
- Where there are substantial numbers of unorganised migrant workers, to explore strategies for organising, recruiting and integrating migrant workers, and to review the outcomes of any related campaigns.
- For trade unions to improve training for shop stewards/representatives of staff in work councils and their awareness on questions and challenges related to ethical recruitment practices, to the employment, contractual issues, working and pay conditions as well as to the induction of migration workers in the health care sector
- Free and appropriate ongoing language support by employers and/or public authorities in receiver countries, and for language support to be provided both as part of vocational training and as stand-alone language classes.
- For EPSU affiliates to continue with awareness-raising about the contents and potential of the EPSU-HOSPEEM Code of Conduct on Ethical Cross-Border Recruitment and Retention and to monitor its use, based on the joint EPSU-HOSPEEM Evaluation Report (2012).
- For public authorities and employers to systematically monitor the work of employment agencies to help safeguarding ethical recruitment practices and to take sanctions against them should exploitative practices be detected, as set out in the EPSU-HOSPEEM Code of Conduct on Ethical Cross-Border Recruitment and Retention
- For trade unions to promote the International Labour Organization (ILO) convention on domestic workers.
- For EPSU affiliates to improve the cooperation with governments and public authorities at all levels to work towards better legal protection of working and employment conditions of migrant care workers in private households, in small or medium sized enterprises or self-employed (including the bogus self-employed) as it is as a rule difficult or impossible to reach out to them or to have them covered by collective agreements
- Inclusion of social/labour clauses on wages as agreed in collective agreements or legislation and other working and pay conditions in public contracts for private (not-for-profit and for-profit/commercial) providers in the context of public procurement procedures to support the principle ‘Equal pay for equal work’ on a given territory.
- For the EU to encourage and push national governments to invest in health care in order to improve the sustainable financing of health care systems, the quality of health services, the attractiveness of health professions and the working conditions of those health workers not migrating/staying behind

- To review any existing compensatory arrangements between sender and receiver countries and to consider the elaboration of compensation mechanisms/agreements, involving employers' associations, the institutions administering health care systems (social insurances or national health services), relevant national ministries and, where appropriate, EU institutions.
- To promote fair treatment for non-EU health workers through, for example, the right to vote in local elections in the host country after four years of residency (consistent with the practice in most EU countries) and facilitating access to naturalisation/citizenship in the host country.
- Giving support to or affiliation to appropriate organisations committed to promoting anti-racism and anti-xenophobia and to consider producing materials that set out the value of migrant workers in particular to health and social services and to combat myths of migration.

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Appendix 1

Questionnaire

I) GENERAL

1. a. Your name:
   .....
   b. Your position in the trade union:.....
   c. What level you work at (national, regional, sectoral, employer, workplace)?

.....

   d. Contact details – email address:.....

2. Which groups of workers do you represent (nurses, doctors, care workers, others)?

3. Please give information about your union's collective bargaining and social partnership arrangements. We are interested in what level your union has social dialogue and negotiation, and on what type of issues.

Levels (please circle one or more)	**Issues** (please tick each box that applies)				
	Pay	**Recruitment**	**Working conditions**	**Training**	**Other**
National					
Regional					
Sectoral					
Employer					
Workplace					

4. Which employers do you have collective bargaining or social partnership agreements with?

Sector of ownership	**Please tick box that applies**
Public/state owned	
Private/for profit	
Other non-profit	

Domestic workers in private homes	
Employment agencies	

II) OUTWARD MIGRATION

5. Which jobs have high levels of outward migration? (tick box)

	High levels of outward migration	Low levels of outward migration
Doctors		
Nurses		
Care workers		

6. What are the main destination countries for workers leaving? (in order of importance)

Order of importance	Destination country
1	
2	
3	
4	

7. What are the reasons for workers migrating out from your country?

	Important	Not important
Low pay		
Lack of job opportunities		
Poor working conditions		
Other		

8. What is the permanence of the outward migration?

	Usually	Occasionally	Never
Temporary (return within 6 months)			
Circulatory			

(Regularly and periodically moving out and back from)			
Permanent outward migration (move and settle)			

9. Is outward migration supported or promoted by government, other agencies or your trade union. Are there bilateral agreements between your country and other countries to facilitate outward migration?

10. Who drives recruitment of workers to migrate? (Tick the boxes)

	Important	Quite important	Not important
Employers			
Agencies			
Individuals			

11. Has outward migration increased since:

	A lot	Quite a lot	Not at all
2004 accession to the EU			
2008 economic crisis			

12. Does your union make information available to workers who are thinking of leaving the country to work elsewhere? Tell us what this is.

13. Does the union have agreements or programmes with social partners and employers to enhance the recruitment and retention of health care workers?

III) INWARD MIGRATION

14. Which jobs have a particularly high level of inward migration?

	High levels of outward migration	Low levels of outward migration
Doctors		
Nurses		
Care workers		

15. What are the main countries of origin of migrant workers (in order of importance)

Order of importance	Destination country
1	
2	
3	
4	

16. Has inward migration increased since:

	A lot	Quite a lot	Not at all
2004 accession to the EU			
2008 economic crisis			

17. What is the permanence of the inward migration?

	Usually	Occasionally	Never
Temporary (return within 6 months)			
Circulatory (Regularly and periodically moving out and back from)			
Permanent outward migration (move and settle)			

18. What are the barriers to inward migration?

	Important	Not important
Qualifications		
Language		
Accommodation		
Poor wages		
Other barriers		

19. Who drives the recruitment of inward migrant workers? (Tick the boxes)

	Important	Quite important	Not important
Employers			
Agencies			
Individuals			

20. What are the major organisations that employ migrant workers.

	Employ a lot of migrant workers	Employ few migrant workers	Employ no migrant workers
Public/state owned			
Other not-for-profit			
Domestic workers in private homes			
Private/ for profit			
Employment agencies			

IV) YOUR TRADE UNION AND MIGRANT HEALTH CARE WORKERS

21. Do you discuss with employers' organisations and/or are you consulted by your government (relevant ministries and public administration) on issues related to inward migration (e.g. shortage of certain professionals; induction of migrant workers; inward migration an issue of health system planning, etc.)? Please comment here.

22. To what extent do your collective bargaining and social partnership arrangements enable inward migrant workers to have the same working and pay conditions as comparable workers from your own country?

23. What efforts does the union make to recruit inward migrant workers? How successful are these? Does the union have agreements and programmes for the training and career development of migrant workers? Please comment here.

24. Does your union work with migrant workers in their community outside of the workplace? If so, please give examples.

25. Is there a Code of Conduct that applies to the employment of migrant workers in your sector and country? This comprises the EPSU-HOSPEEM Code of Conduct on Ethical Cross-border Recruitment and Retention, http://www.epsu.org/a/3715, and the WHO Global Code of Practice on the International Recruitment of Health Personnel, http://www.who.int/hrh/migration/code/practice/en/index.html

Name the agreement	
Date of signing	
Signatories	

26. Are there undocumented workers in the health and care sector?

27. Which countries do they come from?

1	
2	
3	
4	

28. Does your union support them? If so, how does it support them?

29. Can you give any examples of good practice with regard to issues of cross-border mobility of the health care workforce which you would like to pass on to EPSU and affiliated unions?

30. Is there anything else you'd like to tell us about the subject of migrant health care workers? Please write it here.

Appendix 2

List of EPSU affiliates participating in the survey

COUNTRY	ORGANISATION
Austria	Vida
Belgium	CGSP, coordinated with CSC
Bulgaria	Podkrepa
Cyprus	PASYDY
Czech Republic	OSZSP ČR
Finland	They Super JHL
France	CFDT Santé
Georgia	HSMCTU
Germany	ver.di Marburger Bund
Ireland	IMPACT
Latvia	LVSADA
The Netherlands	ABVAKABO
Norway	NSF
Romania	Sanitas Hipocrat
Slovakia	SOZZASS
Sweden	Kommunal Vårdförbundet
United Kingdom	RCN

Appendix 3

List of interviews conducted

In a number of these organisations, we interviewed several people in different positions.

Belgium
CSC Services Publics

Germany
Marburger Bund Union
German Red Cross
German migrant doctor
ver.di

Ireland
IMPACT trade union

Italy
Confederazione Generale Italiana del Lavoro (CGIL)
Confederazione Italiana Sindacati Lavoratori (CISL)

Netherlands
FNV Bondgenoten

Poland
Federation of Trade Unions of Health Care and Social Care Workers (OPZZ)
All-Poland Trade Union of Nurses and Midwives
Department of Nurses and Midwives, Ministry of Health
Department of Higher Education, Ministry of Health (responsible for doctors, dentists and physiotherapists)

Romania
Federatia Sanitas (at national, county and hospital levels)
Ministry of Health (at national and county levels)
Ministry of Labour, Family and Social Protection
Nurses' Order (at national and county levels)
Doctors' Federation (county level)
EPSU (south-east Europe region)
Managers, doctors and nurses in three hospitals (a large city clinical hospital, a specialist county hospital, a small municipal hospital)

Sweden
Vårdförbundet
Kommunal

United Kingdom
Royal College of Nursing (RCN)
UNISON (June 2011)

Appendix 4

Explanatory notes on EU legal frameworks

1. Legal definition of a worker.

A worker in the EU context has been defined by the Court of Justice (CJ) as "a person who is obliged to provide services for another in return for monetary reward and who is subject to the direction and control of the other person as regards the way in which the work is to be done."[15] The CJ applies a wide scope to this definition to include any worker who pursues an "effective and genuine economic activity"[16] thereby covering workers who earn less than the minimum required for subsistence as defined under national law.

2. Article 45 on the free movement of workers.

Article 45 of the Treaty on the Functioning of the European Union (TFEU) on the free movement of workers grants workers the right to move to another member state in order to accept offers of employment actually made, to stay in another member state for the purpose of employment and to remain in the territory of a Member State after having been employed in that State subject to certain conditions. Art. 45 TFEU contains an exception for employment in the public service. Other limitations on the right to free movement are only permitted if they can be justified on the grounds of public policy, public security or public health. The CJ clarified in Case 48/75 *Procureur du Roi v Royer* that work-seekers who had not been given an offer of employment were also given a right to free movement by article 45 TFEU. In case C-292/89 *ex parte Antonissen* the Court added that work-seekers were to be granted "a reasonable time in which to apprise themselves […] of offers of employment". The Court went on to say that "a period of six months […] does not appear in principle to be insufficient to enable the persons concerned […] to take, where appropriate, the necessary steps in order to be engaged."

Article 45 TFEU on the free movement of workers also grants a general right of non-discrimination on grounds of nationality to workers moving from one member state to another in relation to access to employment, remuneration and other conditions of work. This general right of non-discrimination has been supplemented by two Directives: Directive 2000/43/EC implementing the principle of equal treatment between persons irrespective of racial or ethnic origin and Directive 2000/78/EC establishing a general framework for equal treatment in employment and occupation.

Both Directives cover EU and non-EU nationals. However they do not catch difference of treatment based on nationality between those two groups, and do not apply to any requirements related to the entry into and residence of third country nationals within the EU, nor do they apply to any issues surrounding the legal status of third country nationals. Directive 2000/43 prohibits direct and indirect discrimination on the basis of racial or ethnic origin and covers public and private sectors in relation to employment, self-employment, conditions for access to employment, access to vocational training, social security and healthcare, social advantages, and education. Directive 2000/78 similarly prohibits direct and indirect discrimination in public and private sectors in relation to conditions for access to employment, to self-employment, access to vocational training, and employment and working conditions, including dismissals and pay (art. 3). This means that discrimination between workers in the health care sector on grounds of nationality,

[15] Case 66/85 *Lawrie-Blum v Land Baden Württemberg,* Judgment of the Court of 3 July 1986.
[16] Case 53/81 *Levin v Staatssecretaris van Justitie,* Judgment of the Court of 23 March 1982.

racial or ethnic origin is prohibited both with regards to access to employment and once in employment.

The provisions of Article 45 TFEU are expanded upon and clarified in Council Regulation 1612/68 of 15 October 1968 on freedom of movement for workers within the Community (as amended up to Regulation 2434/92) and Council Directive 68/360/EEC of 15 October 1969 on the abolition of restrictions on movement and residence within the Community for workers of Member States and their families. The Regulation and the Directive entitle any EU national to take up and engage in gainful employment on the territory of another Member State and grant a right to equal treatment in respect of working and employment conditions, social and tax benefits. Family members of the EU worker are also granted rights regardless of their nationality. What is or particular interest to this study is Council Regulation (EEC) No. 312/76 of 9 February 1976 which provides that a national of one member state working in another is entitled to equal treatment with the nationals of the host state when it comes to exercising trade union rights, including the right to vote and to be eligible for the administration or management posts of a trade union. In keeping with art. 45 TFEU, the Regulations and the Directive do not extend to employment in the public service, and limitations on the right to free movement can be justified o4n grounds of public policy, public security or public health. However, the Directive and the Regulation still grant important rights to workers employed in the health care sector.

3. National measures restricting access after 2004.

In practical terms, this meant that a worker from one of the member states that acceded in 2004 (apart from Cyprus and Malta) needed a work permit to work in all EU-15 member states with the exception of Sweden, Ireland and the UK. Sweden and Ireland did not restrict entry to the labour market; the UK implemented a Worker Registration Scheme. The Accession Treaties further allowed the extension of these national measures for an additional period of three years. After that, a member state that applied national measures could continue to do so for a further two years if it notified the Commission of serious disturbances in its labour market. For the 2004 enlargements only Germany and Austria took advantage of this option. All other Member States lifted their restrictions between 1 May 2006 and 1 May 2009. Altogether, the national measures restricting access to the labour market cannot extend beyond an absolute maximum of seven years.

4. Social Security rules applicable to special categories of workers.

a. The laws which give effect to these aims are Regulation 883/2004 and Regulation 987/2009. Regulation 883/2004 contains the substantive provisions, while Regulation 987/2009 contains the implementing provisions outlining, for example, competent national authorities and administrative formalities.

b. The Regulation also includes particular rules for certain categories of workers, such as civil servants who are subject to the legislation of the member state to which the administration employing them is subject, and workers who are employed or self-employed in several EU countries. On the whole, the Regulation allows all EU citizens, regardless of their status as for example employees, self-employed workers, students, pensioners or non-active persons to keep their social security benefit entitlements when moving within the EU. Special rules apply for certain groups of people to sickness, maternity and paternity benefits, benefits for accidents at work and occupational diseases, death grants, invalidity benefits, old-age and survivors' pensions, unemployment benefits, pre-retirement schemes, and family benefits.

5. Court of Justice rulings related to Posted workers.

The CJ was asked to give three rulings on the correct method of implementation of the Directive in 2007 and 2008**:**

- C-319/06 *Commission v Luxembourg*.
    - The CJ objected to Luxemburg's extension of additional terms and conditions to posted workers which went beyond art. 3(1) of the Directive such as the requirement of a written employment contract
- C-341/05 Laval (*Laval un Partneri Ltd v Svenska Byggnadsarbetareförbundet, Svenska Byggnadsarbetareförbundets avd. 1, Byggettan, Svenska Elektrikerförbundet*) of 18 December 2007 and C-346/06 Rüffert (*Dirk Rüffert, in his capacity as liquidator of the assets of Objekt und Bauregie GmbH & Co. KG v Land Niedersachsen*) of 3 April 2008
    - In both cases, the social partners in Sweden and Germany were permitted to determine rates of pay for posted workers through collective bargaining. Neither system had a fixed minimum wage to determine a basic rate of pay for posted workers. The collective agreements which fixed the rate of pay were not declared universally applicable across the industry at issue but were agreed on a case-by-case basis. The CJ ruled in both cases that negotiation at the place of work, when minimum rates of pay are not determined in accordance with one of the means provided for by the Posted Workers' Directive, are not permissible under the Directive.

6. Intra-corporate transfers

The existing EU instrument addressing conditions for the admission of intra-corporate transferees in the context of the provision of a service is the 1994 Council Resolution on limitations on admission of third-country nationals to the territory of the Member States for employment which sets out definitions and principles governing admission of this category of migrants. The Resolution defines an intra-corporate transferee as "a natural person working within a legal person, […] and being temporarily transferred in the context of the provision of a service through commercial presence in the territory of a Member State of the [EU] […] and the transfer must be to an establishment (office, branch or subsidiary) of that legal person." Thus, intra-corporate transferees are also covered by Directive 96/71/EC on the posting of workers discussed above (at 2.4.1).

In July 2010 the European Commission proposed a Directive on conditions of entry and residence of third-country nationals in the framework of an intra-corporate transfer. The proposal aimed to establish a simplified procedure for admission of intra-corporate transferees, based on harmonised criteria. The scope of the Directive would be limited to managers, specialists or graduate trainees (under a special scheme) whose prior employment within the same group of undertakings must have lasted at least 12 months. Intra-corporate transferees admitted to a member state would be issued with a specific residence permit allowing them to carry out their assignment in diverse entities belonging to the same transnational corporation, including, under certain conditions, entities located in other Member States. This permit would also give them favourable conditions for family reunification in the first Member State. Negotiations over the proposed Directive are ongoing.

Appendix 5

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

Country	Destination(s) for outward migration	Jobs affected (High/Low levels of migration)	Drivers	Permanence
Austria	No information given	No information given	No information given	No information given
Belgium	France, the UK, Switzerland, Nordic [i]countries	Doctors (high) Nurses (high) Care workers (high)	Low pay Poor working conditions Other	Usually circulatory or permanent
Bulgaria	Germany, the 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, the UK	Doctors (high) Nurses (high) Care workers (low)	Low pay To gain 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)
Ireland	The US, Australia	Doctors (high) Care workers (low)	Lack of job opportunities Recession	Usually circulatory, occasionally temporary and permanent
Italy	Various EU destinations	Doctors (high) Nurses (low) Care workers (low)	Lack of job opportunities (doctors)	Permanent (doctors)
Latvia	The UK, Norway, Sweden, Germany	Doctors (high) Nurses (high) Care workers (low)	Low pay	Usually permanent, occasionally temporary or circulatory
The Netherlands	The UK, US, Canada, New Zealand, Germany	Doctors (not known) Nurses (high) Care workers (low)	Poor working conditions	Permanent
Norway	Very little outward migration and no examples of countries given	Not applicable	Not applicable	Not applicable

Country	Destination(s) for outward migration	Jobs affected (High/Low levels of migration)	Drivers	Permanence
Poland	Germany, UK, Ireland, Norway	Doctors (moderate to high) Nurses (low) Care workers (moderate)	Low pay Lack of job opportunities Poor working conditions	Temporary Circulatory Permanent
Romania	Italy, Spain, France, Germany, the UK, Norway, Sweden	Doctors (high) Nurses (high) Care workers (high/low)[ii]	Low pay Lack of job opportunities Poor working conditions	Temporary Circulatory Permanent
Slovakia	Czech Republic, Austria, the UK, Germany	Doctors (high) Nurses (high) Care workers (high)	Low pay Poor working conditions	Permanent (doctors) Circulatory (care workers)
Sweden	Norway Other Nordic countries English-speaking countries	Doctors (low) Nurses (low) Care workers (low)	Low pay Poor working conditions	Occasionally – temporary, circulatory, permanent
United Kingdom	Australia, Canada, New Zealand, the USA	Doctors (low) Nurses (low) Care workers (low)	Lack of job opportunities Family abroad challenges	Temporary, circulatory, permanent

The order of the countries is given according to the order listed by the respondents of the questionnaires.

Questionnaires were not received from Germany, Italy and Poland. The information reported is on the basis of the interviews conducted.

Appendix 6

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

Country	Source(s) 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%) 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)
Ireland	Philippines, India, Pakistan and NMS	Doctors (high) Nurses (high) Care workers (low)	Qualifications Language Other	Usually permanent, occasionally circulatory, temporary
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)

Country	Source(s) of inward migration	Jobs affected (High/Low levels of migration)	Barriers to immigration	Permanence
Latvia	No countries specified	Doctors (very low) Nurses (very low) Care workers (very low)	Language Poor wages	No information given
The Netherlands	Germany, Belgium, NMS	Doctors (high) Nurses (low) Care workers (indeterminate)	Qualifications Language	No dominant mode: temporary, circulatory and permanent
Norway	Sweden, Denmark, Poland	Doctors (low) Nurses (low) Care workers (low)	Qualifications Language Poor wages Accommodation	Nurses (circulatory)
Poland	No examples given	Doctors (low) Nurses (low) Care workers (low)	Language Poor wages	No information given
Romania	Moldova, Ukraine, China	Doctors (high) Nurses (high) Care workers (low)	Language Poor wages	Usually permanent, occasionally circulatory, temporary
Slovakia	Ukraine, Czech Republic, African countries	Doctors (low) Nurses (low)	Language Poor wages Accommodation	Nurses (temporary) Doctors (permanent)
Sweden	Finland, Denmark, Norway	Doctors (high) Nurses (low) Care workers (low)	Qualifications Language	No information given
United Kingdom	Ireland, Poland, Portugal, Romania	Doctors (high to moderate) Nurses (low) Care workers (unknown)	Qualifications Language Poor wages Accommodation	No dominant mode: temporary, circulatory and permanent

The order of the countries is given according to the order listed by the respondents of the questionnaires.

Questionnaires were not received from Germany, Italy and Poland. The information reported is on the basis of the interviews conducted.

Appendix 7

Average monthly salary in selected European countries, 2005 and 2009 (in €) in the health sector

Country	2005	2009
HIGH SALARY COUNTRIES		
Austria	36,032	33,384
Germany	47,529	56,044
Sweden	34,027	34,746
United Kingdom	42,866	38,047
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, p. 76).

Appendix 8

Remuneration of doctors, ratio to average wage, 2009 (or nearest year)

Country	Specialist	General practitioners
Czech Republic	3.3	n/a
Denmark	4.0	2.8
Estonia	2.1	1.7
Finland	2.6	1.8
France	3.2	2.1
Germany	5.0	3.7
Greece	2.8	n/a
Hungary	1.6	1.4
Ireland	4.5	3.5
Italy	2.6	n/a
The Netherlands	5.5	3.5
Norway	1.8	n/a
Slovenia	2.8	2.5
Spain	n/a	1.9
UK	2.6	3.6

Source: OECD (2011, p. 67).
WHO Global Health Expenditure Database

Appendix 9

Remuneration of hospital nurses, US$ and € PPP* plus ratio to average wage, 2009

*PPP = Purchasing Power Parity

Country	US$ PPP	€ PPP**	Ratio to average wage
Luxembourg	80,000	54,940	1.4
Ireland	54,000	37,090	1.0
Denmark	52,000	35,710	1.1
United Kingdom	52,000	35,710	1.1
Norway	49,000	33,650	1.0
Spain	48,000	32,970	1.3
Netherlands	44,000	30,220	1.0
Finland	38,000	26,100	1.0
Italy	37,000	25,410	1.1
Slovenia	35,000	24,040	0.9
Czech Republic	22,000	15,110	1.0
Estonia	20,000	13,740	1.0
Slovakia	18,000	12,360	0.9
Hungary	17,000	11,680	0.8

Source: Adapted from OECD (2011, p. 77).

** exchange rate: average rate for December 2009: US$ 1= € 0.686811

Appendix 10

Total health expenditure per capita, public and private, in EU countries, WHO estimates

2009

Country	US$ PPP*	€ PPP**
Luxembourg	6,526	4,482.13
Norway (non EU)	5,394	3,704.66
Netherlands	4,388	3,013.73
Austria	4,242	2,913.45
Belgium	4,237	2,910.02
Germany	4,128	2,835.16
Denmark	4,117	2,827.60
Ireland	4,004	2,749.99
France	3,934	2,701.91
Sweden	3,690	2,534.33
UK	3,399	2,334.47
Finland	3,357	2,305.62
Spain	3,150	2,163.45
Italy	3,027	2,078.98
Greece	3,025	2,077.60
Portugal	2,703	1,856.45
Slovenia	2,475	1,699.86
Czech Republic	1,924	1,321.42
Slovakia	1,897	1,302.88
Hungary	1,440	989.01
Estonia	1,372	942.30
Poland	1,358	932.69
Lithuania	1,096	752.74
Latvia	995	683.38
Bulgaria	985	676.51
Romania	773	530.90

Source: WHO Global Health Expenditure Database
http://data.euro.who.int/hfadb/tables/tableA.php?w=1024&h=640
*PPP = Purchasing Power Parity
**exchange rate: average rate for December 2009: US$ 1= € 0.686811

Total health expenditure per capita, public and private, in EU countries, WHO estimates

2010

COUNTRY	US$ PPP	€ PPP**
Luxembourg	6,743.02	5,099.32
Norway (non EU)	5,426.08	4,103.40
Netherlands	5,037.84	3,809.80
Denmark	4,537.08	3,431.11
Austria	4,387.92	3,318.31
Germany	4,332.34	3,276.28
France	4,020.74	3,040.63
Belgium	4,025.12	3,043.94
Sweden	3,756.86	2,841.08
Ireland	3,703.96	2,801.07
United Kingdom	3,479.56	2,631.37
Finland	3,280.90	2,481.14
Italy	3,021.72	2,285.14
Spain	3,027.24	2,289.31
Greece	2,853.18	2,157.68
Portugal	2,818.46	2,131.42
Slovenia	2,551.56	1,929.58
Czech Republic	2,050.96	1,551.01
Slovakia	2,060.24	1,558.03
Poland	1,476.06	1,116.25
Hungary	1,468.60	1,110.61
Lithuania	1,299.46	982.70
Estonia	1,226.28	927.36
Latvia	1,092.52	826.20
Bulgaria	947.42	716.47
Romania	811.00	613.31

Source: WHO Global Health Expenditure Database
http://data.euro.who.int/hfadb/tables/tableA.php?w=1280&h=800
*PPP = Purchasing Power Parity
** exchange rate: average rate for December 2010: US$ 1 = € 0.756237

Appendix 11

Total health expenditure as percentage of GDP* in EU countries, 2009-10, WHO estimates

***GDP Gross Domestic Product**

Country	% GDP 2009
Belgium	11.8
France	11.7
Germany	11.3
Portugal	11.3
Denmark	11.2
Austria	11.0
Greece	10.6
Portugal	10.1
Sweden	10.0
Spain	9.9
Norway (non EU)	9.7
Ireland	9.7
Slovenia	9.7
Finland	9.7
Italy	9.5
UK	9.3
Czech Republic	7.6
Bulgaria	7.4
Hungary	7.3
Poland	7.1
Estonia	7.0
Latvia	6.5
Lithuania	6.5
Romania	5.4

Source: OECD (2011, p. 151)
WHO Global Health Expenditure Database
http://data.euro.who.int/hfadb/tables/tableA.php?w=1280&h=800

Country	% GDP 2010
France	11.88
Germany	11.64
Denmark	11.42
Portugal	11
Austria	10.98
Belgium	10.72
Greece	10.26
Sweden	9.64
UK	9.64
Italy	9.54
Spain	9.54
Norway (non EU)	9.48
Slovenia	9.42
Ireland	9.2
Finland	8.96
Czech Republic	7.88
Poland	7.46
Hungary	7.34
Lithuania	7.04
Bulgaria	6.88
Latvia	6.68
Estonia	6.04
Romania	5.58

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

Appendix 12

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)

Appendix 13

The role of trade unions

Country	Discussion with employers and government	Comparative working conditions of migrant workers	Special strategies for recruitment	Code of conduct
Austria	Cooperation with Ministry of Social Affairs – Definition of key workers/the indispensable workforce (*Schlüsselarbeitskräfte)*; according to Austrian legislation this is a migrant/non-Austrian worker having a qualification that is required in the domestic labour market, earning a salary of at least 60% of 2,460€ per month (2010) (= 1,476€) and their employment also needs to have a relevance/positive impact on the regional labour market	Same conditions	Cooperation of Austrian Trade Union Federation with Ministry of Social Affairs in view of the key workers/the indispensable workforce (*Schlüsselarbeitskräfte)*	There is no code of conduct for the employment of migrant workers in the health care sector in Austria
Belgium	None	Same conditions	None	None
Bulgaria	Discussion with Ministry of Health on inward migration	Same conditions	None, but there is a need to develop such a programme	None
Cyprus	No	Not applicable	Not applicable	None
Finland	Continuously on the agenda with parliament, MEPs, employer organisation and ministries	National and local agreement the same irrespective of nationality	Recruited in the same way as indigenous workers. Some brochures and web pages in foreign languages. No special activities, 'usually	EPSU_HOSPEEM Code has been translated into Finnish with the employer. No other agreements

Country	Discussion with employers and government	Comparative working conditions of migrant workers	Special strategies for recruitment	Code of conduct
			because they have no wish for special activities'	
France	Discussion regarding differences between the salaries of French and non-French doctors	Differences between the salaries of French and non-French doctors	No	None
Ireland	Discussions if issues arise, for example, not paying minimum wage	In theory the same entitlement, but little policing of arrangement	Part of normal recruitment	None
Latvia	No	Same conditions	No dedicated activities	None
The Netherlands	No discussions except regarding HOSPEEM	Same conditions	No efforts because the number of inward migrants is small	Employers have adopted HOSPEEM. Employers have hallmark standards
Norway	Bilateral meetings with the government (Ministries of Health and Social Welfare, Labour, Education and Research, Internal Affairs. Consultative meetings with Directorate of Health and Norwegian Registration Authority for Health Personnel. These meetings discuss developments in the workforce and issues related to inward investment.	We are quite aware that migrant workers are often not given the same working and pay conditions as workers from this country. This is a major issue that the Norwegian Nurses' Organization is quite involved with as an advocate for equal opportunity and equal pay for migrant workers in the health sector.	Union stewards participate in mandatory classes for migrant workers seeking license to work as nurses in Norway. The purpose of the lectures is to give an understanding of the strong role of unions in the Norwegian workplace...Many migrant workers are fearful of union membership because union members are often persecuted in their country. This is a major barrier to migrant workers becoming	The government have adopted a set of principles for ethical recruitment and employment of migrant workers.

Country	Discussion with employers and government	Comparative working conditions of migrant workers	Special strategies for recruitment	Code of conduct
			members. However, we do recruit members through recruitment in these classes. Also out union stewards in the workplace actively recruit new members among migrant workers.	
Romania	Needs to be translated	Needs to be translated	Neds to be translated	Needs to be translated
Slovakia	Yes	Collective agreements apply to all workers. However, in the absence of a collective agreement there is a danger of wage dumping	No efforts or agreement	None
Sweden	Discussions with Swedish Association of Local Authorities and Regions, SALAR (biggest public employer) and relevant national public agencies. Until the enlargement of 2004 there was a network of stakeholders, employers, public authorities and social partners	It is a strong principle that everyone who works in a specific sector is included in collective bargaining: both union members and non-members *ergo omnia* (over 90% TU membership)	The union does not do this as our own task, but we cooperate at times with employers in a regional context and in those cases there has also been interventions regarding, for example, introduction programmes	Our trade union has been involved in the formulation of both the above-mentioned documents, but their significance is not so big as the quantity of professional mobility is still very low.
United Kingdom	RCN consulted by Migration Advisory Committee	Same conditions	RCN Immigration Service	Code of Practice for the international recruitment of health care workers (2004)

Appendix 14

Challenges and recommendations

Challenge	Addressee	Recommended actions
1 Duration, cost and transparency of cross-border recognition of cross-border qualifications	EU	• Based on EPSU positions/requests and to be linked with ongoing policy process in the framework of the revision of Directive 2005/36/EC for the recognition of professional qualifications www.epsu.org/a/8744)
2 The cross-border sharing of information by professional bodies and trade unions on salaries and contractual rights and obligations for doctors, nurses and care workers	Trade unions Professional bodies	• To identify where information exists • To review the accessibility of information (languages, format) • To explore if there are initiatives to set up a point of information-collecting or disposing of this type of information • For EPSU affiliates: to investigate into the possibility of including into the range of services offered for migrant care workers (of a specific profession) a checking of work contracts and/or employment conditions
3 Lack of language skills 1) as a barrier to mobility leading to 2) employment below level of qualifications	Trade Unions Professional bodies Local and national states and education departments Employers	• Free and appropriate ongoing language support by employers and/or public authorities in receiver countries • Language support to be provided both as part of vocational training and as stand-alone language classes
4 Promotion, use and monitoring of EPSU-HOSPEEM Code of Conduct on Ethical Cross-Border Recruitment and Retention (2008) (see www.epsu.org/a/3715) and of the WHO Code of Practice on the International Recruitment of Health Personnel (2010) (see www.who.int/hrh/migration/code/code_en.pdf)	Trade Unions Professional bodies Employers EPSU	• For EPSU affiliates: to continue with awareness-raising about the contents and potential of the EPSU-HOSPEEM Code of Conduct on Ethical Cross-Border Recruitment and Retention • To empower trade unions and professional bodies at a local level to promote and use the EPSU-HOSPEEM Code of Conduct • To report progress to EPSU • To consider blacklisting recruitment agencies not complying

Challenge	Addressee	Recommended actions
		with the principles of ethical recruitment. • EPSU to continue promoting and monitoring the use and implementation of the code, based on the joint EPSU-HOSPEEM E Report (2012) (see www.epsu.org/a/8893)
5 Representation of migrant workers in professional organisations and trade unions	Professional organisations Trade unions	• To explore the possibility of reciprocal agreements for temporary membership in trade unions • To provide information on administrative procedures for the recognition of qualifications or on where to find them and which institutions/organisations to contact • Where there are substantial numbers of unorganised migrant workers, to explore strategies for organising, recruiting and integrating migrant workers and, in particular, to review the outcomes of any related campaigns that have taken place
6 Prevention of social dumping in the private (not-for-profit and for-profit/commercial) sector	EU National governments Trade unions	• Inclusion of social/labour clauses on wages as agreed in collective agreements or legislation and other working and pay conditions in public contracts for private (not-for-profit and for-profit/commercial) providers in the context of public procurement procedures to support the principle 'Equal pay for equal work' on a given territory.
7 Discriminatory treatment for non-EU migrant workers in the health sector	EU National governments Trade unions	• To lobby for equal treatment • Collect and disseminate examples of good practice
8 Invisibility and isolation of (migrant) care workers	Local and regional authorities	• Training of care workers' certification of skills and qualifications and comparability for both across Europe • Integration of home-care workers into local public service networks, for example, by participating in local training and coordinating with other health and care professionals • For TU: to promote ILO convention on domestic workers (www.ilo.org/ilc/ILCSessions/100thSession/reports/provisional-records/WCMS_157836/lang--nl/index.htm) • For TU: to identify and work with community groups and NGOs

Challenge	Addressee	Recommended actions
9 Compensation arrangements between sender and receiver countries	Employers Institutions administering the health care systems Relevant ministries	• To review any existing compensatory arrangements between sender and receiver countries • To consider the elaboration of compensation mechanisms/agreements, involving employers' associations, the institutions administering health care systems (social insurances or national health services), relevant national ministries and, where appropriate, EU institutions
10 Improving/Facilitating access of undocumented workers to citizenship rights	EU National governments	• The right to vote in local elections in the host country after four years of residency (consistent with the practise in most EU countries) • Facilitating access to naturalisation/citizenship in host country
11 Scapegoating of migrant workers and growth of far right	Trade unions	• Giving support to or affiliation to appropriate organisations committed to promoting anti-racism and anti-xenophobia • To consider producing materials that set out the value of migrant workers in particular to health and social services and to combat myths of migration
12 The improved collection and availability of statistics	EU National statistical offices Professional bodies	• To lobby EU and collectors of national statistics to collect and publish data on migrant health care staff (in countries with inward and outward migration) by occupational group, by country of birth and by country of training for both the public and private sector in order to improve the knowledge about actual cross-border mobility/migration and to have a better data basis for health workforce planning.