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POLICY BRIEF 18

How can countries address the efficiency and equity implications of health professional mobility in Europe?

Adapting policies in the context of the WHO Code of Practice and EU freedom of movement

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KEY MESSAGES

- Health workers in the European Union (EU) are free to seek employment in another Member State as guaranteed by EU law. This mobility of health professionals changes the composition of the health workforce in source and destination countries and may aggravate or mitigate existing problems such as shortages, mal-distribution and skill-mismatches of health professionals.
- To mitigate unwanted effects and strengthen positive ones, the Member States of the World Health Organization have adopted the Global Code of Practice on the International Recruitment of Health Personnel. The Code, however, needs to be contextualized for Europe, taking into account the freedom of movement in the EU.
- Mitigating unwanted effects and strengthening positive ones is highly relevant in the EU as some Member States rely to a large extent on foreign health professionals while others experience important outflows. In the EU free mobility area, flows of health professionals are dynamic, often changing direction and magnitude, and affect all countries.
- Countries are faced with the constantly changing conundrum of efficiency and equity, that is, between the free mobility of health professionals in the European labour market on one hand, and the planning requirements of health systems ensuring universal health coverage on the other hand. It is necessary to disentangle the conundrum and make it accessible to policy-makers and stakeholders as health professional mobility:
    - has clear effects on efficiency and equity;
    - is a complex phenomenon, neither positive nor negative *per se,* but implying merits and drawbacks for both source and destination countries; and
    - affects the EU as a whole and destination and source countries simultaneously.
- Three sets of policy options can be used to address the consequences of health professional mobility on efficiency and equity at EU and country level:
    - policy options to foster health workforce sustainability;
    - policy options to manage mobility; and
    - EU action to address the consequences and opportunities of free mobility.
- Countries can choose from a wide range of policy options that correspond best with their needs (Table 2). Implementing policy options will often require strong intersectoral governance and consensus building across government departments and stakeholders.

EXECUTIVE SUMMARY

What's the problem?

The health workforce is a key contributor to the performance of health systems. Shortages, mal-distribution and skill-mismatches of health professionals are however widespread problems which can result in delayed and unsafe treatments, low quality of care outcomes and negative patient experiences. Workforce issues have immediate consequences for the efficiency and equity of health systems. The mobility and migration of health professionals change the composition of the health workforce in both source and destination countries. They may improve or aggravate health workforce problems.

To mitigate unwanted effects and strengthen positive ones, the Member States of the World Health Organization have adopted the Global Code of Practice on the International Recruitment of Health Personnel. According to the Code, recruitment shall take into account the rights, obligations and expectations of source countries, destination countries and migrant health personnel. The Code, however, needs to be contextualized with regards to the free-mobility zone of the European Union (EU). The mobility foreseen in EU legislation is, at best, indifferent with regards to health systems in source and destination countries as it focuses on the individual (health) workers and their rights. They are free to seek employment in another Member State. Countries may try to recruit ethically but it is the health workers that make the decision to move to another Member Sate. The Treaty on European Union does not foresee that health workers can be expected to consider the rights, obligations and expectations of source and destination countries.

The issue is highly relevant for Europe as some EU Member States rely to a great extent on foreign health professionals while other EU countries experience significant outflows of health workforce. Health professional mobility is dynamic and respond to events such as the EU Enlargements in 2004 and 2007 and economic and financial crisis. Destination countries become source countries and vice versa, the magnitude of in- and outflows alters substantially without warning and flows have knock-on effects on the equity and efficiency of health systems.

How do we unpack the policy conundrum?

Health professional mobility, and its consequences for equity and efficiency, is a complex phenomenon because *per se* it is neither positive nor negative for source and destination countries; its effects are changing over time, equivocal, overlapping, hard to pin down and depend on the context and governance of mobility. To unpack this conundrum we have detailed the merits and drawbacks of health professional mobility on the equity and efficiency in destination and source countries and for the EU in general.

- ***The merits of free mobility on efficiency:*** a better balance between health workforce supply and demand across Europe; an easy, cheap and fast way to close workforce gaps in destination countries, including staffing underserved areas; bringing new skills and cultural experiences to countries; in source countries, remittance of migrant workers will create national income, and outflows may also provide political stimulus to tackle workforce issues.
- ***The merits of free mobility on equity:*** the equity of opportunities for health workers; improved access for patients in destination countries when inflows fill gaps.
- ***The drawbacks of free mobility on efficiency:*** funds for training in source countries are redistributed to destination countries; planning the workforce becomes more difficult; skills of mobile health professionals in destination countries are often not used to their full potential. For destination countries, relying on foreign health workers can be an unstable way to replenish the workforce; new arrivals require time, capacity and money for induction courses, language training and mentoring; mobility may impede the addressing of underlying workforce issues. In source countries, health professionals may leave already underserved areas; mobility may lead to increased workload for those that stay behind; young leavers do not pay back to the system; and the loss of the "best and brightest" affects the capacity to address shortcomings.
- ***The drawbacks of free mobility on equity:*** existing inequities between countries can be reinforced when health professionals leave resource-strained health systems to work in more advantaged Member States; in destination countries, foreign health professionals may face discrimination, and caps on the numbers of medical students might be unfair when the system relies on foreign inflows. In source countries, not all health professionals have the same opportunities to move if family obligations or living circumstances do not allow them to exercise freedom of movement and outflows can worsen regional disparities.

What are the key policy options?

Policy options to foster health workforce sustainability For destination and source countries alike, health professional mobility is often a symptom of underlying health workforce issues. Health professionals come and go because the host system does not have sufficient workforce or lacks certain skills, and because the home system is not perceived as providing sufficient rewards and opportunities. Given the challenges which free mobility gives rise to, countries have an interest in fostering a sustainable health workforce – destination countries by addressing the reasons why the system relies on foreign inflows to replenish the health workforce, source countries by tackling the factors which lead health professionals to leave. Policy options which improve health workforce sustainability include (see Table 2):

- better health workforce intelligence and planning;
- training and adapting today's workforce;
- training tomorrow's workforce;

- domestic recruitment;
- better regional distribution; and
- retention.

Policy options to manage mobility These policy options are developed to get the best out of mobility for all parties concerned. This follows the logic that health professional mobility can contribute to strengthening health systems if "properly managed". While certain measures might contribute to reducing in- and outflows, mobility is likely to continue to grow in importance and its extent and directions remain hard to predict. In this context, no EU country can ignore mobility; destination and source countries alike have an incentive to manage mobility – at the national and international level – so as to reap its benefits and minimize negative effects. Policy options which seek to manage mobility include (Table 2):

- ethical recruitment practices;
- country-to-country collaboration;
- integration of foreign-trained/born professionals; and
- facilitated returns.

EU action to address the consequences and opportunities of free mobility Mutual recognition of diplomas and freedom of movement mean that EU health professionals increasingly form one EU health workforce. Individual Member States are not in control of in- and outflows, nor are they fully equipped to deal with the efficiency and equity concerns which mobility brings about, and yet they have come to depend on one another's workforce situations. Policy options which seek to address the consequences and opportunities of mobility at EU level can be regrouped according to four policy objectives (Table 2):

- better mobility data;
- joint planning and workforce development;
- protecting vulnerable systems; and
- protecting/promoting free mobility as a citizens' right.

What to consider when implementing?

Countries will often have to implement several policy options in parallel. The choice of policy options for implementation will need to match the destination and/or source profile of the country. Health professional mobility often affects professions, specialties and regions in different ways. This implies a need for policy coordination to ensure that measures being implemented are compatible and, where possible, reinforce one another.

Most ministries of health in Europe have limited leverage over key aspects of workforce development. Implementing policy options will therefore entail in many cases consensus building and strong intersectoral governance.

1. INTRODUCING THE EFFICIENCY-EQUITY CONUNDRUM

Freedom of movement is a citizens' right within the European Union and one of the cornerstones of EU integration. It implies that EU health professionals are free to seek work in any Member State and to move freely between EU countries. By virtue of the mutual recognition of diplomas and free mobility, the doctors, nurses, midwives, dentists and pharmacists of 32 European countries[1] can be considered to form one EU health workforce: just as the regions of a country, so do the member countries of the free mobility zone experience in- and outflows, exchanges and commuting health professionals.

The mobility of health professionals raises several questions. At the global level, awareness has developed into concern as the scale of qualified health professionals leaving developing countries causes shortages, mal-distribution and other workforce problems to worsen already vulnerable health systems (Meija, Pizurki & Royston, 1979; WHO, 2006). The WHO Global Code of Practice on the International Recruitment of Health Personnel ("the Code") officially recognizes the ethical implications that health professional migration can have for the individuals and countries involved. The Member States of the World Health Organization, including all EU Member States, adopted the Code in 2010, thereby agreeing to avoid actively recruiting health professionals from fragile systems, to favour sustainable health workforce development, and to work together for the benefit of source and destination countries, all while respecting health professionals' freedom to migrate (WHO, 2010).

Box A: The guiding principles of the WHO Code

The Code is a voluntary instrument; without in any way banning migration or international recruitment, it seeks to promote principles and practices that "mitigate the negative effects and maximize the positive effects of migration" (Art 3.4, p.2), especially for developing countries, countries with economies in transition and small island states. Among its guiding principles figures that "international migration of health personnel can make a sound contribution to the development and strengthening of health systems" (Art 3.2, p.2) (WHO, 2010).

[1] Directive 2004/38/EC on the right of citizens of the Union and their family members to move and reside freely within the territory of the Member States applies to the 28 EU Member States and the three EFTA EEA (Iceland, Liechtenstein and Norway). Switzerland is not a Member State of the European Union but has a bilateral agreement on the free movement of persons with the EU. The analysis of free mobility in the EU therefore extends to Iceland, Liechtenstein, Norway and Switzerland in the same manner as to EU Member States. For reasons of simplicity, the term EU will be used to cover these 32 countries in this brief.

Inside the EU, the movement of EU health professionals is not migration but *mobility*: whereas citizens from third countries are subject to national immigration laws, lengthy recognition procedures and labour market policies when seeking to enter a country, an extensive body of EU legislation protects and promotes the freedom of movement of EU citizens. Specifically, Directive 2005/36/EC facilitates the automatic recognition of qualifications of doctors, nurses, midwifes, dentists and pharmacists with an EU country and the Treaty on European Union entitles EU citizens to seek employment, work and settle down in any Member State. Free mobility is legally binding and may not be hindered by governments or other actors. Thanks to a uniform regulatory framework, the mutual recognition of qualifications, relatively short distances between EU countries, and cultural and linguistic proximity shared by many European countries, mobility is easier, cheaper and faster than migration.

Box B: Contextualizing the WHO global code for the EU free-mobility zone

International recruitment, according to the Code, shall take into account the rights, obligations and expectations of source countries, destination countries and migrant health personnel. International recruitment is health system specific and implies some coordination or planning within and between countries.

The mobility foreseen in the Treaty on the Functioning of the European Union is, at best, indifferent with regards to health systems in source and destination countries as it focuses on the individual (health) workers and their rights. The freedom of workers shall be secured within the Union (TFEU, Art 45 para 1). It shall entail the right […] to accept offers of employment actually made; to move freely within the territory of Member States for this purpose; to stay in a Member State for the purpose of employment […]; to remain in the territory of a Member State after having been employed in that State […] (TFEU, Art 45 para 3). Member States shall, within the framework of a joint programme, encourage the exchange of young workers (TFEU, Art 47).

Countries may try to recruit ethically but it is the health workers that make the decision, and the Treaty does not foresee that health workers can be expected to consider rights, obligations and expectations of source and destination countries.

Therefore, to be relevant and effective, the Code needs to be adapted to the conditions of the free-mobility zone.

Health professional mobility became an issue as the Union prepared to expand its membership, and hence the free mobility zone, to 12 new Member States in the first decade of the 2000s.[2] With substantial differences in living standards between the "old" and "new" Member States, it was expected that Enlargement would lead to massive movements. Fearful of the potential effects, countries such as Austria, Denmark, Germany and Switzerland reacted by restricting access to their labour markets for all categories of workers during transitional periods; others (e.g. Ireland, Sweden and the UK[3]) did not raise barriers to the influx of foreign workforce, including to fill service gaps and vacancies in the health system (Ognyanova et al., 2014; Young, Humphrey & Rafferty, 2014). While health professional mobility did not reach the predicted levels (Maier et al., 2011; Ognyanova et al., 2014), intra-EU flows of health professionals are substantial and growing, and highlight that some health systems are considerably better off than others (Glinos, Buchan & Wismar, 2014). Data on the share of foreign doctors and nurses in European countries show considerable differences between countries and the extent to which they rely on foreign health workforce (Figure 1). Health care delivery in Norway and Ireland, relies more than 35% on foreign doctors. The United Kingdom, Switzerland, Sweden and Finland have 20% or more of foreign doctors in the workforce. Spain, Germany and France, countries with large labour markets, have close to 10% foreign doctors in the health workforce. With the exception of Switzerland and the United Kingdom, reliance on foreign nurses appears to be less pronounced although the numerical importance of the nursing workforce should be kept in mind.

On the eve of the 2004 Enlargement, the European Commission noted that potentially inadequate numbers and skills in the workforce represented a serious risk for health systems "with the impact being felt hardest in the poorest Member States" and that it is "difficult for any one country to invest in training health professionals without knowing that other countries will do likewise".[4] For source countries,[5] the fear is that mobility will drain the system of "vital skills, professional knowledge, and management capacity", impeding its performance (Kingma, 2007). But destination countries also recognize that relying on foreign inflows to replenish the workforce can be inefficient and unethical – flows are difficult to predict and to factor into health workforce planning, and may signal deeper underlying health workforce issues (Buchan & Seccombe, 2012; Humphries et al., 2014). Switzerland, for example, strives to reduce reliance on foreign health professionals and increase domestic training (Federal Office of Public Health, 2013). England, Scotland, Ireland, the Netherlands and Norway have introduced national guidelines to promote ethical recruitment. In 2008 these efforts were supplemented by a code of conduct on ethical cross-border recruitment and retention in the hospital sector signed by the European Federation of Public Service Unions and the European Hospital & Healthcare Employers' Association in their function as recognized social partners in the health sector at EU level (Merkur, 2014). In a review of this Code,

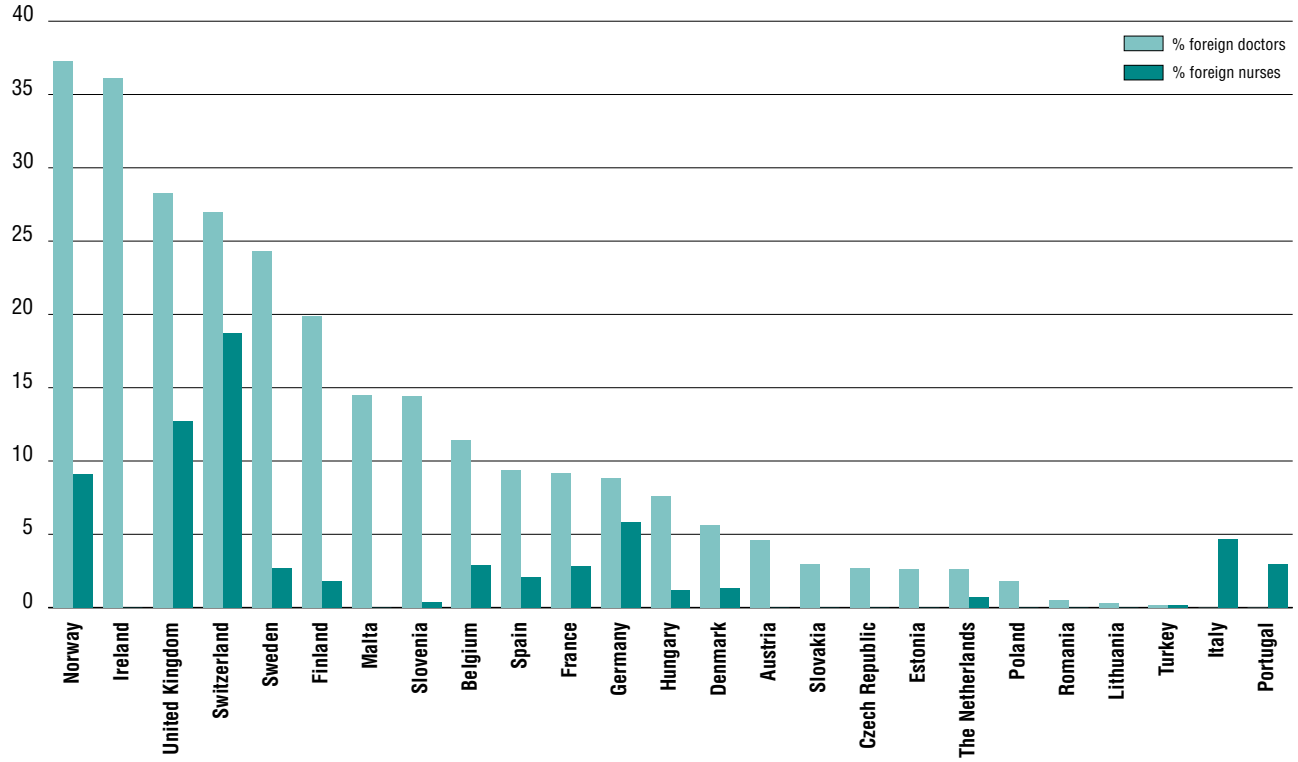
[2] 10 countries entered the EU on 1 May 2004: Cyprus, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia and Slovenia. In 2007 Bulgaria and Romania became EU members. Croatia joined the Union in 2013.

[3] Ireland and the UK did not impose labour market restrictions on nationals from the 2004 wave of accessions, but did on nationals from Bulgaria and Romania.

[4] European Commission, Communication from the Commission, Follow-up to the high level reflection process on patient mobility and healthcare developments in the European Union, 20.04.2004 COM(2004) 301 final.

[5] The terms source and destination countries are defined in Section 3.

Figure 1: Share of foreign-trained doctors and nurses in selected European countries, 2014 or latest year available[1]



Source: OECD data (Mercay, Dumont & Lafortune, 2015).

[1] Data on doctors: from 2013 for France, Germany, Hungary Romania and Turkey; from 2012 for Denmark, Finland, Poland, Sweden and Switzerland; and from 2011 for the Netherlands, Slovakia and Spain. All data on doctors represents foreign-trained professionals except for Germany. United Kingdom data does not include Northern Ireland.

Data on nurses: from 2013 for Hungary, Portugal, Romania, Slovenia and Turkey; from 2012 for Denmark, Finland, Poland, Sweden and Switzerland; from 2011 for The Netherlands and Spain; and from 2010 for Germany. Danish nursing data only includes professional nurses and excludes associate professional nurses. Finnish nursing data refers only to general nurses. German nursing data to citizens born abroad, not German by birth (except ethnic German repatriates) and the highest degree in nursing acquired in a foreign country.

Data on doctors and nurses, whose place of training is unknown, have been excluded from the calculation of the parentage of foreign-trained doctors.

social partners in eight EU countries reported having used or to be using the Code (EPSU-HOSPEEM, 2012).

The debate is evolving in the EU. Recognizing the shared challenges and the interdependence of Member States, a 2008 Commission paper[6] and conclusions from the Council in 2010[7] laid the foundations for the Action Plan for the EU Health Workforce and for closer cooperation, including on health workforce planning and forecasting.[8] The Plan estimates that the EU could have an estimated shortfall of 1 million health professionals (2 million including long-term care staff) by 2020 if appropriate measures are not taken (European Commission, 2012).[9] The EU 2014–2020 Health Programme makes health workforce sustainability a priority and proposes to "monitor mobility (within the Union) and migration of health professionals, [and] foster efficient recruitment and retention strategies" (EU Regulation 282/2014).

The developments at country, EU and global levels signal that health workforce mobility is firmly on the policy agenda. Free mobility between dissimilar and diverse systems gives rise to equity as well as efficiency concerns, trade-offs and dilemmas. Destination countries, source countries and the EU as a whole are affected in the short as well as long term, in obvious and in ambiguous ways. So while mobility is easier, cheaper and faster than migration, the question is whether it is also better for the health professionals and the countries involved.

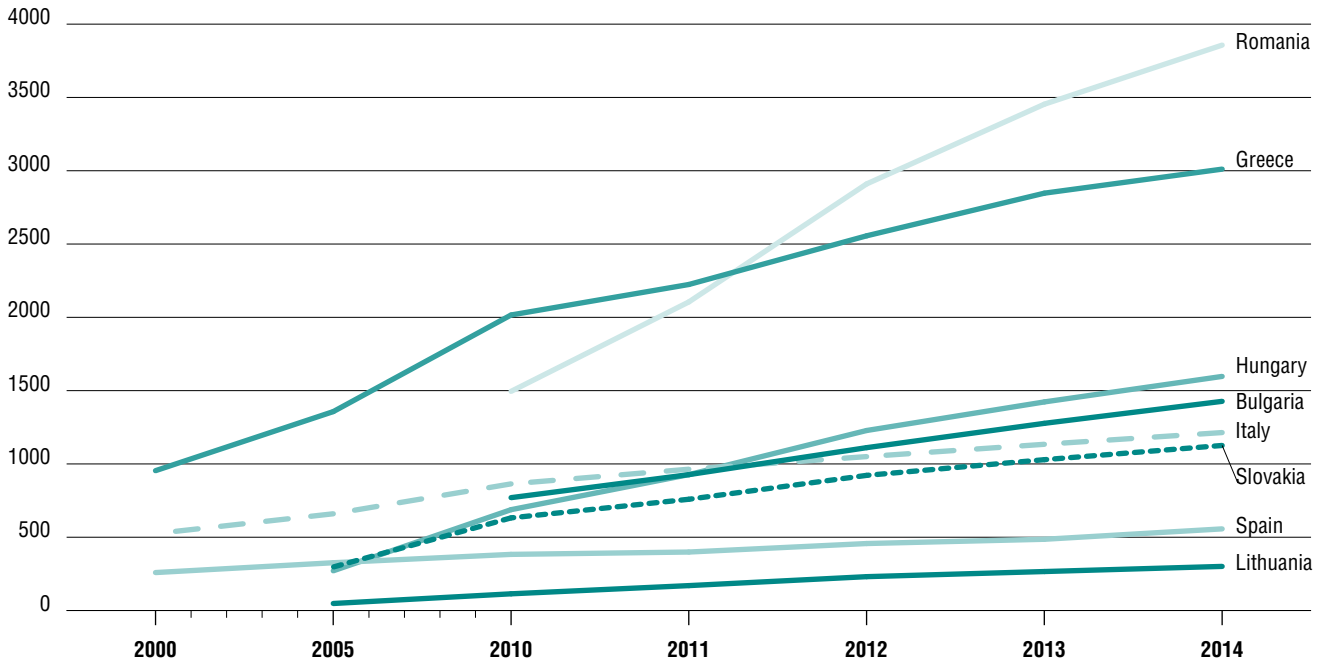
[6] On the European Workforce for Health: http://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:52008DC0725&from=EN

[7] https://www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/en/lsa/118280.pdf

[8] http://euhwforce.weebly.com/

[9] http://ec.europa.eu/dgs/health_consumer/docs/swd_ap_eu_healthcare_workforce_en.pdf

Figure 2: Stock growth of foreign medical doctors in Germany, selected nationalities, 2000–2014



Source: Ärztestatistik, Bundesärztekammer (Arbeitsgemeinschaft der deutschen Ärztekammern), accessed through German Federal Health Reporting Portal: https://www.gbe-bund.de/oowa921-install/servlet/oowa/aw92/WS0100/_XWD_FORMPROC?TARGET=&PAGE=_XWD_304&OPINDEX=3&HANDLER=XS_ROTATE_ADVANCED&DATACUBE=_XWD_332&D.000=ACROSS&D.342=DOWN&D.001=PAGE&D.928=PAGE#SOURCES, accessed 17/07/2015.

This policy brief argues that while free mobility is an undisputed achievement, it can lead to inefficiencies and inequities if not properly governed. To help countries mitigate unwanted effects and strengthen positive ones, the brief proposes a framework to understand the equity/efficiency conundrum and policy options for managing health professional mobility in the evolving European reality.

The brief sets out by outlining the most important trends which make up today's mobility context (Section 2). Section 3 goes on to unpack the efficiency-equity conundrum by analysing the implications of health professional mobility for those concerned – countries, health professionals and the EU. These insights inform the policy options put forward by the brief to help actors mitigate the undesirable effects of health professional mobility (Section 4), as well as the implementation considerations (Section 5) which allow for the variations across Europe in terms of policy contexts, governance, health system development, etc.

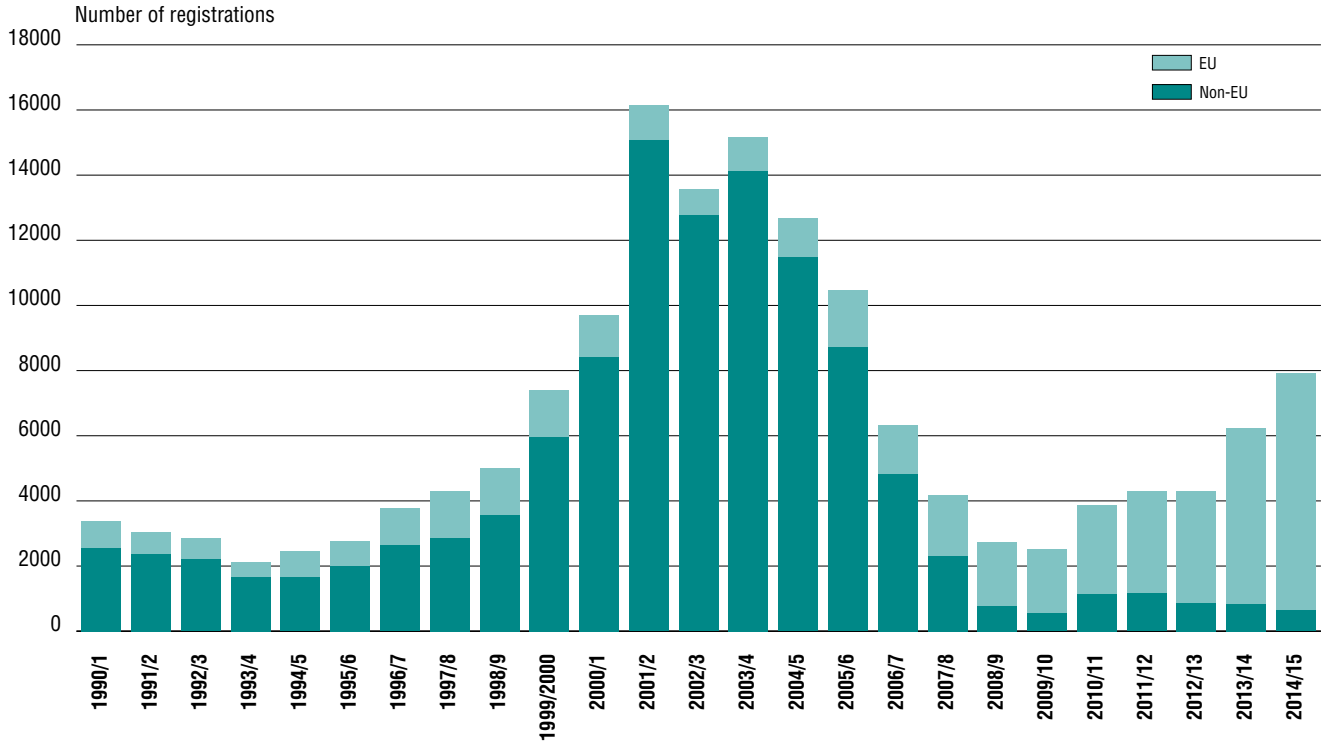
2. TRENDS IN MOBILITY: A NEW MAP OF EUROPE?

2.1 Mobility in the context of EU enlargements and the economic crisis: changing directions

Health professional mobility responds to important events taking place in Europe. The east-to-west flows brought about by EU enlargements have been joined by new south-to-north flows as health professionals from crisis-hit systems seek better opportunities and working conditions abroad. Data suggest that the economic crisis and austerity measures might have a greater and more enduring impact on European mobility patterns than Enlargement has had, or that the crisis is contributing to a "delayed" Enlargement effect (Mercay, Dumont & Lafortune, 2015). To the flows from Eastern and Central European countries should be added the mobility of health professionals particularly affected by the crisis from "old" Member States. In Greece, an oversupply of doctors means that mainly doctors leave: stock data from Germany show that numbers of Greek doctors grew by 50% in 2010–2014 (compared to 37% in 2005–2009), and the stock growth of doctors from Romania and Hungary also rose markedly from around 2011 (Figure 2). In Spain, Portugal and Ireland, nurses have been particularly affected by difficulties in finding employment. In a large destination country, such as the United Kingdom, nurses trained in these three countries have constituted around 90% of applications for recognition of qualifications since 2009 (Buchan, 2015) (Figure 3). In France, numbers of foreign-trained dentists from Romania, Spain and Portugal have increased markedly in recent years, representing 83% of new foreign-trained registrations in 2014 (ONCD, 2015).

The economic crisis has made clear that the direction of flows can change without warning. In the span of two decades, countries such as Ireland and Spain have gone from being source countries in the 1990s to attracting foreign-trained health professionals around the mid-2000s as demand was increasing, to again experiencing outflows

Figure 3: Trends in "inflow" of nurses to the UK, as measured by annual registration of EU and non-EU international nurses, 1990–2015



Source: NMC/UKCC data; Buchan, 2015.

of doctors and/or nurses since around 2010, when the effects of the crisis hit (López-Valcárcel, Pérez & Quintana, 2011; Buchan & Seccombe, 2012). As the economic strength and relative attractiveness of domestic health systems of EU Member States are changing, so do the directions of mobility. The economic and political uncertainty which several EU Member States are facing will likely continue to contribute to the volatility of flows, making it difficult for both destination and source countries to predict which health professionals will come and go. This is all the more important given the growing weight of intra-EU flows.

2.2 Intra-EU flows: changing policy options

Several factors contribute to increasing the scale and relative importance of mobility between Member States compared to migration between the EU and third countries. For destination countries, intra-EU mobility can be easier, cheaper and faster than recruiting from non-EU countries, while the successive waves of EU enlargements in 2004, 2007 and 2013 have seen the number of EU countries grow from 15 to 28 today.

In the United Kingdom, for example, the number of EU-trained nurses overtook the number of nurses from non-EU countries admitted to the UK nursing register in 2008/9 for the first time and has become the main source of recruits in recent years, supplanting the "traditional" source countries of English-speaking Australia, India and the Philippines (Figure 3), and a similar trend is visible in Ireland (Mercay, Dumont & Lafortune, 2015). In Germany, the number of doctors with EU nationality grew eight-fold between 1991 and 2014, faster than foreign stocks from any other region. A similar trend is visible in France (Delamaire & Schweyer, 2011). In "new" Member States, expatriation rates for nurses grew considerably in the decade between 2000/01 and 2010/11 in Bulgaria (from 2.6% to 4.4%), Hungary (from 2.4% to 4.3%), Poland (from 4.6% to 7.7%) and Romania (from 4.9% to 8.6%) (Mercay, Dumont & Lafortune, 2015). These trends are likely to continue since the last labour market restrictions imposed on the nationals from acceding Member States expired in late 2013 (Ognyanova et al., 2014).

Other factors influencing intra-EU flows include the economic and financial crisis which evidence suggests is causing a net increase in EU health professional mobility (Dussault & Buchan, 2014). As the effects of the crisis are far from over, this trend is likely to continue. The growing number of health professional students for example from Sweden, France, Portugal and Germany who seek university and training posts in other EU countries also contributes to intra-EU mobility (Ribeiro et al., 2013; Safuta & Baeten 2011; Offermanns, Malle & Jusic, 2011; Socialstyrelsen, 2013): they move "on their way out" to the destination country and many of them are likely to return home as "foreign-trained" after their studies.

The Code, as well as country-level commitments to ethical recruitment, might also lead European countries to recruit

less from developing countries and to replace non-EU inflows with EU health professionals.

The growing importance of intra-EU flows matters for policy-making because countries in the free mobility zone have less control over EU mobility than over migration to and from the EU. Whereas countries can control the inflows of third-country nationals via immigration laws and professional regulatory requirements, mobility depends on factors such as the relative attractiveness of health systems, market forces and broader health workforce policies in both home and host country, factors which are only partially within the remit of policy-makers. Free mobility can also undermine the objectives of national education quotas – countries cannot stop inflows, including of their own nationals who return after studying abroad.

Free mobility means that intra-EU flows are relatively "unmanaged" and "unmanageable" – they are difficult to steer in direction and in length of stay (Buchan & Seccombe, 2012). Moreover, countries may have less precise data on mobility because of less strict registration requirements for EU nationals. In this context countries can influence mobility by adopting broader policy responses, for example to domestically train or to retain health professionals. This is especially true for source countries for which it is even more difficult to steer or predict outflows to other EU Member States. Increasing intra-EU flows means that their efforts should focus on "prevention" – i.e. retention measures.

2.3 Demand, demography and interdependence: growing mobility

Global demand for health workforce is increasing but is not being matched by a similar growth in supply. On the demand side, pressures stem mainly from a growing world population (Campbell et al., 2013). Within the next two decades (2035), the world is predicted to face a shortage of 12.9 million health professionals, according to WHO estimates (ibid).

Demographic factors also play an important role. The population of Europe is ageing and so is its workforce. The European Commission talks about the "retirement bulge": around one-third of medical doctors in the EU were over 55 in 2009, and by 2020 3.2% of all European doctors are expected to retire annually (European Commission, 2012). The situation might be even more alarming for nurses (Buchan, O'May & Dussault, 2013). As Europe's active workforce is shrinking, not only will countries be competing for health workforce but also different sectors of the economy will be competing to attract sufficient recruits.

When countries do not produce sufficient numbers of health professionals but have the resources to employ more, mobility can become a way to fill vacant posts. Policy decisions and policy changes on international recruitment, especially in countries with attractive working conditions and labour markets that have the capacity to absorb large numbers of migrant health professionals, may have almost instant knock-on effects on countries with less favourable conditions. Global competition for qualified health professionals is likely to increase against this backdrop of projected shortages and as the skills and competences of health professionals become increasingly portable. Mobility makes countries interdependent. The result is that countries can no longer view their health workforce policies in isolation from developments in other countries.

3. UNPACKING THE EFFICIENCY-EQUITY CONUNDRUM: A MATRIX

Countries are faced with the constantly changing conundrum of efficiency and equity, that is, between the free mobility of health professionals in the European labour market on one hand, and the planning requirements of health systems ensuring universal health coverage on the other hand. Mobility is a complex phenomenon because *per se* it is neither positive nor negative for source and destination countries; its effects are changing over time, equivocal, overlapping, hard to pin down, and depend on the context and governance of mobility. The matrix proposed serves to unpack this conundrum. Countries can use the matrix as a tool to analyse their specific situation and clarify how health professional mobility influences efficiency and equity in their health system, other systems and Europe-wide.

In what follows, the efficiency and equity implications of free mobility are examined from the perspectives of the EU, of destination countries and of source countries. Table 1 gives a visual representation of the matrix. Building on earlier work looking at the opportunities and costs/challenges brought about by health professional mobility (Buchan, 2007; Buchan, 2015), the *matrix* regroups implications as merits, that is, when health professional mobility contributes to efficiency or equity in the EU, a country or a health system, and *drawbacks*, that is, when mobility creates or

Box C: Why focus on efficiency and equity when addressing mobility?

Efficiency has become the centre-piece of EU health policy. The Commissioner for health and food safety was mandated in 2014 to develop expertise on performance assessments of health systems, "[…] which can inform policies at national and European level".[1] This expertise is also meant to inform the work of the European semester of economic policy coordination. In this context, country-specific recommendation on health system reform focuses specifically on efficiency (Greer et al., 2014). The Code also promotes efficiency because the "[s]hortage of health personnel constitutes a major threat to the performance of health systems" (WHO, 2010).

Equity between countries is central to the Code. It is deemed unethical to increase inequities by recruiting health professionals from countries already suffering from shortages. Equity within countries plays an important role too. In 2006 the then 25 health ministers of the EU officially endorsed equity as one of the overarching values in health systems. Equity was defined in terms of equal access according to need, regardless of ethnicity, gender, age, social status or ability to pay (Council, 2006).

[1] http://ec.europa.eu/commission/sites/cwt/files/commissioner_mission_letters/andriukaitis_en.pdf, accessed 12/08/2015.

aggravates inefficiency or inequity at EU, country or system level (see also Glinos, 2015). Each of the twelve possible combinations is described below with concrete examples from across the EU. An exception has been made to equity improvements in the EU, destinations and sources which are looked at together due to the scarcity of evidence.

The terms source country and destination country deserve some explanation. While they can be defined respectively as a country from which health professionals leave and a country to which health professionals migrate, in reality the concepts are more blurred. Most, if not all, countries experience both inflows and outflows; Italy, for example, experiences outflows of medical doctors but inflows of nurses, while in Ireland inflows of foreign-trained doctors replace outflows of domestically trained doctors. Countries usually have a "double profile", being simultaneously sources and destinations even if to varying degrees. In terms of policy analysis, this means that most countries cannot ignore either perspective but are concerned by the implications of mobility both as a destination and as a source.

We should also note that the matrix was primarily developed for mobility that results in extended stays abroad. Other forms of mobility which are common in the EU such as temporary flows and cross-border commuting will likely have different, more moderate impacts for countries and individuals.

Table 1. The effect of free mobility in terms of efficiency and equity in the EU, destination countries and source countries

Implications/ Level	EU	Destination	Source
Merits:			
• Efficiency	A	B	C
• Equity	D	E	F
Drawbacks:			
• Inefficiency	G	H	I
• Inequity	J	K	L

Source: The authors, see also Glinos, 2015.

3.1 Merits of free mobility

A: Efficiency – EU

From an EU labour market perspective, free mobility has the promise of enabling a better balance between supply and demand. Unemployment and underemployment have, for example, led medical doctors from Italy, Spain, Greece and Romania to seek work elsewhere in the EU. A survey of European nursing associations showed that rising unemployment for nurses was a concern in over half of the 34 countries (European Federation of Nurses Associations, 2012). Instead of letting skills and competences go unused, it is more efficient from an EU perspective – and arguably more rewarding for the individuals – if the skills of mobile health professionals are used to full potential in destination countries.

B: Efficiency – destination

Because mobility is easier, cheaper and faster than migration, it can mean considerable efficiency gains for destination countries, for example when foreign-trained health professionals fill services gaps and workforce shortages. In Switzerland, one in three nurses and one third of doctors are foreign-trained,[10] mainly from neighbouring countries (Hostettlera & Kraft, 2015); in Spain and Germany, foreign doctors alleviate regional shortages as they settle down in regions considered less attractive by nationals; in France 40% of newly registered anaesthetists and 20% of newly registered paediatricians were EU-nationals, mainly from Romania, in 2007 (Wismar et al., 2011), while one in three newly registered dentists was trained in another EU country in 2014 (ONCD, 2015).

But benefits go beyond service delivery. In the UK, a government review into the balance of competences between the UK and the EU in the area of health concludes that the EU Single Market adds value in the health sector. The review quoted the Royal College of Nursing: "Nursing in the UK has benefited enormously from the UK's membership of the EU, from free movement of professionals and from agreed minimum employment and working conditions in Europe" (HM Government, 2013).[11]

Foreign health professionals can also add to the cultural diversity of the workforce, bring in new skills and competences, and reduce the average age of the health workforce, and the extra supply may keep shortage-driven wage increases in check (López-Valcárcel, Pérez & Quintana, 2011). Other savings include senior staff having time to expand domestic training thanks to foreign health professionals alleviating workloads (Young, 2011), as well as the vast amounts of money, time and organizational capacity required to educate and train health professionals domestically.

C: Efficiency – source

Free mobility can present efficiency advantages for the source country on different levels. One is that of mobile health professionals sending or bringing remittances back home, as do, for example, nurses from eastern European countries working in Germany (Ognyanova et al., 2014). Returning health professionals may increase expertise in the home system when they improve their skills and qualifications abroad (see, for example, Galan, Olsavszky & Vladescu, 2011), such as in the case of exchange programmes (Wismar et al., 2011). Mobility can also be a policy stimulus to tackle workforce issues as the threat of exit makes governments more responsive. In 2010 some 3800 publicly employed Czech doctors joined the protest movement "Thank you, we're leaving", threatening to collectively resign and subsequently obtaining salary increases and improvements to the educational system (Alexa et al., 2015). Also in Lithuania, Hungary and Slovakia

[10] http://www.bfs.admin.ch/bfs/portal/en/index.html

[11] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/224715/2901083_EU-Health_acc.pdf

protests and/or negotiations have been associated with emigration intentions and concessions by governments.

D, E, F: Equity

There is little evidence on how free mobility may improve equity at EU and country level. This is not to say that such improvements do not take place. One of the greatest achievements of the EU is to give 500 million people the right to freely move, work and live anywhere in the Union. Free mobility contributes to "equity of opportunities". EU citizens share opportunities in all Member States. Working in an attractive, rewarding health system is not only an option for the nationals of that country but for all health professionals: Finnish doctors seek career advancement abroad, Belgian nurses are attracted by flatter work hierarchies in the Netherlands, Slovak doctors can access better equipment abroad, while Austrian and Romanian (junior) doctors do their specialization in Germany and Belgium respectively (Wismar et al., 2011). In destination countries, mobility may improve equity of access for patients when foreign health professionals alleviate health workforce shortages, as noted, for example, in Spain and in the UK (López-Valcárcel, Pérez & Quintana, 2011; Young, 2011).

3.2 Drawbacks of free mobility

G: Inefficiency – EU

Free mobility may lead to inefficiencies because it (re) distributes health professionals and funding within the EU. Free mobility challenges domestic planning, which seeks a predictable, stable and needs-based supply of health professionals. While migration can be controlled (see Section 2.2) and may be an explicit component within overall national planning in countries with identified shortfalls in health professionals due to a low level of domestic training, free mobility follows the choices of health professionals and does not always align with health system priorities and the requirements of universal health coverage. To protect their systems from expected inflows, 17 European countries[12] restricted free movement of labour from acceding Member States in 2004 (Ognyanova et al., 2014).

Whilst not all EU countries fund the training of all their health professionals, given the large share of government funding going into medical and nursing education, mobility redistributes millions of Euros of tax-payers' money between EU countries. The lack of transparency on the exact extent and direction of in- and outflows, and absence of compensation mechanisms to offset countries' gains and losses, arguably aggravate inefficiencies in how mobility distributes health workforce and funding.

An unbalanced distribution of health workforce across the EU territory could potentially pose a public health risk if shortages reach critical levels. It is not efficient or safe if the lack of qualified health professionals means that health systems are unable to provide adequate care, including containing propagation.

Finally, free mobility can lead to inefficiency when the skills of mobile health professionals are not used to full potential in the destination country. The Estonian nurse who divides her time between Estonia, where she works in emergency care, and Norway, where she works in a nursing home, is but one example of how mobility can be wasteful for countries and health professionals when (specialized) skills go unused (Saar & Habicht, 2011). In Switzerland, an estimated 4000 foreign-trained doctors work as hospital assistants, and other similar examples of mobile health professionals not being able to use their skills and qualifications abound across Europe (Bertinato et al., 2011; Delamaire and Schweyer, 2011; Mercay, Dumont & Lafortune, 2015; Ognyanova et al., 2014).

H: Inefficiency – destination

For destination countries one form of inefficiency is that foreign inflows can be an unstable source of workforce replenishment; this might be particularly pronounced for inflows of EU health professionals for whom it is generally easier, cheaper and faster to move within the EU than it is for non-EU health professionals. Foreign-national doctors in Germany are four times more likely than German-national doctors to move abroad (Ognyanova et al., 2014). Ireland and the UK are known to be "stepping stones" for onward mobility, while reports show Finnish, Romanian and Spanish migrant doctors reversing mobility by returning home. Employers in Poland are reported to headhunt Polish doctors abroad to return (Kautsch & Czabanowska, 2011; Kuusio et al., 2011; López-Valcárcel, Pérez & Quintana, 2011; Galan, personal communication, 2014). EU flows are also less manageable than non-EU flows. As EU law bans discrimination, destination countries can only guide EU health professionals to specific areas using the same mechanisms as for domestically trained staff, and have no mechanisms for limiting their stay. By comparison, in Germany, for example, immigration procedures give non-EU doctors access to the German labour market if they take up work in underserved regions (Ognyanova & Busse, 2011), while migration schemes can define the duration of non-EU health professionals' stay (Safuta & Baeten, 2011; Buchan & Seccombe, 2012).

Another aspect to consider is the importance of integrating foreign health professionals into the new system and the time, capacity and money it takes to organize induction courses, language training, mentoring, etc. Receiving inflows can be both demanding and costly, absorbing capacity of experienced health professionals, and can cause inefficiencies if patient safety is compromised due to improper language assessment and induction (Braeseke, 2014; Ognyanova et al., 2014; Young, Humphrey & Rafferty, 2014).

Finally, mobility may impede necessary policy change to address underlying workforce issues. In Ireland, for example, inflows of foreign-trained doctors replace the outflows of Irish-trained doctors but distract decision-makers from

[12] All EU15 countries, excluding Ireland, Sweden and the UK, plus Iceland, Malta, Norway, Liechtenstein and Switzerland. Countries gradually started lifting restrictions from 2006 onwards.

tackling retention problems (Humphries et al., 2014). According to Buchan and Aiken (2008), "a shortage may not indicate a shortage of suitably skilled and qualified people, but rather the unwillingness of those skilled individuals to work under the available conditions".

I: Inefficiency – source

In source countries inefficiencies can arise when health professionals leave underserved regions (Galan, Olsavszky & Vladescu, 2011; 2013) or when shortages make medical specialties particularly vulnerable to outflows, as for example in Belgium, Estonia, Hungary, Lithuania, Poland and Slovakia (Maier et al., 2011). Between 2004 and 2014 18% of Polish doctors who specialized in anaesthetics and certain categories of surgery applied for certificates to leave the country, compared to an average of 7% among all doctors (Mercay, Dumont & Lafortune, 2015). In these cases it is highly probable that patient care is affected.

Mobility also impacts on remaining staff who face greater burdens and lower work satisfaction, for example when posts are left vacant or closed down due to recruitment stops, with adverse consequences for quality of care (Kingma, 2007; Galan, Olsavszky & Vladescu, 2013; Bruyneel et al., 2014). The loss of workforce can be all the more problematic for the organization of patient care as outflows occur suddenly and are rarely planned for.

But losses go beyond service delivery. Outflows undermine returns on investments where countries pay for the education of health professionals. When the health professionals who leave are predominantly young – as is the case in, for example, Estonia, Hungary, Italy, Poland, Portugal, Romania and Slovakia (Wismar et al., 2011; Ribeiro et al., 2013) – they have had little time to "give back" to their home country system and might be more likely to stay in the destination country as they seem to adapt more easily to living and working abroad (Young, Humphrey & Rafferty, 2014; Galan, personal communication, 2014). While migrants often intend on returning home at the moment of leaving, return to the home country is less likely once professional and personal ties are established in the destination.

When health professionals leave, source systems also lose those with the capacity to shape today's and tomorrow's workforce. Whether it is experienced health professionals working as team leaders and educators or those with the drive to improve and reform the system who leave, the departure of talent and potential institution-builders can lead to a vicious circle where shortcomings in the system trigger mobility, and the absence of "the best and the brightest" means that shortcomings are not addressed (Kapur & McHale, 2005).

J: Inequity – EU

The differences in working conditions, salary levels, status of health systems and living standards across the EU mean that some Member States have an advantage in terms of attracting and retaining health professionals, while other countries that are not appealing or competitive enough to attract inflows rely on their own means and invest considerably in domestic production, health workforce development and retention. The situation can lead to inequity and self-reinforcing disparities: Member States which, in addition to not receiving inflows, experience outflows, end up subsidizing part of the health workforce of more advantaged destination countries with no "compensation". Second, mobility patterns reinforce existing disparities as EU Member States with fewer resources tend to lose health workforce, while those with more tend to receive workforce. Third, to the extent that economic hardship and austerity measures trigger outflows and aggravate health problems, the systems and populations with the greatest needs might end up with less.

These concerns are present when agencies and employers from wealthier destination countries organize recruitment fairs and promotional events, for example around university campuses in source countries, or contact final year students to recruit them abroad before they have even qualified. While this is entirely legal, the question from an EU perspective is whether these (aggressive) techniques are fair. Source countries such as Estonia, Greece, Hungary, Italy and Romania can hardly compete when certain destinations offer salaries five to ten times higher than what newly trained health professionals can expect to earn at home (see, for example, Fujisawa & Lafortune, 2008; Wismar et al., 2011).

K: Inequity – destination

At country level, inequity often relates to the differences between the mobile and the non-mobile workforce. In destination countries, free mobility can result in discrimination when foreign health professionals (systematically) face less favourable working conditions than domestically trained staff. Studies in Belgium, France, Ireland and Sweden suggest that foreign-trained doctors are more likely to experience stalled career progression and lower pay, work below their skill level, and perform less attractive chores and shifts, at times combined with working in isolated, remote regions (Delamaire & Schweyer, 2011; Safuta & Baeten, 2011; Wolanik Boström & Öhlander, 2012; Humphries et al., 2013; 2014). A study of eight European destination countries shows that foreign-trained nurses are more likely to perform tasks below their skills level than those domestically trained nurses (Bruyneel et al., 2014).

Another aspect of inequity concerns educational quotas. Countries such as Belgium, Ireland and Switzerland cap the number of university places and health-related training posts to control workforce numbers but show a degree of reliance on foreign inflows (Safuta & Baeten, 2011; de Haller, 2014; Humphries et al., 2014; Mercay, Dumont & Lafortune, 2015). While this raises equity issues in terms of effects for source countries, it also raises the question of whether it is fair that suitably qualified young people are prevented from entering health professional education in their country because of a continued reliance on international recruits. In the UK, for example, the number of applicants for nursing studies on an annual basis is two to three times the level of those accepted.

L: Inequity – source

In source countries, mobility brings equity concerns for the health professionals staying behind and for patients. While mobility is far from always an easy experience for the migrant (Glinos, Buchan & Wismar, 2014), it also affects those who remain in what are often already disadvantaged systems (Kingma, 2007). Social equity as well as the diversity and dynamism of the workforce are at stake if certain profiles of health professional, such as those with family obligations, older health professionals and those with no foreign language competencies, are less able or likely to exercise their right to free mobility. Outflows might also exacerbate (territorial) inequity in terms of regional workforce imbalances and problems with access to care. In Romania, poorer rural regions have low coverage of medical doctors and experience important outflows (Galan, Olsavszky & Vladescu, 2011; 2013), while peripheral or smaller hospitals have problems in attracting and retaining medical as well as nursing staff, a situation which is made worse by emigration (Galan, Olsavszky & Vladescu, 2013). In Bulgaria, lack of specialists means that patients in rural areas have to travel longer distances to access specialized services (Mercay, Dumont & Lafortune, 2015).

4. POLICY OPTIONS: HOW TO MAKE MOBILITY WORK BETTER

In the preceding section we have unpacked the efficiency-equity conundrum surrounding health professional mobility. We have started by clarifying the overlapping and contrasting effects mobility can have for the EU, for destinations and for sources. Free mobility leads to both synergies and trade-offs as it impacts on efficiency and equity in multiple ways. The challenge for observers and policy-makers is to obtain as comprehensive a picture as possible of how health professional mobility affects health systems.

This section examines which options policy-makers in countries and at EU level have to make mobility "better", that is, to address its negative effects and promote its positive effects. This is an ongoing activity with no single or simple answer to it. An array of policy options is possible and policy-makers will have to decide on the mix of options which suits their purpose, current priorities and context. To facilitate the task, the brief catalogues and describes the various policy options according to three broad categories: policies at country level which seek to strengthen health workforce sustainability; policies at country level which seek to manage mobility when it does take place; and policies at EU level which seek to address the consequences of free mobility.

In what follows the three categories of policy options will be briefly summarized and examples will be provided for each category. Table 2 lists the exact policy objectives and policy measures of each category. The variety of measures included in the list ranges from well-known policy options which have been tried in countries to options as yet untested but with potential relevance. In the absence of any panacea or ready-made solutions, the aim of the overview is to be as comprehensive as possible and inform policy-makers about options at their disposal.

4.1 Policy options to foster health workforce sustainability

For destination and source countries alike, health professional mobility is often a symptom of underlying health workforce issues. Health professionals come and go because the host system does not have sufficient workforce or lacks certain skills, and because the home system is not perceived as providing sufficient rewards and opportunities. Given the challenges which free mobility gives rise to (cf. Section 3), countries have an interest in fostering a sustainable health workforce – destination countries by addressing the reasons why the system relies on foreign inflows to replenish the health workforce, source countries by tackling the factors which lead health professionals to leave. This is also one of the main tenets of the Code – to strengthen health workforce development as an alternative to international recruitment and migration. Ensuring a sustainable health workforce can be a way to "prevent" mobility and its potentially undesirable effects, by reducing the drivers for mobility.

Policy options which seek to increase health workforce sustainability can be regrouped into six policy objectives: better health workforce planning; training and adapting today's workforce; training tomorrow's workforce; domestic recruitment; better regional distribution; and retention (Table 2). Each objective presents a range of policy measures to choose from. Box D describes a concrete example of how policy-makers, together with provider and professional organizations, may prioritize attracting young people into certain health professions as a way to counter shortages and train the future workforce.

Box D: Attracting young people to nursing, radiography and medical laboratory technology studies in Denmark

A three-year recruitment campaign, called the Hvid Zone Campaign (in English: White Zone Campaign), was designed and implemented in Denmark to increase the number of people entering training in the fields of nursing, radiography and medical laboratory technology and to raise awareness of the career opportunities in these fields. The campaign, which ran from 2009 to 2011, emphasized digital media, including social media, and was included in the existing websites for programmes and activities of professional schools. Led and financed by the Ministries of Education and of Health, Danish Regions, Danish municipalities, professional organizations and university colleges, the campaign targeted a 44% increase in the number of people entering training in the three concerned fields. By 2011 the increase in uptake of the three programmes far exceeded the target.

Source: European Commission, 2015.

Table 2: Policy options to make mobility work better

Policy options to foster health workforce sustainability	
Objectives	*Measures*
Better health workforce intelligence and planning	Measures include investing in health workforce intelligence (incl. on stock, composition, flows, regional distribution, vacancies, motivations), in demographic scenario modelling, and in mobility data; coordinating planning with training institutions and provider organizations.
Training and adapting today's workforce	Measures include continuous professional development; re-skilling; redefining skills in line with population needs; life-long learning.
Training tomorrow's workforce	Measures include attracting (young) people to healthcare; steering students to shortage professions; investing in educational capacity; allocating senior staff time to teaching; adapting curricula to demography and disease profiles; lifting or re-evaluating educational quotas.
Domestic recruitment	Include entry stage measures to attract new graduates/ recruits to domestic jobs by creating opportunities for employment, professional development and career progression, as well as measures to encourage return to practice with financial incentives, retraining courses, and mentoring.
Better regional distribution within the country	Measures include promoting networks and extended team work; setting up contact points; guaranteed employment; housing and social benefits; regional investment.
Retention	Measures include creating supportive and safe workplaces; flexible working hours; professional autonomy; expansion of roles; remuneration; grants in exchange for working in the system after specialization; career progression.
Policy options to manage mobility	
Ethical recruitment practices	Introduction and implementation of guidelines and codes at national or international levels, such as the Code, to encourage especially employers to recruit and employ ethically.
Country-to-country collaboration	Measures include bilateral agreements between destination and source countries with mechanisms to share training costs, promote circular mobility, provide additional training prior to return, define the type and number of health professionals to be trained for international recruitment and/or encourage professionals to settle down in particular locations.
Integration of foreign-trained/born professionals	Measures in destination countries include induction and language courses; mentoring; practical help to settle down in host system; legal frameworks to facilitate recognition and authorization to practise processes; preventing discrimination.
Facilitated returns	Measures in or by source countries to encourage returns and to allow returning health professionals to use skills acquired abroad and reintegrate the workforce, e.g. by offering concrete employment opportunities.
EU action to address the consequences and opportunities of free mobility	
Better mobility data	Investing in mobility "R&D" including updated flow data; mapping exercises of national policies to address mobility; data on migrant itineraries and motivations; evaluation of instruments, e.g. bilateral agreements and codes of practice including the Code and their implementation at national and organizational levels; mobility impact assessments.
Joint planning and workforce development	Measures include investing in European health workforce intelligence and regional forecasting models; introducing EU-wide CPD programmes; coordinating training capacity and health workforce production.
Protecting vulnerable health systems	Measures include an EU compensation fund to compensate for training costs in source countries; EU structural and cohesion funding and technical support to strengthen vulnerable health systems in source countries.
Protecting/ promoting mobility	Measures include monitoring adherence to freedom of movement and anti-discrimination; EU-funded scholarships targeting specific disciplines/regions; mechanisms for knowledge and skill transfers between Member States.

Source: Authors' compilation, adapted from Buchan, 2007; Wiskow, Albreht & de Pietro, 2010; Wismar et al., 2011; Delamaire, 2014; Mercay, Dumont & Lafortune, 2015; Plotnikova, 2014; European Commission, 2015.

Box E: Triple Win nurses – sustainable recruitment of nurses from four countries to Germany (2013–2016)

Faced with increasing nursing shortages, Germany has made bilateral agreements with countries such as Bosnia and Herzegovina, Serbia and the Philippines, which are reporting surpluses. The Federal Employment Agency's International Placement Services and the German Agency for International Development established a joint project to place 2,000 qualified nurses with German healthcare providers by 2014. The project cooperates with the employment agencies of the partner countries to select, assess, prepare and place the nurses, and provides them with support in their country of origin, upon arrival in Germany and during their stay there. This creates a triple-win situation by which:

- In the destination country shortages are addressed; heavy bureaucratic procedures for the recognition of qualification and work permits are replaced by direct agreements.
- In the source country, labour market pressure is alleviated, remittances contribute to national income and returning nurses bring new acquired skills.
- The health professional has job opportunities and is welcomed in the host country.

In a previous pilot project (2011–2012), around 80 nurses were placed with German employers. Project monitoring has verified that these nurses possessed a high level of professional qualification. Employers were highly satisfied with the international nurses.

Source: GIZ, Deutsche Gesellschaft für Internationale Zusammenarbeit, https://www.giz.de/en/worldwide/20322.html, accessed 21/07/2015.

4.2 Policy options to manage mobility

Policy options in this category seek to get the best out of mobility for all parties concerned. This follows the logic of the Code which advocates that migration can contribute to strengthening health systems if "properly managed" (Art 3.2). While certain measures might contribute to reducing in- and outflows (see Section 3), mobility is likely to continue to grow in importance and its extent and directions remain hard to predict. In this context, no EU country can ignore mobility; destination and source countries alike have an incentive to manage mobility – at the national and international level – so as to reap its benefits and minimize its negative effects.

Four sets of policy options to manage and steer mobility can be identified: ethical recruitment practices; country-to-country collaboration; integration of foreign-trained professionals in host systems; and facilitated returns into source systems (Table 2). These will often be used in parallel as they manage mobility both between countries and by improving the situation of mobile health professionals within a country. Bilateral agreements can, for example, bundle details on recruitment, induction, training and return dates. Box E illustrates such a project which incorporates aspects of all four policy options to ethically recruit foreign-trained health professionals and help them settle in the destination country.

Box F: European monitoring of health workforce mobility and migration: joint data collection on non-monetary healthcare statistics

EUROSTAT, the OECD and the WHO Regional Office for Europe are using a joint questionnaire for collecting healthcare statistics in their Member States. In 2014 "health workforce migration" was introduced for the first time in the Joint Questionnaire to improve the monitoring of international health workforce mobility and migration through the collection of a minimum dataset that would be relevant to both source and destination countries, and feasible for most European and non-European OECD countries to report data. This data collection responds to a current gap in the OECD, EUROSTAT and WHO-Europe databases. It will also serve as part of the required inputs to the National Reporting Instrument, the self-assessment tool used by the World Health Organization to monitor the implementation of the Global Code of Practice on the International Recruitment of Health Personnel (adopted by the World Health Assembly in May 2010), gathering data for the up to 62 countries that are receiving the Joint Questionnaire.

Source: OECD, EUROSTAT & WHO-EUROPE, 2014.

4.3 EU action to address the consequences and opportunities of free mobility

Mutual recognition of diplomas and freedom of movement mean that EU health professionals increasingly form one EU health workforce. Individual Member States are not in control of in- and outflows, nor are they fully equipped to deal with the efficiency and equity concerns which mobility brings about, and yet they have come to depend on each other's workforce situations. Destination countries may "benefit" more from mobility but they also rely on the training capacity of source countries – what would happen if Romania stopped training anaesthesiologists? – and on the situation in other destination countries as they compete for inflows. With less individual autonomy, joint policy responses make more sense. Concerted EU action presents added value not only to deal with the consequences of mobility but also to promote the opportunities it presents for individuals who are free to pursue their aspirations and for health systems which receive skills that are not or cannot be produced domestically.

Policy options which seek to address the consequences and opportunities of mobility at EU level can be regrouped according to four policy objectives: better mobility data; joint planning and workforce development; protecting vulnerable health systems; and protecting/promoting free mobility as a citizens' right (Table 2). Box F gives an example of how the European Commission's statistical service is collaborating with the OECD and the WHO Regional Office for Europe in the area of healthcare statistics to improve mobility data.

5. IMPLEMENTATION CONSIDERATIONS

This section looks at implementation considerations for destination countries, for source countries and for the policy options at EU level. Before examining implementation considerations from these three perspectives, two general observations are worth making.

One important observation to make is that countries often will have to implement several policy options in parallel. Health professional mobility can affect professional groups, specialties and regions in different ways. This also implies a need for policy coordination within countries to ensure that various measures being implemented are compatible and, where possible, reinforce one another. For implementation to be successful, coordination efforts will also need to include stakeholder engagement. Decisions/actions on health workforce and mobility policies involve a broad range of actors.

Second, implementing policy options entails in many cases consensus building and strong inter-sectoral governance. Most governments in Europe have limited leverage over some key aspects of workforce development. University-based training, for example, is in most countries not in the remit of the ministry of health but rather in that of the ministry competent for science and education. As an additional complication, medical and nursing schools often sit at the regional level with some autonomy accountable to regional governments. Many aspects of health workforce policy are performed by self-governing bodies of the professions. Clinical guideline development, licensing, registration, compliance with professional standards and mal-practice procedures are often controlled by medical societies, professional chambers or nursing and medical councils. Working- and pay-conditions are negotiated between the social partners. Most countries have coordination mechanisms in place to bring these different functions into alignment, but often their capability to resolve issues is limited because of a lack of agreement on policy priorities. Therefore part of the inter-sectoral governance is to build consensus on the health system reforms and the workforce role.

5.1 Countries experiencing inflows: implementing policies for health workforce sustainability and for managing mobility

For destination countries, a first step in the policy process is to identify which need, gap or shortcoming inflows make up for in the domestic health workforce. Different scenarios are possible, calling for specific policy options (see also Table 2):

The health system replaces domestic by foreign health professionals: where a foreign-trained health workforce is needed because the system loses domestically-trained health professionals to emigration or attrition, it is important to understand why health professionals leave the country/health sector and to design and target *retention* and *domestic recruitment* policies accordingly. In the Irish context, for example, Humphries and colleagues (2013) note that "a shortage may not indicate a shortage of suitably skilled and qualified people, but rather the unwillingness of those skilled individuals to work under the available conditions". Improved working and employment conditions will help to retain both domestic and foreign-trained staff, and to *facilitate returns*. Measures to better *integrate foreign health professionals* will also favour retention, as will *ethical recruitment practices* which include informing potential migrants of what they can expect of the host system prior to arrival.

The health system does not produce the right type or number of health professionals: where mobile health professionals make up for inadequate domestic production, the question is whether the shortcomings are due to limited study places, unfilled study places (poor take-up), attrition during studies, or lack of specialized training posts. Inflows of foreign-trained nationals who return after studying abroad may, for example, signal excessively tight educational quotas. Depending on the cause(s), policy efforts need to focus on *health workforce planning* to align educational and training capacity with system and population needs, and on *training today's and tomorrow's workforce* bearing in mind the time required for specific measures to produce results. Given this lag, *country-to-country collaboration* with source systems may be particularly relevant while waiting for domestic capacity to come on-stream. In terms of *ethical recruitment,* transparency, for example on the duration of contracts, will be important.

The health system faces regional mal-distribution of health professionals: where a system needs foreign health professionals to fill gaps in underserved areas, measures for a *better regional distribution* need to attract and retain health professionals in areas such as scarcely populated regions or deprived urban zones. In France, measures include bonuses to encourage young doctors to settle down in these areas (Delamaire, 2014). *Country-to-country collaboration* with source systems may also offer ways to encourage foreign-trained health professionals to practise in specific locations, although such measures need to be supplemented by solid *integration policies* given the difficulties involved with working in regions or structures suffering from workforce shortages and by *ethical recruitment practices* to ensure that foreign health professionals are properly informed of working conditions ahead of moving.

Small countries: five out of eight small countries in the WHO European Region participate in the European free mobility zone, either as an EU Member (Cyprus, Luxembourg, Malta) or through the European Economic Area (Liechtenstein, Iceland). Small countries can be considered a distinct type of destination because they cannot realistically produce all the required health professionals with all specializations domestically and therefore depend on health professional mobility for workforce sustainability. Mobility is indispensable both to allow nationals to be educated and/or trained abroad, and to attract foreign-born health professionals. Policy options in small countries will focus on how to *manage mobility;* in particular, *country-to-country collaboration* with source countries can be useful, but also with countries which can receive and treat patients requiring highly complex care not available in small countries.

5.2 Countries experiencing outflows: implementing policies for health workforce sustainability and for managing mobility

For source countries, the policy process starts with identifying why health professionals leave the country, in order to determine what policy options can be pursued. Several scenarios are possible (see also Table 2):

Unsatisfactory working and employment conditions: in systems which suffer from outflows due to unattractive or uncompetitive conditions, *better health workforce intelligence* can help determine which factors motivate health professionals to leave. As reasons can vary from, for example, insufficient income to unmanageable workloads, job insecurity or poor prospects for career progression, *retention measures* will have to be fine-tuned to address the (perceived) shortcomings. Improving working and employment conditions also brings the advantage of contributing to *facilitate returns*. The Irish Health Service[13] has, for example, launched a recruitment campaign to attract migrant Irish nurses to return to Ireland by offering a relocation package and a series of benefits including permanent contracts, CPD and flexible working arrangements.

Lack of training posts/study places: in systems where health professionals leave because of insufficient opportunities to train or specialize in the home country, policy efforts are likely to involve *health workforce planning* to assess the workforce needs of the system and coordinate training capacity accordingly, as well as measures to *train and develop the future health workforce*. Given the time required to, for example, set up new training facilities, measures to *facilitate returns* and *country-to-country collaboration* with destinations can be interesting to encourage circular mobility and knowledge transfer.

Unemployment: in a system which is not able to employ the health professionals it trains, it is important to establish whether this is due to the inability to meet the costs of employing health professionals, or a structural overproduction of health professionals. In the former case, financial measures such as channelling funding to the health workforce budget might be a solution, while in the latter case *health workforce planning* could help to better adjust educational capacity to the needs of the system. *Country-to-country collaboration* to explore options for destination systems to co-fund mobile health professionals' education and training could offer a way to partly compensate for the costs of outflows.

Crisis-hit countries: the economic and financial crisis which hit Europe from 2008/09 has affected health systems and health workforce mobility considerably, although to varying degrees (Dussault & Buchan, 2014; Thomson et al., 2014). The countries hit hardest by the crisis form a sub-group of source countries because of a distinct constellation of factors: the implementation of austerity measures have worsened the employment and working conditions of the health workforce with knock-on effects for mobility incentives; the general social, economic and political context is likely to encourage outflows, including of health professionals; the health system cannot afford to hire or retain workforce; and the country is likely to suffer from the effects of structural unemployment caused also by "inflows" of health professionals previously employed in the private sector seeking to return to public sector work. In these circumstances, policy options will need to focus on low-cost *retention measures*. In Hungary, for example, tax revenues from "sin foods" have been earmarked to fund a scholarship programme which commits participating resident doctors to work in the country after specializing for a duration equivalent to that of the bursary (Dózsa & Szigeti, 2015; European Commussion 2015). In Romania, emergency measures have introduced a scholarship for young doctors who were particularly affected by salary cuts (European Commission 2015a).

5.3 Implementing EU level policy options for addressing the consequences and opportunities of free mobility

The EU has a special role in the implementation. It can address all areas of Union policies, such as the recognition of diplomas and the functioning of the EU labour market. But it can also help to set the political agenda by initiating research and discussion and creating platforms for best practice exchanges between Member States. This capacity to instigate debate and action is of utmost importance whether implementation takes place at EU or country level. Most activities so far have been bundled under the European Commission Action Plan for the EU Health Workforce.[14] The Action Plan focuses on four topics, including improving health workforce planning and forecasting, better anticipation of skills needs, stimulating exchange on recruitment and retention, and supporting ethical recruitment. To implement the Action Plan, the Commission sponsored a host of projects, first and foremost the Joint Action on Health Workforce Planning and Forecasting which has become a European platform of more than 80 members to share good practice and to develop methodologies on forecasting health workforce and skills needs. Its results include a study on the applicability of the WHO Code in the context of the Single Market.[15] To improve the qualifications of healthcare assistants, with a particular emphasis on cross-border mobility, a project is researching the feasibility of a common training framework for health care assistants under the Directive 2005/36/EU on the recognition of professional qualifications, while a recent European Commission study reviews effective recruitment and retention strategies to inspire solutions for organizations and countries to attract and retain health workers (European Commission 2015, 2015a). The implementation of the Action Plan and general health workforce issues uses Member States' resources

[13] http://www.hse.ie/eng/services/Campaigns/nurserecruitment.787711.shortcut.html

[14] Commission Staff Working Document on an Action Plan for the EU Health Workforce. SWD(2012) 93 final. http://ec.europa.eu/dgs/health_consumer/docs/swd_ap_eu_healthcare_workforce_en.pdf

[15] http://euhwforce.weebly.com/uploads/2/3/0/5/23054358/150609_wp4_who_applicabilty_report.pdf

and a multitude of Commission instruments, derived from a range of programmes under different Directorate Generals (Greer, 2014).

A second point, which should be taken into consideration when implementing policy options, is the strengthening of intersectoral governance at European level. Working across different levels with Member States is challenging. But just like in the Member States, many important policies are outside the remit of DG SANTE, such as the directive on the mutual recognition of professional qualifications, which is with DG GROWTH and working conditions which is the responsibility of DG Employment. Of growing importance is the influence of the European Semester which, in the context of fiscal governance, issues country specific recommendations (CSR) including on health care and the health workforce.

Finally, when choosing among policy options, a further improvement of the data situation would be of great help. WHO, OECD and EUROSTAT have included for the first time in 2014/2015 in their joint data collection a part on health workforce migration, including data on stock and flows of foreign-trained doctors and nurses.[16] It will be of great importance that these data are made publicly available in a timely manner and that the international agencies work closely with experts and Member States in helping to close data gaps and improving the data quality and comparability.

6. CONCLUSIONS

This brief analyses the impact of free mobility of health professionals for destination countries, source countries and the EU as a whole, and presents the policy tools decision-makers can use to mitigate the negative and encourage the positive effects of mobility. In doing so, the analysis builds on an earlier brief (Buchan, 2008), and adapts the scope of analysis to focus on the EU-specific context of freedom of movement and take account of the WHO Global Code of Practice on the International Recruitment of Health Personnel adopted in 2010.

The effects of health professional mobility do not lend themselves to easy conclusions. In source and destination countries and at EU level, mobility advances efficiency and equity in some contexts, but creates or aggravates inefficiencies and inequities in others. Mobility can help balance the supply of and demand for health workforce, stimulate skills transfer and fill service gaps, just as it may contribute to worsen intra-EU disparities, distract policy-makers from tackling underlying health workforce issues, or be wasteful if the skills and qualifications of incoming health professionals are not used to full potential.

Health professional mobility is not in itself "good" or "bad", but targeted, well-conceived policy measures can make it work better. In line with the Code, which calls for strengthening health workforce development and for "properly managed" migration, the brief lists policy options which aim at fostering health workforce sustainability and options which aim at managing mobility, but adds a third level – EU-level policy options responding to the consequences and opportunities of free mobility. Such an approach recognizes the complexity of mobility and argues that policy action must be correspondingly clever to deal with the multiple, equivocal, overlapping and dynamic effects of health professional mobility. The first set of policy options will be useful to seek to prevent some mobility by addressing the shortcomings which lead health professionals to migrate; the second set of policy options seeks to get the best out of mobility for systems and health professionals since EU flows are likely to remain important; and the third set of options recognizes that in the EU free movement zone, where individual countries have less room for manoeuvre, collective means and joint policy action might be the only way to fully respond to the reality that mobility creates a labour market where EU health professionals increasingly form one EU health workforce.

[16] OECD, EUROSTAT, WHO Joint Data Collection on Non-Monetary Healthcare Statistics. Joint Questionnaire 2015. http://www.oecd.org/statistics/data-collection/Health%20Data%20-%20Guidelines%202.pdf

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The **Division of Health Systems and Public Health** of the WHO Regional Office for Europe supports the Member States in revitalizing their public health systems and transforming the delivery of care to better respond to the health challenges of the 21st century by: addressing human resource challenges, improving access to and quality of medicines, creating sustainable health financing arrangements and implementing effective governance tools for increased accountability. It assists Member States in answering critical questions.

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