

# **“Mobility of Health Professionals”**

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The European Health Management Association has recently completed a study<sup>1</sup> which examined the impact of the Single European Market on health services. This study has demonstrated that the SEM will have a substantial effect on health services in a number of areas, and the recent Peerbooms judgement has illustrated this very clearly in terms of the free movement of patients. This paper, however, focuses in particular on one aspect of the SEM – the free movement of professionals – and will demonstrate that, while the actual numbers of health professionals practising in other Member States may be relatively small, the potential impact on the health services of Member States is substantial.

The right of doctors and nurses to move and practise freely within the European Union was established with the “Mutual recognition of diplomas” directives of the mid 1970s. This paper will not explore the details of these directives nor, indeed, the considerable impact in terms of specialist training. The purpose of this paper is to explore the consequences of the free movement of healthcare professionals in terms of its impact on the effective functioning of health systems. There are, I believe, at least five significant ways in which health services may be affected:

- Scarcity may lead to a European market
- A European market would have consequences for salary levels
- Economically poorer countries would have difficulty in retaining their health professionals
- A European market might also affect the ability to provide effective services (both positively and negatively)
- Wealthy countries might downsize their training programmes, relying increasingly on supply from poorer countries and, in consequence, smaller countries would find themselves training people for export

## 1. SCARCITY AND THE EUROPEAN MARKET

It is clear that, in most European countries, there are some medical and nursing specialist areas where there appears to be a chronic shortage – anaesthetists and paediatric intensive care nurses are examples. While some European countries have turned to developing countries, such as the Philippines, Pakistan and India, to overcome these shortfalls there is a growing backlash against the notion of importing expertise from countries which can ill-afford to lose such expensively trained expertise. On the other hand, as the concept of Europe becomes an increasing reality, EU citizens become more willing to contemplate working in another EU Member State. There has been a long tradition of Irish nurses working in the UK, but in the last year the UK has also attracted nurses from Finland and the UK government has reached agreement with Spain to “import” up to 5000 nurses.

It is clear that the ability to communicate effectively with patients is a critically important factor for almost all clinicians, and there is some evidence<sup>2</sup> that employers are more likely to recruit clinicians either from countries which share the same language as the recruiting country or where that language is widely taught. This would lead one to the conclusion that there is a potential for movement between the Francophone countries, between the German speaking countries as well as with those CEE countries where German is the 2nd language (Hungary in particular), and perhaps especially to and from the UK, since English is increasingly the *lingua franca* in the medical world. Communications skills, however, are not the only factor. A study by Jinks et al<sup>3</sup> demonstrates that medical unemployment or lack of

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<sup>1</sup> The European Union and Health Services – the Impact of the Single European Market on Member States: Summary of a Report to the European Commission. European Health Management Association, Dublin, May 2001 ISBN 0 907727 07 7

<sup>2</sup> Buchan, J. (2000) Pressure is on. Health Service Journal 26-27.

<sup>3</sup> Jinks C, Ong BN, Paton C. Mobile medics?: the mobility of doctors in the European Economic area. Health Policy 2000;54:1:45-64.

training positions was the most frequently cited reason for doctors from EEA countries to move to the UK, combined with the high reputation of UK medical training.

The movement of healthcare professionals, therefore, is likely to result from a combination of “push” and “pull” factors – poor circumstances in their home country and enticements from the recruiting country. There is little hard evidence on the numbers of clinicians moving between EU Member States, although it appears that the numbers, while small, are not insignificant. The Jinks study<sup>3</sup> also shows that, for the UK at least, the numbers of doctors coming to the UK from EEA countries are in decline since 1996, when there were approximately 1500 registrations from EEA countries, compared with 3800 registrations from UK citizens and 4000 from “overseas” doctors. EEA registrations in 1996 therefore accounted for about 19% of all UK registrations – most of these young doctors seeking training and experience in the UK but few intending to remain permanently in the UK. The reliance on EC nurses in the UK is much less significant (see Figure 1),

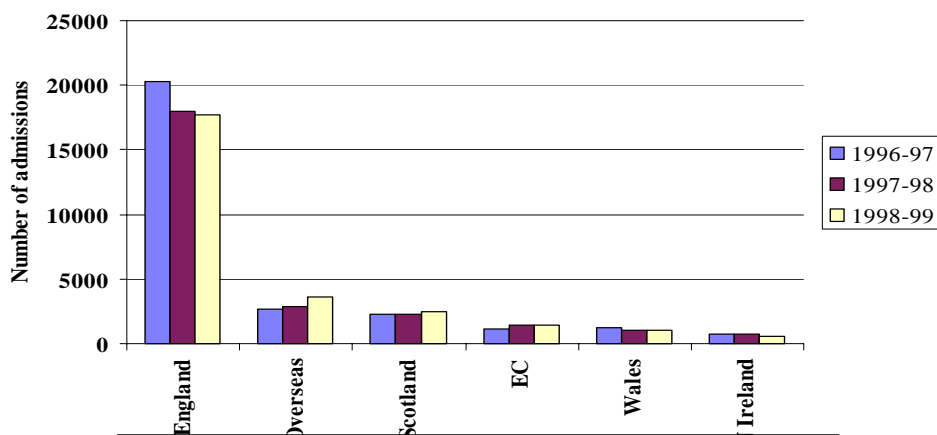


Figure 1: Nurses registered with the UKCC (1996-1999) from Jinks et al

However, as this paper will demonstrate, the potential impact on health services is considerably greater than the number involved.

## 2. SALARIES AND THE EUROPEAN MARKET

Where there are scarcities across Europe, it is likely that a European market in these “scarce goods” will develop. This will inevitably mean that countries will begin to compete with each other for doctors and nurses who are essential to the effective functioning of health services. In a Single European Market where, since Kohll and Decker – and, more recently, Peerbooms – citizens are very aware that the SEM applies to healthcare, patients will not accept that certain health services cannot be provided because of the shortage of expertise. They will argue either that they wish to be sent to countries where such services are available or – more probably – they will demand that the necessary health professionals should be found to keep their healthcare systems functioning effectively. While sickness funds might be willing to export their patients under such circumstances, governments in Beveridge systems will be very reluctant to suffer the political embarrassment of admitting that they cannot provide an adequate service, and hospitals in Bismarckian systems will be anxious to provide a full service to their patients.

Competition will therefore develop either on the basis of pay, working conditions, training or career opportunities and – to a lesser extent – language. Countries with higher pay scales will find it easier to attract scarce specialists, while countries with low pay scales will tend to lose those specialists. If these low-pay countries wish to keep their specialists, then they will have to pay the “going market rate” – effectively the highest pay scales within the European Union. In effect, there will develop a European market for scarce specialists, and this will lead to increased pay scales in low-pay countries, which will inevitably have consequences for the pay scales of other nurses and doctors, who will be unwilling to be paid at lower rates than their colleagues from other EU Member States working alongside them in the same hospital. Naturally, pay is not the only factor which will govern the decision of a doctor or nurse to move to another EU country. If working conditions or training opportunities are significantly better, or the cost of housing is substantially lower, these might also influence the decision.

In this emerging European market, employers will have to look at the entire package of benefits in order to attract and retain specialists, and they will no longer be able to view the market as a local or national market.

### **3. IMPACT ON POORER COUNTRIES**

If this European market does indeed develop, as suggested in the previous paragraphs, the consequences for the poorer countries of Europe will be serious. In the end, it will become impossible for them to retain those specialists, both doctors and nurses, who are in demand across Europe, and their health services will inevitably suffer the consequences. This will be particularly true in the countries of Central and Eastern Europe, where pay scales are relatively low (even taking into account the under-the-table payments) and the attraction of jobs in Western Europe must seem alluring.

### **4. IMPACT ON HEALTH SERVICES**

The mobility of professionals is likely to have a substantial impact on the provision of services, particularly in countries with land borders that have good and easy communications. Take, for example, the Maastricht-Aachen area. If a hospital in Maastricht decided to open a specialist orthopaedic unit specialising in joint replacement, it is likely that such a unit might attract orthopaedic surgeons from Aachen, creating in effect a regional supra-national centre of excellence. Such a development might cause a “snowball effect” attracting patients not only from the Netherlands, but also from Germany and Belgium, and hence inducing doctors also to transfer their practices. Eventually – the nightmare scenario – this might leave the Aachen hospital with insufficient orthopaedic surgeons to offer an effective accident and emergency service.

While such a scenario is unlikely, it does illustrate that health services can no longer assume that they operate within impermeable national boundaries, and health service managers will have to be increasingly aware that developments in neighbouring countries might have an impact on their own services.

There is, of course, a positive side to the impact on health services. Countries with a surplus of doctors would provide the resources either for poorer countries or for countries with a shortfall in the supply of doctors or nurses. This was the case recently, when Germany had a temporary oversupply of doctors, who found ready opportunities for employment in the UK NHS.

## **5. TRAINING**

If wealthier countries can attract both doctors and nurses by offering them higher salaries and better working conditions than are available in their countries of origin, there may be a temptation for those wealthy countries to reduce the number of medical and nursing schools accordingly. This would lead to substantial savings in their educational budgets, but would leave them vulnerable to an external supply. Poorer countries, in contrast, would find themselves training doctors and nurses for export – investing heavily in training and getting a very poor return on that investment.

If the accession states in Central and Eastern Europe, for example, experienced a shortage of doctors due to emigration, the consequence might be that these states would also abandon or diminish medical education. This would probably result in the growth of private medical education to produce doctors for private suppliers of healthcare, thus providing disproportionate benefit to the wealthy.

## **CONCLUSIONS**

This paper has presented a number of possible consequences of the mobility of health professionals. It has demonstrated that, while the numbers involved may not be substantial, if only because people are likely to remain in their own country for linguistic, cultural and social reasons, nevertheless managers and policy makers need to be aware that the impact may be disproportionate to the numbers involved.

So, what can or should be done to ameliorate the negative effects and to encourage the positive effects? At a policy level, it appears that there is little that can be done. The free movement of people is an essential part of the SEM, and it is highly improbable that healthcare could or should ever be excluded. While it seems logical to suggest that human resource planning by Member States and even by the European Commission should be developed to take into account this European dimension, it is now widely recognised that human resource planning is notoriously unsuccessful at national level, let alone at European level. People will go where they want, and do what they want whatever the planners might decree! It would be helpful, however, to have more accurate figures (as well as trends) on the numbers of health professionals working in other EU Member States – something that the European Commission might sponsor. At a policy level, the best that can be hoped is that those responsible for medical and nursing education, as well as those responsible for the delivery of services, should have regular dialogue at a European level in order to predict and ameliorate the consequences of the free mobility of professionals.

At the managerial level, it will be essential for healthcare managers to understand the dynamics of the healthcare systems in neighbouring countries and to be vigilant to developments occurring in those neighbouring countries which might have an impact on the supply and demand of health professionals.