



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

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Executive Summary and Recommendations

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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

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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.

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- 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.

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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

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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.
- 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.

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- 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.

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- 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.