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Going beyond numbers: A typology of health professional mobility inside and outside the European Union

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Abstract

In a context of current and forecasted global health workforce shortages, attention around health professional mobility is mounting as observers and policy makers recognise its role in supplying health systems with the workforce they dependent on to function, or depleting these systems of their doctors and nurses. The paper proposes a typology of health professional mobility composed of six types of mobile health professionals and three types of borders. The framework draws attention to the individual's decision to migrate and to the role laws and borders play as determinants for mobility opportunities. In doing so, the typology is able to identify which types of mobile health professionals are likely to escape data collection, to highlight the distinction between free mobility within the EU and migration outside the EU's external borders, and to act as tool for designing policies adapted to the diversity of health professional mobility.

1. Introduction

Observers of health professional mobility in Europe have noted three developments taking place over the last decade: the numerical increase in mobility; the persistent or growing reliance of some countries on foreign inflows of doctors and/or nurses; and the diversity of migratory patterns and behaviours (Dayrit et al., 2008; Humphries et al., 2013; Ribeiro et al., 2014; Wismar, Maier, Glinos, Dussault, & Figueras, 2011).[1] At the same time, awareness and concern are mounting about an imminent global health workforce crisis: according to European Commission estimates, the EU will face a shortage of 970,000 health professionals by 2020 implying that ca. 14% of health care services risk not being delivered. Similar shortages are expected in e.g. the USA and China, while the World Health Organization sets the current shortage at 7.2 mill, up from the 4.3 mill previously estimated, and forecasts a shortage of 12.9 mill health professionals by 2035 (Campbell et al., 2013). The global scale of the problem implies that numerous countries are affected and that low-income and high-income countries compete for qualified health

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professionals. There are serious concerns that health workforce migration is contributing to severe shortages of qualified personnel in lower-income countries, often where the needs are greatest (Dayrit et al., 2008).

Medical exceptionalism, a position developed by Alkire and Chen (2006) in relation to policy responses and migration, makes the case that ''[a]s crucial instruments of health, doctors and nurses should be treated differently (. . .) for ethical reasons that go far beyond their own well-being'' (p. 116). Health and access to health care are recognised as human rights by the Charter of Fundamental Rights of the European Union (Art 36) (Gekiere, Baeten, & Palm, 2010) and by the Universal Declaration of Human Rights (Art 25(1)). In this argument, the vital importance of health services renders health professionals indispensable and their migration too consequential to ignore. But health care is also exceptional in that it is a welfare service subject to global market forces. In most of Europe but also elsewhere, the health care sector is considered and governed as a public service part of the welfare state (despite growing pressures for privatisation). As governments have a responsibility to their citizens to provide health care, having the right number of health professionals with the adequate mix of qualifications and specialisations across the national territory becomes a key concern for the state. The social importance of the services involved mean that the mobility of health professionals would be more akin to the migration of school teachers and welfare workers that that of other highly skilled groups such as engineers and accountants. Yet, while the provision of most welfare services is heavily dependent on national curricula and country-specific qualifications, medical education as well as practice standards are undergoing a process of internationalisation and *market-driven convergence* (Cortez, 2009) which facilitate migration. Governments of source and of destination countries thus have significant policy and electoral interest in managing in/outflows to and from their health systems, but are challenged by global market forces of supply of and demand for health workforce.

These developments have contributed to placing health professional mobility on the policy agenda. At the global level, the Member States of the World Health Organization adopted the WHO Global Code of Practice on the International Recruitment of Health Personnel in May 2010 (only the second non-binding code in the history of the WHO since the adoption in 1980 of the International Code of Marketing of Breast-milk Substitutes (Dayrit et al., 2008)) (WHO, 2010). At the EU level, the European Commission's Action Plan for the EU health workforce published in 2012 (European Commission, 2012) and the Joint Action on Health Workforce Planning and Forecasting launched a year later (European Commission, 2013) signal an increasing recognition of the need to factor incoming and outgoing flows into decisions on the planning and production of health workforce. Several EU Member States face important in- or outflows of health professionals, to the extent that certain destination countries risk becoming dependent on foreign inflows to replenish the health workforce. In Ireland e.g. 40% of newly registered nurses between 2000 and 2009 were from outside the EU (Humphries, Brugha, & McGee, 2009, cited in Humphries et al., 2014) while the number of foreign-trained doctors registered on the medical register increased by 259% between 2000 and 2010 (Bidwell et al., 2013, cited in Humphries et al., 2014). In Belgium, 25% of all newly licensed doctors with basic medical training were foreign-trained in 2008 (Safuta & Baeten, 2011) while 43% of dentists who received a licence in 2006–2008 in Finland were foreign-trained (Kuusio et al., 2011); in Austria, the proportion of foreign-national dentists reached 41% in 2007 (Offermanns, Malle, & Jusic, 2011). High reliance on foreign inflows was also visible e.g. in the UK (42% of newly registered doctors) and Italy (28% of newly registered nurses) in 2008 (Bertinato, Glinos, Boscolo, & Ciato, 2011; Young, 2011). Data on emigration intentions from source countries show that e.g. 8.2% of practising doctors in Poland had applied for verification certificates by Dec 2007 (Kautsch & Czabanowska, 2011). In Bulgaria, the number of doctors applying for certificates grew from 260 to 440 between 2009 and 2012, while in Portugal, the number of nurses applying almost doubled in the 10 first months of 2012 (3202) as compared with 2011 (1724) (Dussault & Buchan, 2014).

Informing policy processes is made difficult by the fast-changing, dynamic nature of health professional mobility. Data collection is challenged as migratory patterns change much more rapidly than other population phenomena and are ''the only demographic statistic currently produced simultaneously by two different national statistical institutes – one the country of departure and one in the country of arrival'' (Thierry, Herm, Kupiszewska, Nowok, & Poulain, 2005). Most, if not all, European countries report insufficient updated and comprehensive data on outflows but also on inflows (Glinos, Maier, Wismar, Palm, & Figueras, 2011; Maier et al., 2014). A commonly used measurement of emigration in the EU – the number of requests for certificates of verification of their qualifications by doctors and nurses intending to leave – is imprecise as only a proportion of health professionals requesting the document go on to migrate, while many others migrate without the paper as far from all European employers ask for validated certificates. Moreover, mobility and employment patterns in the EU are becoming increasingly diverse with short-term contracts, rotas, self employment (including via private recruitment agencies), dual (part-time) employment, and commuting between countries e.g. for weekend shifts, making it more difficult for data collectors to capture the mobile health