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 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 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 the World Health Report (2006) estimation of a shortage of more than 4 million health workers across the world, of which one million in EU alone. The EU enlargement has 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.
Problems with the implementation of the EU documents regarding recognition of professional qualifications still existed in the new member states. 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 exchanging 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 Romanian nurses from among the most competent have emigrated in the last years, not all of them 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 hard to be covered by those who continue to work in the country, overwhelmed by the workload. There are hospitals where fully equipped sections cannot be used for lack of qualified staff, particularly anaesthesiologists.

Many of the new graduates cannot be absorbed in the health system due to the job freeze whereby only one new person can be employed to 7 leaving the system.

In the public system the average salary for a doctor after 10 years of practice is 900 Ron (a little over 200 euro), one reason for migration. Another reason is the lack of hope in a better life in the longer-term. 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. 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 the doctors are unhappy with their work, over 47% 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.

The data analysis shows that 13% of the doctors who are leaving are aged 30 and under, and 48% are aged 31-45. 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; 1/3 are working in their specialty whereas 2/3 are working as caregivers.

The unions consider that there is a need for developing a clear strategy for the next 10 years to which all the players concerned should participate.

Slava’s presentation was followed by comments regarding the political fluctuations which was making social dialogue difficult, with 3 ministers and 2 managers of the health insurance agency changed in 5 years. The unions succeeded to get a 10-15% wage increase for various categories of health workers. They were also negotiating for better working conditions. More funding was made available following the trade union and health organizations’ push, but the ministry of health was changing mentality very slowly. The government was planning to stimulate those areas where there was a deficit of professionals, anaesthesia, pathology and forensic medicine, with funds from the EU. Unfortunately, even at the EU level health was 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 on the approach of the unions in receiving countries towards migrant health workers. PSI could share information with all the affiliates about international instruments and agreements regarding migrants’ rights. Education programmes for emigrants as well as for affiliates in receiving countries were be a good tool. International organizations, such as WHO and UN, have developed policies on ethical recruitment that could be useful to the unions.

Claudia Petcu informed that in Romania 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 making efforts to maintain membership, but they were losing members through emigration. The high migration rate, alongside with the job reduction by the 1/7 ratio had determined important staff shortages in the hospitals. Some hospitals had to close during summer so people working there could take their holidays. The government had shut down many hospitals and the mortality rate in the respective areas had increased.

Statistics showed that since 2007, when Romania joined the EU, 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. 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 restructuring of the health services involved outsourcing to private care providers. Individual employers decided whether to employ a migrant health worker or not. Private employers were not so tough about recruitment which could contribute to de-skilling of work.

The study on Romania was part of an EPSU Europe-wide project which involved a team of 4 persons from Hertfordshire University, UK (cf. for the outcomes: http://www.epsu.org/a/8920). Steve Shelley had done the research on Romania. The study showed that the Romanian health system was changing from the centralised form to a mix of centralised and decentralised system. Privatisation was growing very fast.

Precise data regarding the number of migrant health workers were not available, but it was estimated that approximately 3% of the doctors and 5-10% of the nurses were leaving every year. Initially the main destinations were the ‘romance’ countries, Italy, France, Spain, but there was more and more interest in the UK and Scandinavia. Due to the economic crisis, recruitment to Spain and Italy had decreased.

Migration affected specialist staff more than general staff. Many of the migrants were young females. There were important regional variations. Many health professionals were leaving the country or moving to urban areas, not willing to work in the rural area. Circular and return migration existed to some extent, in some cases emigrants came back and resumed their jobs – the law allowed them 2 years absence while keeping their jobs. There were also people going 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 was absent. There were frequent negative media stories about informal payments to people working in health care facilities. Hospital mergers were high on the government’s agenda.

After Steve’s presentation, the Romanian participants informed that things had changed since 2012 and the ratio of employment was one-on-one since January 2013. Eighty hospitals had been shut down and only 2 reopened afterwards. The staff had been redistributed to other medical centres or forced to retire.

One positive change was the fact that privatisation, much flagged by the previous government, had been avoided through the efforts of the civic society.

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 for the next 5 years. The UN Social Protection Floor guarantees the 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 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 done by sub-groups of people in different occupations. 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. For social services, one objective is to see where they are in the affiliates’ structures globally. Information will be collected to map 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 health and social services will be made and a set of options for action will be presented to the EB meeting of 2014.

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

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 being very poor because the municipalities were not investing to improve them. All public hospitals were funded from a public budget. Transparency of how the money was spent was important.

**Item 7: Testimony of Romanian migrant health care workers**

Dan, a member of Sanitas federation, spoke about his experience 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 working conditions had been much better than in Romania, the relationship between co-workers also better, job descriptions more clear and the pay by far higher. There had been no problems with the recognition of the professional qualification. 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 to Romania and then had left again also to Italy, through a recruitment agency. Again no problem in Italy. Upon his return to Romania, he had felt disappointed 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 90% of the migration cases were like that. 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.
A different case was that of Rozalia, another generalist nurse, member of Sanitas federation, who was happy to be back in the country. She had left for Spain in 2007 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 in Spain her studies qualified her only as an assistant nurse. Rozalia had attended a course for social home care and had succeeded to get a job.

Another case was that of Mirela, a nurse who had left in 2000 through a recruitment agency and had spent 4 years in Italy. Working in a hospital, she had been very well treated and integrated and she had appreciated very positively the hospital management. After that experience, it had been impossible to work again in a Romanian hospital and finally she abandoned her profession and started another kind of business. Other colleagues who had emigrated to England or Ireland had had similar experiences. Out of 30 nurses who had migrated, only 2 had returned.

The Romanian government had no strategy regarding training and job assignments in the health system. 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. Most graduates were seeking jobs in the bigger towns avoiding the countryside. The costs for commuting were high compared to the low salaries and paying the rent would take up more than half of their income.

Sanitas federation was informing its members about the existing contacts with other trade unions from other countries. In some destination countries, local unions would contact the migrant workers as soon as they arrived.

**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 different 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 in discussion.

As concerns the European social dialogue in the hospital sector, the main issues on the agenda were: 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 were well represented on the trade union side but there were 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 made the EPSU-HOSPEEM Framework Agreement legally binding, having to be transposed into national law and/or procedures within 3 years. EU was going to review if they did so. The ministries of health had to work with the unions on its implementation.

EPSU together with HOSPEEM were running a joint project on the prevention of 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, involved the CEE and SEE countries and the German speaking ones(http://www.epsu.org/a/9116 and http://www.epsu.org/a/9396). 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 EPSU: http://www.epsu.org/r/2.

In the discussions that followed, Slava Zlatanova informed that the Bulgarian vice-minister of health and the 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.

Social dialogue at national and regional level was good, but not at European level. Language was one of the problems. There was one employers’ organisation from municipal hospitals in the private sector, registered with the Chamber of Commerce. But those employers did not appreciate social dialogue at European level.

Social dialogue structures existed in the big hospitals where there were also health and safety committees which worked pretty well. Those committees were meeting every 3 months and proposing measures to improve the working conditions. A good manual on health and safety was available at the PSI head office.

The Bulgarian health unions were running a project on labour protection in cooperation with the Norwegian colleagues from LO funded by the Norwegian government. The unions intended to have a workers’ representative in the committee on labour protection. The main issue was 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, people had discussed about an electronic network for the SEE health unions. The network would be useful for the exchange of information and experience in the region.
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 social dialogue was working well at national level. Even in the crisis context, progress had been made and the government had signed a new collective agreement which provided for a wage increase 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 the argument that proper funding of the health services would slow down the emigration process. The restrictive policy for the health sector and the wage freeze of the last years were the main reasons for so many people leaving the country. There was a need for public investment. The IMF and the World Bank had admitted that the austerity measures had not led to positive results, but had increased poverty. 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.

As concerns Romania, the previous government had modified the trade union law, the Labour Code and the law on social dialogue without consulting the unions. With the new legislation, the national trade union centres had lost their main purpose – negotiating the collective agreement at a national 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 encouraged the replacement of the contracts for an indefinite period of time with the contracts for a determined period of time. 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. With the introduction of those legal changes, social dialogue had ceased in Romania. The new government was trying to revigorate the social dialogue commission at the level of the health ministry. A collective agreement had been signed with positive provisions in it, such as a 13% wage increase for 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 lost 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 prior to 2011. The new team from the ministry of health seemed positive towards social dialogue, but the unions remained cautious.

There was a need to improve the law on health. Privatisation and contracting out were still on the government’s agenda. The unions were trying to stop it and protect the interests of their members and of the patients as much as possible.
Another important item was regionalization which implied local public health centres being dissolved and with it the loss of trade union members. 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 control over the health facilities and to take the wage system of the health workers out of the state budget.

The ministry of health had proposed an agreement to the unions with regard to wages, working conditions, evaluation of work performance, regionalization. The unions were negotiating with the ministry of labour for social workers who were subordinated to the local administrations. The difficulty was that there was no structure for the local administration authorities to negotiate with.

In Bulgaria, the unions had succeeded to negotiate a good collective agreement at national level. 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. There were not enough specialists and they were overworked, often becoming themselves patients and sometimes making mistakes.

New hospitals and health facilities were being built in bigger cities. In small towns the medical equipment was very old, since the 80s. The unions were asking for a plan to restructure 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.

Collective agreements were compulsory in all the Bulgarian health facilities, public or private. The employees preserved their rights after privatisation, but 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 facilities. 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. In the country side there were no doctors and the unions were trying to negotiate special pay for those who would be willing to go to the countryside.

One important issue for the unions was improving their public image. Events like the Migration Conference were important and it was good to use the media to publicise them. In Romania 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.

In Bulgaria the situation was better, when the unions negotiated at national level, they would invite the press and inform about the outcome of the negotiations. Also, when strikes and protest actions were organised, they were always mediated. The mayors who concluded a CBA wanted to make it public and invited the media.

After the conference organised by EPSU, the unions were determined to pay more attention to migration.
**Item 11: Trade union work on migration at national/regional level**

The participants formulated some ideas with regard to the work the unions should/would do in relation to migration. The Bulgarian group considered that the unions needed to make an analysis of the factors that led to migration, such as the lack of an adequate policy for human resources, hard work, low pay, lack of equipment, lack of perspectives for career development and also the intense activity of the recruitment.

The union policy vis-a-vis these aspects included:
1. Changing the working conditions, increasing wages and possibilities for career development - using social dialogue and lobbying the politicians at national level to change the health legislation and the training system;
2. Helping members with information about the destination countries;
3. Concluding bilateral agreements with trade unions from the countries of destination - EPSU could help establish the contacts with those unions;
4. Introducing 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 the migrants 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 centres for those who want to leave the country;
6. Collaboration with professional organisations of health care workers to integrate migration on the agenda of the various activities organised for/by health professionals;
7. Cooperation with international organisations with regard to updates on legislative changes in the countries of destination.

**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, 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.