European Migration Network

Managed Migration and the Labour Market

The Health Sector

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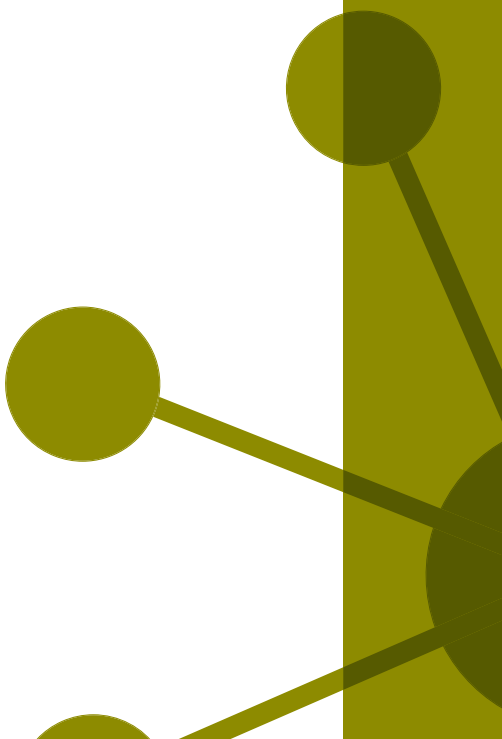

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Executive Summary

This EMN study on "Managed Migration and the Labour Market – The Health Sector" has been carried out by eleven National Contact Points (**Austria, Belgium, Estonia, Germany, Greece, Ireland, Italy, Latvia, Sweden, The Netherlands** and **United Kingdom**) of the European Migration Network (EMN).

As outlined in the Introduction (Section 1), one of the aims of this study is to contribute to the development of appropriate policies on labour migration for the health sector, by presenting an overview of the current situation and needs in the participating Member States in a comparative manner. Indeed, and as outlined in the Methodology (Section 1.1), given the heterogeneity of the available data within the participating Member States, one can consider that each Country Study provides the most current, comprehensive collation of information on migrants in their national health sector. Already one impact that this study has had is to highlight, to the competent authorities in a number of Member States, the need to collect such data in a more consistent, accurate and (perhaps) centralised manner.

A summary of the topical issues in each Member State's health sector and the role of migration (Section 2) is given. As one might expect, the needs differ between Member States. Some, like **Greece** and **Italy**, are currently experiencing a shortfall of nurses, but an excess of trained doctors, whereas for others, such as **Belgium**, **The Netherlands**, their current needs are being met by their nationals or other EU-nationals. This presents some difficulties for **Belgium**, which does not have a *numerus clausus* (or quota system) for medical studies, unlike its neighbouring Member States (France, The Netherlands). For **Italy**, this shortage of nurses seems to be exacerbated by the requirement that healthcare workers wishing to participate in public competitions for positions at public facilities must possess EU-citizenship. Austria is facing an increasing demand for healthcare workers, particularly in the care of the elderly. This, to a somewhat more limited extent, is also an issue in **The Netherlands** and **Sweden**, the latter expecting most difficulties in terms of labour shortages in the 2020s. A similar situation exists in **Germany**, where, primarily owing to demographic changes (affecting also other Member States), migrant healthcare workers are expected to become increasingly important. **Estonia**

and **Latvia** are experiencing severe shortages, as a significant proportion of their national healthcare workers move to other (EU-15) Member States, for a number of reasons. The healthcare system in **Ireland** is under severe strain, which is partly attributed to the impact of the European Working Time directive and increasing "feminisation" (i.e. an increasing proportion of women doctors) of the medical practitioner workforce. A number of challenges are also being faced in the **United Kingdom**, and more specifically England, with its financial deficits leading to staff cuts, hospital closures and freezes on recruitment. Whilst migrant workers make up a significant proportion of healthcare workers, and make a very important and valued contribution to the healthcare sector, there is a desire to reduce reliance on them.

A summary of the data on the employment of migrants in the Health Sector presented in each Country Study is given (Section 3). Such data were difficult to obtain as the available material is limited and had to be obtained from a number of diverse sources. Despite some caveats to the data, it is possible to provide an indication of the scale of the health sector in each Member State and the contribution of migrants from other EU and non-EU countries. For most Member States, the proportion of non-EU nationals is currently relatively low. For example, in Austria, of the 76,131 employees working in hospitals in 2004, 1,494 (or 2%) were non-EU nationals. The exception is the **United Kingdom**, which in 2004 had 136,000 non-EU/EEA healthcare workers, or 7% of the total, the majority of whom were women.

The entry procedure and process by which qualifications are recognised and validated (Section 4) demonstrated that similar practice(s) are followed. Generally, migrant healthcare worker applications are processed in the same way as for other migrants, the procedure followed depending more on whether the person is an EU-15, EU-10/EEA or non-EU/EEA-national. An ethical recruitment policy (Section 4.2) is followed in the **United Kingdom** and, to some extent, in **Ireland** and this also is outlined. The recognition of qualifications (Section 4.3) obtained outside a particular Member State to a large extent depends on the country in which the qualification was acquired, the nationality of the healthcare worker concerned and whether a bilateral or multilateral agreement exists. For example, recognition of qualifications from other Member States is covered by Community legislation, which also covers EEA (including Switzerland) states. Non-EU/EEA nationals in particular have to go through a period of validation (Section 4.4), sometimes even if they obtained their qualification in an EU/EEA state. The various types of validation procedures are outlined, including also formal verification of linguistic requirements (Section 4.5).

A number of Member States are currently reviewing their policies (Section 5) with regard to labour migration, including, or specifically for, the Health Sector. In **Austria**, the recent focus has been on increasing the cultural competence of the health sector within an increasingly culturally diverse society. In **The Netherlands**, **Sweden** and **United Kingdom**, such policy development is occurring in the context of the admission of highly-skilled workers.

Finally, the Concluding Remarks (Section 6), give an overview of how the main findings of the study could be used for policy development.

1. Introduction

This Synthesis Report aims to summarise and compare, within a European perspective, the findings from eleven National Contact Points (**Austria, Belgium, Estonia, Germany, Greece, Ireland, Italy, Latvia, Sweden, The Netherlands** and the **United Kingdom**) of the European Migration Network (EMN), on the current situation of and needs for migrant healthcare workers in the EU - a topic of increasing importance at national, EU and global level. This Synthesis Report, which is based upon Country Study reports produced by each participating National Contact Point, are primarily intended for policy makers, particularly at national and European levels, as well as relevant administrative bodies, specialists and management personnel in the Health Sector. Given the nature of a Synthesis Report, more detailed information can be found in each Country Study, and one is strongly recommended to consult these also. Already presentations by **Estonia**([1]) and **Italy**([2]) of their findings to a wider audience have taken place.

Migration management has been a central issue in political and academic debates over the last decade. The labour market, especially the supply of and demand for economic migrants, has been a central focus, with the Health Sector being increasingly viewed as an area of high migrant labour demand, including in the EU. The recent "World Health Report 2006 – working together for health"([3]) revealed an estimated shortage of almost 4.3 million doctors, midwives, nurses and support workers worldwide, with the shortage being most severe in the poorest countries, especially in sub-Saharan Africa. Whilst the report highlights that shortages in the EU are not as acute, still there are some medical professions/ Member States where there are, or in the near-term will be, specific needs and these are highlighted for those Member States contributing to this study. For example, **Greece** and **Italy** in particular, have identified a need for more nurses, including in the home, which would not be met by intra-EU mobility of healthcare workers, including from EU-10 Member States, alone.

([1]) See http://www.migfond.ee/ee/uudised_en.php?action=view&id=5

([2]) See http://www.emnitaly.it/ev-15.htm

([3]) Available from http://www.who.int/whr/2006/en/index.html

This EMN study, therefore, aims to contribute to the development of appropriate policies by presenting what is the current situation and needs in the participating Member States, in a comparative manner.

Following this Introduction, which also outlines below the Methodology used, current topical issues in the health sector of each Member State and the role of migration is given. This is followed by a summary of the number of healthcare workers, including from other EU and non-EU countries, with some examples of current trends described. The necessary steps for a migrant healthcare worker to take up an appointment are then outlined; covering the entry procedure(s), any ethical recruitment policies that may exist, the recognition of qualifications and their validation and linguistic requirements. Finally, policy initiatives which are being developed by some Member States are summarised, followed by concluding remarks. Note that reference to "Member States" is specifically only for those contributing to this study and, as mentioned previously, more detailed information on a contributing Member State may be obtained directly from the respective Country Study.

1.1 Methodology

The EMN does not engage in primary research per se, instead drawing together, evaluating and making accessible already available data and information. The desk research undertaken, often involving also members of the national network, for this small-scale study encountered some difficulties as the available material is limited and had to be obtained from a number of diverse sources. These sources included the relevant Ministry of the Member State government; National Statistical Offices; Employment Agencies; the various professional associations for health workers (from which detailed statistics not available from a national statistical office were often obtained); brochures, information leaflets and websites of different healthcare institutions; research publications; international studies (e.g. OECD, WHO) and conferences; and media reports. Other means were through a seminar organised by the Counselling Centre for Migrants (**Austria**); the creation of an ad-hoc Scientific Committee (**Italy**), drawn from various relevant stakeholders to advise on the content of the study; and peer review of a draft by collaborators who had contributed to the study (**Ireland**, **United Kingdom**). Given the diversity of the information available, **Austria** and **Estonia** suggested that additional useful information could be obtained through interviews with the various different actors (e.g. provincial governments, administrators of large hospitals, public employment services, NGOs), and, in fact, **Greece**, **Ireland** and **Sweden** did conduct some interviews.

With regard to statistics, often this was not available on a yearly basis or for earlier years. As a result of the low sampling rate for some healthcare professions in, for example, **Ireland**, **United Kingdom**, some of the data should be considered as indicative, rather than definitive.

It was agreed to focus the study as much as possible on the following ISCO-88 (International Standard Classification of Occupations)([4]) occupations:

- Medical doctors/Physicians
- Dentists
- Dental assistants
- Pharmacists
- Pharmaceutical assistants
- Nursing and midwifery professionals and associate professionals
- Psychologists
- Physiotherapists and associated professionals (e.g. Chiropractor, Podiatrist)

Where this was not possible, the closest matching classifications were used. Each Country Study also defined what it has used for its definition of '(im)migrant' and for its 'indigenous' (or autochthonous) population. This highlighted one difficulty in being able to truly compare data as, even within one Member State (e.g. **United Kingdom**), there are sometimes different meanings depending on the source of data. For the purpose of this Synthesis Report, the term 'migrant' is used to refer to a non-EU national who moves to take up a position in the healthcare sector of a Member State. In some cases, it was not always possible to obtain directly nationality data, sometimes because such data were simply not collected.

([4]) For definitions see: http://www.ilo.org/public/english/bureau/stat/isco/isco88/major.htm

One impact that this study has had already is to highlight to the competent authorities in a number of Member States (in particular **Greece, Ireland, United Kingdom**) the need to collect such data in a more consistent, accurate and (perhaps) centralised manner. For example, data collection practices even between different government ministries were found to be inconsistent with the needs of this study and it is hoped that a consequence will be to help to improve future data collection methods. An example of a system that attempts to address this deficit is in **Belgium**, where a central register ("kadaster") of those licensed to practice has been further developed. This is becoming more easily accessible and provides information on the nationality of physicians, dentists and physiotherapists. Currently, preliminary information on nurses is also available, and this is being updated.

For many of the Member States contributing to this study, therefore, and following extensive efforts, the information, data and bibliographies presented may be considered as the most current, comprehensive collation of information on migrants in their national health sector.

2. Topical Issues in Health Sector and Role of Migration

Each Country Study provides a description on the structure of healthcare within their Member State, as well as an overview of recent significant national developments, with specific emphasis on the role of migration. This section, therefore, attempts to 'paint a picture' of such developments within this context.

Austria is facing an increasing demand for personnel working in the health and care sector (estimated to be 30,000 in the coming decade), with the lack of qualified personnel in the care for the elderly in particular, being widely reported in the media. Initiatives have been implemented to facilitate the employment of nationals from EU-10 Member States to address this shortfall in the near term, as well as to encourage young people (unemployed or who want to change jobs) to take up a career in care professions. It is assumed that also illegal migrants fill this gap to a certain extent. The culturally diverse societies (which are a result of immigration in past decades) also place an increasing demand in healthcare services by requiring that they reflect this diversity.

In **Greece**, it is the shortfall of nurses that is particularly acute, which is at least partly fulfilled by migrant nurses, with it being acknowledged that there is probably a large (though unknown) number of illegal home care workers. Conversely, there is a high and increasing number of doctors, which outstrips the available positions (except in more remote areas), leading to a significant number of doctors moving to other Member States, notably Italy, Germany, United Kingdom, as well as the USA. New challenges in the provision of healthcare to migrants have also been created. These include, like for **Austria**, the provision of healthcare which respects cultural diversity, as well as linguistic barriers; a change in the epidemiological profile in Greece, with the appearance of new epidemics/diseases associated with migrants; and an increasing demand for healthcare provision in certain frontier regions (e.g. Ipeiros and others bordering Albania), which is linked to the need for regional co-operation on health issues with neighbouring non-EU countries.

Italy too tends to have an excess of doctors, with a limited number also moving to other Member States. There is also an increasing demand for nurses with already some 20,000, primarily non-EU, citizens working in Italy. It is anticipated that this number will have to increase significantly, both because of the ageing

Italian population, which is placing further burdens on the healthcare system, and because fewer native Italians are attracted to this vocation, with the number of positions available currently greater than the number seeking them. The requirement that healthcare workers wishing to participate in public competitions for positions at public facilities must possess EU-citizenship, creates some difficulties in meeting this need with non-EU nationals. Some recent court rulings, on cases which challenged this citizenship requirement, have declared this practice illegitimate. Currently non-EU nationals can only work at such public facilities if they have been recruited either via a direct call (with a fixed length contract) or by being hired by contracting nursing co-operatives, recognised by the Ministry of Health, or through temporary employment agencies. In fact, this third-party recruitment of nurses predominates, and this has made their work situation very vulnerable. The sector which is currently most affected by migration is family assistance (e.g. someone appointed to work in the home), which employs approximately 500,000 foreigners (or 5 out of 6 such workers) and is expected to increase in the future. Such family assistance includes more and more nursing duties, in addition to domestic duties, giving rise to "caregiverism", i.e. continual assistance 24 hours a day. Given this, the dependency on migration to satisfy healthcare needs is becoming more and more apparent and, despite the sometimes negative image of immigration, such healthcare workers are an indispensable resource.

Owing to major demographic changes and the continuously increasing significance of the health sector in **Germany**, which is both publicly and privately organised, the extent of migrant employment in this sector, and the occupation in which they are working, is also considered to become increasingly important. In the same context, there have also been numerous proposals for reforming the health care system, the ultimate aim being to limit its cost (which in 2003 was €240 billion). Current proposals call for restricting the funding of statutory health funds by all members in accordance with the principle of solidarity, and limiting the contributions of employers, who currently pay 50% of their employees' contributions. Instead, imposing differentiated contributions on insured persons, according to their individual risks ("personal responsibility"), are proposed. Since 2002, the debate has focussed on reforms that would abolish the current duality of statutory and private health insurance funds, the main proposals being on health premiums and different forms of a so-called "citizens' insurance" (Bürgerversicherung).

Belgium has a well-developed healthcare system, which does not seem to suffer from a lack of personnel at present. In fact the opposite seems to be the case, with a significant number of healthcare workers from neighbouring Member States (The Netherlands, France, Germany), as well as from Italy, studying or practising in Belgium. In contrast to France and The Netherlands, the lack of a *numerus clausus* (or quota system) and the possibility to follow an educational programme with a greater chance of succeeding, as well as the common languages, are seen as the main contributing factors. For example, the French-speaking community of Belgium is currently experiencing a flood of students from France (e.g. for physiotherapists, more than 75% of the students are from France) and a post-secondary vocational degree in nursing can be achieved after three years, whereas in France this degree no longer exists. This influx of medical students is the subject of a growing debate as to whether or not Belgian nationals are subject to discrimination with respect to foreign students who come to specialise in Belgium, sometimes to avoid the *numerus clausus* in their country. One consequence of this is a recent (February 2006) proposal to limit the number of foreign students studying in Walloon to 30%. Another development concerns the planning of nursing needs in the Brussels region, which has identified a huge, untapped reserve of second-generation women with a migrant background (primarily of Turkish and Moroccan origin) who typically are confronted with high unemployment and lack of educational opportunities. As well as addressing the growing needs for nurses, identified as a "bottleneck profession", this initiative to encourage a vocation in nursing is also seen as a way for better integration and emancipation. As well as efforts like this to encourage more Belgian nationals into the healthcare profession, measures are also being taken to make it easier to recruit nurses from the EU-10 Member States, in preference to those from a non-EU country.

There are currently no major personnel shortages in **The Netherlands** either, nor are there expected to be in the near future, except for auxiliary personnel in nursing and care homes and in home care. In the event of a rapid economic upswing, shortages in nursing can

also be expected. At the end of the 1990s, there were acute personnel shortages in the labour market (including the health sector) and one of the possible solutions for employers was recruitment from abroad. Although this took place on a limited scale, it still engendered a lot of political and social discussion within the context of the restrictive migration policy of the Dutch government. Whilst it was sometimes argued that labour migration should be used to solve future personnel shortages in the health sector (owing to the demographic shift towards an older population; a decreasing workforce; the unattractiveness of this sector compared to others) this did not meet with a positive response. Critics, for example, pointed towards the considerable supply of un-utilised labour already in The Netherlands; and also to the risk of unfair competition. Initial experiences of employers with such workers were not entirely positive and the 'brain-drain' effect was cited as well. Consequently, additional restrictions were temporarily imposed on certain categories of migrant healthcare workers and today, even for employers, recruitment from outside The Netherlands is considered as a last resort, although there were some (largely unsuccessful) initiatives to recruit healthcare workers from Slovakia, Indonesia and Poland in particular, albeit without the strong support of the government.

Sweden's demographic shift towards an older population is expected to create most difficulties in terms of labour shortages in the 2020s, particularly for nurses and for the care of the elderly. Like **The Netherlands** and **Germany** for example, the Swedish attitude to labour force migration is that the need for labour should only be fulfilled by foreign labour in cases where this need cannot be fulfilled within Sweden or other EU/EEA countries. Instead of using foreign labour, it is considered that the needs of the labour market should first be met through national policy measures, such as training programmes. Thus, the contribution of migration is anticipated to be negligible. For example, it is estimated that the migration of nurses from non-EU/EEA Member States will be around 150 to 200 per year, representing less than 0.2% of the total number of nurses in Sweden, in the coming years. For doctors also, this is expected to be insignificant, with the labour market situation for doctors in Germany and Denmark considered to have the greatest influence on the number of foreign doctors in Sweden.

In **Estonia** a reform of the health service is underway, moving away from a mainly state-controlled centralised system towards a decentralised one, and from a general state funded system to one based on health insurance. The Health Care Administration Act (1994) provided the legal basis for such reforms. This Act was later thoroughly revised in order to adapt the healthcare sector to the requirements of the market economy. As a result of the revision, the Health Care Services Organisation Act was passed in 2004 on the basis and in place of the Health Care Administration Act. Current policy initiatives in this sector are aimed at increasing the average life expectancy in Estonia, which is currently lower than the average for the EU-10. Migration is not currently prominent in the policies being developed, principally because there is a very small number (43 professionals, mostly from Latvia and Finland) working in the health sector since Estonia's accession to the EU. Nevertheless, there is an increasingly acute lack of doctors and nurses in particular, since they prefer to move to other (EU-15) Member States, mainly Finland. It is interesting to note that in contrast, fewer dentists leave Estonia and this is attributed to their income being financed largely by private patients and their greater freedom to arrange their work schedule, as they tend to have their own private practise. This demand from abroad creates more difficulties in the development of the national health sector workforce needs. In order to address this phenomenon, it is suggested that policy-makers in the health sector should address the factors which have been identified as influencing the decision to leave Estonia, notably the better salary; better working conditions and quality of life; disappointment in Estonian life and in the permanent reforms of the healthcare system; more professional opportunities abroad; and lack of working places in several healthcare professions. The increasing age of its healthcare workers is also identified as a serious issue which will need to be addressed in the coming years.

Latvia is experiencing similar challenges to Estonia, with a severe shortage in healthcare workers, which is becoming more and more pronounced each year, as current workers change their profession, retire, or take up positions outside Latvia, and because fewer young people are studying medicine. With the existing rate of training and licensing of new doctors, it is estimated that it would take some 200 years to replace the 400 practising general practitioners who are close to retirement (20% are currently over 60 years old). Nurses

also are in short supply with approximately 500 nurses per 100,000 population and the need for 700-900 nurses per 100,000 population in order to provide a quality service. The number of foreign nationals employed in the health sector in Latvia is very low, constituting 0.53% or 132 healthcare workers of the total number and coming primarily from Russia. The Latvia Minister of Health recognises that the shortage of healthcare workers is real and that the situation will grow worse in the coming years, because time is needed to educate and train new workers. However, there is not a specific policy for addressing this situation through immigration, except for the intention not to facilitate or encourage the inflow of cheaper healthcare workers from, for example, Belarus, Ukraine or Russia.

In spite of increased expenditure from 1997 to 2002, the healthcare system in **Ireland** is under severe strain. Significant increases in the number of nurses and medical practitioners have taken place in the period 1998 to 2004 and labour costs now account for approximately two-thirds of health expenditure. A 2003 review of medical staffing argued for further increases in the number of consultants, primarily owing to the impact of the European Working Time directive. Increasing "feminisation" of the medical practitioner workforce (i.e. an increasing proportion of women doctors) will also mean that the absolute number of doctors needs to increase. In the nursing profession there has been significant investment in order to improve the supply of Irish nurses. It is not universally accepted, however, that there is a shortage of nurses, with some commentators arguing that difficulties occur because Irish nurses spend time on tasks that could fall within the remit of other personnel, e.g. of healthcare assistants.

The health sector in the **United Kingdom**([5]), and more specifically within England, is also currently facing a number of challenges involving structural changes, financial debts and recruitment difficulties, which have been highlighted in a number of high profile media reports. Its financial deficits (currently reported to be £500 million, approx. €750 million), has in turn led to staff cuts, hospital closures and freezes on recruitment. The 10-year National Health Service (NHS) Plan (from 2001) in England, aimed to improve healthcare services, access, waiting times and facilities. However, the Department of Health recognised (in 2001) that nursing shortages (including specific skills shortages and not just overall numbers), as well as an insufficient number of medical doctors/practitioners, were one of the biggest constraints in delivering public services and achieving these aims. The NHS Plan, therefore, aimed to increase the number of nurses to 20,000 by 2004 (and achieved this in 2002), with one of the main methods of achieving this being the recruitment of foreign workers. This massive investment in staff and increased training places meant that recently there are more doctors, nurses and other healthcare workers in the NHS than ever before. Migrant workers have made a very important and valued contribution to the healthcare sector in England, but were never intended as a permanent substitute for UK/other EU workers. Given the increase in staff numbers, the current difficulties faced by the NHS and the planned new migration policies, there is now less reliance on migrants in this sector, particularly in England.

([5]) Note that not all information in this Synthesis Report represents the whole of the United Kingdom. This is due to the devolved assemblies/parliaments operating in Wales, Scotland and Northern Ireland, which manage their own health departments separately from England (although immigration policy is the same). Where information/data pertains to England only, this is stated.

3. The Employment of Migrants in the Health Sector

Data on healthcare workers in each Member State have been provided As mentioned in Section 1.1, comprehensive data from a single source was often not possible and extensive efforts were undertaken by the EMN to provide the best possible collation of these various sources. Thus, one could consider that the data presented represents the most comprehensive available for a particular Member State.

Whenever possible, the intention was to present data on the number of national and non-national (Male and Female) healthcare workers per occupation (Medical doctors, Dentists, Pharmacists, Nurses, etc.) for each year from 1997 to 2004 inclusive; the (percentage) change in these numbers; estimates of the number of vacancies for each occupation in 2004; and a breakdown per nationality of the number of migrants per occupation, again for each year from 1997 to 2004 inclusive. There was also interest in obtaining data on the number of EU-10 nationals who had undertaken mobility to an EU-15 Member State following accession and, again whenever possible, these data have been provided.

Whilst it is not the purpose of this Synthesis Report to present again the data, the following table attempts to provide an indication of the scale of the number of persons employed in the health sector (broadly broken down by Member State nationals, other EU-nationals and non-EU nationals) and the number of vacancies (to indicate the current need) in order to provide some comparison between Member States. Given the caveats to the data outlined in the various Country Study's (such as small sample sizes, the inconsistencies in definitions used), and that data are not available from all Member States, one should focus on the relative magnitudes as an indication or illustration of the health sector in a particular Member State and how it compares to others.

The following examples serve to illustrate the findings from some Member States and again further information, as well for those Member States not referred to, is given in the respective Country Study. For the reasons given previously, one can not make a comparison between Member States in the changes in healthcare workers over the years that data are provided for. For example, and noting that after accession of the EU-10 Member States, **Ireland**, **Sweden** and **United Kingdom** imposed no restrictions on the movement

of EU-10 nationals, no impact([6]) is observed in their data, which might be more as a result of the lack of sufficient data.

In **Austria**, for the year 2004, a total of 76,131 employees were working in hospitals in the occupations considered in this study, of which 4,410 were foreign nationals (6%). Among these foreign nationals, 2,916 (66%) are other EU nationals and another 1,494 employees (34%) are non-EU nationals. Migrant employment seems to play a rather significant role in the following areas: physiotherapists (9%), qualified paediatric nurses/child carers (8%), occupational therapists (8%), midwives (7%), general qualified health carers and nurses (7%), and the assistant nursing service (5%). In all these professions, except for the assistant nursing service, the majority of non-nationals are other EU citizens. According to information obtained from the validation of diplomas, an important country of origin in the EU is Germany. Unfortunately, whilst the total number of medical doctors is known (38,422 in 2004, including hospitals plus doctors in private practice), data on their citizenship or country of birth is not available.

Germany has seen an increase in the proportion of non-German doctors and dentists since 2002. Using data obtained from employees subject to social insurance contributions, between 1999 and 2002, non-German doctors and dentists made up 3.5% to 4% of the total number. A sharp increase for doctors to 4.5% occurred in 2003, rising to around 5% in 2004 and 2005 (equating to 8,052 doctors in 2005). An increase in the number of non-German dentists began in 2001, and is currently around 4.5% to 4.8% (equating to 340 employees subject to social contributions in 2005). The proportion is slightly higher for nurses, being 6.7% in 2005. With regard to the total number of doctors (including self-employed and civil servants), out of a total of 307,577 doctors in 2005, 94.05% were of German origin; 1.75% were from other EU-15 Member States, with most from Austria and Greece; 0.7% were from an EU-10 Member State, with most from Poland; and 3.5% were from other countries, including Iceland and Liechtenstein. These proportions are similar when calculated on the basis of employees subject to social contributions. The emigration of German doctors to Scandinavia and/or USA, Canada for better working conditions and income has been observed to increase, which is expected to result in a consequent increase in the proportion of non-German nationals.

Similar proportions are found in **The Netherlands**, where the total number of healthcare workers from Turkey, Morocco, Surinam, Dutch Antilles and other so-called non-western countries, were estimated to be up to 23,000([7]) (or 5.2% of the total) in 2004. When analysing where foreign diplomas have been obtained upon registration with the competent authorities, it is observed that the largest number of physicians come from South Africa (104 in the period 2003 to 2005) and Surinam (22 in the corresponding period). Similarly for nurses, the main countries of origin are Indonesia (54), Surinam (47), the Philippines (40) and the Dutch Antilles (35), which is still relatively minor. In keeping also with the policy described in Section 2, labour migration to the health sector is considered negligible in size.

As also mentioned in Section 2, **Greece** appears to be producing more doctors than needed, with shortages tending to be only in more remote regions, making it a doctor exporting, rather than importing, country. This could also be considered to have an impact on the rather small number of foreign doctors, particularly non-EU nationals. For example, in the Attica region, which represents about one-third of all doctors in Greece, other EU nationals make up 1.6% of the total, and those from non-EU countries less than 1%. Similar percentages are seen in other regions of the country and for dentists. Whilst there is very limited corresponding data for nurses, the indication is that the situation is not very different with, in 2004, an estimated 3,172 foreign (predominantly non-EU national) medical auxiliaries out of a total of 106,134. The situation with homecare is, however, considered to be very different, with the general view, supported by the (albeit limited) data available, being that migrant women, mainly from neighbouring non-EU countries, are increasingly undertaking domestic nursing duties for the care of elderly people, and this is expected to become more significant with Greece's ageing population.

([6]) Whilst not specifically addressing the health sector, a report on the experiences of enlargement for **Ireland** and **Sweden** is available from http://www.sieps.se/publ/rapporter/bilagor/20065.pdf and for the **United Kingdom** from http://www.dwp.gov.uk/asd/asd5/WP18.pdf.
A report on the impact of accession for the EU as a whole is available from http://eur-lex.europa.eu/LexUriServ/site/en/com/2006/com2006_0048en01.pdf.

([7]) This figure includes people born in The Netherlands with at least one parent from one of these countries.

A similar situation exists in **Italy**, which currently employs 342,000 nurses, but with a national shortage estimated to be in the range of 62,000 to 99,000, and increasingly for the care of the elderly. Whilst immigration is one solution to address this situation, and referring to the conditions for recruitment outlined in Section 2, in 2005 only 6,730 foreign nurses, 2,125 from outside Europe, were recruited via agencies recognised by the Ministry of Health. However, it is estimated that there are some 20,000 foreign nurses working in hospitals, hospices and nursing homes, who have been recruited via temporary employment agencies.

By contrast, the proportion of foreign healthcare workers in **United Kingdom** is significantly higher, being, for example, 183,000 (or 9.4% of the total) in 2004, of which 133,000 were women. It is interesting to note that the number of non-EU/EEA workers makes up the greatest proportion (at 136,000), and these are mostly, in order of largest number first, for nurses, midwives and medical doctors/physicians. Migrants are, however, represented in all healthcare occupations. When analysing Work Permit approvals for the period 1997 to 2004, most were granted to nationals from Zimbabwe, USA, Trinidad and Tobago, South Africa, Philippines, Nigeria, Pakistan, India, Ghana, China and Australia, but note that some of these permits may have been for other non-health related workers working in medical environments (e.g. hospital cleaners/caterers). Overall, and noting the caveats to the data presented, migrant healthcare workers, particularly from non-EU/EEA countries and for the professions mentioned previously, are considered to be very important to the United Kingdom Health Sector and contribute a substantial number to its workforce. The indication is that, in recent years, international recruitment has experienced considerable growth, although it may now be stabilising or even beginning to decrease as a result of the reduced need for migrant healthcare workers.

Year: 2004	Member State										
Professional occupation by Nationality	**Austria**	**Belgium**	**Estonia**	**Germany**	**Greece**	**Ireland**	**Italy**	**Latvia (Year: 2000)**	**The**	**Sweden (Year: 2003)**	**United Kingdom**
Doctors/Physicians											
- Nationals	N/A	43,679	5,189	155,564	N/A	76.9%	50,584	5,389	N/A	N/A	131,000
- Other EU Nationals	N/A	3,203	11	3,703	N/A	3.1%	3,829	10	N/A	N/A	5,000
- Non EU-Nationals	N/A	510	8	4,349	N/A	20%	8,698	1,180	N/A	N/A	23,000
Total	**38,422**	**47,392**	**5,208**	**163,619**	**53,943**	**11,800**	**63,111**	**6,579**	**56,541**		**160,000**
No. of Vacancies	N/A	145	N/A	2,048	N/A	N/A	340	49 (2005)	N/A	N/A	4.3%
Nurses/Midwives											
- Nationals	46,094	120,004	10,578	669,755	N/A	91.7%	336,916	11,088	N/A	88,311	1,249,000
- Other EU Nationals	2,320	2,864	5	9,405	N/A	2.4%	1,989 (2005)	13	N/A	5,096	30,000
- Non EU-Nationals	940	1,197	4	16,878	N/A	5.9%	4,741 (2005)	3,127	N/A	3,505	94,000
Total	**49,354**	**124,065**	**10,587**	**696,039**		**50,200**	**342,273**	**14,228**	**229,035**	**96,912**	**1,373,000**
No. of Vacancies	N/A	4,345	N/A	2,920	N/A	771	4,860	114 (2005)	N/A	22,292	2.6%
Dentists											
- Nationals	N/A	8,557	1,337	7,274	N/A	96.7%	N/A	994	N/A	N/A	24,000
- Other EU Nationals	N/A	370	2	123	N/A	3.3%	N/A	1	N/A	N/A	2,000
- Non EU-Nationals	N/A	63	2	217	N/A	0%	N/A	209	N/A	N/A	1,000
Total		**8,990**	**1,351**	**7,620**	**13,316**	**1,700**		**1,204**	**9,836**		**27,000**
No. of Vacancies	N/A	11	N/A	114	N/A	N/A	N/A	11 (2005)	N/A	N/A	4.3%
Pharmacists											
- Nationals	N/A	N/A	763	37,982	N/A	91.3%	N/A	1,335	N/A	N/A	37,000
- Other EU Nationals	N/A	N/A	0	233	N/A	8.7%	N/A	2	N/A	N/A	1,000
- Non EU-Nationals	N/A	N/A	1	323	N/A	0%	N/A	444	N/A	N/A	2,000
Total			**764**	**38,541**		**2,500**		**1,781**	**4,960**		**40,000**
No. of Vacancies	N/A	105	N/A	376	N/A	N/A	890	29 (2005)	N/A	N/A	1.9%
Physiotherapists											
- Nationals	2,288	27,257	N/A	131,586	N/A	94%	N/A	N/A	N/A	29,973	50,000
- Other EU Nationals	206	1,329	N/A	2,560	N/A	6%	N/A	N/A	N/A	1,337	1,000
- Non EU-Nationals	28	516	N/A	1,043	N/A	0%	N/A	N/A	N/A	1,114	1,000
Total	**2,522**	**29,102**		**135,190**		**1,800**			**33,880**	**32.424**	**52,000**
No. of Vacancies	N/A	549	N/A	1,966	N/A	N/A	1,450	1 (2005)	N/A	1,226	4.1%

Table 1: Indicative overview of healthcare workers in the Member States (Reference Year: 2004, unless stated otherwise)

Notes:

1. "N/A" means that data are "Not Available" and note that "Other EU Nationals" includes the other EU-24 Member States.
2. For **Austria**, data on nurses, midwives and physiotherapists comprises only personnel working in Austrian in-patient hospitals (but not out-patient clinics).
3. For **Germany**, data (except vacancies) are provided from employees subject to social contributions. These figures increase significantly if all workers are included, e.g. total number of Doctors/Physicians is 306,435, of Dentists it is 64,997. Note that, for **United Kingdom** also, the Totals are not necessarily the sum of breakdown owing to small samples for some nationalities.
4. For **Ireland**, only percentages are used in the breakdown owing to concerns about capturing non-Irish nationals in the survey used to provide the data.
5. For **Italy**, the number of National Doctors/Physicians is an estimate based on the sum of those in the public (47,111) and private sector (16,000). Similarly, the number of National Nurses/Midwives is an estimate too.
6. For **The Netherlands**, the numbers presented comprise all people registered as competent for a particular profession, not all of whom may still be working in their profession. Whilst the number of vacancies per profession is not available, in 2004, there were a total of 14,500 vacancies for the healthcare and welfare sector.
7. For **Sweden**, data for doctors, dentists and pharmacists are grouped together, being (in 2003) a total of 39,888: 31,669 SE nationals; 3,957 other EU-nationals and 4,262 non-EU nationals, the number of vacancies being 3,168.
8. Vacancy data for **United Kingdom** (England only) is given as the Vacancy Rate (i.e. percentage of total number of available positions whether or not they are filled).

4. Entry and Recognition of Qualifications

Each Country Study explains the procedure(s) necessary for the entry of a non-national healthcare worker in their Member State, as well as the legal framework and national qualifications required for the various healthcare professions addressed. How these are applied, or any additional training/qualifications that are required for non-nationals of a particular Member State, are also described.

4.1 Entry Procedure

As for any migrant, healthcare workers are subject to the general laws and procedures which regulate immigration, residence and access to the labour market, e.g. issuing of a Work Permit often requiring a written job offer, and these are summarised in each Country Study. For example, in **The Netherlands**, entry procedures are covered by both the Aliens Employment Act (Wav), similarly in **Sweden**, and the Aliens Act. In **Germany**, medical doctors and other such medical professionals come under the general regulation for qualified skilled workers or for self-employed and, in cases of excellent qualifications, as highly-skilled. Residence and work permits for nursing staff from a non-EU/EEA state are regulated through a joint administrative procedure by the German Federal Employment Agency with the labour administration of the country of origin (currently only Croatia) and after an individual labour market assessment. In **Italy**, owing to the need for more non-physician professional healthcare specialists, foreign nurses can be recruited independent of the quotas established by the government. Conversely, other medical professionals, such as doctors/physicians, are admitted only in accordance with the quota established for autonomous workers.

The Netherlands and the **United Kingdom** previously had (and still do have some) special procedures for the healthcare professions. However, currently all Member States process healthcare worker applications in the same way as for other migrants, with the procedure followed depending more on whether the person is an EU-15, EU-10/EEA or non-EU national in compliance with national and EU law. In the **United Kingdom**, it is also dependent on whether a job is denoted as falling within a 'skills shortage' occupation. If this is the case, then particular work permit procedures make it easier for an employer to appoint a non-EU/EEA national with specialist skills that cannot be filled by a national or other EU/EEA worker.

4.2 Ethical Recruitment Policy

Some Member States have taken specific actions in order to develop an ethical recruitment policy, particularly for healthcare workers from developing countries. **Belgium** considers that medical doctors from non-EU countries can continue to obtain further specialisation in their field, but reserves the right to limit courses, in order to obtain the qualification as a medical doctor, to a maximum of three years.

For the **United Kingdom**, the NHS does not actively recruit from any country that does not wish to be recruited from. This includes all countries in Sub-Saharan Africa and the Caribbean. In this context, a "Code of Practice for International Recruitment of Healthcare Professionals"([8]) has been developed which guides the international recruitment of healthcare professionals. The main principle is that developing nations who are experiencing shortages of healthcare workers should not be targeted for recruitment. In addition, the Department of Health has agreed that the Code should apply to major players in the independent (i.e. not public) healthcare sector. The Independent Healthcare Forum and the Registered Nursing Home Association both endorse the Code of Practice and where national contracts are signed with private sector suppliers to increase capacity in the NHS, compliance with the Code of Practice is a contractual obligation. Although there is no active recruitment, it is possible that some healthcare workers are still being employed from such countries, via independent providers who do not endorse this code, or recruitment via speculative approaches from the workers themselves.

In **Ireland**, the two public recruitment bodies for nursing (the HSE Nursing/Midwifery Recruitment and Retention National Project and the Dublin Academic Training Hospitals (DATH) Recruitment Project), undertake a needs analysis and select (via a tendering process) employment agencies to go to potential sending countries. These agencies are given a list of countries that they may not recruit from (currently South Africa and Nigeria, as well as four Indian states) and they take account of the United Kingdom's Code of Practice for International Recruitment (described above). In 2001, Guidance for Best Practice on the Recruitment of Overseas Nurses and Midwives was developed with the following principles:

- Recruitment by Irish employers should be limited to those countries which support overseas recruitment.
- Employers intending to recruit from overseas should liaise with the health board or health authority, Nursing and Midwifery Planning and Development Unit and Personnel Department.
- Employers should bear the cost of the overseas recruitment process and no recruitment fee should be charged to the recruit.
- The cost effectiveness of international recruitment should be assessed.
- Only registered recruitment agencies should be used.
- The employer should monitor the quality of the service delivered by the recruitment agency.
- The employer should provide acceptable accommodation for six weeks, at a subsidised cost and then provide assistance to the nurse in sourcing private accommodation.

In 2005, nurses were recruited from The Philippines (mainly for care of the elderly) and India (mainly for acute care), while in 2006, nurses from India only were targeted, the selection of countries depending on the type of personnel needed.

4.3 Recognition of Qualifications

The recognition of qualifications obtained outside a particular Member State, to a large extent depends on the country in which the qualification was acquired, the nationality of the healthcare worker concerned and whether a bilateral or multilateral agreement exists. For example, recognition of qualifications from other Member States is covered by Community legislation([9]), which also covers EEA (including Switzerland) states. In such cases, validation is no longer necessary or possible, although there is often a recognition procedure (detailed below). Recognition of qualifications of citizens from an EU-

([8]) Available from http://www.dh.gov.uk/assetRoot/04/09/77/34/04097734.pdf

([9]) For example, Directives 93/16/EEC (for doctors), 78/686/EEC (for dentists), 85/433/EEC (for pharmacists) and 77/452/EEC (for nurses). See http://ec.europa.eu/internal_market/qualifications/specific-sectors_en.htm. To date, all Member States (except Czech Republic for 93/16/EEC and 78/686/EEC), have communicated the transposition of these directives into national law.

10 Member State presents some difficulties, as the relevant directives apply only to those qualifications obtained after accession. Generally, the requirement is for vocational qualifications that are at least similar to the corresponding national levels of qualification and legal vocational regulations.

The body responsible for recognising qualifications depends on the type of profession and ranges from a university and/or appointing hospital, professional association or council (**Greece, Ireland, United Kingdom**), to the National Board of Health and Welfare (Sweden), and (federal or regional) government Ministry (**Austria, Belgium, Estonia, Germany, Italy, Latvia, The Netherlands**). For example, in **Belgium**, the recognition of a diploma is a regional competence, whereas the permission to practice a medical profession is a federal competence. In **Germany**, the official licence to practice medicine is issued by the responsible authorities in the federal states, following an application and presentation of the required qualification certificates, whilst in **Estonia**, this is the responsibility of the Health Board, an agency of the Ministry of Social Affairs. In **Austria**, the administrative validation fee is €150, and in **Sweden**, the National Board of Health and Welfare charges 2000 SEK (approx. €215) for validation of degrees awarded to doctors and psychologists in a non-EU/EEA country. The cost for other occupational groups is 600 SEK (approx. €65), and it is free if the qualification has been obtained in the EU/EEA. In Italy, the procedure for receiving a visa and for the preliminary recognition of a degree obtained elsewhere remains slow and difficult, although the recognition of degrees can also be undertaken by foreigners who are not yet in **Italy** by presenting the original degree at the Italian embassy. The recognition of such degrees is, however, generally bound to the quotas defined by the flows decree for autonomous or subordinate activities.

If a bilateral or multilateral agreement exists then the validation process is somewhat simplified. However, such agreements only exist in **Austria** (e.g. for certain university study degrees with Bosnia and Herzegovina, Croatia, Italy, Liechtenstein, Macedonia, Serbia and Montenegro, Slovenia and Pontifical universities), United Kingdom (various agreements and Memoranda of Understanding were formed with the Philippines, Spain and India and South Africa) and, to a lesser extent, in **Germany** (with Croatia).

4.4 Validation of Qualifications

Non-EU/EEA nationals in particular([10]) have to go through a period of validation, sometimes even if they have acquired their qualification in an EU/EEA state (**Austria**). EU/EEA nationals who have obtained their qualifications in a non-EU/EEA country may also have to follow the same validation procedure (**Austria, Ireland, Sweden**). The examples given below illustrate the types of validation procedures followed and in each Country Study one can find more details of the validation procedure.

In **Greece**, the academic recognition of degrees from foreign institutes, already accredited as equivalent to the Greek ones, involves successful participation in exams on certain courses according to the field studied. For doctors, for example, recognition of their university degree requires successful exams in pathology, surgery, paediatrics and obstetrics. Professional experience is recognised by the Council of Recognition of Professional Equivalence of Higher Education Diplomas (SAEI), a body supervised by the Greek Ministry of Education and Religious Affairs, in accordance with the relevant EU directives, even for applicants who hold a degree from a non-EU/EEA country, although they should have their degree recognised in another EU Member State and have practised the profession in question in that Member State for at least three years. So far, no institutional framework has been established for all other cases of non-EU/EEA nationals who seek to have their professional experience recognised.

([10]) For nationals of EU-15 Member States, validation is covered by the relevant directive, whilst for EU-10 nationals, similar procedures to that described are followed.

In **Estonia**, their qualification (curriculum) is compared to that required nationally and, if required by the regulation of the Minister of Social Affairs, the migrant shall be either sent to undergo an adaptation period or take an aptitude test to assess their level of qualification. The adaptation period can also be called training under supervision. Work experience is also taken into consideration and in cases where the curriculum is more or less comparable and the migrant has relevant work experience obtained in their previous country of residence, the health care professional can be registered (which then gives the right to work) without any adaptation period.

In **The Netherlands**, a new procedure for determining the professional competence of the applicant is currently being introduced in a phased manner. Since 1st December 2005, a new procedure has applied to physicians. At some point in the future this procedure will also be introduced for other professional groups. Once the submitted documents have been assessed and verified by the relevant bodies, the applicant will take a knowledge and skills test in the form of an assessment. This assessment consists of a general part, which tests, among other things, knowledge of the Dutch language and of the Dutch health sector, and a medical part. The applicant can further substantiate their application by means of a portfolio listing their previous experience. Following the test, a consultancy meeting is held, which will assess if, and if yes for what aspects, additional training is required in order to be able to meet the Dutch requirements for professional practitioners in the health sector.

In **Sweden**, non-EU/EEA national healthcare workers who have obtained their degree outside the EU/EEA, must apply for a re-examination of their foreign education as a basis for Swedish certification. The person must show that they have acquired sufficient knowledge of the Swedish language for the profession in question. The applicant must also complete a supplementary training programme at Swedish degree level, as well as participate in a course on society and constitutional studies and a practical traineeship, which should be carried out under supervision and be assessed by a certified supervisor. During this period, a salary according to the relevant agreements for trainees is given. Only after this is completed can a formal application be submitted to the Swedish Board of Health and Welfare.

4.5 Linguistic Requirements

As one might expect for the health sector, the ability to communicate in a Member State's official language(s) was cited as a requirement for all, with **Belgium** highlighting also that this was an important barrier for migrant healthcare workers. Formal verification of language competence is often included as part of the recognition of qualifications. For example in **Austria**, the language ability of medical doctors is considered to be sufficient if the person has five years of professional experience in the German-speaking region, has studied in German or acquired the Matura (school-leaving exam in Austria) in German. If the applicant does not fulfil any of these requirements, they are obliged to pass a language exam. In **Greece**, a certificate is required denoting their competency in Greek which is issued, after relevant examinations, by the University of Athens or of Thessaloniki. In **The Netherlands**, a level that is at least equal to the state examination for Dutch as a Second Language, programme II, is required. Similarly in **Italy**, knowledge of written and spoken Italian has to be certified through an interview and a written test. Interestingly, EU healthcare workers are exempt from such a test, and this is a concern for the professional associations who consider that linguistic problems might occur. In a similar vein, for the **United Kingdom**, it is not a formal requirement per se for a migrant to speak English, but it may well be cited as a requirement on a specific job advertisement. Healthcare workers in **Estonia** are obliged to follow the official language requirements stipulated in the Public Service Act, with managers and physicians of healthcare institutions required to master the Estonian language to the highest level, and all other healthcare workers to at least an intermediate level. In **Sweden**, healthcare workers with a university-degree obtained outside the EU/EEA must take a course in Swedish for immigrants. This course is free-of-charge and it is available to all people registered in Sweden. After completing the course in Swedish, they must then undertake a course in healthcare related Swedish, which also is free-of-charge.

5. Policy Initiatives

A number of Member States are currently reviewing their policies with regard to labour migration, including, or specifically for, the Health Sector and some of these are outlined below.

The recent focus in **Austria** has been on increasing the cultural competence of the health sector, which becomes more and more necessary in a culturally diverse society. Topics covered include the health conditions of migrants themselves, and their access to healthcare; the intercultural care of elderly migrants; and cultural diversity in the care and nursing sector. An expert group was commissioned to study such aspects, recommending that the topic of intercultural competence should be emphasized more in education and training (including advanced professional training) for healthcare professions. Other recommendations were to recruit more persons with migration backgrounds for healthcare (like for **Belgium**); to have a higher number of interpreters and intercultural mediators; and to produce more information material in multiple languages, in order to help prevent language barriers and, as a consequence, wrong medical treatment. Another important recommendation is to explicitly inform migrants about health prevention measures and healthcare services.

In **The Netherlands**, there is currently no fully defined policy of managed migration in place, not only for the health sector, but for other sectors as well. However, recent arrangements for the admission of highly-skilled workers have occurred and a proposal has been announced to change the admission policy for migrants who want to work on a self-employed basis. The Dutch government is also currently working on modernising its entire policy (non-asylum related) on migration, with one of the expected foci being on highly skilled workers. The faster admission of migrants who, for instance, contribute to innovation and to the competitive strength of Dutch business, or to academic research in Dutch universities, is one of the starting points in this modernisation. Whether this labour migration must be temporary in nature, also in view of the undesirability of brain drain, continues to play a role in the debate.

In **Sweden**, a parliamentary Committee for Labour Immigration was appointed to examine the regulatory framework regarding labour force immigration, with

the aim of producing a regulation permitting extended labour force migration from countries outside the EU/EEA. This committee was asked to investigate also the need for labour force migration, to assess the consequences of such migration on the labour market and in general, and propose actions. The final Committee Report was submitted to the Government on 18th October 2006, for consideration and decision by the Parliament.

On 7th February 2005, the **United Kingdom** government published 'Controlling our borders: making migration work for Britain'([11]), which is the Home Office's Five Year Strategy for Asylum and Immigration. Contained within this was the idea of a points-based system for managed migration, further details of which were announced on 7th March 2006. The current complex migration system will be gradually phased out and replaced with a simpler, more objective system whereby potential migrants must meet a sufficient number of points in order to work or study in the United Kingdom. The new system aims to identify and attract only those migrants who contribute most to the United Kingdom (for example, highly-skilled workers, such as surgeons or scientists, and those who are coming to fill gaps in the labour market that cannot be met from the domestic workforce, such as teachers and nurses). It also aims to be more effectively managed to improve compliance and reduce abuse of the migration system, with greater emphasis on employer responsibility in ensuring that migrants comply with their condition(s) of stay in the United Kingdom.

([11]) Available from http://www.archive2.official-documents.co.uk/document/cm64/6472/6472.pdf

6. Concluding Remarks

This European Migration Network (EMN) study on managed migration in the health sector serves to illustrate the current situation in the participating Member States, as well as to identify the need for a more consistent approach to the collection of relevant data. As outlined in the Methodology, data on migrants within the healthcare sector is limited and often distributed across several sources. Given the anticipated increasing importance of the contribution of migrants to the healthcare sector across the EU, it would, therefore, seem appropriate that future data collection methods are improved, also to ensure comparability between Member States. Current systems, like, for example, the register developed in **Belgium**, could serve as useful references for any such methods.

As one might expect, there are differences between Member States in terms of their needs, with nurses seeming to be the most common healthcare worker required, for example, in **Greece** and **Italy**, whilst **Estonia** and **Latvia** are facing shortages in almost all healthcare professions. Domestic or home care is also seen as an area of increasing need, particularly for the elderly. For the EU-15 Member States, the current approach is to address present needs firstly through promoting the healthcare profession to their nationals, and then recruiting from other Member States, as well as EEA, followed by non-EU nationals. This is not, however, an inexhaustible supply which will meet the growing future needs of all Member States. This is also not an approach which can be adopted by most EU-10 Member States.

One obvious way of addressing this situation is to recruit more healthcare workers from outside the EU, which then raises *inter alia* the issue of "brain-drain", particularly from those countries already lacking in sufficient numbers of healthcare workers. Efforts to develop a clear policy strategy at EU-level to promote the recruitment of such healthcare workers to not only best suit the needs of particular Member States, but also to the benefit of their countries of origin, resulting in a "win-win" situation, might seem appropriate. Recently, the European Commission published (in December 2005) a Communication on an "EU Strategy for Action on the Crisis in Human Resources for Health in Developing Countries"([12]) which outlined the EU's coherent and co-ordinated response to the planned decade of action on human

resources proposed by the 57th World Health Assembly. Among the actions proposed is to consider a European Code of Conduct for Ethical Recruitment of Health Workers, elements of which already exist in **Ireland** and in the public sector of the **United Kingdom**, in order to develop a more co-ordinated approach to the recruitment of health workers from Africa in particular, which does not, for example, further degrade healthcare in their country of origin.

Thus, initiatives exist to address the situation from the viewpoint of countries of origin, but not yet in respect to determining whether there would be added value in developing a co-ordinated EU approach to the recruitment of healthcare workers from outside the EU/EEA, which takes into account the different situation and needs of the Member States. Such an initiative could also incorporate a more consistent EU approach to the recognition of qualifications obtained outside the EU/EEA; the impact of the movement of EU nationals between Member States, in particular from EU-10 to EU-15; and would also need to take into account the evolution (e.g. reforms, changes in national policy) of such needs within a Member State(s). Another aspect to consider could be in advance validation of qualifications, including of the required linguistic requirements. Of course, whether it is considered that such an initiative would be appropriate would have to be addressed by policy-makers and indeed may be considered within the planned development of a directive on highly-skilled workers, which is foreseen in the Policy Plan on Legal Migration([13]).

Another area of potential added value concerns the transfer of experiences and best practice with regard to intercultural competence in health care services, in order to facilitate the access of resident migrants, as well as nationals of migrant background, to these services. **Austria** and **Belgium**, for example, are developing policies targeting their migrant community, such as promoting their employment in healthcare occupations, which not only would help to overcome language barriers, but would also contribute to integration measures.

Finally, this study serves to demonstrate how the European Migration Network can bring together information on the current situation/policy/practice in the Member States on a particular topic, in a relatively succinct manner, and, through this Synthesis Report, provide a comparative analysis. In this way, it demonstrates how it can provide support for policy- and decision-makers in the EU.

([12]) COM(2005) 642final, available from http://europa.eu.int/eur-lex/lex/Notice.do?checktexts=checkbox&val=418735%3Acs&pos=1&page=1&lang=en&pgs=10&nbl=1&list=418735%3Acs%2C&action=GO&visu=%23texte

([13]) COM(2005) 669final, available from http://eur-lex.europa.eu/LexUriServ/site/en/com/2005/com2005_0669en01.pdf.

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