Viorel Rotilă

The impact of the migration of health care workers on the countries involved: the Romanian situation

Abstract

This article examines the east-west migration of health care workers in the context of EU integration. Taking as its starting point three research studies carried out by the author into attitudes towards migration and the quality of professional life of Romanian heath care workers, the article pinpoints some of the major policy issues implicit in the migration debate, including the need of western states for labour to support their own health care systems and their ability to attract it in the context of a free market from states whose health care systems are less able to support the loss of personnel in this way. The article develops a formal theoretical model of the 'push' and 'pull' factors implicit in migration decisions and, in the context of an examination of the causes of migration, focuses on the factors which facilitate and discourage such decisions. It concludes with a study of the effects of migration, focusing largely on the health care systems of departing countries but also encompassing the impact in destination ones.

Keywords: *Romania, health care systems, health care personnel, east-west migration policies, free movement of labour, EU integration and the internal market, 'push' and 'pull' factors, model of migration decisions, loss of training investment.*

Introduction

The migration of medical staff can be seen as one of the main effects of globalisation, since it implies major social and personal changes, both for those leaving a country as well as for the ones left waiting at home. The phenomenon of the migration of health care workers has been termed the 'care drain' or the 'health care brain drain'. By the migration of health care workers, we mean the movement of this category of employees from their native country (also called the *departing country*) to another country (also called the *destination country*). Considering the necessary time required to train a health care worker, we believe that the migration of this category of employees should be taken as a part of the 'brain drain' process and as an even more accurate assumption in the case of the migration of doctors.

In researching this social phenomenon, we were concerned about the causes that encourage migration, i.e. about the circumstances that favour its development and sustain its impact, both in departing countries and in destination ones. Thus, it is important to develop models of migration which look at the timings of these movements, decisions to relocate, choice of country and so on.

The EU situation

As stated in an ILO document (ILO, 2006: 1), it may be highlighted that the media has drawn attention to a leaking of staff from eastern countries to western ones without having any real proof of such a phenomenon being displayed, thus creating more of a media hysteria. A very important question may, however, be drawn: is there a consistent migration of health care workers from eastern Europe towards western Europe? The difficulties of a real social investigation are, once again, revealed by the lack of a monitoring system at pan-European level. To shed some light on this issue, this article presents a case study of the data we hold at this moment on the situation in Romania.

It is obvious that there is a certain attraction of salary levels in western Europe compared to those in eastern Europe; under these circumstances, the present fluctuations in western countries will be overcome by an east-west flow of labour. For example, in the UK, about one-half of new employees in health care departments, and nearly one-quarter of newly-employed doctors, are foreigners. This shows that, without the migration factor, the UK health system could collapse (ILO, 2006: 17). It must be stated, however, that, even though compared to eastern countries salaries in the UK are considerably higher, nurses have started to leave their current jobs, being more drawn to job offers in the US and Australia.

For institutional reasons, the European Union supports the migration of health care workers (like any other kind of migration inside an integrating Union in what is termed mobility) in order to compensate for the lack of staff in the western part of Europe. The mobility of health care workers is a very big issue for the EU on the following grounds: it is said that this will lead to a better labour market in the Union with which to deal with globalisation (for example, to ensure equilibrium between lowly-staffed areas and more heavily-staffed ones); it contributes to workers gaining new skills; it trains workers to adapt to the demands of new labour markets; and it eases living standards and the working environment (ILO, 2006: 24). One part of the mobility strategy is those directives which concern the recognition of qualifications at the European level. There are situations in which the decisions of the Commission have led to a stressing of the demand for more health care staff: for example, the directive concerning working time has led to a demand for personnel as a result of the cutting back of employees' working hours.

Even though some European states are confronted with acute labour force shortages, they do not have specific policies on migration because of the desire to minimise the negative effects and maximise the positive ones; this attitude leads to other unresolved issues and even the reaching of extreme situations (as in the case of Italy, which encouraged illegal migration and acted impulsively towards the problems caused by some immigrants, problems caused by their own ignorant attitudes). In some cases, there has even been an informal selection of immigrant workers based on their ethnicity.

Case study: Romania

We have analysed the migration of medical staff as it applies in Romania for two particular reasons: it fits the profile of those eastern countries which are relevant sources of migration for western Europe and, at the same time, we have enough information on this area through our own research studies. In the following pages, we will present

some results from three research studies we carried out in 2006 and 2007. The 2006 study was called *The quality of the professional life of health care employees and migration trends, 2006* (Rotilă, 2006); in 2007, this research was continued (Rotilă, 2007a) and a further research study developed from it called *Consequences of health care workers' migration from Romania: health care managers' prospects, 2007* (Rotilă, 2007b).

The study *Consequences of health care workers' migration from Romania: health care managers' prospects, 2007* (Rotilă, 2007b) was accomplished with the help of the Ministry of Health of Romania. The subjects of the research study were all health care managers, the objective of the study being to find out the impact of migration on those involved.

Figure 1 – Do you have a lack of personnel as a result of migration? (Rotilă, 2007b)

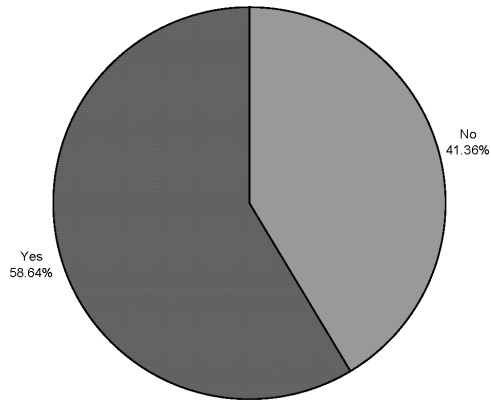
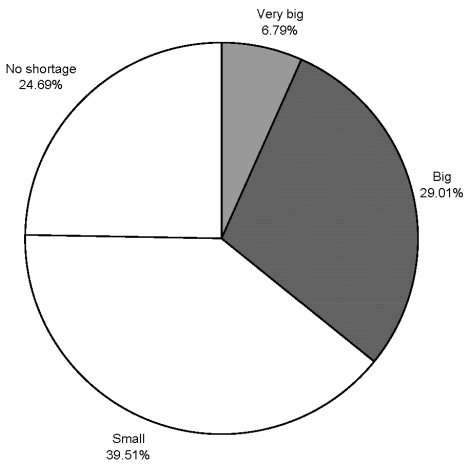


Figure 2 – How big is your labour shortage? (Rotilă, 2007b)



It is clear that 60% of managers perceived the cause of staff shortages to be migration by health care workers. Concerning the percentage of health care units noticing shortages, 36% of unit health care managers reported a major shortage of staff, while just 25% declared that they did not have a staff shortage problem.

Figure 3 – Is the professional level lower because of migration? (Rotilă, 2007b)

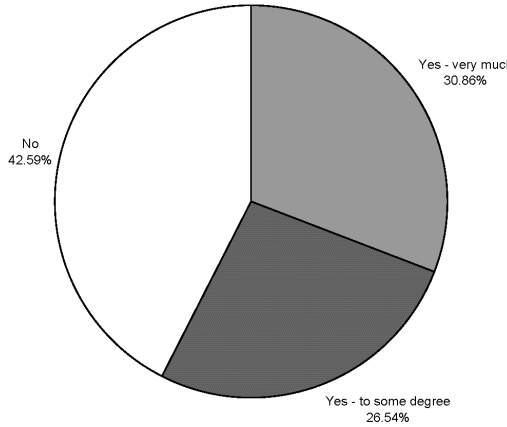
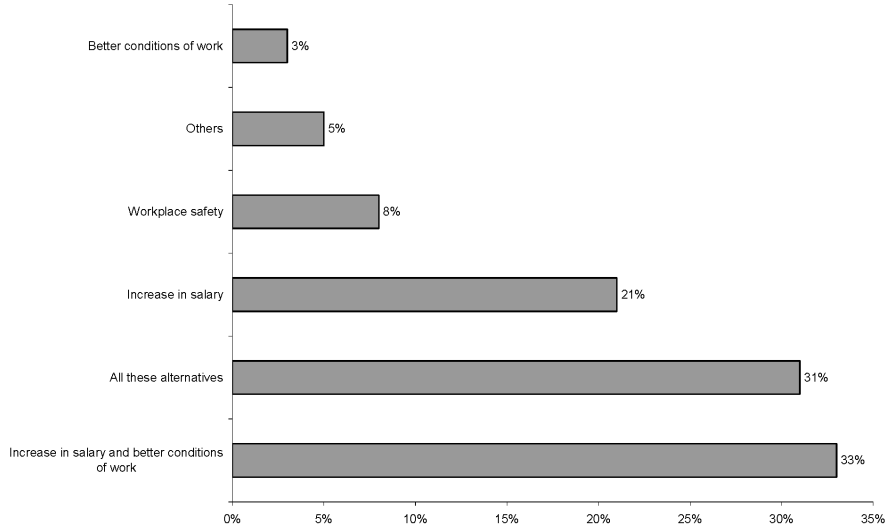


Figure 3 shows that almost 60% of managers believe that the migration of health care workers is the cause of a lower level of professional training.

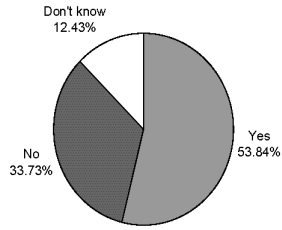
Figure 4 – What are the factors that could determine people remain in your hospitals? (Rotilă, 2007b)



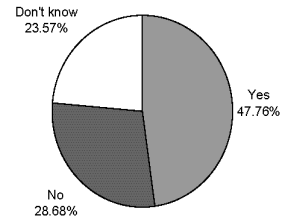
Concerning the measures of migration control, the most important is enhancing salaries in conjunction with instituting better working conditions.

Studies of health care staff working in Romania showed the following results:

Figures 5 and 6 – Are your rights as employees respected? (2007 and 2006)



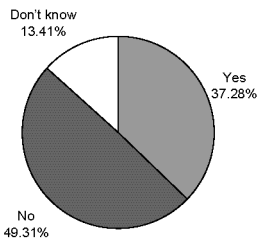
(Rotilă, 2007a)



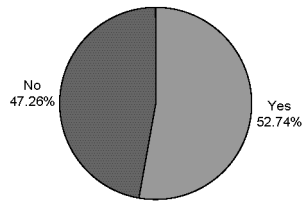
(Rotilă, 2006)

In 2007, only 54% of respondents answered that their rights as employees were being respected although, compared to 2006, we can see an improvement in this area. If we look at those who do not believe that their employee rights are being respected, we can see a year-on-year growth of about 5%. I investigated this perspective as part of the indicator called *working conditions*, an indicator that is also part of the 'push' factors influencing migration.

Figures 7 and 8 – Do you feel motivated in your profession? (2007 and 2006)



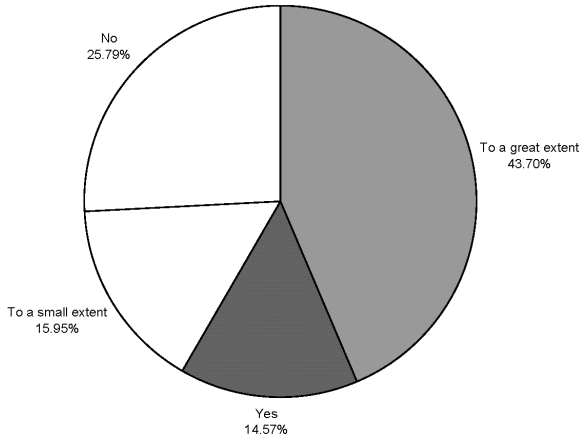
(Rotilă, 2007a)



(Rotilă, 2006)

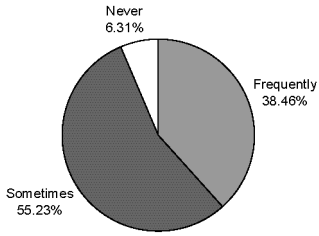
From a modern management perspective, we can see an important lack of motivation amongst respondents, about 50% referring to themselves as being unmotivated by their jobs. Compared to 2006, we can see a significant decrease in the percentage of those who report they are motivated (also reflected in the sizeable percentage of people who are unsure whether or not they feel motivated in their work, implying indifference towards this aspect), as well as a slight increase in unmotivated respondents.

Figure 9 – Do your working conditions allow you to practise quality nursing? (Rotilă, 2007a)

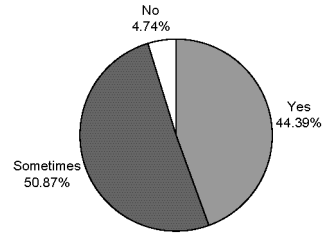


About 40% of respondents consider that their working conditions do not allow them to offer quality health care, or else allow them to do so only to a small degree; this situation reveals the importance of considering this factor as part of the motive for migration.

Figures 10 and 11 – Are you appreciated by patients? (2007 and 2006)



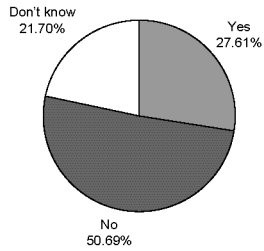
(Rotilă, 2007a)



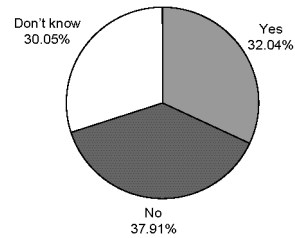
(Rotilă, 2006)

Considering the percentages here, we can state that there is something of a problem in the relationship between patients and health care system employees. This problem is noticed by staff (even if quality analysis would show that this has other causes from the patient or employee point of view). Compared to 2006, we can see a decrease in the percentage of people who consider themselves 'frequently' appreciated by patients and an increase in the percentage that do not consider themselves at all appreciated by patients.

Figures 12 and 13 – In your opinion, is a badly-paid but safe job better than a well-paid but insecure one? (2007 and 2006)



(Rotilă, 2007a)

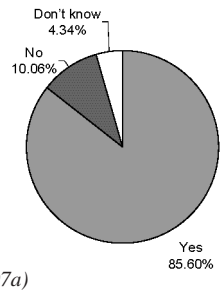


(Rotilă, 2006)

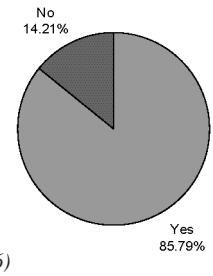
Comparing 2006 to 2007, we can see an important growth in the percentage of people that do not believe a poorly-paid, but secure, job is better than a better-paid, but insecure, one. This indicates a change in mentalities concerning jobs; a switching of interest towards higher salaries, albeit with additional risks.

It can be highlighted that more than half of those who appreciate the safety of their job are tempted to migrate; in contrast, 9% of respondents are not tempted to migrate even if they do prefer better salaries to a secure job. This can lead to the demonstration of a certain preference for working inside the country. Over half those who indicated that salaries are not sufficient for a better living standard prefer a better-paid job, even if it is insecure, assuming in this way a preference for risk. We must consider that 49% of respondents are part of the category that wants to migrate. This once again shows a tight link between salary levels and a desire to work abroad.

Figures 14 and 15 – Do you have colleagues working abroad? (2007 and 2006)



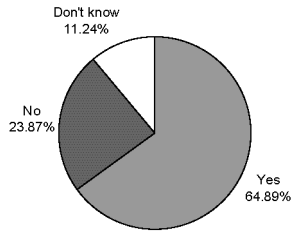
(Rotilă, 2007a)

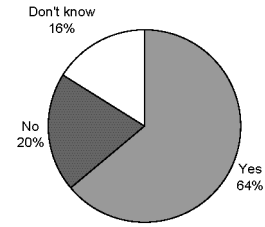


(Rotilă, 2006)

The response to this question indirectly indicates, on the one hand, a high rate of migration and, at the same time, that this works in such a way as to influence migration decisions. Comparing 2006 to 2007, we can see the same percentage of respondents declaring that they had colleagues working abroad, which shows a constant level of migration.

Figures 16 and 17 – Are you tempted … to work abroad for an attractive salary (2007)? … to work in another country (2006)?

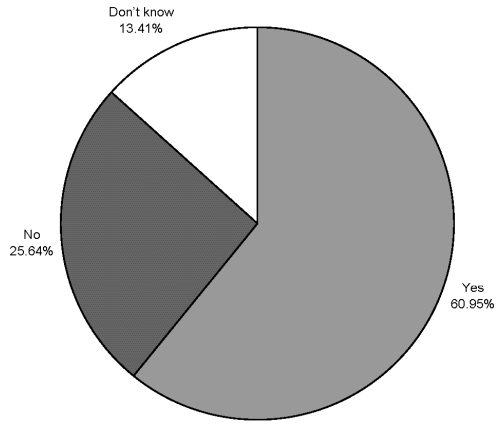




(Rotilă, 2007a) *(Rotilă, 2006)*

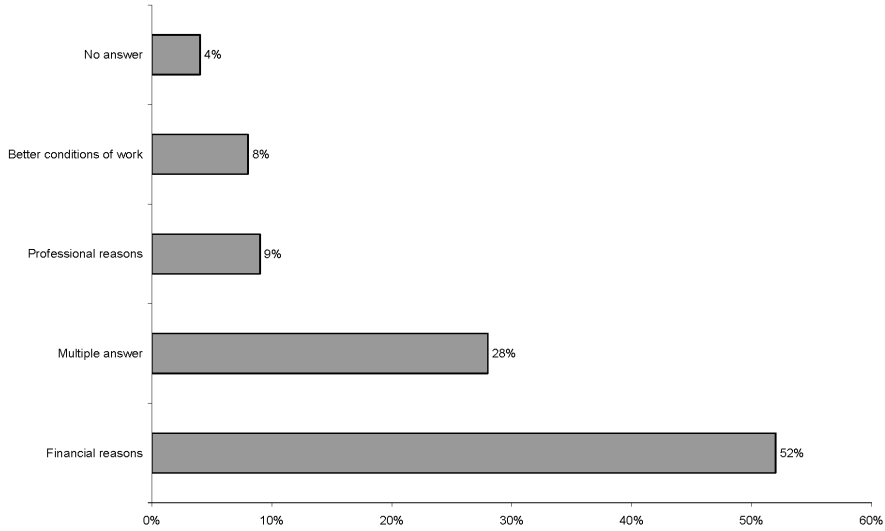
Sixty five per cent of respondents declare being tempted by the prospect of working abroad because of the higher salary which indicates, once again, the problem of poor salaries as being the main cause of migration. Compared to 2006, we can see very few changes. The majority of respondents tempted to migrate have colleagues that have already left, which suggests that their success in doing so offers a pressure to migrate.

Figure 18 – Do the opportunities offered by Romania's integration with the EU motivate you into thinking about working abroad? (Rotilă, 2007a)



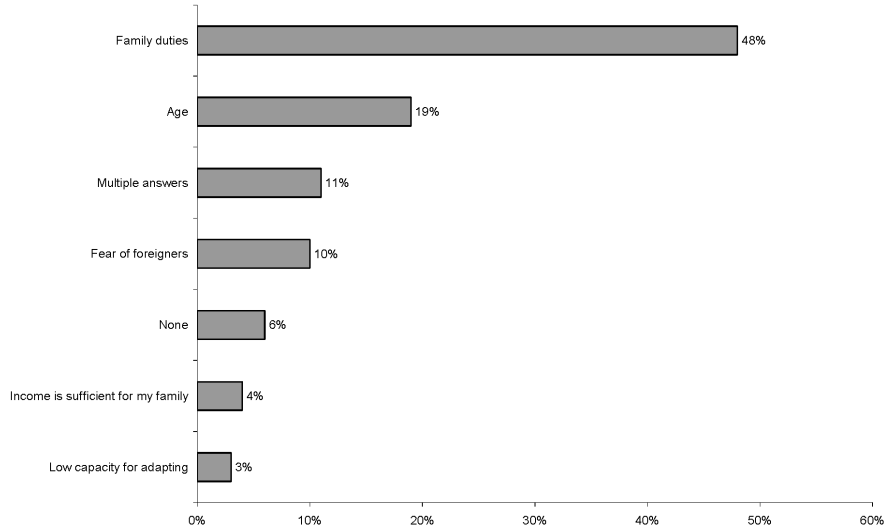
For 61% of respondents, integration within the EU represents an opportunity to find better-paid jobs in EU member states.

Figure 19 – Which of the following reasons could persuade you to work in a foreign country? (Rotilă, 2007a)



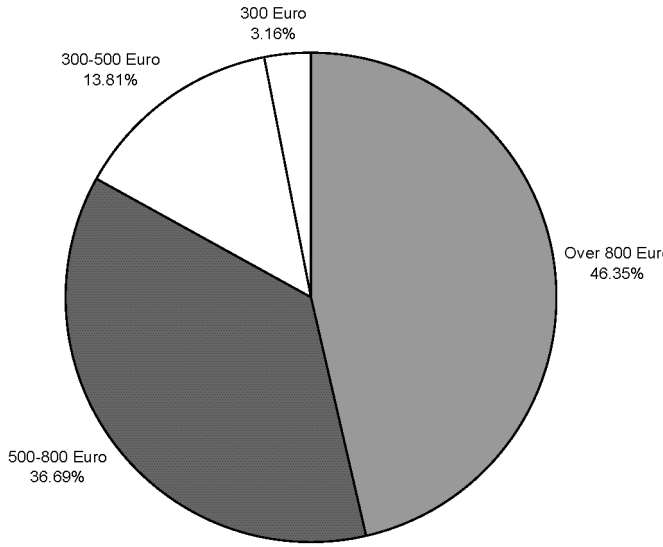
The main cause of possible migration is the possibility of higher rewards. It is clear that financial reasons are the most important factors given by respondents in their decision to migrate for work reasons.

Figure 20 – What reasons would prevent you from taking the decision to work abroad? (Rotilă, 2007a)



We can see here that the main obstacle that can occur to the making of a decision to migrate is family obligations, as highlighted by 48% of respondents. Taking second place is age. Concerning the reasons that would prevent migration for work, the family obligations here refer mostly to marriage. In addition, we can observe that the category that does not feel the need to migrate for a better salary tends to be married; a situation in which we can assume that the husband/wife has a better salary.

Figure 21 – What salary would be sufficient to make you ignore an offer to work abroad? (Rotilă, 2007a)



Over 36% of respondents consider that a salary of €500-€800 would definitely keep them from migrating, while more than 46% of respondents believe that a salary of over €800 would do so. These data indicate that expectations of salary levels are higher than are presently being received, but lower compared to the average salary level in EU countries. The results show that most employees would migrate for a salary of €500 to €800 or more, which highlights once again the financial motive and also the poor salary levels in health care, shown in their discontent regarding salaries in the country.

Summary

In conclusion, we can highlight the following data:

The study on *The quality of the professional life of health care employees and migration trends, 2006* showed the following conclusions:

Employees do not have a good opinion of the health care system while interest in health care reform is low because the outcomes have not met their expectations. The majority of health care staff stated that they were not able to provide quality services under their present working conditions. Also, respondents stated that they have insuf-

ficient salaries to ensure a comfortable standard of living. The same percentage of employees stated that migrating offers a good opportunity for financial comfort. Sixty four per cent of respondents take account of leaving to work in other countries; their main reason is financial.

The *Quality of the professional life of health care employees and migration trends, 2006* study showed these main points:

About 40% of respondents stated that their present working conditions do not provide them with the means to deliver quality health services, or to do so only in a small way. The answers of 52% of respondents showed that an insufficiency of resources and the poor management of those that do exist are considered to be the main causes of the problems in health care.

We saw that 52% of respondents consider that political interference in the management system is the major cause of a problematic health care system. Half of those interviewed indicated that they do not feel motivated in their jobs, linking this in particular to their salary level. The trend towards migration in the health care system was the same in 2007 as it was in 2006: 65% of respondents are tempted to migrate for a better salary, while 86% declared that they have colleagues working abroad, which shows the breadth of the phenomenon. The main reason for migration was 'low salaries'.

The *Consequences of health care workers' migration from Romania: health care managers' prospects, 2007* study indicated the following highlights:[1]

Romania has to deal with a high rate of migration of health care workers, determined by major differences between salary levels in Romania and in other countries (Italy in particular). The massive amount of migration leads to a decrease in the level of the professional training of staff, thus interfering with service quality. The Romanian health care system is confronted with a lack of trained staff, a problem which is growing worse. The principal measure to control migration would be a significant increase in salaries, accompanied by an improvement in working conditions.

It must be pointed out that, in Romania's case, the difference between the salary levels of those employed by the Department of Health in the country and those employed abroad is very large both in relative numbers (the sum of the gain) and also in real numbers (the sum of the goods that can be bought): prices, for the same product, are much higher in our country than those abroad.

1 We should mention here that, despite the research being developed in conjunction with the Department of Heath, all parties having access to the totality of information developed, the Ministry does not recognise the results of the study: the Minister of Health, Mr. Eugen Nicolaescu, stated in the media that the study was inaccurate. This contradiction between the data shown by the studies and the statements of politicians concerning the state of the health care system comes from the desire to create a better image of the system than is actually the case, as well as from the economic interests of the politicians in this area.

Currently, we consider that the migration of health care nurses[2] is the most common problem; in the case of doctors, the picture is not so much one of a massive migration following EU integration but one of a more gradual migration that encompasses two very important categories: young people capable of overcoming cultural and linguistic barriers; and skilled specialists, most often overqualified for their positions.[3] In both situations, this reflects a choice which is leading to a decrease in the average training level of those who remain in the country.

The causes of migration

In analysing the causes of migration, we consider it necessary to research two groups of factors that occur in the migration process: factors which are decisive and factors which are facilitative. In addition, separating them into two categories might sometimes have a relative sense, since some of the facilitative factors may be able to act as decisive ones; and *vice versa*.

Decisive factors

In looking at the decisive factors, we developed a simple division into two sub-categories: 'push' factors, i.e. those at work in the origin country pushing people to migrate; and 'pull' factors, i.e. those at work in destination countries which attract people to migrate.

Push factors

These refer to conditions existing in the origin country, migration being caused mainly by:

- low salaries in the origin country
- the lack of decent working conditions
- the lack of professional[4] and educational opportunities.

It is clear that this list of push factors is not exhaustive; it indicates only the most important issues. We ought also to consider other factors, such as the insufficient resourcing levels of the heath care system, which leads to insufficient resources for delivering quality services;[5] the surplus staff and unemployment amongst this category;

2 The study *Consequences of health care workers' migration from Romania: health care managers' prospects, 2007 (Rotilă, 2007b)* indicated that, out of 2 288 employees that migrated in the first nine months of 2007, 1 835 were health care nurses, 339 were doctors and 54 were from other, higher levels of medical staff.

3 We should point out that this is about the potential elite and the present elite that is placed in the second category concerning job applications; for the last of these, they have most often had prior contact with the western system.

4 That has multiple causes; in Romania, we have the following: corruption; nepotism; and the lack of a selective value mechanism.

5 This can be interpreted in terms of a moral choice in the context of practitioners stating that they know how a patient should be treated but that they cannot carry it out for reasons to do with the lack of resources; many lives lost are the result of this. In this case, there is a gap between science and possibilities that might lead to some problems of a professional guilty conscience.

and other causes which are determined by the social and economic conditions applying inside the country. In some cases, for example, corruption is a push factor in Romania, especially through money being demanded from people in order that they may be employed.

Pull factors

These determine the level of attraction in the working arena through:

- better earnings
- better working conditions
- the existence of professional opportunities
- the material and professional success of those that have already left
- the enhanced standard of living.

We might talk about a degree of causality in the existence of the pull factors as being necessary in analysing migration trends, since the demand for medical staff in some western countries is a relevant indicator in this way. Trends concerning migration in Europe must be viewed within the circumstances of demographic movements, migration causing a growth in the population and ensuring the necessary level of workforce. We can see that the aging of the western population (caused by a growth in life expectancy and a decrease in the birth rate) is leading to a general workforce deficit; the predictions in this area up to 2050 are dire, national and EU-level politics being dependent on them. We might observe that the rate of aging of the population influences the shortage of medical staff in two main ways:

- decrease in employment
- aging of the workforce
- increase in demand for health care services.

Facilitative and discouraging factors

We consider that we should separate those factors that act to facilitate the migration of health care staff from those which determine the migration of this social-professional category, and that we must also establish what relationship exists between all the factors.

Facilitative factors

We do not intend to provide an exhaustive enumeration of all these factors, but we consider that, among the factors that are likely to facilitate an increase in the migration of health care staff, we have the following:

- growth in the accessibility of long-distance transport
- presence of recruitment agencies
- increase in the exchange of information, favoured by the internet
- international and inter-state agreements, as well as between union organisations
- immigration policies developed by states and regions that have a shortage of medical staff
- international standardisation of the forms of professional training
- agreements concerning the recognition of diplomas
- increase in services that benefit migrant workers through the legal framework created by the EU or by inter-state agreements.

Considering the orientation of the EU towards creating a single labour market, it is expecting that this will encompass a recognition of the diplomas for each and every country, which may imply an emphasis of migration from eastern to western Europe. Key in this sense is the EU directive which establishes that a medical professional registered in the system of any one country may practise in any other EU state. As long as this remains a facilitative factor as regards migration, it is left for us to determine the impact.

The trend towards a standardisation of medical equipment is also a facilitative factor in migration because it indicates a unification of the professional abilities required in this field.

Among other facilitative factors, there are the linguistic conditions which refer to the greater accessibility of English-speaking countries, as well as of other related countries (for example, for native Romanian speakers it is easier to learn to speak Italian or Spanish).[6]

A decision to migrate is attained by several factors at the same time, such as those concerning the personal situation and those that depend on personal and professional status.[7]

In Romania's case, the possibilities of migrating to the west, especially Italy, as well as the status of these jobs in the destination countries compared to other jobs that Romanians choose abroad (in the context of a powerful nationwide migration), has led to an increase in the rate of training in this field.[8] This indicates that the migration of medical staff must be seen in the general context established by the phenomenon of migration both in destination and in departing countries. Thus, if there is a powerful trend towards migration in a country, this will lead to an increase in the number of employees of the Department of Health considering migrating and in those who actually decide to do so, as well as in the numbers choosing training in this field as a result of the opportunities offered in this context. Additionally, if destination countries permit it, this phenomenon will further encourage migration as a result of there being more people of the same nationality in the destination country, as well as that health care workers may be accompanied by his/her wife/husband, or other family members, that may also work there. All these elements are part of what we call 'secondary migration' factors, helping the 'push'-'pull' system that we identify when thinking of causality factors in the migration of health care workers generally, and especially of health care nurses.

Discouraging factors

We should take into consideration in particular the following factors which may discourage migration:

- the necessity of obtaining a visa
- examination costs

6 Considering the large number of Romanian health care nurses who work in Italy, this assumption seems to be verified.

7 It is necessary to create a theoretical model based on the decision to migrate so as to discover the relationship between the factors that determine it.

8 On this issue, we can consider in some ways the training of health care nurses for 'export', an unintended phenomenon that is nevertheless implied within such a development.

- large transport costs
- the lack of accommodation possibilities
- linguistic barriers
- cultural barriers.

In some cases, the absence of one of the facilitative factors may change it into a discouraging one.

The theoretical model

The complex dynamics of the health care staff system in departing countries imply the reception of trained staff in the respective countries and natural exits (retirement, profession changers, etc.), as well as those leaving for other states. We believe there is a need in this particular case to build a theoretical model, a model which could indicate the possible problems and the points that need to be addressed with adequate policy tools. For example, in Romania's case, the Minister of Health has repeatedly stated that the migration of health care workers does not cause problems in the system because it is not widely manifest and because those who leave are quickly replaced.[9] If this were true, we would have a situation (real only in theory) in which there would be a considerably large rate of migration and no side effects for the departing country. We consider that the need for a model of this kind is sustained by the complexity of factors that interfere in the process, it being analysed within the greater context of the dynamics of the labour market which are specific to every country in the EU.[10] Also, the migration of health care workers needs to be set within the issue of migration in general, since it is linked to a number of factors that are found in both processes.

After analysing the ways in which all these factors interact, we have drawn the parameters for the resultant theoretical model in Figure 22.

9 As shown in the study data that looked at managers in the health care system; they oppose the Minister's position, stating numerous problems that have arisen along with the migration of medical staff.

10 Examining the European Union context, we can ask ourselves if migration in the traditional way actually occurs, given that the freedom of movement of workers is one of the principles that governs this area.

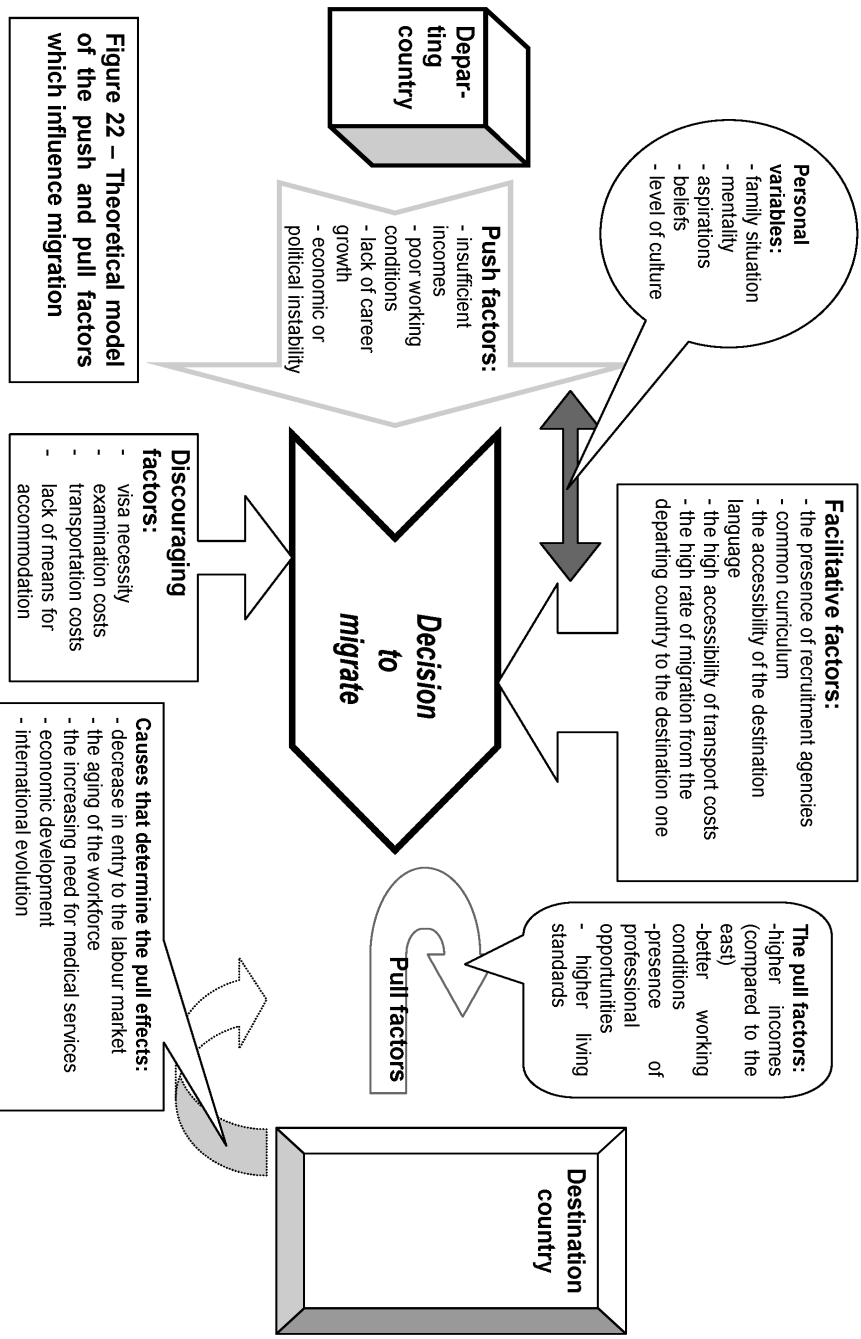


Figure 22 – Theoretical model of the push and pull factors which influence migration

We have sketched here only the general directions of the forces involved; an explanation of the relationships that emerge between each of the factors is also necessary. For example, we can ask what is the effect of 'push' factors in the absence of 'pull' ones? In order to answer this question, we must start by establishing the relationship between the two factors and then between these two and the facilitative ones as well. If most of the 'push' factors survive in the absence of 'pull' ones, and if, under these circumstances, the number of exits from medical professions is still at a high rate, then the locus of the determining causes can be identified within departing countries, making any measures by destination countries to stop migration useless.

The effects of migration

We believe that an analysis of the effects of migration should be oriented in two ways: their effects on departing countries; and their effects on destination countries. In both cases, discrete mechanisms and consequences are implied. Obviously, a theoretical model of migration should include, in another layer, its effects, one of these being able to react as causes that imply the increase or decrease of migration, or as facilitative or discouraging factors.

The effects on departing countries

We may consider the several side-effects of migration on departing countries as follows:

A decrease in the level of professional training of staff remaining in the country

We may identify that this has two sources:

- the high percentage of well-paid employees that leave and the departure of those with experience
- those who fill vacant positions (when put out to competition) are often selected by bribe[11] and not by a fair, qualitative selection.

Affects on society's need for a functioning health care system capable of ensuring quality health care services

In this domain, the level of vulnerability of the system matters, migration having a side effect especially on the attempts of developing countries to improve their health systems (Buchan *et al*, 2005: 3). We should point out that the functioning of health care workers in the system is affected as well as the whole existing nationwide process of migration. For example, in Romania, the situation created by migration[12] has led to major problems as a result of a decrease in the number of paying citizens contributing to the social security health care system. The majority of Romanian citizens working in other states are people active in the labour market and paying social security contributions in the country in which they are working; at the same time, these

11 In some cases, contests are transformed into auctions. Amongst 'professional folk', there are rumours of bribes paid to employers of thousands of euros, the average sum being somewhere between €2 000 and €3 000. We consider this aspect needs to be taken into serious account in a separate study to obtain correct and thorough information.

12 Estimates refer to three or four million citizens who have migrated for work, but with the caution that there is no certain information upon their number.

people have family members living in Romania (some of them children, elderly or unemployed people) and who benefit, without any payment, from the services of the social security health care system. We can state in this case that the solidarity principle is being violated by citizens working in other states and not being alongside their own families.

We should refer at this point in the EU context to the portability of pensions, but we do not have a particular instrument for other rights deriving from social security. We believe that building a social security system and a health care system is required on a pan-European basis. In this way, this can contribute to ensuring a balance between citizens' right to move inside the EU and the need to support national health care systems. We consider that the solution presented from this point of view, at the EU level, is to guide contributions towards the family; in this way, part of the contributions paid by working members may be oriented towards the location of other family members who are insured, even if they are not contributing members, and who benefit from medical services. In this context, we believe that a definition should be offered as regards the family that includes the principle of solidarity.[13]

'Loss' of investment made in the training of departed staff

Those who depart demonstrate good skills in linguistic and cultural integration; an indicator of their higher level of training.

Loss of important human resources, the training of which takes several years

(NB in medicine the training period both for nurses and doctors is a lengthy one). It is possible that staff migration has a selective character; that people more qualified and more bold are more tempted to make this step, a situation that can lead to a reduction of capacity in the supply of medical services. This loss needs a coherent strategy regarding human resources in the health care system based on predictions and simulations of the effects of migration.

Concerning the lack of medical staff in eastern Europe, to the migration of health care workers we can add the link between the expansion of the economy and the necessary increase of workers in the medical sphere,[14] which leads to stress being places on the fault lines. In Romania, for example, the large number of health care immigrants may be added to economic growth. That there is no recognition at the official level emphasises the initial trends. Even if some health units do not claim labour shortages, such a situation is arrived at by an unequal geographical apportionment nationwide. Yet, we do not have an exact number for those who have left, for nurses trained, for employees, etc. so as to allow us to make a fair assessment of the staffing situation and to generate staffing strategies.

13 In other words, the solidarity principle ensures the functioning of social security health care.

14 Through this connection, we are aiming at an increase in the standard of living which implies a growth in life expectancy, one of the components of which is also an increase in the quantity and quality of health care services.

We can also indicate the following side-effects of health care migration:

- a decrease in the training capabilities of the new generation (a decrease in teachers, trainers, etc.) which can have a long-term effect on the ability to generate new entries to the profession
- a decrease in the general training level set by the selective values effect of migration
- a reduction in the exchange of experience between generations
- an overloading of the staff remaining with extra tasks (an increase in the volume of work), which might lead to an increase in migration trends
- frustration and lack of motivation for those that have remained in their own country
- increasing staff shortages.

If we consider the level of financial reward as a symbol of social value, the lower level of salaries in the Department of Health compared to other departments is rather grim; this can interfere in terms of encouraging migration, especially in the case of the area of long-term staff training. Evidently, the long period of time necessary for training in the health care field is one of the elements that should be taken into consideration when assessing migration and migration trends. The difference in the level of reward of those who have migrated and of those who are still at home is a very effective stimulant to strive for higher income in the country (even if that means taking money or accepting any kind of bribe from patients or, in extreme cases, even demanding such). This difference acts to demoralise workers concerning the level of recognition in their work as demonstrated by such low salaries.

We believe what needs to be established is the ways in which factors determining the lack of staff in western countries can imply staff shortages in departing countries, thus increasing the shortage (and, if so, there should be an estimate as regards the timescale for this). For example, if we consider the lower birth rate and increased life expectancy (factors that may well lead to a decrease in entries to the health care profession, as well as an increase in the demand for medical services), we should anticipate the moment when each of these factors will act to increase the present shortages. Concerning entries to the profession in the case of eastern European countries, it needs to be taken into consideration that the general level of migration can lead to major labour force shortages, shortages that might have an effect on entries to the health care profession as well. From a certain perspective, it is more efficient to act by increasing health care professions in destination countries in order to reduce migration.

In the context of the massive migration of Romanian health care workers, we may ask ourselves how this process can be evaluated; in other words, should this be seen as a positive or a negative phenomenon; or should we take into consideration the complexity of the situations that create the conditions which could be interpreted both positively and negatively?

The migration of health care workers is not always linked to problems in the functioning of health care systems if there is a decent strategy to lure medical personnel; we have the example of the Philippines, India and Cuba which have invested in training medical staff and then 'exported' it, looking for a long-term goal, such as in what those workers bring when they return. To take account of such advantages, there should be certain dynamics in the process and that those who leave do not take all their family with them in order that they return periodically. In other countries,

though, even a small percentage can cause very negative effects. Therefore, we should consider the effects of migration more thoroughly considering both the positive and the negative implications, in both departing and destination countries.

Besides the standard model of migration from departing countries to destination ones, we should be careful of other models that interfere, or that might interfere, such as the leaving of destination countries and the return to departing ones. When considering a return to departing countries, we can refer to positive effects, such as the exchange of competences (the reverse of the 'brain drain' flux), the financial consequences and the positive changes in mentalities.[15]

We must also consider that, in the migration field, the rewards from migration are a very important financial resource for under-developing countries, one that is more stable than direct investment or foreign aid (Dilip, 2003). Under these circumstances, we should take a better look at the context of the migration of health care workers in eastern and south-eastern Europe. Considering the high qualifications of this socio-professional category and the European Union context, we should also consider definitive migration, i.e. along with their families, since this is likely to lead to a further decrease in the financial area. We can also notice that, when considering migration, there is a higher rate amongst women and, as studies have shown (Connell and Brown, 2004, for example), women are more selfless than men in the same situation as they send a larger amount of money home. It is obvious, then, that we need to take a better look at incomes remitted to departing countries. This can be explained also by the high rate of earnings of these workers, perhaps the highest amongst migration workers, a fact which leads to increased financial resources.[16]

When we have a situation of a natural evolving growth but a weak economy, migration can be seen as providing an emergency door for the economy of that country and for the well-being of some of its citizens (Connell and Brown, 2004). However, given the demographic predictions in Europe, I do not think such situations can really occur and have a significant effect.

The effect on destination countries

Undoubtedly, the primary effect of migration in destination countries is a positive one, which is the resolution of staffing problems without the need for extra efforts by the state or private institutions to put together the resources to train this type of staff. Plus, in most cases migration involves young workers, without any family with them, and the most they do is pay their taxes to maintain social security systems. The sums paid by migrant workers often help to balance the social security budgets of destination countries. However, there will never be a case of a win-win situation taking departing and destination countries together, despite the remittances that migrant workers send home.

15 Here we mean the modification of mentalities especially concerning civic spirit, starting from our observation that migration is followed by changes in individual values. Obviously, we consider negative changes as well as positive ones.

16 It must be observed that these enhanced financial possibilities can act towards increasing the level of remittances or, otherwise, as a stimulant for bringing the family to destination countries, this leading in turn to a shortage of remittances.

The effects of migration are far more complicated than this, though, and not all are as positive for destination countries. For example, like a medicinal treatment applied to an organism, the solving of organisation's internal staffing problems via the hiring of workers from abroad may inhibit proper policies aimed at training their own staff. Even if it is possible to talk about compatibility in forms of training (especially in this new EU context), some differences are retained that can affect the functioning of systems in destination countries. Furthermore, migrant workers are there for work and so extra hours are often demanded from them despite the lesser salary. This might create pressures to decrease salaries more generally, a decrease that affects native workers directly.

Cultural differences and the long periods of time that are required for the cultural integration of working migrants may cause some problems to health care systems; to solve this situation, some intercultural training of nurses specifically to eliminate the cultural prejudices that can interfere with the treatment of patients is a good idea (Nichols, 2007). Foreign workers remain under a xenophobic shadow which can surface at any given time, especially in states that have just opened the gates of their health care systems for foreign workers but without having any culture of migration or the intellectual resources to integrate working immigrants. We can identify Italy in this case where subsequent to several Romanian incidents on Italian soil involving Romanians, and in particular as an effect of the media and political manipulation of these, a massive anti-Romanian wave was stirred up all over the country. This led to pressure on Romanian nurses working in Italy who now avoid speaking their language in public places. It is obvious that this kind of reaction has made some Italian citizens uncomfortable knowing that it is Romanians who are treating them.

Trends

The rapid development of the Department of Health, caused by the increasing number of types of health care services that are offered and of their complexity, also leads to an increase in the number of health care workers.[17] The development of the Department of Health is directly connected to the level of increase in the economy,[18] OECD studies even indicating a direct link between an increase in the number of medical staff required and the level of increase in gross national product (Simoens *et al*, 2005). At the same time, there is a powerful connection between an increase in the demand for health care workers and the standard of living of the population, other studies verifying a direct link between an increase in the number of doctors and nurses and the level of patient satisfaction and safety (WHO, 2002).

The increase in the demand for medical staff is also connected to advances in technology. We must also observe that the Department of Health is one of the few government departments in which technological evolution has determined a continuing increase in the demand for medical staff capable of working with these new tech-

17 Paradoxically, despite the economic increase registered in the past five years, the percentage of health care workers is still lower.

18 Relevant in this way is the difference between economically-developed countries and those in development concerning health care workers as a percentage of total workers (ILO (2002) *Statistics of employment in health services* refers to the International Standard Industrial Classification of all Economic Activities (ISIC, Ref. 3, 1990)).

nologies. This is a distinctively human-centred department, fitting into the 'services' category (even if, in the EU, health departments have not been retained within this category), where people take care of people. This means a low rate of replacement of the labour force with technological innovations.

The trends in this field are an increase in the level of migration of health care workers, determined by the maintenance and, sometimes, a forcing of the pace of 'push' factors, as well as a continuing lack of health care workers in destination countries that determine the 'pull' factors. If we consider destination countries as well-developed countries, economically speaking, then, even in circumstances of a growth in the development of departing countries, this will lead either to a maintenance of their status as destination countries or else they will become departing countries too. The western model is evidently leading, in circumstances of sound economic development, to a demographic decrease which implies the following:

- a decrease in the birth rate, having its main causes as: the decline of the family; the desire for financial security, thus restricting the number of children to a maximum of one or two per family; the desire for professional success (women's desire for careers having a negative effect on the birth rate); etc.
- an aging of the population as a result of an increase in life expectancy.

We should observe that the aging of the population is associated with an increase in demand for health care services, especially if we consider the development of living standards. This population category has the greatest financial resources and is more open to pay for necessary treatments, something which determines extra pressure on the system. Moving the model of elderly treatment within the family to an institutionalisation of them is also a factor that enhances demand for health care services.

Practical policies

To resolve the shortages of heath care staff in some western countries, some authors (Aiken *et al*, 2004: 69-77) have suggested that two measures be set down: nationwide investment in training the necessary staff; and building the professional skills of staff in developing countries to ensure staff where needed. This second model refers to the case of the Philippines, where the state has an 'export' policy for health care workers.[19]

One of the problems faced by those responsible for health care policies is observing the freedom of movement of skilled health care staff, and the possibility of their leaving to working abroad, without this affecting the fundamental right of the population to minimum health care services (Hamilton, 2004).

The visa system (for non-EU citizens) is a way of restricting the phenomenon of migration (where desired), as are work permits; they both work as instruments of control. The recognition of qualifications might be added to these. Also, through the international codes of recruitment of health care workers, some recruitment from particular countries might be prohibited because of problems with the security of their

19 The Philippines government is interested in the amounts of money sent to families back home.

health systems. In this way, some attempt is made to balance the right of the citizen to free movement with society's right to have a functioning health care system.

We state as principal recommendations for these kind of policies the following (Buchan *et al*, 2005: 4):

- establishing an international monitoring system for the migration of health care workers
- developing an accurate policy in departing countries to overcome the lack of staff caused by migration
- orienting studies towards the identification of the costs and benefits of the migration of health care workers
- distinguishing the good practices in this field from the bad
- improving the image of health care workers in departing countries; poor image being one of the causes that determine migration.

Promoting the image of health care workers in society may be an effective method of restraining migration with regard to policies both in departing and in destination countries.

To intervene in recruitment companies is effective only to a small degree; real potential here may, however, be attained by establishing some codes of ethics within the Department of Health. Migration happens because of the system of supply and demand operating within the market mechanism, extended by the development strategies of such companies. Ethical recruitment codes can improve the fate of health care workers who migrate and can sometimes reduce migration. This is accomplished by turning down attractive offers of bribes and, when working with state institutions, by avoiding recruitment from states that have a shortage of staff. Studies and evaluations concerning the best and worst practices on this kind of migration are also necessary (Buchan *et al*, 2005: 24).

It is important to identify those factors that can contribute to keeping staff in their own countries, factors that are not only economic in nature; starting from this point, some good retention strategies need to be established and put into practice. For the migration of nurses, we should consider the trends already present at the time of the research because they have a double function: they possess a level of prediction concerning the phenomenon; and they also take into account 'fluidity' and level of attraction to other variables that often lead to re-orientations.

A very good example of such a policy concerning the migration of health care staff is offered by Buchan *et al*. (2005: 26), indicating some compensatory elements that have not yet been put into practice, such as compensating departing countries for their expenditure on professional training and educational support. It is obvious that, in this EU context, the accent being placed upon freedom of choice of workplace makes it hard to establish such compensation. However, the lack of any kind of compensation leads to a situation where well-developed countries benefit from the few resources of those which are in development.

A solution is thought to lie in reaching some agreements on this matter between states, agreements that will take into consideration the interests of each of the states, thus determining a win-win situation; except that this kind of agreement cannot be set at the level of EU states because, in the context of Community law, labour migration has a powerful 'internal market' character. Given the level of professional training and the EU context, we might consider that there is an implicit interest in stimulating

the migration of medical staff because it contributes to the creation of a European framework in this field via the implicit transfer of the 'know-how' that could ease the problems.

Conclusions

In dealing with the problem of the migration of health care workers, the main obstacle is the lack of standards and methods which are common to all the countries as a first step in discovering the necessary information to identify the extent of the phenomenon. Through a study of the law as it should be, we believe that the establishment of these kinds of mechanisms may be enforced. A very important role in this way is, therefore, to be played by the professional organisms of every state.

Many of the conditions that encourage migration concern human rights (the right to migrate being one of them), so naturally we cannot limit the effects just by eliminating the causes. Nevertheless, the question still remains whether migration should be stopped or only its effects, in circumstances in which the migration of health care workers needs to be viewed within the wider perspective. In other words, some communities benefit from this phenomenon while others do not. As long as the length of this phenomenon causes major problems for this particular professional category, the measures that envisage an improvement in the status of the job (salaries, recognition of social status (through appropriate salaries, for example), and so on) might determine an increase in the number of persons choosing this profession.

The problem of migration raises an ethical question: is it morally acceptable for developed countries, in order to cover their shortages, to 'import' staff from developing countries, causing important disturbances in so doing? This question may be answered in several ways. First of all, one aspect concerns people's rights to move around and choose their workplace. Thereafter, an ethical problem is raised by the existence of 'push' factors which can be interpreted in line with a negative view of departing countries (Buchan *et al*, 2005: 25).

Many implications of the migration of health care workers have been identified throughout several studies, but we believe that insufficient attention has been brought to the subject; that elements of its foundation have not been sufficiently researched, elements on which I have tried to shed some light in this article. The necessity of thorough research in this field is even more important in the EU area, where stimulatory policies for the circulation of the labour force can have unseen effects as regards health care workers.

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