S-E European Conference
Workforce Migration in the Health Care Sector
Bucharest, 20-21 February 2013

Conference Report

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Item 1: Opening. Aims and objectives. Introduction of participants.

The conference was organized at the request of the Bulgarian and Romanian health unions affiliated to EPSU and PSI, both countries much affected by the high emigration rate of the health workers. The conference was attended by 32 representatives from the 4 unions involved: Federation of Trade Unions – Health Services – CITUB, Medical Federation – Podkrepa, Romanian Trade Union Federation Sanitas and Federation Syndicale Medico-Sanitaire Hipocrat.

The aims of the conference were to look at the challenges and also opportunities presented by the health workers mobility in Europe, its impact on the quality of and access to the health services and on the working conditions of the health care workers and to agree on the trade union policy at national, regional and international level. An important aspect referred to integrating national work into the EPSU/PSI policy for the health care sector.

From EPSU and PSI the conference was attended by the health officers, Mathias Maucher and Odile Frank respectively.

Another guest speaker was Dr Steve Shelley from Hertfordshire University, UK, who made a presentation on Health worker mobility and employment relations responses.

Item 2: Health care workers mobility in Europe – opportunities and challenges

Marina Irimie, EPSU/PSI Secretary for S-E Europe, made a presentation about the current state of migration in Europe and the foreseen perspectives for the future years. The presentation dealt with the driving factors of migration and recruitment practices, challenges and opportunities for both sending and receiving countries and the social impact of migration of the health workers. The presentation pointed out to the over 20 million migrant workers residing currently in the EU (4% of the total EU
population) and to the labour shortage in EU-15 of 38 million workers estimated by the ILO by the year 2050 if no corrective measures are taken. The internal migration flow within the EU has increased significantly since the last enlargement, mainly going east-west or south-north. Whereas most CEE source countries had estimated on average 2-3% of young people loss, in Romania the percentage exceeded 10% already in the first five years after the EU integration. The country has lost over 1/4 of the active population through emigration.

The main areas for migration are health, education and research, construction and house keeping. The World Health Report (2006) estimated a shortage of more than 4 million health workers across the world, of which one million in EU alone. Severe staff and skill shortages in the health systems of many countries have given a boost to active recruitment from abroad. The EU enlargement affected the inflows of foreign doctors and nurses from new accession states. Starting with 2004, Poland and Lithuania were at the forefront of these developments, followed very rapidly by Romania, presently the number one exporting country.

According to the T-jobs recruitment website, in 2011 alone in Romania 16,500 doctors and nurses signed contracts to work abroad, double compared to the previous year when only 8,100 people had signed such contracts.

In the discussions that followed, Mathias Maucher asked why the Romanian government continued to sign contracts with other governments in the EU countries for the export of health professionals, when there is a EU Directive in force concerning recognition of qualification of the medical professionals.

The colleagues from Sanitas federation responded that problems with the implementation of the EU documents still existed in Romania. There were cases when a diploma used for 10 years in the country was not recognized by the Ministry of Labour when the person applied for migration.

Odile Frank pointed out to the important psychological aspects related to migration. She also referred to the UN Convention on the Rights of Migrants.

Plamen Radoslavov referred to the health reform in Bulgaria and expressed a special interest in an exchange of information with the Romanian colleagues on the use of electronic medical recipes. He also suggested the introduction of electronic trade union cards which could be used in a number of countries in Europe.

**Item 3: Impact of the health workforce mobility on the quality of and access to health services – Dr. Florian Chiru, Hipocrat Federation**

Dr. Florian Chiru, sector manager in a famous Romanian hospital in Bucharest, stated that the responsibility for the strategy in the health sector stands with the governments. In Romania, there is a governmental department for the mutual recognition of the qualification diplomas.
Some 20,000 nurses from among the most competent have emigrated from Romania in the last years, most of them privately. Not all of them are necessarily young. The main destination countries are Italy, Spain, France and Greece. Not all of those who left the country were able to get equivalents job as nurses, some had to accept lesser jobs in social care. Their places remain vacant and their absence is hard to be covered by those who stay and continue to work in the country, overwhelmed by the workload. There are hospitals in the country where fully equipped sections cannot be used for lack of qualified staff, like the cardiovascular section in a children’s hospital in Bucharest where all anaesthesiologists have left.

In terms of professional training, there’s been a regress of the education pre-university system in the last years. Many of the new graduates cannot be absorbed in the health system due to the job freezing whereby only one new person could be employed to 7 people leaving the system. In the private health facilities access is limited and experience is required to get a job.

In the public system the average salary for a doctor after 10 years of practicing is 900 Ron (a little over 200 euro). This is one of the reasons why so many doctors and nurses are leaving. Another important reason is the lack of hope in a better life in the longer-term, like 10 years from now. The recruitment agencies are very active, facilitating the large scale migration of the health workers.

**Item 4: Impact of migration on the working conditions of the health care workers in the S-E European countries – country presentations**

Slava Zlatanova, from the Federation of Trade Unions – Health Services – CITUB, made a presentation regarding migration in Bulgaria. She mentioned the key economic factors affecting labour migration, including discrepancies in economic developments, differences in terms of technology and expertise, significant differences in salary levels, working conditions and labour market security, as well as in professional accomplishments and economic well-being.

Bulgaria has a National Strategy for Migration, Asylum and Integration 2012-2014. It aims to introduce effective national policies in managing migration processes.

In Bulgaria, there are 32,000 registered doctors and 47,000 registered healthcare specialists – nurses, midwives, rehabilitators and others. A study has revealed that the majority of doctors are unhappy in their work. The conclusions of the study were:

- 83% of public hospital doctors are unhappy with their pay.
- 49% of hospital and university clinic doctors are very dissatisfied.
- 48% of private sector doctors are happy with their job security.
- Over 47% of respondents are thinking of changing their workplace. Of those, 78.4% are considering going overseas, 16.3% moving from the public to the private sector, and 5% are even considering changing their profession.
One of the reasons for dissatisfaction is the health managers’ appointment on political grounds rather than for their competence.

The data analysis shows that 13% of the doctors who are leaving the country are aged 30 and under, and 48% are aged 31-45. Of those, 11.3% are internal medicine specialists, followed by anaesthesiologists and other specialists. The countries they most often emigrate to are Germany, France and the United Kingdom.

There is a high risk of increased healthcare workers shortage in Bulgaria. Over 50% of the practising doctors are aged over 50 and 20% have reached the retirement age. A total of 1,293 nurses left Bulgaria in 2011; the qualifications of 1/3 of them were automatically recognised, whereas 2/3 are working as caregivers.

There are parts in Bulgaria where there is a ratio of one nurse to one doctor, although 2 nurses to one doctor would be required.

Another alarming aspect is the big regional discrepancies. There are areas without any doctor or medical care available. The continued emigration of medical staff will aggravate the lack of medical professionals and the quality of the health services.

The unions consider that all the players must be included in the debate on Bulgaria’s healthcare strategy for the next 10 years. A clear professional and political vision must be formulated. The policies of retention of medical specialists both in their profession and in the country must address the fundamental reasons for leaving.

Slava’s presentation was followed by comments from the other Bulgarian participants who added that political fluctuations had made social dialogue difficult in the last years, with 3 ministers being changed in 5 years and 2 managers of the health insurance agency. The unions had succeeded to get a 10-15% increase for various categories of health workers. They were also negotiating for better working conditions in order to keep the professionals in the country. Small steps had been made to help health workers in terms of their professional qualification. More funding had been made available following the trade union and health organizations push, but the ministry of health was changing mentality very slowly.

In the areas of anaesthesia, pathology and forensic medicine there is a deficit of professionals. The government will stimulate these specialties with funds from the EU. Unfortunately, even at a EU level health is not regarded as a high priority.

The Bulgarian unions have signed bilateral cooperation agreements with unions from the countries of destination for the migrant workers, such as Spain, Italy, Greece, England and in preparation with Austria. The transport workers federation has even issued a membership card which makes it possible for a union member to join the union in any other country. PSI and EPSU were requested to help with the bilateral contacts.
Odile Frank commented that PSI could have a global policy with respect to the approach unions in receiving countries could have towards migrant health workers. PSI could share information with all the affiliates about international instruments and agreements in force regarding migrants’ rights. Education programmes for emigrants as well as affiliates in receiving countries would also be a good tool. International organizations, such as WHO and UN, have developed useful policies on ethical recruitment that could be useful to the unions.

Mathias Maucher asked what the bilateral agreements contained and why 1/3 of the applications for recognition of professional qualification of the Bulgarian nurses were turned down.

The response was that there was no documented information regarding problems related to recognition of nurses qualification. In some cases, the migrant nurses chose to work in social services because they were better paid. In principle, there was no problem for Bulgarian nurses to get a job in another country.

As concerns bilateral agreements, such agreements were negotiated by the national confederations for all the sectors. They provided concrete information regarding union contacts in the destination countries. Some models existed also in PSI, including in the PSI project on migration. EPSU could play an active role in facilitating bilateral agreements.

Emilia Bacheva, from the Medical Federation – Podkrepa, mentioned that the unions had already raised the issue of the transfer of union membership to other countries and the use of electronic membership cards and suggested that it was an idea worth trying.

Claudia Petcu, from the Romanian Trade Union Federation Sanitas, made a brief presentation of the situation in Romania, where changes in the health system were happening very fast and the unions had to react very quickly so that little time was left for other work. The unions were interested to maintain their membership, but they were losing many members through emigration. The high migration rate, alongside with the government’s policy to block the vacant jobs and allow hiring one new employee to 7 leaving the system had determined important staff shortages in hospitals. Some of the hospitals had to be closed during summer so people working there could take their holidays. The government had shut down many hospitals and the consequence was an increase in the mortality rate in the respective areas.

Statistics showed that since 2007, when Romania joined the EU, until February 2013 some 28,000 doctors and 17,000 nurses had put forward emigration files of which 80% had been validated in terms of diploma recognition, language skills, etc.

Recognition of qualification did not pose many problems. The training system in Romania had been modified so that nurses were getting a university degree upon graduation. In other EU countries lower qualification was required, while Romania
was imposed to introduce higher education system for nurses. There was a need for a unitary policy in the EU with regard to professional qualifications.

Item 5: Health worker mobility and employment relations responses in Romania – Presentation by Dr Steve Shelley, Hertfordshire University, UK

Dr. Steve Shelley informed that in UK the restructuring of the health services involves outsourcing to private care providers. Individual employers decide whether to employ a migrant health worker or not. The main qualities they are seeking after are interpersonal skills, team working, ability to work with patients. Private employers are not so tough about recruitment which could contribute to de-skilling of work.

The study of Romania was part of an EPSU Europe-wide project (cf. for the outcomes: http://www.epsu.org/a/8920). A team made up of 4 people from Hertfordshire University, UK, worked on the EPSU project and Steve did the research on Romania. He visited Romania in January 2012, travelled in 3 cities in the country, spoke with government officials, trade union officers, hospital managers, doctors and nurses. His findings showed that the Romanian health system is changing, from the centralised form to a mix of centralised and decentralised system. Hospitals are run by the government (58), but also by municipalities, county and city councils. Privatisation represented the lowest proportion in the EU a couple of years ago, but has been growing very fast. Some specialities are more open to privatisation than others, such as gynaecology which is attractive to profit making.

During the research, it was difficult finding out the number of migrants, as precise data were available. It is estimated that approximately 3% of the doctors and 5-10% of the nurses are leaving every year. As for the destination, in the beginning it was mostly towards the ‘romance’ countries, Italy, France, Spain, but recently people have shown more desire to move to the UK or Scandinavia.

Migration affects specialist staff more than general staff. Many of the migrants are young females. There are important regional variations. Many health professionals are leaving the country or moving to urban areas or just not willing to work in the rural area. The conclusion is that Romania is not just a sender of migrant health staff, it also has an internal migration.

Circular and return migration exists to some extent, in some cases emigrants come back and resume their jobs – the law allows them 2 years absence while keeping their jobs. But there are also cases of people who may go to the private sector or to other activities. In gynaecology, for instance, more staff were lost to the private sector than to migration.
National training planning is absent. There are frequent negative media stories about informal payments to people working in health care facilities.

The EU accession and the economic crisis have contributed to the state of things. More recently, recruitment to countries like Spain and Italy has decreased due to the impact of the crisis on these countries.

In Romania, it is possible to select health workers within the limit of those who have left or died or when the situation becomes really critical, like one nurse doing the work of 3-4 and in case he/she leaves the facility would have to be shut down.

In terms of the restructuring process, hospital mergers have been high on the government’s agenda.

After Steve’s presentation, Claudia Petcu, General-Secretary of Sanitas federation, commented that things had changed in the last months and whereas until 2013 public health facilities could hire one new person for 7 others leaving the system, since 2013 the ratio was one-on-one applied for future vacancies only. That was so because of the staff shortage which had become critical. The work volume was so high, that there were places where nurses could not take their annual leave because there were no others to cover for their absence. On top of that, in some cases they didn’t get paid for over time.

Eighty hospitals had been shut down of which only 2 were reopened afterwards. The staff who used to work in the 80 hospitals had been either redistributed to other medical centres or forced to retire. Many had refused to commute 40-50 km/day, without additional pay and with a salary of less than 180 euro/month, for the auxiliary staff.

One positive change was the fact that privatisation, much flagged by the previous government, had beed avoided through the efforts of the civic society. Unfortunately that had not been a union initiative.

Maria Morarescu, General Secretary of Hipocrat federation, expressed her agreement with regard to Steve’s research and conclusions and expressed her union’s readiness to work with him in future if the study continued.

One recommendation regarding the future work was to speak with some Romanian migrants working in the UK.

**Item 6: PSI Strategy for the Health Care Sector – Odile Frank, PSI Health Officer**

Odile Frank introduced the PSI Programme of Action 2013-2017 (Resolution no.1) which includes migration among its priority topics. The Programme includes proposals for the work in the next 5 years in the health sector.
One of the main objectives is achieving social justice through trade union rights and quality public services. The UN Social Protection Floor provides that all people should have access to social protection. The Floor is co-led by the ILO and WHO and involving 17 collaborating agencies, including the IMF and the WB.

The Social Protection Floor provides for guarantees of two types: basic income security and universal access to essential affordable social services in the areas of health, water and sanitation, education, food, housing and others.

The Social Protection Floor is one of the 4 pillars in the ILO Decent Work Agenda and a core part of the Global Jobs Pact. The ILO Social Protection Floors Recommendation no.202 of 2012 provides that “all in need have access to health care” and “persons in need of health care should not face hardship and an increased risk of poverty due to the financial consequences of accessing essential health care”.

PSI will start a wage indicator survey in 2013. The survey will be done by subgroups of people engaged in different occupations. The Health Services Taskforce represents all health and social care workers. The sub-groups will aim to find out about individual needs of the various groups. High priority will be given to health and safety.

PSI will develop specific strategies to address migration issues in all sectors. For the social services, one objective is to see where they are hidden in all the affiliates’ structures globally. A detailed plan will be developed for collecting information that maps the occupations in health: salaries, working conditions, employment conditions. An Ethical Recruitment campaign will be developed, focusing on the implementation of the WHO Code of Practice. The main areas of activity will be: multi-sectoral alliance building, mapping of recruitment practices and protecting migrant workers’ rights.

In 2013, PSI will coordinate the affiliates’ action at the Third Global Forum for Human Resources in Health to oppose outsourcing and support better remuneration for health workers. A detailed analysis of the trends in the health and social services sector will be prepared and a set of options for action will be presented to the Executive Board meeting of 2014.

A professional sub-network for nurses will be developed, dealing with issues specific to their profession, such as health and safety, working conditions and employment conditions.

A strategy for social services work will be presented to the 2013 Steering Committee meeting.
In order to achieve the best results, it is important for the unions to strengthen their ties with the civil society.

At the end of Odile’s presentation, Ivan Kokalov commented that in Bulgaria the unions had succeeded to stop privatization. In some cases, the results had not been necessarily positive, the conditions in some hospitals having deteriorated because the municipalities running them had not invested to improve them. All public hospitals were funded from a public budget. Transparency of how the money was spent was an important issue.

Odile replied that privatisation starts to exclude people from access to services. In general, after privatisation services tend to be good, but then the private employers start to greed and exclude people from access.

**Item 7: Testimony of a Romanian migrant health care worker**

Dan, a member of Sanitas federation, spoke about his experience working in an Italian hospital for 2 years. It had been a positive experience, he had joined the Italian college of nurses and had had no problem related to his work. The only problem related to payment had been with the cooperative in Rome which had been his contact initially, but with the help of an Italian trade union, of which he was not a member, he had been able to get his money back. The cooperative was buying workplaces in some hospitals and then hiring staff and paying them.

In Italy, the working conditions were much better than in Romania, the relationship between co-workers were also better, job descriptions more clear and the pay by far higher. The ratio nurses/patients was 1/10. There had been no problems with the recognition of his professional qualification in Italy. Dan had felt more respected and better treated in Italy than at home and was very content with his personal and professional development. He had returned after a while and then had left again to Lombardia, also in Italy, this time through a recruitment agency. Again no problem in Italy. Upon his return to Romania, he felt disappointed by the working conditions and was prepared to leave again. Out of the 40 Romanians who had left Romania together with Dan, only 2 had returned in the country. His advice for his colleagues – go and work abroad at least for one year.

Claudia Petcu commented that Dan’s was a happy case and that 90% of the migration cases were like that. Discrimination appears in the street, not at the workplace and problems exist more often with other migrant nurses.

The main driving forces for emigration were the lack of perspective and the lack of respect. Generally, those who were leaving were around 40 years old and trained in the classic education system, which was much better than the one used in the last years, following the reform of the education curriculum.
But not all the cases of migration for work in other countries had been equally happy. Rozalia, another generalist nurse, member of Sanitas federation, was happy to be back in the country. She had left for Spain in 2007, on her own, and it had taken her 2 years and a half and a lot of money to have her documents legalised at the ministry of education in Madrid. Finally her diploma was recognised but her studies qualified her only as an assistant nurse, because in Spain nurses had advanced studies and the Romanian system was not in line with this requirement at that time.

People in Spain had behaved better or worse, depending on the persons. Initially, there had been nobody to guide her and she had had no contact with the union. In addition, the image of Romanians in general was not good in Spain. Finally Rozalia attended a course for social home care and met a Spanish woman who helped her very much integrate at work. But the main problem remained homesickness.

Another case was that of Mirela. She had left in 2000 through a recruitment agency and had spent 4 years in Italy, as provided in the contract. Working in a hospital, she had been very well treated and integrated and she appreciated very positively the hospital management. After that experience, it had been impossible to integrate again in a Romanian hospital – previously she has worked in an oncology hospital, and finally she abandoned her profession and started another kind of business. Other colleagues who had found jobs in England and Ireland had had similar experiences. Out of 30 nurses who had left together, only 2 had returned.

In the comments that followed the 3 case studies, the Romanian participants stated that the government had not adopted any strategy regarding the training and job assignments in the health system. After accomplishing their studies, many young graduates would be unemployed. There was no correlation between supply and demand of health care workers. There were many nurses trained in private schools whom the labour market could not absorb due to the job freezing. In addition, most graduates were seeking jobs in the bigger towns avoiding the countryside. The costs for commuting were high compared to the low salaries (less than 300 euro per month) and paying the rent would eat up more than half of the income.

Sanitas federation informs members regularly about the existing contacts between the Romanian federation/confederation with other trade unions from other countries. In some countries with which cooperation agreements have been signed, local unions will contact the migrant workers as soon as they arrive.

**Item 8: EPSU Policy for the Health Care Sector – Mathias Maucher,**
**EPSU Policy Officer “Health and Social Services”**

Mathias Maucher referred to the EU legislation, starting with the Working Time Directive which affects health, social services, firefighters and special sectors like nuclear power, more than others. In relation to that Directive, it had not yet been possible to find a compromise with employers on the definition of working time and
the opt out procedure (as the exception and only under the precondition that it is being based on a collective agreement). Unfortunately, no initiative was expected until the next EU elections in 2014.

With regard to Recognition of Professional Qualifications, there were various points of view among the trade unions affiliated to EPSU, e.g. the admission condition to the profession of general nurse in term of number of years in secondary school. Amongst others the UK unions wanted stricter rules on language knowledge. It was important to know the stand point of the other countries, particularly the sending countries.

Continued Professional Development/Lifelong Learning was a subject on which it had not been possible to get employers agree that it is employers’ obligation to provide continuous professional training. The issue was still under discussion.

In relation to the research done by Steve Shelley and the team from Hertfordshire University, all the recommendations formulated by the researchers, except for one, refer to the receiving countries. It is time to digest what had been done until now and decide what to put on the Programme of Action and 2014 Congress Resolutions of EPSU in preparation for the EU elections of next year.

As concerns the European social dialogue in the hospital sector, the main issues on the agenda are recruitment and retention; ageing workforce; (code of conduct on) ethical cross-border recruitment; prevention from sharps injuries; prevention of third-party violence and harassment; recognition of professional qualifications. Bulgaria and Romania are well represented on the trade union side but there are no employers partners from these countries.

In relation to Sharps Injuries, the social partners, EPSU and HOSPEEM, had negotiated an agreement in 2009 which the governments had to implement and which was transposed into the EU Directive 2010/32/EU on the prevention of sharps injuries in the hospital and health sector. The Directive makes the EPSU-HOSPEEM Framework Agreement legally binding, having to be transposed into national law and/or procedures within 3 years. EU is going to review if they do so. The ministries of health should work with the unions on its implementation.

EPSU together with HOSPEEM were running a joint project on the prevention from sharps injuries (http://www.epsu.org/r/629) which contained 3 regional seminars of which the third one, due to take place on 16 April in Vienna (http://www.epsu.org/a/9116 and http://www.epsu.org/a/9396), involved the CEE and SEE countries and the German speaking ones as well as EPSU affiliates from some of the former CIS countries. The unions from every EU country were entitled to 2 sponsorships at least, maybe more because employers didn’t have members in all those countries. The conclusions of the project were to be drawn in a final conference scheduled for 20 June in Barcelona.
Another project organised jointly by the European social partners, including EPSU and HOSPEEM, had focused on third party violence. The project had included 3 regional seminars and a final conference organised in 2011.

For the future work in the European Social Dialogue Committee, EPSU and HOSPEEM had agreed on a framework of actions on “Recruitment and Retention” from 2011 on.

More info on health and social services was available on the last slide of Mathias’ presentation and on the website of the European Federation of Public Service Unions (EPSU): Sector “health and social services”: http://www.epsu.org/r/2.

In the discussions that followed Mathias’ presentation, Slava Zlatanova informed that the Bulgarian vice-minister of health and president of the health insurance company had participated in the first meetings of the European social dialogue committee. But due to the frequent changes in the government, it was not possible to have a stable social partner. The unions were still trying to include the Bulgarian employers in the European committee.

Ivan Kokalov added that in Bulgaria there was good social dialogue at national and regional level, but not at European level. Language was one of the problems. There was one organisation representing employers in municipal hospitals in the private sector, registered with the Chamber of Commerce. But those employers did not appreciate social dialogue at European level.

In Bulgaria, there are social dialogue structures in the health sector, including in the big hospitals were there are also health and safety committees which work pretty well. These committees should meet every 3 months and propose measures to the employers to improve the working conditions. Until a few years ago, the national committee discussed with the labour inspectorate the working conditions. Now they are reviewing the work of the committee. All the cases of violence and stress have to be reported and the materials developed by the unions in a previous project run together with PSI are very useful. A manual on health and safety is available at the PSI head office.

The Bulgarian health unions are running a project on labour protection in cooperation with the Norwegian colleagues from LO funded by the Norwegian government. The unions intend to have a workers’ representative in the committee on labour protection which should be able to take measures when people’s safety is at risk. The main issue is how to increase the competencies of the social dialogue structures on health and safety.

At the S-E European Health Seminar organised by PSI in Istanbul in 2009, with the participation of Jose Mancias, people discussed about an electronic network for the SEE health unions. The idea is still valid and such a network would be useful for the exchange of information and experience between the countries in the region. Also
very useful would be exchanges between Bulgaria and Romania with regard to the implementation of the EU legislation at a national level.

In Romania, social dialogue is not working well at all in the case of the territorial labour inspectorates. Even after the intervention of the mediation commission they refused to cooperate.

**Item 9: Institutional framework for workers’ participation in social dialogue at a national level in the health care sector - country contributions**

Ivan Kokalov reinforced the idea that in Bulgaria, at national level social dialogue was working well, including in relation to legislation. Even in the crisis context progress had been made and the government had signed a new branch collective agreement which provided for a wage increase of up to 10-15% for some categories of employees. Employers were not happy with that.

Funding of health services was an issue discussed in the social dialogue meetings. The unions were using as an argument the fact that a proper funding of the health services would slow down the emigration process. They were working together with other professional organisations of doctors and nurses. Constant updates on the number of migrant health workers were available.

The restrictive policy for the health sector and the wage freeze of the last years since the crisis had started were the main reasons for so many people leaving the country. The IMF and the World Bank had admitted that the austerity measures had not led to positive results, but had increased poverty. There was a need for public investment. People were in the street, protesting against the low wages and poor living conditions. Social dialogue was a tool to solve the problems.

There was a clause in the law on labour protection which provided for setting up a fund of 2.5 million euro for health and safety. The money could also be used to organise training for union representatives on health and safety issues. A similar program was run by employers for small and medium enterprises.

As concerns Romania, Claudia Petcu informed that the previous government had modified the legislation on trade union activities, the Labour Code and the law on social dialogue without any consultation with the unions, through engagement of the government’s liability. With the new legislation, the national trade union centres had lost their main role – negotiating the collective agreement at a national level as the minimum frame from which negotiations could be carried further at sectoral or local level. The various branches of activity had been turned into sectors and re-arranged in such a way that it had become extremely difficult for the unions to gain representativeness in the respective sectors. The health sector had been put together with the sanitary veterinary sector, where unions did not exist, therefore it was very difficult to get recognition as a representative union for that weird combination of sectors.
The legal changes forbade strikes during the life of a collective agreement and encouraged the replacement of the contracts for an indefinite period of time with the contracts for a determined period of time which were becoming more and more frequent. The probation period had been extended from 3 to 6 months after which the person could be fired without any obligation on behalf of the employer. Since those legal changes had been introduced, there had been no social dialogue in Romania and the Economic and Social Council was not functioning anymore.

Still, some progress had been made after the new government had come into office, trying to revitalize the social dialogue commission at the level of the health ministry. A collective agreement had been signed with some positive provisions in it, such as a 13% wage increase for the years 2013-2014 plus getting back all the benefits lost in 2009.

Item 10: Priorities for the trade union policies in the health sector at national level – country presentations

For the Romanian unions, priority was given to getting back all the rights of their members that had been taken away in the last 3 years. One main issue on the agenda was re-negotiating the collective agreement at sectoral level and re-instating the old labour legislation that had been in force prior to 2011. The unions were putting pressure on the ministry of health to make use of social dialogue and consult with the unions for further changes. The new team installed at the ministry of health seemed positive towards social dialogue, but the unions remained cautious judging by their experience with the previous government.

No new health law was envisaged, but the intention was to modify and improve the existing one. Privatisation and contracting out were on the government’s agenda. The unions could not oppose it completely, but were trying to protect the interests of their members and of the patients as much as possible.

Another important item on the government’s agenda was regionalization which was going to affect the unions very much. The process implied local public health centres being dissolved and with it the loss of trade union members. Also, the health workers would no longer pertain to the ministry of health but to the local authorities. The unions wanted the ministry of health to maintain the control over those health facilities.

The ministry of health had promised to consult with the unions and had formulated a proposal for an agreement with Sanitas federation with regard to wages, working conditions, evaluation of health workers performance, regionalization. The union was also negotiating with the ministry of labour for social workers who were subordinated to the local administrations and were low paid and working under hard conditions. The difficulty was that local administration authorities did not have an
employers’ structure and it was hard to negotiate with them. The unions wanted to take the wage system of the health workers out of the state budget.

In Bulgaria, the unions had succeeded to negotiate a good collective agreement at national level. Radoslav Plamen informed that wage increases had been negotiated in 2 stages: July 2012 and January 2013. Special payment was negotiated for the night shifts (100%) and for on-call work (100%). Negotiations continued for preserving the jobs and ensuring an adequate number of specialists. The standard for the doctors’ ratio was observed, but not for nurses. There were not enough specialists and they were overworked, often becoming themselves patients and sometimes making mistakes that would affect people’s health or even lives.

Over 70% of the doctors and nurses were over 50, even over 60. In 10 years’ time the situation would become very critical. New hospitals and health facilities were being built, but only in bigger cities. In small towns the medical equipment was very old, dating since the 80s. The unions were asking for a plan of restructuring those facilities. Some departments in the state hospitals were privatised. There were 73 hospitals in Sofia, many of them private. In the private hospitals, there were no unions and no collective agreements and salaries were very low. In Bulgaria, nurses were making on average 200 euro/month, compared to Germany were they were offered 2,500 euro/month, a good enough reason for people to migrate.

Collective agreements were compulsory in all the Bulgarian health facilities, whether public or private. The employees preserved their rights after privatisation, but the problem was for how long. A series of services were contracted out, such as cleaning, catering, etc.

The big municipal hospitals had not been privatised. There was competition between the private and the public health services. Conditions in the new hospitals were better, of course paid for. The good specialists were attracted to the private sector and in most cases the patients would follow them.

The government did not assume responsibility for the provision of quality health care. In the country side there were no doctors and the unions were trying to negotiate special bonuses for the health workers who were willing to go to the countryside.

One important issue for the unions was improving their public image and their relationship with the media. Events like the Migration conference were important and it was good for the unions to use the media to publicise them. Claudia Petcu informed that the union media were going to write about it and put the event on the website, but the central media were only interested in scandals.

Slava Zlatanova informed that in Bulgaria the situation was better, when the unions negotiated at national level, they would invite the press when the agreement was finalised and inform them about the negotiations. Also, when strikes and protest
actions were organised by the unions, they were always mediated. When a mayor concluded a CBA, he/she would want to make it public and invite the media.

For the unions, in the context of all the difficulties they had to deal with on a daily basis, migration was not quite on top of their agenda. Maybe after the conference organised by EPSU the unions would pay more attention to this topic. In general, if members call and ask for help, they will receive information and contacts abroad, but the unions have no strategy as such in this area.

**Item 11: Trade union work on migration at national/regional level**

The participants worked in groups and formulated some ideas with regard to the work the unions should/would do in relation to migration.

Margarita Petrova, from Medical federation – Podkrepa, presented the views of the Bulgarian group. The unions needed to make an analysis of the factors that led to migration, which represented a threat to the union stability. Among those, the lack of an adequate policy for human resources in the health sector, hard work, low pay, lack of equipment, lack of perspectives for career development were determining factors for migration of the health professionals. Also an important contribution was considered the intense activity of the recruitment agencies.

The union policy vis-a-vis these aspects contained:

1. Changing the working conditions, increasing wages and possibilities for career development. In order to obtain that, the unions need to use social dialogue and lobby the politicians at national level to change the health legislation and the training system;
2. Helping members who want to work abroad with information about the destination countries;
3. Concluding bilateral agreements with trade unions from the countries of destination - EPSU could help to establish the contacts with those unions;
4. Introduce electronic membership cards for the trade union members that could be used in other countries in case of migration

From the Romanian participants, the focus was on:

1. Setting up counselling centres for migrant workers in the destination countries;
2. Developing a website (by EPSU) with a forum for discussions regarding the conditions for migrant workers in the destination countries;
3. Developing information materials for people who want to go and work abroad;
4. Educating the union representatives on issues related to migration;
5. Setting up local information centers for those who want to leave the country;
6. Collaboration with other professional organisations of health care workers to integrate migration on the agenda of various activities organised for/by health professionals;
7. Cooperation with international organisations with regard to updates on legislative changes in the countries of destination.

It is important to find the ways by which the health professionals wouldn’t be forced to leave the country on a large scale. In a country like Romania, where one in 5 nurses are leaving the country, in the shortest of time the staff crisis will become very critical.

Item 12: Integrating national/regional work into the EPSU/PSI policy for the health care sector; contributions to the European Health Sector Social Dialogue re migration of the health workforce

Mathias Maucher summarised the main points discussed in the 2 days of the conference as follows:
- EPSU’s role in fostering relations between trade unions in the countries of origin/destination for health workers migration;
- Useful to share experience and information - examples of cooperation agreements from Bulgaria and Romania to be circulated and posted on the website;
- Proposal by Bulgarian and Romanian affiliates for EPSU to set up, on the website of EPSU, a resource centre with regard to migration;
- EPSU to mobilise members in the receiving countries to share information with the migrant workers in their own languages.

The concerns of the SEE unions with regard to the health workers migration and its impact on the health care services in their countries would continue to be on the agenda of the social dialogue committee at a European level. The union representatives from Bulgaria and Romania were encouraged to continue to participate in this committee and inform their colleagues from other EU countries about their problems and together try to find the best proposals for solutions to be put forward to the EU in order to address them.