MAIN FINDINGS AND RECOMMENDATIONS OF THE PROJECT

“WORKING TOGETHER TO ADDRESS HEALTHCARE WORKFORCE MOBILITY IN EUROPE”

Duration 2020-2023

Implementing agency - European Institute of Health and Sustainable Development (EIHSD), Lithuania

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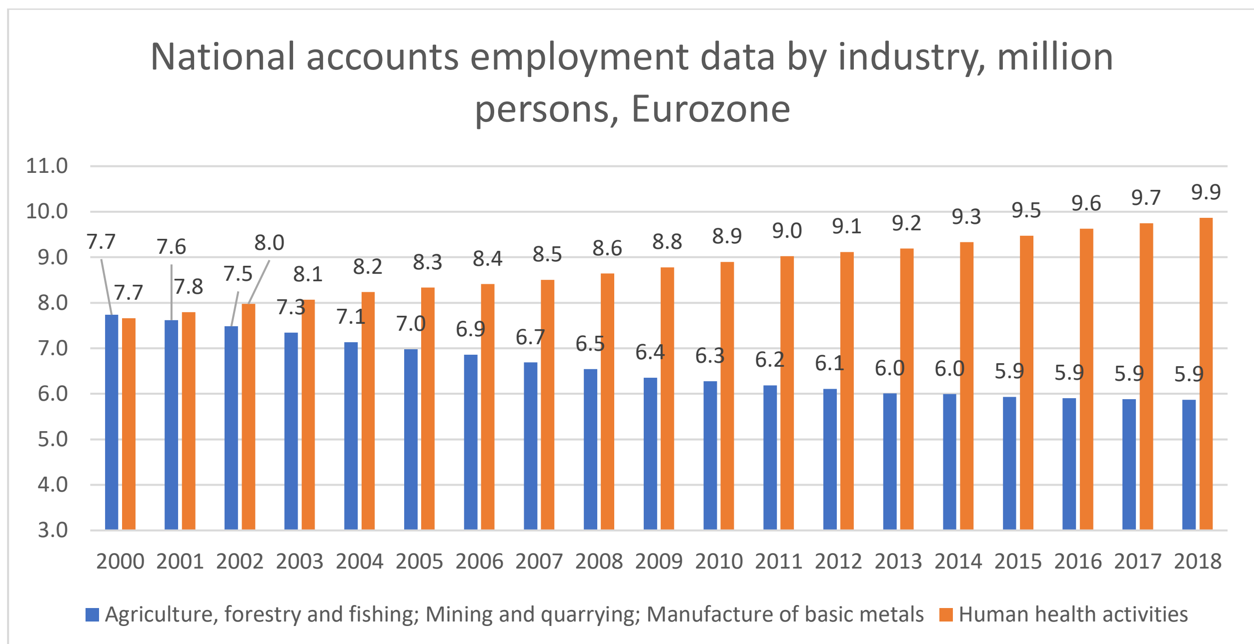
I. Covid-19 reveled the fact that was obvious for European citizens but almost tera incognito for European institutions: Healthcare workforce is one of most precious assets of the modern EU

Figure 1. Employment in Eurozone, Eurostat



Eurostat figures for the Eurozone (Figure 5) show that employment in health is now almost twice as large as economic sectors that dominated European policy at the start of European integration (European Coal and Steel Community, Common Agricultural Policy).

II. International mobility/migration is a phenomenon with the history as long as the history of humanity but nowadays, in time of globalization, it is a very dynamic process with a potential to destroy existing institutional structures of MS

Table 1. International migration in the EU

	2010-2011	2020-2021
Belgium	132,497	94,592
Bulgaria	NA	43,421
Czechia	-41,548	77,971
Denmark	22,020	22,889
Germany	391,976	571,673
Estonia	-4,989	10,825
Ireland	-51,517	46,572
Greece	-33,894	-16,092
Spain	-80,375	367,427
France	65,802	297,810
Croatia	-8,336	-5,144
Italy	683,417	247,696
Cyprus	34,055	10,084

Latvia	-55,717	-3,436
Lithuania	-116,122	39,646
Luxembourg	18,664	16,996
Hungary	25,072	20,578
Malta	1,733	5,845
Netherlands	56,723	183,505
Austria	50,360	92,196
Poland	-171,734	88,470
Portugal	-20,516	66,916
Romania	-95,966	-63,518
Slovenia	1,538	20,845
Slovakia	6,349	6,685
Finland	30,552	40,719
Sweden	95,236	75,928
Total net losses of EU source countries	-680,714	-88,190
Total net migration to 27 countries of the EU	935,280	2,317,678

Source. Eurostat

Data presented in the table 1 shows that in the aftermath of the recession of 2008-2009 most countries of the Central and Eastern Europe and Mediterranean region were losing population due to emigration within and outside of the EU:

- During 2010-2011 cumulative losses of 11 source countries were 680.7 thousand.
- Total net migration to the EU 27 countries was 935.3 thousand during 2010-2011.

10 years later migration patterns in Europe are quite different with just four countries losing population due to emigration:

- During 2020-2021 cumulative losses of 4 source countries were 88.2 thousand. Just one country recorded net migration above 10 thousand per year.
- Total net migration to the EU 27 countries was 2317.7 thousand during 2020-2021.

The period of 2020-2021 is before the war in Ukraine started, thus the inflow of refugees from Ukraine is not reflected in the table.

Deep analysis of why net emigration from the “periphery” of the richest countries of the EU is likely falling beyond the scope of the project but some suggestions how to explain the pattern have been developed.

- Economies of the EU member states in the process of the integration into EU single market are converging according to GDP per capita calculated by PPP methodology and consumption per capita. Personal income gains generated by international mobility and the scope of economic migration between countries of the EU is reduced because of the convergence.
- Economies of the EU eastern member states are converging from that of Ukraine, Moldova, Countries of southern Caucasus. Economic opportunities and visa free regime were supporting migration from the Eastern neighborhood regardless of the military conflicts and political instability in this region.

Huge inflow of migrants from outside Europe, first off all from the Middle East and Africa was the main cause of growing net migration to the EU in 2020-2021. The increased inflow, as it was clearly demonstrated by BREXIT debates, results in certain opposition to all immigration including that coming from the EU member states.

Growth of migrant inflow in 2023 and political waves caused by the process across the Europe is an indication that tectonic movements of people will continue to rock the continent. However, complex, long-term approach how the EU has to tackle the issue despite the of the New Pact on Migration and Asylum is far from being developed.

III. The theory of humane capital is 60+ years old but even today political debates and mainstream research is concentrated on financial transactions, but not on a human capital

Table 2. International capital outflow and inflow, billion euro. Lithuanian case

	Net emigration, thousand	Outflow of human capital, billion	Net financing of the EU and net FDI	The balance of capital flow
2004	32.1	-2.75	0.97	-1.79
2005	51.1	-4.37	1.07	-3.30
2006	24.6	-2.11	1.18	-0.93
2007	21.8	-1.86	1.39	-0.47
2008	16.5	-1.41	1.44	0.03
2009	32.0	-2.74	2.09	-0.65
2010	77.9	-6.67	1.96	-4.72
2011	38.2	-3.27	1.97	-1.30
2012	21.3	-1.82	2.11	0.29
2013	16.8	-1.44	2.11	0.67
2014	12.3	-1.06	2.14	1.08
2015	22.4	-1.92	1.14	-0.78
2016	30.2	-2.58	1.74	-0.84
2017	27.6	-2.36	1.86	-0.50
2018	3.3	-0.28	2.30	2.02
Total 2004-2018	428.1	-36.64	25.46	-11.18

Source Lithuanian national statistics

The upbringing of people requires public investment into education and private investment of families at least up to the period the child will reach 18 years of age. Public investments according to Lithuanian statistics during 2000-2020 period is: one year in preschool cost 2400 euro or 7200 euro per preschool child (per 3 years), year of primary and secondary education – 2100 euro or 25200 per student (per whole training period), and that of university training per year – 4100 euro. Additionally, families spend their own resources approximately 49100 euro per child. Cumulative investment into one person that emigrates is equal to 85600 euro.

428.1 thousand people left the country from 2004 (the year Lithuania entered the EU) to 2018. 36.6 billion euro of humane capital was exported during the period. During the same period net foreign direct investment (FDI) and financing of the EU according to authors estimates equaled 25.46 billion euro. The balance of capital flow (human and financial) was negative (-11.18) billion.

IV. International mobility of healthcare workforce has certain positive outcomes that partially support policies of free movement of labour but the mobility not always is creating European value added in health

The policy of free movement of labour was based on assumption, that it always is Win-win scenario.

Theoretically health in the EU wins the most then international mobility of health care workforce are contributing health gains in both source and destination countries. Situations then positive health aspects in source and destination countries coincide are leading to *win-win scenario*:

- Immigration contributes to reduction of healthcare personnel shortages as a consequence of it to shorter waiting times, higher quality of health services, better geographic access, brings extra clinical as well as language skills in destination countries. Expats returning to the country of origin are bringing back newly acquired clinical, managerial, and cultural expertise.
- Health in the source country may also improve if expats are not coming home but paying back the health system of origin by transferring health technologies, networking, and providing health services to their nationals that are visiting the destination country. Ukrainian health professionals that are seeking refuge in the EU but at the same time serving their nationals is an example of win-win at least on a temporary basis.
- Stimulus to select medical studies and seek professional excellency created by an opportunity to work abroad are generating gains in health of source countries that outweigh health losses related to emigration of health professionals.

Pan-European, regional, and bilateral cooperation in health should focus on strengthening international mobility of the health care workforce if it leads to win-win scenarios. The cooperation may include research of good practices, projects encouraging bonds of expats with countries of their origin, coordination in training, recruitment, and retainment of health professionals.

Unfortunately proponents of free movement are underestimating the fact that mobility of healthcare workforce quite often is developing according to win-loss scenario.

Creation of European net value added goes beyond investment into win-win solutions. It may be formed even if source country is facing loses in health:

- Medical professionals are emigrating because national health systems are failing to provide higher salaries, proper working conditions and/or to assure the workload needed for full-time work according to his/her professional qualifications. Cross-border reallocation of underused human resources may contribute to health gains that exceed health loses in the source country.
- Emigrating medical professionals sometimes are unemployed or often are employed in non-medical jobs because of limited opportunities to practice as medical professionals and/low relative income of health personnel at home country. Such a pattern of international mobility creates no short-term health losses in the country of origin but by reducing the supply of medical professionals is harmful in mid-term.

International mobility of health personal my lead to destruction of health of Europeans, to *negative value added in health:*

- Medical professionals who are employed full time according to his/her professional qualifications are emigrating because of non-compatible salaries in source and destination countries. Such mobility may have zero European value added if the workload at home and

abroad is the same or even negative if productivity of a professional is reduced after changing the place of residence. Quite often the decrease of productivity is related to performing jobs that do not utilize all the potential of a migrant (for example a licensed nurse who worked at home in the surgery department is working as a career in a family of an elderly person).

- Professionals employed in life saving but understaffed departments in source country are moving to almost optimally staffed positions or departments that provide services not critical from the perspective of saving lives. For example, surgent is moving from emergency clinic in home country to clinic of cosmetology abroad.

Accounting of European value added for win-loss scenario requires an agreement on methodology of assessments. The basic theory behind these assessments is founded on assumption that value of health of each European is the same and that any international reallocation of human resources that leads to improvement of health in country of destination that exceeds health loses in the source country is efficient for the EU. However, indicators that are used to measure improvements in health (for example QALY) are mainly used in academic or applied research but are not integrated into the fabric of political debates that are shaping policies of international mobility of health personnel.

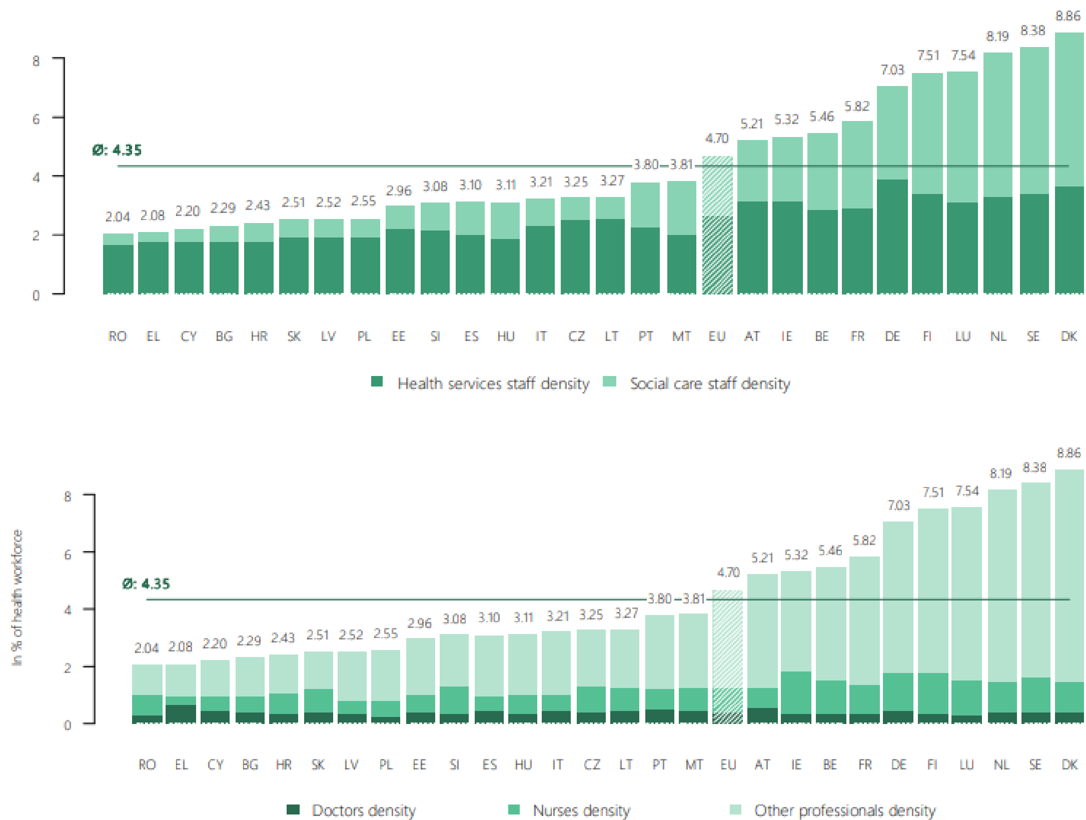
Systemic monitoring of international mobility with win-loss outcomes is almost absent in the EU. Development of the monitoring system is needed to provide evidence-based knowledge on health outcomes of mobility and to strengthen policy development.

Pan-European, regional, and bilateral cooperation in health should focus on improvement of health status across the EU including the discouragement of international mobility of health care workforce that leads to negative health outcomes. The cooperation may include mitigation of health personal shortages, studies of good practices, reflection of importance to look for win-win solutions in the recruiting practices, fine tuning projects encouraging bonds of expats with countries of their origin, coordination in planning, training, recruitment, and retainment of health professionals.

The development of indicators agreed on the EU level that reflect costs and benefits provided by international migration is instrumental on the path of gaining evidence-based knowledge in the field.

V. The EU is renowned for the convergence of economies of its members. The EU today is much more homogeneous in comparison to the situation that was 20 years ago, if measured by the GDP in PPP per capita but there is no certainty on convergence of health systems. Density of healthcare workforce is so different across member states and even most advanced national health systems are facing regional imbalances described as "Too far, too old, too few".

Figure 2. Health workforce density per 100 inhabitants be sectors and professions in persons, 2017



Source: BASYS based on Eurostat.

VI. Health and care workforce in Europe: time to act* (WHO, 2022) *introduced "TEN ACTIONS to strengthen the health and care workforce". What about actions coordinated on the EU level?

Action 1. Align education with population needs and health service requirements.
Action 2. Strengthen continuing professional development to equip the workforce with new knowledge and competencies.
Action 3. Expand the use of digital tools that support the workforce.
Action 4. Develop strategies that attract and retain health workers in rural and remote areas.
Action 5. Create working conditions that promote a healthy work–life balance.
Action 6. Protect the health and mental well-being of the workforce.
Action 7. Build leadership capacity for workforce governance and planning.

Action 8. Strengthen health information systems for better data collection and analysis.
Action 9. Increase public investment in workforce education, development and protection.
Action 10. Optimize the use of funds through innovative workforce policies.

All EU member states being also members of the WHO European region indorsed in Bucharest the document (Bucharest Declaration on the Health and Care Workforce, 22-23 March 2023) but we don't know what (if any) EU policies are going to be inspired by the call of WHO: "WHO (2022), Health and care workforce in Europe: time to act".

VII. Main findings and recommendations of the project "Working together to address healthcare workforce mobility in Europe"

Years 2020 -2023 are marked by groundbreaking initiatives named as building blocks of a European Health Union. The success of all these initiatives is conditioned by proper actions of health professionals but there is a risk that health personnel heralded as national heroes during the pandemic may vanish of the political radars in parallel to fading memories of Covid-19.

In 2023 State of the Union Address by President von der Leyen, she mentioned: "We have set the building blocks for a Health Union, helping to vaccinate an entire continent – and large parts of the world… I believe that the next enlargement must also be a catalyst for progress. We have started to build a Health Union at 27. And I believe we can finish it at 30+…"
The EU has ambition to finalize the development of a EHU in line with growing from 27 to 30+ member states. European strategy that explicitly targets development of healthcare workforce is needed to cement one additional new building block of an EHU.

Year 2024 will be marked by elections to European Parliament and refreshed Cabinet of the European Commission. The new political season is a perfect time to work towards the health care model that what regards healthcare workforce will be labelled "Closer to the patient and optimal size, fit for provision of universal health coverage" instead of "Too far, too old, too few". The Healthcare Workforce Strategy that foresees urgent, mid-term and long-term actions should become the key element of new building block of EHU architecture.

The EU should concentrate on actions with the potential to create European value added in health. The Manifesto for a European Health Union that was presented for health community on EHFG 2020 provides suggestions regarding main avenues of coordinated action. Each of these avenues requires activities in the domain of healthcare workforce.

- Solidification of emergency preparedness and response.

Continuous and coordinated planning and training of health personal is needed to be prepared for future challenges.

Decades of cost containment resulted from widespread perception that capacities of health care institutes should be used almost up to full capacity. What either is the measurement (hospital bed occupancy ratio, number of visits per doctor per day, number of personnel per hospital bed). Growing waiting lists were not taken seriously over Europe until the emergency. Infrastructural planning has to be reconsidered. Reserves of physical and human resources should be foreseen for reduction of waiting lists during the normal and sustaining health systems during emergency times, by member states and the EU.

Health systems appeared close to collapsing during the 2020-2021 because of Covid-19. The EU has very little health capacity to help suffering in Ukraine, Turkey, Morocco, Libya.

During the pandemic reallocation of health personnel even between boundaries of individual member states was very complicated. The EU needs algorithms and regulation that would assure urgent upscaling of healthcare workforce mobility during the big scale health emergencies in the future.

- Working together to address the unequal distribution of health workforce capacities in Europe.

Extend pan-European cooperation into planning and execution of training and recruitment of medical personnel.

Upgrade monitoring of accessibility of health services with the emphasis on equitable distribution of the healthcare workforce across the EU.

A system of incentives is needed to promote optimal levels of training, recruitment and retaining of health personnel.

Brain drain and brain waste of health professionals due to aggressive promotion of cross border mobility of health professionals should be discouraged

Strengthen the role of Health in Country Specific recommendations for the member states in the cycle of the European Semester, using the “State of Health in the EU. Country profiles” instrument

- Enhancing cooperation on the management of rare diseases.

No one EU country alone has no chance to treat their patient with rare diseases. And creation of pan European reference networks for rare diseases is a good example of moving together into right direction.

Increase the mandate and scope of the European Reference Networks, developing them as legal entities, supporting them with stable financing resources and assisting them to take advantage of developments in digitalisation and artificial intelligence. There is urgent need to train health care professionals to better understand and diagnose rare diseases on the basis of pan European standardized methodologies.

- Expansion of European cooperation in R&D.

Europe needs to make sure hospitals and healthcare professionals are incentivised to take part in clinical research to ensure that new knowledge is generated and to recognise that research work is rewarding for staff and help secure retention of talents.

The pan-European activities such as Innovative Medicines Initiative and health related elements of PF/Horizon2020/HorizonEurope, EFSI/InvestEU, EIB/EIF, COSME are working for competitiveness of European science and industry but the EU is behind the US in supporting R&D.
The pan-European cooperation in *R&D* has to be expanded with stronger focus on training (especially postgraduate) of relevant health personnel and more inclusive what regards research conducted in new member states.

- ·Developing a Global Health Policy, working with the UN and its specialized agencies, and especially a strengthened World Health Organization.

Progress in training, retainment and allocation of healthcare workforce are key for Global health policy. Bilateral, multilateral, and global cooperation has to be enhanced if signatories to the 2030 Agenda for Sustainable Development (2015) are serious about achieving objectives marked by SDGs.

Documents that foster pan-European and global healthcare workforce policies

The Treaty of Amsterdam (1997). A *high level of human health protection shall be ensured in the definition and implementation of all the Union's policies and activities*

The Schengen Agreement (1985)

The judgments in Kohll and Decker case by the Court of Justice (1998)

The Charter of Fundamental Rights of the European Union (2000).

EU's Working Time Directive (2003/88/EC)

Professional Qualifications Directive; 2005/36/E

The Lisbon Treaty (2007).

Council conclusions (2010), On investing in Europe's health workforce of tomorrow: Scope for innovation and collaboration

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The 2030 Agenda for Sustainable Development (2015)

European Pillar of Social Rights (2017)

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OECD (2019), Recent Trends in International Migration of Doctors, Nurses and Medical Students, OECD Publishing

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WHO (2021) Drawing light from the pandemic: A new strategy for health and sustainable development

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