



**ROUNDTABLE ON MOBILITY OF HEALTH PROFESSIONALS**  
**Meeting report**

***Mobility of Health Professionals (MoHProf) Project***

Funded under the EC DG Research Seventh Framework Programme (FP7) – Health Theme

## **Introduction**

The Roundtable on Mobility of Health Professionals was organized within the framework of the EC funded ‘Mobility of Health Professionals’ (MoHProf) project aiming to investigate and analyse current trends of the mobility of health professionals, i.e. nurses and doctors, to, from and within the European Union, including return and circular migration. Designed as a consultative process with stakeholders and policy makers, the roundtable, formed an essential component of the MoHProf project.

## **Hosting and Participation**

Hosted and organized by the International Organization for Migration (IOM), the roundtable was held in Brussels on April 27<sup>th</sup>. The roundtable fostered participation of policy-makers from various European Commission Directorate Generals, as well as representatives from Member States, international organizations, European Union funded projects, European professional associations and NGOs.

## **Objectives**

The roundtable aimed at providing initial insights from the first research phase (macro) into the mobility of health professionals by studied countries’ profiles and covering the topics of migration flows, motives and circumstances of migration, push and pull factors, information on health status, health system and policy framework, etc. and invite stakeholders and policy makers to contribute in providing inputs and defining the priorities for the second study phase (micro).

## Speakers and Presentations

Bernd Hemingway, Regional Representative, Regional Liaison and Coordination Office to the EU, International Organization for Migration (IOM) welcomed the participants in the roundtable and underlined the importance of understanding the growing phenomenon of health workers mobility, impacting the health systems of receiving, transit, and sending countries both in EU Member States and third countries. He further introduced the project consortium, covering organisations in the 5 continents and welcomed the diversity of participants to the Round table - a guarantee for rich and successful discussion.

Roumyana Benedict, Senior Regional Migration Health Manager, (IOM) opened the roundtable discussion and invited Ms. Isabel de la Mata, Principal Advisor with Special Interest in Public Health, DG SANCO, European Commission to present her key address to the audience.

Ms. De la Mata provided an overview of EC priorities and initiatives regarding the mobility of health professionals in Europe as well as to global health and notably presented the Green Paper on the European Workforce for Health and Open Consultation held (published results in December 2009). She highlighted that health care is a key strategic sector for the EU, and appropriate education and training is one of the issues requiring attention. She concluded by wishing a fruitful discussion to meeting participants.

### **Session I: Presentation of the key findings from the macro research country studies**

#### *Introduction to the 'Mobility of Health Professionals' Project and its two research phases*

Dr. Caren Weilandt (Deputy Director, Scientific Institute of the Medical Association of German Doctors, Germany) initiated the session by underlining the objectives and methodology of the MoHProf project which includes a literature analysis and in-depth interviews based on thematic guidelines with key stakeholders in the health system and health professionals (HPs) in selected countries: important EU destination countries (Austria, Germany, France, Ireland, Netherlands, Portugal, Sweden, UK); important sending countries (Africa: Angola, Egypt, Ghana, Morocco, Kenya, South Africa; Asia (Philippines, India), Europe: Bulgaria, Lithuania, Poland, Roman, Russia, Ukraine); important destination countries for EU staff (Canada, USA, Australia).

The project has been structured in three phases:

- Phase 1: analytical framework and research tools (finalized)
- Phase 2: qualitative and quantitative research on macro level<sup>1</sup> in EU and third countries: 25 Country Reports (to be finalized)
- Phase 3: qualitative and quantitative research on micro<sup>2</sup> level in EU and third countries (April 2010 – December 2010)

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<sup>1</sup> The macro research has for objective to collect existing data on the macro or national level including the analysis of regulations, incentives, programs, etc., as well as interviews with macro-level key stakeholders (i.e. stakeholders from national professional associations)

<sup>2</sup> The micro level research has for objective to generate qualitative data on the impact of regulations and program on the micro level by interviewing key stakeholders on the micro level (i.e. health professionals)

- Recommendations and dissemination of findings at International Conference on Health Workforce Mobility in October/November 2010 (March 2011 - November 2011)

***Western European Countries: France, Germany, Netherlands, Portugal, Sweden, United Kingdom***

Prof. Svensson (Consultant, Scientific Institute of the Medical Association of German Doctors, Germany) first presented findings from a selected number of Western European countries. He highlighted the fact that these countries are to varying extent destination countries and to a smaller extent sending countries (with the exception of Portugal). Data on immigration is available, however often scattered in different organizations. Data on emigration is weak, anecdotal or missing. In this respect, the study findings suggest the need of creating an EU observatory with links to national focal points to continuously monitor migration streams and motives within, to and from the EU countries and provide policymakers with factual background for their policy decisions.

Specific country findings:

- France: Immigration from non-EU Member States is minimal. There appears to be no active recruitment of health professionals abroad, nor discussion of ethical recruitment. Qualified professionals from non- EU Member States may be disfavored to take advantage of potentially less qualified health workers from new EU Member States.
- Germany: Emigration of health professionals from Germany is of minor importance. The ones migrating go either to English or German speaking countries. The largest proportion of foreign physicians in Germany originates from Austria. Rates of foreign nationals in health professions remain lower than in the overall workforce. The most significant group of immigrants in the health/social sector work is in care of the elderly and home care. It is estimated around 100 000 immigrant health care workers in the field of elderly care, mainly physicians from new EU Member States in ambulatory care.
- Netherlands: Migration of health professionals is currently not high on the agenda, although there is a net immigration surplus, mainly dependant on inflow from other EU countries. Cross-border work is relatively common from Belgium and of Dutch doctors to border regions in Germany. Migration of physicians and nurses abroad is of minor importance.
- Portugal: Portugal is a country that has changed over time from receiving to a sending country. Unemployment among nurses, dentists and technicians due to overproduction push them to emigrate to the UK, Ireland and Sweden. There are no policies to retain health workers and there is a significant diaspora in the country from Mozambique and Angola.
- Sweden: Sweden is a main employer in the health care sector, actively recruiting physicians and dentists abroad. The market for nurses is saturated due to the sufficient number of local nurses that balances the available vacancies. Training and educational efforts are mainly aimed at foreign physicians, coming from Eastern European countries and Germany. There is a large, mainly short term, cross border traffic of nurses and doctors to Norway due to the EU work directive and higher salaries.
- UK: The UK has nine separate bodies for different categories of health workers that set standards and register practitioners. Since the mid 1990s, the UK prioritized funding to

train and recruit sufficient national health personnel. Official policy states (soon to be law) that UK will apply ethical practices for recruitment of foreign health professionals, as well as recognise and support the health services and promote health in low income countries. Ghana and Kenya, both former UK colonies used to be major source of health professionals to the United Kingdom, mainly in the capacity of nurses. Lately, there has been a rapid decline in registration of foreign physicians who come from non-EEA countries while the largest EU sending country was Germany.

### ***Sending Countries from Central Europe and the Baltic***

Dr. Kaczmarczyk (Centre of Migration Research of the Warsaw University, Poland) presented findings from Austria, Ireland, Lithuania and Poland:

- Austria: The country has a strong immigration pattern accompanied by outflow of health professionals. There are a number of factors responsible for this, including historical and linguistic links with Germany and neighboring CEE countries. The educational system plays an important role as there are no entry exams in Austrian medical schools and the recognition of diplomas is relatively quick. However, the transition from school to work in Austria is difficult which pushes many young Austrians to go and study in Germany. Similar to other western European countries, Austria suffers from regional disparities between rural and urban areas and illegal migrant workers in the 24-hour care.
- Ireland: The case of Ireland demonstrates the positive effect of targeted political and economic interventions on the mobility of health professionals. Such were found to be the reorganization of the health system and governmental investments in selected policies, the changes in the educational system, the revision of the migration policy and especially the green card scheme success story. The positive demographic tendencies and the economic prosperity in addition serve as pull factors for HPs to Ireland.
- Lithuania: The country has experienced a rapid economic growth in all sectors, including health, however it was found to be greatly affected by the financial crisis. Being a country in transition, with large number of aging health professionals, large shortages of health professionals in 10 years time are to be expected. The pre-crisis governmental politics of increasing the wages of health professionals over 100% appeared to have worked temporarily, however following the financial crisis, the situation worsen both in terms of salaries and prestige. The migration rates for Lithuania are low and specific patterns of mobility are observed such as commuting and weekend shifts in Poland.
- Poland: The findings suggest negligible and very diverse immigration with respect to sending countries. Again, the structure of the health system and its reorganization appears to be the major push factor for health professionals moving abroad. Another serious problem is the difficult transition from university to specialization and the limited access to specialization positions, though being also under reorganization.

### ***Sending countries from South-East Europe and former USSR republics***

Prof. Kostadinova (University of Medicine in Varna, Bulgaria) presented the findings from the macro study in Bulgaria, Romania, Russia and Ukraine. She highlighted the fact that many of the conditions influencing the health mobility in Eastern European countries such as low pay and poor working conditions overlap with one another. This is attributed to similar economic

and health care infrastructures present in the region. The problems faced by all four countries mirror their historical past and economic experience and are now reflected in pushing health professionals to migrate to wealthier European regions. An additional factor for the significant immigration outflow is the long-lasting restructuring of the health care system. The lack of satisfaction with the reform, the political instability and the quick recognition of diploma after the 2007 entry to the EU in the case of Romania and Bulgaria further affect the high outflow rates. Language and historical links play an important role in the case of Romanian health professionals' decision to migrate to France and/or Italy. Better educational possibilities abroad in respect to the low quality of education and career opportunities/specialization in their home countries are another major push factor. On the other hand, family responsibility, social and cultural connections appear to be major stay factors in the region.

For Russia and Ukraine, the major push factors are the low remuneration and regional disparities (larger cities vs. rural areas) in health mobility and especially with regard to specialization. According to Prof. Kostadinova the pull factors for foreign health professionals attracted to these countries, on the other hand, are the higher remuneration, better working conditions, modern technologies, career development opportunities, better living standards, and recognition of diplomas as compared to the other countries in the region. At the same time both countries face aging population and increased need for health professionals mainly recruited from the former USSR republics.

### ***Sending countries from Africa (and interregional movement)***

Prof. Dambisya (International Organization for Migration) presented the findings from six African counties: Kenya, Angola, Ghana, Egypt, South Africa and Morocco.

The findings reveal shortages and misdistribution of workforce between rural/urban and public/private sector facilities (Kenya, Angola, Ghana); fair numbers, but misdistribution between public/private and rural/areas (South Africa; Egypt) and little attention to the outflow of health professionals (Angola, Morocco).

In terms of mobility patterns, health professionals from Angola move mainly to Portugal; from Kenya to the United Kingdom (especially nurses); from Ghana towards Anglophone countries - United Kingdom, United States and Canada. South Africa serves as a receiving, transit and source country with a temporary and declining nurse migration to the United Kingdom while Egypt's health professionals migrate mainly to Middle Eastern countries with temporary and circular migration to the EU. In Morocco, the international migration is not perceived as a problem, even though there are definite patterns of Moroccan doctors moving to France, Spain, Italy and Eastern Europe.

The common push factors for all six countries are low pay, lack of benefits, no incentives for promotion, interest in further education and training. Poor public service conditions and obligations to work in remote/hardship areas (Morocco, South Africa), corruption and political instability are further factors influencing the decision to migrate. Stay factors are the urbanization and economic growth and high quality of life (Morocco, Ghana and Angola) and increased demand for secondary healthcare services, i.e. private practice. In the same time, health professionals prefer to move and settle down in the EU countries because of the high

demand, associated with higher pay, level of freedom and integrity in the workplace, job stability and fear of starting all over again in home country, lack of return incentives.

### ***Source countries perspective (Asia)***

*Prof. Marilyn Lorenzo/, Prof. Jennifer dela Rosa, Institute of Health Policy and Development Studies of the University of the Philippines (IDPHS) (unable to attend on account of visa issues; account based on their handed presentation)*

The Asian sample covered the cases of Australia, India and Philippines. Similar to other country cases, the Asian countries suffer from increased migration outflow of health professionals. In this respect, the Philippines are a major source country and lead all Asian countries in the number of migrant professionals world-wide with close to 130,000 health professionals abroad (most of these migrants are reported to be nurses). India ranks second with an estimated 86,000 health professionals worldwide. Unlike the Philippines, India mostly sends out physicians, which makes up about 65% of all their health professional migrants. Australia is a transit country – both a destination and source country. About 4,500 or (64% of all HRH migrants) Australian nurses and 2,000 (28% of all HRH migrants) Australian physicians were reported to be migrant health professionals worldwide in 2001. The knowledge of emigration from Australia is limited as it reflects only the data obtained from the exit card when leaving Australia.

The key findings in Asia pointed out during the presentation:

- The emigration of health professionals seems to be driven by external demand of destination countries as well as by existing conditions or situations in source countries (such as poor work conditions and low pay) and destination countries (promise of better compensation and career opportunities).
- While all types of health workers have the opportunity to emigrate, nurses and doctors seem to constitute the bulk of health professional migrants.
- Currently available data on the mobility of health professionals showed that source countries may have information on temporary and permanent health professional migrants, but data on the same migrants when they arrive in destination countries are not available. Such may include placement, entry, citizenship, licensure/ certification and retention. Particularly data on circular migration especially on re-entry is not available. There is limited data on the emigration of skilled health professionals especially in India and Australia.

An important outcome of the study that has to be further discussed is the creation of policy development center to research on how to make mobility of health professionals mutually beneficial for both source and destination countries and promote/develop the role of bilateral and multilateral agreements to contextualize the conditions of mobility across countries.

### ***Destination countries for EU health professionals (US, Canada)***

Dr. Mary Pittman and Dr. Christine Brown Mahoney (Public Health Institute in Oakland, USA) presented their findings from the study on health professional mobility to the United States and Canada. Dr. Pittman highlighted the fact that the United States have projected a shortage of 100,000 physicians, 1 million nurses, and 250,000 health professionals by 2020. In the same time, the changes in the public health insurance coverage, implemented in 2010 in

expanding and coordinating eligibility, services offered and the modifications of payment and insurance mechanisms would increase the demand for health care workers and the urgency of better planning. A list of pull factors to the United States amongst which diverse population, democratic nation, high quality of life, strong economy, advanced medical technology and more opportunities for women attract significant numbers of health professionals to compensate the higher demand, however it will present a challenge for countries which experience a brain drain of medical staff.

Canada also suffers from health professionals shortages, having a physician's density below the OECD average, a decrease in health workforce capacity due to practitioner's age, and an increased need for chronic care management and end-of-life services. In the same time a number of pull factors attract health professionals to the country amongst which high life expectancy, multiculturalism, close proximity to the United States, political stability, high quality of life, strong and diversified economy, publicly financed and administered health care system.

### ***Introduction to the next phase of the MoHProf project: the micro-research***

Following the overview of country studies, Dr. Caren Weilandt introduced the next study phase of the MoHProf project – the micro research. She explained that the micro study will provide a deeper analysis of the individual choices and detailed information on the characteristics and driving forces of mobility of health professionals in terms of mechanisms and strategies observable, and provide data on the sectorial and regional dimensions of mobility. Through interviews with recruiting organizations, recruitment agencies, migrant health workers, diaspora organizations, students at medical/nursing schools and other key informants relevant at the national level, the micro research phase will be able to illustrate in detail the process, motivation and experience of health professionals in respect to mobility.

Some of the issues that the next phase of MoHProf will investigate:

- What strategies of mobility do different subgroups of health professionals apply?  
*Strategies such as getting medical certification from origin country, applying for medical/nursing school in a different country or migrating under different occupational title.*
- What are the typical patterns of mobility for certain professions? Which groups are mobile, which are not and what are the reasons behind it?  
*Research in some countries such as Egypt has shown that doctors are much more mobile than nurses, what are the reasons behind this phenomenon?*  
*Investigating whether professionals work short term in different countries without settling*
- What are the legal and organizational bases for employment?  
*Investigating recruiting organizations, agencies, health professionals' regulatory bodies and their methods in helping find health professionals' employment.*
- How is the migration process stimulated by different factors such as social networks, recruitment agencies and hospitals?  
*Investigating how the migration health process is stimulated by the close connections between health professionals and the hospital demands for more staff. As seen in the Lithuanian case nurse shortages is rampant – how does that stimulate the mobility process?*

- What kind of institutional actors are involved in the mobility process?  
*Investigating how professional health regulatory bodies in health such as nursing and medical councils, Ministry of Health and Ministry of Labor influence the mobility of health professionals.*
- What are the main driving forces behind the decision to migrate/re-migrate?  
*Further investigating the push/pull factors that are responsible for the mobility of health professionals throughout the world.*
- What is the impact of the educational systems on mobility?  
*As seen in the Lithuanian case where the lack of entry exams to Austrian medical schools played a great role in the mobility of Lithuanian health care workers to Austria, educational systems play an important role in the mobility of health professionals.*
- How can the monitoring of health professional migration as basis for an effective health workforce planning be harmonized and improved in Europe?  
*By monitoring the migration of health professionals throughout Europe would there be a clearer picture of what are the issues, opportunities and problems facing not only the health care professionals, but also the health care systems of Europe.*
- How can/what steps can be taken in order for the mobility of health professionals to the European Union be mutually beneficial for both sending and receiving countries?
- How can EU Member States contribute to the strengthening of retention strategies within the source countries?  
*As seen with the current research, many Member States suffer from poor internal working conditions and low wages, what strategies can be employed to improve these conditions and thus prevent health professionals from leaving. Do we need to train more health professionals overall?*
- How can MoHProf contribute to the supporting of the implementation of the WHO code of practice on the international recruitment of health personnel, adopted at the 63 World Health Assembly in May 2010?  
*In which ways if any an overview project such as MoHProf can contribute in supporting the situation of the health care personnel in Europe and globally?*

## **Session II: Interactive workshops in working groups on key issues for the micro-research phase**

After the presentation of project findings in the first session of the roundtable, participants were divided in two groups to debate the following three questions:

I//What are the priority areas for policymaking as relates to mobility of health professionals into, within and out of the EU?

II/What evidence is needed?

III/What could MoHProf contribute?

***Group 1 (Chair: Maria Gallotti, Senior Expert on Migration, ILO Brussels) Rapporteur: Dr. De Roodenbeke (International Hospital Federation (IHF), France)***

Dr. De Roodenbeke reported, after the animated discussion, that representatives from member states, international organizations and research institutes, present in the group discussion, came with the following list of proposals that need further attention during the project's micro phase: the role of training programmes and qualification possibilities, recruitment criteria and continuous education possibilities and how they relate to mobility, choice of staying or leaving the country; utilization of the health work force and the relation to the pension reforms and the question of how to optimize available skills; regional disparities between rural and urban areas within the countries and maldistribution of health professionals; inconsistencies within the national policies and how health managers manage to balance between the local pressure of delivering care and recruiting the necessary health workforce with the financial resources available; lack of data on emigration from the EU; mechanisms of temporary migration; irregular employment and consequences for the sector; gender and diversity issues and the importance of gender dimension of mobility.

***Group 2 (Chair: Jean-Marc Braichet, Acting Coordinator Health Workforce Migration and Retention Unit, Department of Human Resources for Health, WHO Geneva) Rapporteur: Prof. Dambisya (IOM)***

Prof. Dambisya reported the following topics of interest for the participants in the second work group discussion: education policies and the low investment in training of health professionals in the context of high global demand, ageing populations and longer care needed; forecasted shortages of health workers in Europe and the US and the continuous recruitment of health workers from abroad, when often no additional places are planned in the medical schools; validity of qualifications across the border and how this can be translated into the quality of care; mobility of students as a growing phenomenon in the EU; outflow of less skilled, mid-level professionals from hospitals and respective discrimination practices; human resources planning; integration of health professionals after migration.

The WHO Global Code of Practice on the international recruitment of health personnel (adopted in May 2010 at the sixty-third World Health Assembly) was also discussed. The Code addresses mobility patterns but has also looked at geographical distribution within a country and distribution between the different specializations. After the code adoption, the first priority is to make Member States and policy-makers aware of the existence and content of the Code and press for its further implementation. Then, there will be a *need to study the*

*actual implementation of the Code and its directives by collecting information in the EU and other countries and how it will affect healthcare managers' individual decisions to recruit.*

And finally, the representatives of the French Chamber of Pharmacists were invited to present their project on **HPROCARD** (European Health Professionals Card), funded by DG EMPL, whose main objective was to facilitate the free movement of health professionals in Europe (i.e. pharmacists, doctors, midwives, nurses, dentists) by developing a card with two faces – a national side with information on the national competent authority, granting national authorization to work, and an EU side with minimum set of information, needed to facilitate the mobility of health professionals abroad. A second step of the project would be to add a microchip to the card, connected to national registers and databases. The idea of the card is not to sanction health professionals but to improve their traceability and whether they are fit to practice, to speed up the process of registration and increase patient safety. Participants in the group agreed on the usefulness of such EU tool and suggested adding questions on its feasibility and usability during the micro phase of the research.

***Session III: Plenary session (Chair: Susanne Weber-Mosdorf, Deputy Director-General, WHO Brussels)***

Ms. Weber-Mosdorf opened the plenary session by expressing her satisfaction with the research project on health workforce mobility. She stated that she will be looking forward to the final results and is ready to use the data on health policy recommendations and engage countries in policy debates on these issues. Ms. Weber-Mosdorf highlighted two important contradictions in the field of health workforce mobility nowadays: the political importance of the health workforce shortfalls and the very scarce data. At the moment, there seems to be understanding of the importance of the health workforce and its mobility for the sustainability of health systems; however there are health systems that are not looking at their sustainability. This is also a question of responsibility of EU Member States to act and to find a balance between the right of people to attain the highest health and the right of doctors to move between countries. This balance depends on policies and policy makers and for political solutions there is need of better data. Member States should recognize and address the need of having good data to formulate good policies.

***Group 1 (Rapporteur. Dr. Eric de Roodenbeke, Director General, International Hospital Federation (IHF), France)***

Dr. De Roodenbeke reported the following list of major issues to study further during the project's micro phase:

1. **Role of training programmes and qualification possibilities** which is key for the harmonization of the care quality and patient safety in EU Member States: *need of in-depth examination of the volume of production of professionals per country and how this links with the different countries' educational systems and limitations and student mobility programmes (what is importation of human resources - foreign born or foreign trained?).*
2. **Recruitment criteria and continuous education possibilities** and how they relate to mobility, choice of staying or leaving the country; *need to monitor the recruitment*

*systems (and actors such as the agencies, intermediaries; hospitals which are in the obligation to 'serve themselves' to deliver care); need to look at retaining strategies and flexibility in (and harmonization of) working conditions and options to improve health professionals' qualifications.*

3. **Utilization of the health work force** and the relation to the pension reforms and the question of how to optimize available skills: *need to e.g. address 'brain waste' by using professionals' full training, combat attrition (escaping the profession for lack of incentives or non-fulfillment of expectations) and allow flexible options such as late retirement, part-time employment, and perhaps temporary migration mechanisms etc.*
4. **Regional disparities between rural and urban areas** within the countries and maldistribution of health professionals which is in many countries a more serious problem than (out) migration: *need to further explore the relation between regional disparities and migration; the role of retention programmes and other good practices.*
5. **Inconsistencies within the various national policies** and how health managers manage to balance between the local pressure of delivering care and recruiting the necessary health workforce with the financial resources available; the role of the unions: *need of analysis whether national labour and migration policies are consistent with the human resources shortages, how healthcare systems are affected and what are the challenges faced on a country level.*
6. **Lack of data on emigration from the EU.** While there is normally information on migration to and within the EU at the country level, most of the countries do not have information on emigration outside of the EU: *need of qualitative (also quantitative) information to better understand the pattern and the mechanisms of emigration from the EU.*
7. **Mechanisms of temporary migration:** investigation of existing mechanisms, motivation, conditions and outcomes for temporary or repeated periodic migrations.
8. **Irregular employment and consequences for the sector:** *need to improve the information on the types of employment and services that irregular employees are offered to perform; how this irregular employment (often under-skilled, other times over-skilled) is filling specific gaps and how this affects the quality of services and work opportunities in this sector.*
9. **The gender and diversity issues** and the consequences of the evolution of the gender/diversity balance on the profession and the importance of gender dimension of mobility: *need of more knowledge on the issue of diversity and equal opportunities regardless of gender and ethnic origin for career development.*

#### **Group 2 (Rapporteur: Prof Yoswa Dambisha, IOM)**

Prof. Dambisha reported the following major issues to study further during the project's micro phase:

1. **Education policies and the low investment in training** of health professionals in the context of high global demand, ageing populations and longer care needed; forecasted shortages of health workers in Europe and the US and the continuous recruitment of health workers from abroad, when often no additional places are planned in the medical schools: *need to create a platform for exchange of information between EU Member States and third countries on the issue of health professionals' training and mobility; need of well-planning in training of health professionals based on future demand and foreseen national imbalances.*
2. **Validity of qualifications across the border** and how this can be translated into the quality of care: *need to ensure the quality and transferability of qualifications.*
3. **Data collection on health professionals' mobility.** In order to track the migration of health professionals, one needs to answer the questions of how many go, where they go, whether they come back. The gap between public authorities and statistical institutes responsible for official national statistics while lacking the policy point of view was noted. Data exchange across countries is problematic and often it is difficult to trace the competent regulatory authority for different medical professionals

At the moment, such data is collected by both EUROSTAT and OECD. A workshop, jointly organized by OECD, WHO and EUROSTAT in June 2010 in Paris is to discuss the creation of minimum dataset to be collected by the respective countries on the mobility of health professionals. There is also a new EU regulation on migration data so that the EU and EUROSTAT will start collecting data on mobility/migration/emigration but not per occupation. Other EU regulations on public health statistics and on health safety at work would also target patient and professionals' mobility. Various other EU regulations (e.g. working time, automatic recognition of qualifications) have an impact on mobility of health professionals.

4. **Mobility of students** as a growing phenomenon in the EU; *need of investments in educating enough health professionals and ending limitations so that students do not seek education abroad; need to track the migration of students and limit the dependence on third country professionals.*
5. **Outflow of less skilled, mid-level professionals** from hospitals and respective discrimination practices. A lot of outflows occur from the medical profession to other sectors (and the private health sector): *need to analyse the loss of health professionals to other sectors/ intersectoral mobility, the issues of integration and discrimination, and what can be done in terms of offering opportunities in the profession be it in the sending or the receiving countries.*
6. **Human resources planning**, country demands and national expenditure on education of both high and low skilled groups and their respective projectization for a period of 10-20 years (principle should be self-sufficiency, and then deciding whether we need to contain, address, encourage or redirect mobility respectively): *more information on country needs would guide in the development of mid and long-term planning of the health care resources.*

7. **Integration of health professionals after migration:** living and working conditions, opportunities for training, discrimination, recognition of qualifications/experience.

## Conclusions and Closing Remarks

Dr. Caren Weilandt, Deputy Director, Scientific Institute of the Medical Association of German Doctors (WIAD) was pleased in sharing some of the initial results and snapshots from the macro phase and discussing them with the participants. The consortium will certainly benefit from the extremely useful discussions and will integrate the recommendations to the research. She thanked all presenters for their contributions and the audience for participating in the meeting.

Some of the crucial goals to guide the team in the following research months will be: to combine quantitative and qualitative data; to investigate how the mobility of health professionals could be mutually beneficial for both sending and receiving countries; to investigate illegal flows to the health system and how to better address them; and to explore the causes, impact and the importance of the general migration measures on health care system functioning; ultimately, to study HPs migration for effective, harmonized and improved policy actions in the EU.

Ms. Weber-Mosdorf, Deputy Director-General, WHO Brussels, closed the discussions, wishing a successful micro phase. Being herself very optimistic about the endorsement of the WHO Global Code in May, she concluded that what is urgently needed is not global ethical conduct, but rather local ethical behavior and policies. For those policies there is a need of good data and thus she is looking forward to receiving the final project findings and start working on the country level.

Roumyana Benedict, Senior Regional Migration Health Manager, International Organization for Migration closed the roundtable by first thanking the chairs, presenters, rapporteurs and participants for all their input and invite them all to continue to be interested and provide comments, and, in their capacity of policy makers, to help the project team in the collection of data, inform stakeholders of MoHProf activities and finally take active part in the forthcoming MoHProf final conference planned for the Fall of 2011.



**ROUNDTABLE ON MOBILITY OF HEALTH PROFESSIONALS**  
**AGENDA**

***Mobility of Health Professionals (MoHProf) Project***

Funded under the EC DG Research Seventh Framework Programme (FP7) – Health Theme

The International Auditorium, Boulevard du Roi Albert II, No. 5 / 2, 1210 Brussels

<b>Tuesday, 27 April 2010</b>	
08:30 – 09:00	<i>Registration</i>
09:00 – 09:15	<p><i>Welcoming address</i> <b>Mr. Bernd Hemingway</b>, Regional Representative, Regional Liaison and Coordination Office to the EU, International Organization for Migration (IOM)</p> <p><i>Opening remarks</i> <b>Ms. Roumyana Benedict</b>, Senior Regional Health Manager, Regional Liaison and Coordination Office to the EU, International Organization for Migration (IOM)</p> <p><i>Key address</i> <b>Ms. Isabel de la Mata</b>, Principal Advisor with Special Interest in Public Health, DG SANCO, European Commission</p>
09:15 – 09:30	<p><i>Introduction to the Mobility of Health Professionals Project and its two research phases</i> <b>Dr. Caren Weilandt</b>, Deputy Director, Scientific Institute of the Medical Association of German Doctors (WIAD)</p>
09:30 – 11:00	<p><i>Presentation of key findings of the macro-research</i> <i>Chair:</i> <b>Ms. Roumyana Benedict</b>, Senior Regional Health Manager, Regional Liaison and Coordination Office to the EU, International Organization for Migration (IOM)</p> <p><i>Western European countries</i> <b>Prof. em. Per-Gunnar Svensson</b>, WIAD Consultant and <b>Dr. Caren Weilandt</b>, Deputy Director, Scientific Institute of the Medical Association of German Doctors (WIAD)</p> <p><i>Sending countries from Central Europe</i> <b>Dr. Pawel Kaczmarczyk</b>, Centre of Migration Research of the Warsaw University (CMR)</p> <p><i>Sending countries from South-East Europe and former USSR Republics</i> <b>Prof. Todorka Kostadinova</b>, Medical University of Varna (MUV)</p> <p><i>Sending countries from Asia</i> <b>Prof. Dr. Marilyn Lorenzo/ Prof. Jennifer dela Rosa</b>, Institute of Health</p>

	<p>Policy and Development Studies of the University of the Philippines (IDPHS)</p> <p><i>African countries</i>  <b>Prof. Dr. Yoswa Dambisya</b>, IOM, Regional researcher</p> <p><i>Destination countries for EU health professionals (US, Canada)</i>  <b>Dr. Mary Pittman/ Dr. Christine Brown Mahoney</b> Public Health Institute (PHI), US</p>
11:00 – 11:15	<p><u>Introduction to the next phase of the MoHProf project: the micro-research</u>  <b>Dr. Caren Weilandt</b>, Deputy Director, Scientific Institute of the Medical Association of German Doctors (WIAD)</p>
11:15 – 11:30	<i>Coffee break</i>
11:30 – 12:30	<p><u>Interactive workshop in working groups on key issues for the micro-research phase</u></p> <p>Group 1:  <i>Chair: Ms. Maria Gallotti</i>, Senior expert on migration, ILO Brussels  <i>Rapporteur: Dr. Eric de Roodenbeke</i>, Director-General, International Hospital Federation (IHF)</p> <p>Group 2:  <i>Chair: Mr. Jean-Marc Braichet</i>, Acting Coordinator Health Workforce Migration and Retention Unit, Department of Human Resources for Health, WHO Geneva  <i>Rapporteur: Prof. Dr. Yoswa Dambisya</i>, IOM, Regional researcher</p>
12:30 – 13:00	<p><u>Plenary session with final conclusions</u>  <i>Chair: Ms. Susanne Weber-Mosdorf</i>, Deputy Director-General, WHO Brussels  <i>Rapporteurs: Dr. Eric de Roodenbeke</i>, Director-General, International Hospital Federation (IHF) and <b>Prof. Dr. Yoswa Dambisya</b>, IOM, Regional researcher</p> <p><i>Conclusions: Dr. Caren Weilandt</i>, Deputy Director, Scientific Institute of the Medical Association of German Doctors (WIAD) and <b>Ms. Roumyana Benedict</b>, Senior Regional Health Manager, Regional Liaison and Coordination Office to the EU, International Organization for Migration (IOM)</p>
13:00 – 14:00	<i>Lunch</i>

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