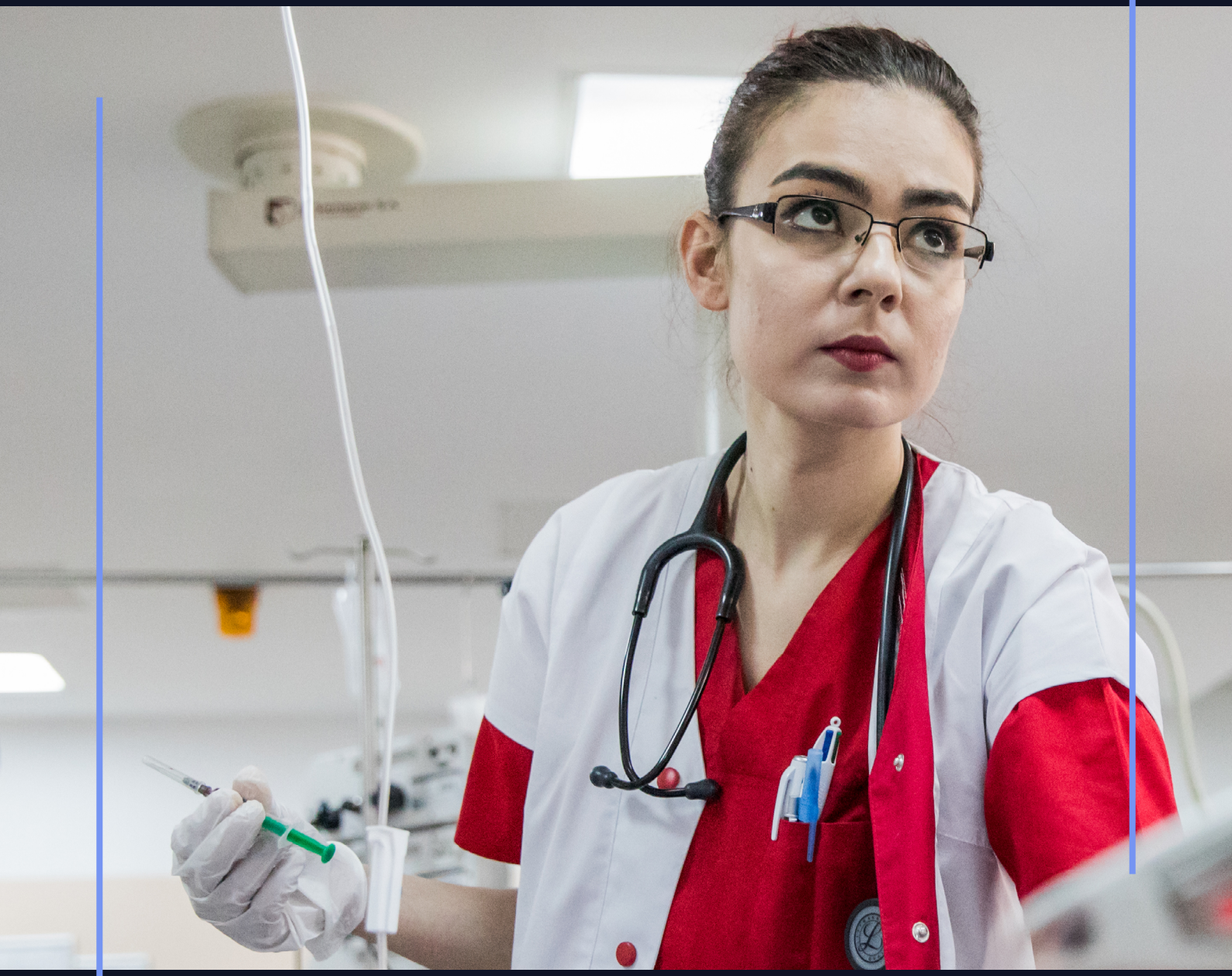
Working Together to Address Health Workforce Mobility in Europe

Recommendations for Action



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A doctor treating a patient in the emergency room at a hospital in Bucharest, Romania, January 23, 2019.

Executive Summary

The free movement of people is a cornerstone of an open and integrated Europe. Yet, the labor migration of Europeans from lower-income countries in southern and eastern Europe to higher-income countries in northern and western Europe has had significant impact on the workforce—including the loss of skilled health professionals in their most productive years.

Indeed, since 1989, hundreds of thousands of European health professionals have left their countries of origin for more promising opportunities in the west and north. Denied opportunities for decent work at home, and recruited by countries facing their own labor shortages, their mobility is a byproduct of a failure throughout Europe to develop health workforces in an evidence-based and strategic way. Ultimately, this failure threatens the human right to health. If this situation persists, it could erode the promise of European solidarity and contribute to further unwarranted backlash against European integration.

The reasons for this workforce migration are complex—they are triggered in part by high unemployment rates and poor conditions in originating countries, and higher salaries, professional development opportunities, and perceived better work environments in receiving countries, among many other factors. These causes defy quick fixes. They call for multi-sectoral and regional approaches to governing the free movement of labor in a manner that benefits all Europeans.

The Open Society Foundations are committed to the freedom of all Europeans to decide where to reside and make a living, and to enjoy full labor protections, wherever they choose to live. It is the mutual responsibility of both originating and receiving states to develop and implement comprehensive, long-term workforce development plans and an appropriate public debate as adequate policies are profoundly missing across the European Union.

This policy brief offers six key insights drawn from a literature review and interviews with European experts on the migration and mobility of health professionals from post-2004 EU member states of central and eastern Europe. We present these insights within a perspective on human rights, gender equality, and solidarity.[1,2]

Introduction

While free movement of people is essential to an open and integrated Europe, the labor migration of Europeans, particularly from east to west and south to north, is a conundrum for originating and receiving member states. Between 1989 and 2017, an estimated 20 percent of Romanians, 12 percent of Bulgarians, 7 percent of Poles, and 5 percent of Hungarians lived and worked abroad.[3] In that same period, Latvia lost 27 percent of its population and Lithuania 22.5 percent .[4]

The challenges of integrating labor migrants into host countries dominate the public discourse. Less appreciated is the strain migration places on countries of origin, particularly when they lose population and skilled laborers who are in their most-productive years to more economically attractive destinations. While countries of origin may benefit from financial remittances sent home by migrant workers, migration poses risks for the sustainability and fiscal capacity of the social welfare, education, and health care systems, as well as for the prosperity of population, science, and economic development in the country of origin. It is the obligation and need of both originating and receiving member states to address this challenge.

Labor migration has implications for the ability of member states' governments to deliver on public goods and the social contract they have with their citizens. As Fubini writes, "given that highly educated [and skilled] workers represent a disproportionately large share of the overall emigrant population, the EU core has benefited from this brain drain, while the periphery has lost out."[3] This inequity has the potential to fuel anti-EU sentiments in recent and candidate member states in eastern and southern Europe. Yet, receiving states are not solely responsible for the problem: while they may bear responsibility for recruiting skilled workers, originating states fuel emigration when they fail to enact and implement strategies to develop and retain their health workforces.

Reflecting on the promise of an open and integrated Europe 30 years after the fall of the Berlin Wall in November 1989, the Open Society Foundations commissioned a small team of research consultants to review the evidence and formulate recommendations about better regulating and mitigating the negative effects of labor migration in the health sector. When large numbers of health professionals—including medical doctors, nurses, midwifes, nurse-assistants, health technicians, pharmacists, dentists, and other skilled workers—emigrate in large numbers following labor market demands, apparent trade-offs may emerge between the strengthening of the receiving countries and the weakening of the originating countries for ensuring quality health care services to their populations. An imbalance is created between the health care needs in receiving countries vis-a–vis those of originating countries. This hampers the ability of sending states to deliver on essential health care services and secure essential public health functions. If this situation persists, it might erode the promise of European solidarity as expressed in the treaty of the European Union and contribute to a backlash against European integration.

Countries that benefit from economic stability enjoy a culture and institutional capacity of strategic integrative planning, and are able to invest in the health workforce and anticipate their future workforce needs in relation to other policy and legislative domains, including demographic, epidemiological, technological, environmental and social change, economic space, and education. By contrast, some source countries for labor migration such as Serbia[5,6] facing the pressure of external debt and austerity measures, might have been advised to restrict fiscal space for social spending with the aim to rationalize public services including health care and education. In this context, it should come as no surprise that emigrant health care professionals, exercising the human right to freedom of movement, have found a way to replace a restricted living and working environment with a better standard of life in a progressive and democratic society. Indeed, many health professionals have emigrated from wealthier countries like Germany to Switzerland; the difference is that these countries are able to replenish their workforces from other member states in Europe.

The Open Society Foundations are committed to the freedom of all Europeans to decide where to reside and make a living, and to enjoy full labor protections wherever they choose to live. Consistent with the right to work and the right to health, Open Society also believes it is the mutual responsibility of both originating and receiving states to develop and implement comprehensive workforce development plans. Such plans shall provide real choice to health professionals and sustain the principle of European solidarity. These principles notwithstanding, we find an appropriate public debate and adequate policies profoundly missing across the entire European Union.

Health Professional Migration and Mobility

Health workforce migration and mobility is not a new phenomenon. As early as 1979, the assistant director-general of the World Health Organization (WHO) concluded that "the migration of physicians and nurses is essentially an incidental result of the unequal development of different nations and of different regions and social groups within nations."[7]

Thirty years later, in 2008, the European Commission[8] (EC) acknowledged that all member states face foreseeable challenges: the demographic transition of an ageing general population as well as ageing health workforce may lead to insufficient personnel replacement for the required health services; the lack of social and ethnic diversity of the health workforce; the lack of attractiveness of a wide variety of health care and public health-related jobs to new generations; fiscal pressure due to a reduction of the active workforce relative to the dependent population; the migration of health professionals in and out of the European Union; and the unequal mobility within the European Union, in particular the movement of health professionals from poorer to richer countries within the European Union, as well as from third countries from outside the European Union.

This policy brief draws six key insights from a rapid literature review and from interviews with European experts on the migration and mobility of health professionals from post-2004 member states of central and eastern Europe. We offer these insights through a lens of human rights, gender equality, and solidarity.[1,2]

Six Key Insights on Health Workforce Mobility in Europe

1. While the magnitude and net directions of health professional migration flows change over time, there is an increasing trend of movements from lower-income countries in southern and eastern Europe to higher-income countries in northern and western Europe.

The mobility and migration of European health workers mirrors larger trends on the continent. Health professional migration and mobility across the European region existed well before the former Soviet Union dissolved and the European Union expanded in a changing geopolitical context. The accession of 13 new members in 2004, 2007, and 2013, however, did considerably increase the flows from eastern and central EU member states toward the western European Union. Available data show that outflows have rarely exceeded 3 percent of the domestic workforce in the year of accession[9]; however, the impact of the loss of medical professionals was often experienced as a dramatic loss, and has led to critical shortages in countries such as Bulgaria and Romania. In Romania, for example, 14,000 medical doctors left the national health system between 2007 and 2013 and chose to practice abroad.[10*]

The financial and economic crisis in 2007–2008 further affected migration and mobility flows and health workforce development. The reduction or freezing of salaries and staffing levels caused health professionals, mainly from eastern and southern Europe, to look for job opportunities elsewhere, mainly in western and northern Europe. The impact of the financial and economic crisis on health professional mobility and migration only became visible after a few years.[11] It negatively affected the availability of qualified health professionals in countries worst affected by the fiscal crisis.[12]

The United Kingdom has used international recruitment as a source of staff deployment for decades.[13] Brexit-related uncertainties, however, have made the United Kingdom a less attractive destination country for nurses with EU citizenship. This has pushed the United Kingdom to increase its recruitment of nurses from countries such as India[14] and the Philippines.[15]

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*Data on health workforce mobility and migration in this report is based on secondary sources from publications and shows general trends. Data of stocks and flows of health professionals from individual countries might not be comparable—which, is amongst others reasons, linked to various categories of health professionals (licensed/professionally active/practicing) that are not visible in databases. The quality of data on monitoring health professional mobility in Europe needs further improvement, particularly on short-term movements, emigration, and return mobility.

Efforts have been made to improve health workforce mobility and migration data. The Organisation for Economic Co-operation and Development, Eurostat, and the WHO Regional Office for Europe have joined forces on data collection related to health, including statistics on the health workforce in Europe. These organizations depend on the inputs of data at the country level. (See Joint Data Collection On Non-Monetary Health Care Statistics at: https://www.oecd.org/statistics/data-collection/Health%20Data%20-%20Guidelines%202.pdf). The WHO has made an effort toward ensuring comparability by defining the core data and data sources on human resources for health to be used/reported on a country level. (See National Health Workforce Accounts at: https://www.who.int/hrh/statistics/nhwa/en/ (https://www.who.int/hrh/statistics/nhwa/en/).

How Romania struggles to retain its health professionals

Romania, an upper middle-income country and member of the European Union since 2007, is currently a key source country for western Europe, with many Romanian doctors, nurses, and other health professionals migrating to work in countries such as the United Kingdom, France, Germany, Italy, and Spain. Once a common trend, the "brain drain" seems to have increased after EU accession in 2007.[16] Indeed, 14,000 medical doctors (in 2012 less than 40,000 medical doctors were licensed[17]) left the national health system between 2007 and 2013 and chose to practice abroad.[18,10] While every insured person should have access to the same health care benefits regardless of their socioeconomic situation, there are inequities in access to health care across many dimensions, such as rural versus urban environments[19] and marginalized (e.g., the Roma) versus other populations.[19] Health outcomes also differ across these dimensions.[20] In short: high levels of migration coupled with retention issues, complicate Romania's efforts in providing basic health services for rural, underserved, and marginalized populations, as well as in achieving equitable health access for all.[10]

2. The main underlying causes of health professional migration and mobility are of socio-demographic, financial, organizational, managerial, and political nature.

The individual decisions by health care professionals to seek work in another country are triggered by economic factors, such as unemployment rates and higher salaries, but also by professional development opportunities, perceived better work environment or work-life balance, and language and cultural factors.[11,21]

In originating countries, underinvestment in medical education and employment, as well as the lack of a strategic approach to workforce development, can create a lack of employment opportunities in the public and private health sector and push people to go abroad. Diminishing job and career prospects (e.g., due to financial and economic crises or austerity measures) or dissatisfaction with the policies in the health sector (e.g., poor and deteriorating circumstances because of a country's underinvestment in the health sector and education) can cause health professionals to leave their country or profession. Big differences in wages between (neighboring) countries for similar competences, care services, and staff profile could potentially lead to health professional migration as well.

Not all European countries enjoy the same options for retaining and replenishing their health workforces. Some EU member states that implemented austerity measures, such as France, are still wealthy enough to use "pull" factors to encourage inflow of health professionals from countries where the wages are even lower to fill vacancies that remain unattractive to domestically trained workers.[11] All of these factors influence individual choices, resulting in a balancing act that skews the equitable distribution of health workers across Europe.

An ageing population and ageing health workforce increases the demand for health services. When demand increases and vacancies for health professionals are not filled, countries need to find ways to address their labor shortage. Some western European and Scandinavian countries overcome these health care needs via international recruitment. Other countries do not engage in active recruitment because they aim for domestic self-sufficiency of the health workforce or they have policy or ethical concerns regarding the potential negative impact of international recruitment from countries that are less well resourced. This indicates that there is a political space offering choices whether to revert to active cross border recruitment or not.

To invest in the domestic health workforce or to recruit from abroad? Germany as an example of political deliberation and choice to revert to active international recruitment.

The lack of nurses, often referred to as Pflegenotstand (care crisis), constitutes a serious challenge for the German health system. The Federal Ministry of Health anticipates that the future care needs will range between 110,000 and 200,000 additional nurses by 2025.[27] These considerable numbers constitute a serious threat to the health systems of the main (and often much smaller) countries from which Germany sources these needs.

In 2012, the German government started to actively recruit nurses from low- and middle-income countries in eastern Europe and outside Europe. Recently, German immigration laws were changed in order to grant immigrating nurses easy access to the German labor market. The recruitment activities of the German government target countries such as the Philippines, and Vietnam,[28] Serbia, Bosnia and Herzegovina, and Albania, and eastern EU members (in particular Romania). In order to illustrate the risk that this development holds for the source countries, one needs to contrast Germany's size, a major European actor with 80 million inhabitants and a need for an estimated 200,000 nurses by 2025,[27] with a country such as Albania, which has only 10,000 nurses and midwifes in total.

Emigrants are in search of a promised land and enter the German labor market with high expectations. Eventually, some nurses find themselves working in "down-skilling" positions in a sector, which, due to deteriorating working conditions, has already been abandoned by many of their German colleagues. As the rising numbers of immigrant nurses gives employers the opportunity to exploit their weaker position in the labor market, this leads into a vicious downward cycle: salaries and worker's rights further deteriorate while workloads increase. Newly recruited nurses may find themselves in unfair business practices such as adhesion contracts, which force them to stay for several years in order to work off the initial investments in recruitment and language training. Mainstream German media have labelled these contracts "modern forms of debt bondage."[29]

3. Health worker mobility is not simply a problem in itself, but should rather be understood as an opportunity to even out the principles of free mobility with those of solidarity and of equal opportunity.

Health professional mobility is a fact of life, not a problem to be solved. It offers advantages to the many people that benefit directly and indirectly from the mobility in a free labor market, which is an indispensable principle of the European project. It also has the potential to address workforce shortages not only in between e.g., France and Belgium, or Belgium and the Netherlands, but across the much larger EU labor market. Health professional migration follows a colonial history: France, for instance, receives health professionals from francophone African countries, Spain from Latin America, and Portugal from both continents. There are different sorts of emigration, some more temporary and periodical, and others more permanent. We need to understand the root causes and the intended and unintended consequences of migration in order to be able to address them.

The complexities of health professional mobility tend to emerge when one looks at the patterns from a systems perspective. Such a perspective reveals an inequitable distribution of health professionals in the European Union according to, amongst many other reasons, wage differentials between countries. It shows an unfair and problematic distribution of health professionals that follows the principles that "people follow money"[22] and "there is no health without a health workforce."[23]

Within the European Union, there is currently no regulation in place to prevent the "drain" from poorer member states or less well-equipped health systems.[24] Yet the manner in which countries attempt to solve domestic health workforce shortages might also affect other countries, in

particular whether countries opt for strategic planning to address domestic health needs or for international recruitment. The problem arises when the freedom of movement becomes instrumental in recruiting "cheap labor." The challenge—and the opportunity—for Europe is to channel the inherent freedom of movement through common European values such as solidarity and equity.[22] This is only possible if we analyze power relations between different actors in relation to health workforce mobility.

4. Quick fixes interfere with long-term and evidence-informed policy making and investments in the health workforce.

Health systems in the newer and candidate member states of the European Union have been suffering for decades. In the countries that became members to the European Union in 2004 , 2007, and 2013, there is a longstanding trend of health professional mobility from rural to urban areas that has weakened rural health systems. This trend began during the political changes in the late 1980s and early 1990s. An ageing population, including ageing health personnel, places further pressure on resource-poor and rural or remote areas. The result is under-resourced hospitals, management problems, a lack of structural reforms in the health systems and fiscal domain, rundown equipment and buildings, overloaded staff with high administrative burdens, low status of nurses, and underpaid doctors.[25] Health worker mobility must be understood and addressed in this context.

These health system challenges also exist, though to a lesser extent, in the European Union.[15] Labor shortages in the EU[15] countries are exacerbated by ageing populations and health workforces, as well as internal structural problems within their own health systems.[25] This contributes to the high demand for new staff to replace retired health professionals and fill other vacancies.

Health workforce migration flows are also governed by labor market principles. Older (and often richer) EU member states can mitigate their own losses of health professionals with immigration from the newer member countries. These newer member countries, in turn, do not have easy access to replacement of these health professionals themselves, at least not from within the European Union. The EU market as a single market supports this by removing technical, legal, and bureaucratic barriers in order to ensure free movement of goods, services, capital and persons. However, the European Union does not have any mitigation action for the consequences of free mobility. The European Union support for the poorest regions tends to be focused on general economic activity, not on specifics of the health care sector.[26]

Ultimately, active international recruitment of health workers is no substitute for long-term and strategic health workforce planning. Such international recruitment is not well coordinated in relation to an assessment of the supply, demand and needs in the European Union as a whole, and is therefore not a sustainable solution. However, in the short term it remains politically attractive as a "quick fix" to the health worker shortage of many countries. The result is that it is not discussed openly, but rather kept "under the radar" and used to defer sustainable and evidence-based solutions.[22]

How to facilitate health workforce mobility and migration

Bilateral agreements have been proposed to facilitate health workforce mobility and migration between EU Member States or EU Member State with a European, non-EU, Member State.[30,31] But so far, only very few bilateral agreements show good practice and guarantee sustainable health systems strengthening and positive impact in the sending country, too.[32] A new trend and discourse currently emerges around these bilateral public-private partnerships, such as the Global Skills Partnerships,[33] which seeks to source skills from developing countries to address the skills shortage in developed countries. These partnerships hold risks for reciprocal, equitable, and sustainable solutions from a health systems perspective, as they try to invest in, and leverage, affordable conditions for skills

creation and demand competencies in an internationalized labor markets. However, there is no evidence the political effects of such agreements will become of mutual benefit for international relations, development aid provision and migration policies, and regional integration.[30] It might only lead to short-term, one-side cost-efficiency gains and solutions, unless tightly designed, governed, financed and monitored by public oriented institutions, including national governments, trade unions and civil society.[32]

5. Commodification, commercialization, and privatization of public services interfere with the principles of solidarity and shared responsibility in support of equitable sustainable health workforces.

It is well recognized that long-term investments and structural reforms in the health care sector are needed to address health labor market failures, which are leading to the inequitable distribution of health care workers in Europe. Efforts focused on policy, funding, and strategic planning to improve the retention of health professionals—including foreign-trained workers—have the potential to improve their performance.[13] However, financial constraints, austerity measures, and public sector cost-containment have hampered these efforts and actually decreased available health care funding in many countries, while the health care demand continues to increase.[11] This results in feeding the cycle of international recruitment and weakening health systems in originating and receiving countries alike.

Ironically, the mutual recognition of professional qualifications across Europe is arguably part of this problem. Such mutual recognition was deliberately designed to increase flexibility and mobility on the EU labor market, to further liberalize the provision of services in the European Union, and to remove barriers to private sector recruitment. This is very much in line with policies in many EU countries to further privatize and deregulate public functions, including health care services. Although it has contributed to the quality of health care, it has increased health inequities, too, and has substituted for a more comprehensive public-sector approach to health workforce development.

Yeates and Pilinger warn that international migration of health workers and the cross-border provision of health and social care services are significant features of the contemporary global economy that increasingly is typified by the marketization, commercialization, and privatization of public services in the so-called service economy.[2] Current policy trends risk benefiting the private sector at the expense of public goods, both because they may not be subject to regulation, and because financial institutions and European economic agreements can overrule governments—that is, they can put restrictions upon governments with regard to their public services financing and provision.[34] In health, this potentially undermines the public sector as a provider of health care and the state as a steward of the right to health.[35]

An accompanying trend is the commercialization of medical education.[36] This can contribute to the mobility of medical students, which impacts the mobility of health professionals in general. As with health workers, medical students should enjoy options both at home and abroad, and European countries should extend opportunities for foreign medical degrees with common European interests in mind. Dual practice is present in many systems used as a countermeasure for brain drain from the country.[37]

6. Gendered power relations are replicated in health workforce migration.

Gender affects how all people live, work, and relate to each other, including in relation to the health system. Research shows that structural gender inequalities are replicated in the health system—in differential pay, working conditions, opportunities for professional advancement, access to health care, and many other areas—and may even widen during labor migration and mobility.[2,38,39]

To give but one example, women represent around 70 percent of the health workforce globally. But on average they earn 28 percent less than men.[39] Denial of professional development opportunities, discrimination, harassment, and violence in the workplace are more common for women than they are for men. Opportunities for professional growth in originating countries are similarly lower for women, increasing the incentive for them to migrate into situations that further expose them to abuse and discrimination. When it comes to regulating health workforce migration or negotiating bilateral agreements that facilitate health worker migration one should consider the protection of women.

Further analysis using gender frameworks is required to better understand how gendered power relations are constituted and negotiated in health systems and labor mobility.[40] Comprehensive solutions to labor shortages and health workforce development should promote gender equity and seek to reduce gender discrimination in both originating and receiving countries.

Recommendations

To policymakers in national governments:

1. Undertake and implement long-term strategic planning for a sustainable health workforce

Developing a sustainable health workforce requires long-term commitment, strategic planning, and capacity building. There are no short-cuts to providing meaningful professional opportunities for health workers in countries at varying income levels. National governments need to strengthen their institutional and management capacity with regard to workforce planning, policy making for health development, and evidence-based decision making. This requires recognition that the main impact of health workforce planning on the health system will only become visible after a couple of years, which is often beyond the budgetary cycles and political terms of government.

The principles underpinning national health workforce development should include a gender perspective. Equally, the development of health workforce strategies should engage a broad range of actors including health professional organizations, trade unions, employers' representatives, and civil society. All relevant ministries (health, education, labor, foreign affairs and finance at a minimum) need to engage and make a firm commitment from the side of decision makers in policymaking. The highest levels of government need to support the process of developing and implementing evidence-guided reforms and interventions for human resources for health.

2. Invest in health workers

Active recruitment of health workers from other countries has the potential to undermine European solidarity. Countries that turn to international recruitment need to better understand and reflect on the structural factors contributing to the labor shortage. Why do young people in the domestic labor market avoid the health sector? Investment in education and deployment of health professionals, in decent work and in wages in both source and destination countries are equally important.

Investing in health workers requires an inter-sectoral dialogue on investment strategies, governance, information, and fiscal sustainability. Economic advice is necessary to move away from orthodox approaches focusing on "economic stability" towards a more flexible use of fiscal policy

space as to invest in public services. Heterodox economic plans should be seen as investments in long-term health and wellbeing.[41] Unlike unregulated recruitment policies that favor an unfettered private sector, labor mobility works best when it is governed and monitored, when home institutions in countries of origin are supported, and when the employment of staff in the labor markets of countries of origin is stimulated. Health worker mobility can be a healthy and sustainable feature of an integrated Europe, but only if there is a well-regulated labor market based on fair business principles and free from corruption practices in the country of origin.

3. Respect the rights of migrant, foreign, and minority health workers

The potential negative impacts of migration on health workers need to be addressed proactively, with a focus on the supply, attraction, retention, and development of the health workforce in the most underserved areas. Relevant labor laws, social protection plans, and health insurance coverage need to be reviewed and revised for the general well-being of foreign-trained and/or migrant health workers. The integration of foreign health professionals into domestic labor markets is emphasized in the WHO Global Code of Practice I, the Global Strategy on Human Resources for Health, and the Action Plan for the EU Health Workforce. In addition to full labor and social protection, options for such integration may include, but are not limited to, identifying mentors in order to support immigrants in their integration and professional development.

4. Commit to policy coherence based on shared responsibilities and the solidarity principle

Health professional migration, mobility, and health workforce development should be regarded as a high-level political priority on both national and European agendas. Far from a sector-specific issue, the mobility of health workers links health sector and labor market policies, and as such should be addressed in a comprehensive and coherent manner. Just as single sectors cannot solve this problem alone, nor can single governments: what is required is regional governance to articulate the roles and responsibilities of all countries in promoting an equitable health workforce in Europe. This will require a sustained policy dialogue articulating the actors, responsibilities, financing, specific actions, and impacts needed at both the domestic and foreign policy level to address this problem. Overall coordination and the institutional capacity of governments need to be improved in order to achieve inter-sectoral and regional governance mechanisms, evidence-informed health workforce policies, and ultimately: a sustainable health workforce.

To policymakers from European institutions and multilateral agencies:

Health professional mobility and migration needs to be addressed at European regional as well as national and bi/multilateral levels. The World Health Organization has to play a role in collaboration with the European Union. These institutions should stress the need for a sustainable health workforce as a matter of health equity and the right to health, and to marshal the technical assistance and political and financial incentives needed to develop such a workforce. They need to stress that a lack of sustainable workforce planning and financing negatively impacts not only health professionals, but also the health of the general population, including the provision of essential public health functions.

The European Union should provide support as part of their mandate to stimulate inclusive economic growth and European integration. EU funding can be used to support countries in their capacity building for sustainable health workforce planning as well as structural reforms of the health care sector with a public service perspective. The European Union could also support and coordinate mutual exchange programs for medical or nursing students between countries to learn specific skills. We recommend establishing a special part inside the regional development program[42] (REGIO) specifically designed and aimed at addressing the challenges of the health sector of the least developed regions in Europe to contribute to sustainable health workforces.

It is important that the European Union support dialogue between source and destination countries. Too often, active recruitment of health professionals takes place without considering the impact it has on the source country's health system. Dialogue should be facilitated from a health systems perspective, based on population needs and a fundamental understanding that national health systems are interconnected. A specific health workforce mobility observatory could be established, for instance linked to WHO's European Observatory on Health Systems and Policies.

It is also important that the European Union establishes governance bodies and regulatory procedures that apply a shared responsibility perspective to health professional mobility and migration. A single country is not able to deal with cross-border migration, which by its very definition is a transnational issue. The European Union should develop policy responses to addressing unequal mobility flows that refrain from restricting mobility, but that contribute to a public understanding that a fair distribution of Europe's health workforce is a matter of concern for all Europeans. For example, financial restitution mechanisms can be linked to potential bilateral agreements so that originating countries are not unduly burdened by international recruitment. Similarly, an EU governance body could give relevant advice to economic policy, such as the European Semester, with the aim of seeking policy coherence in relation to workforce investments across Europe.

Wherever governments design policies to address labor shortages or health professional mobility, they must do so in consultation and agreement between all countries that are affected. Policies that triply benefit sending countries, destination countries, and individual migrant health professionals should be favored. More evidence about the impact of bilateral agreements will be needed for such policy development. This is also valid for the call for circular migration as policy development, a term often used, but of which no compelling evidence is available.

The Directorate-General for Health and Food Safety (DG SANTE) of the European Union can potentially act as a regional broker to encourage more evidence-informed bilateral agreements between EU member states and countries around the European Union. It can act as a third party by providing templates for bilateral agreements and improving their monitoring. In so doing, the European Union and member states should comply with the WHO Global Code of Practice on the International Recruitment of Health Personnel. To avoid a race to the bottom and competition between several bilateral agreements, it would be advisable if the European Union itself adopted a regional governance model based on the WHO's Global Code of Practice.

To civil society, trade unions, and health professional organizations:

Civil society, trade unions, and health professional organizations are in a valuable position to monitor employment, health equity, and human rights issues as they arise for both domestic and migrant health workers. They have a critical role to play in raising awareness of the impact of health workforce mobility, promoting accountability to a common European agenda, and fostering dialogue between member states.

Civil society, trade unions, and health professional organizations can:

1. **Build evidence.** This involves assessing and analyzing available intra-EU mobility data, collecting evidence on active international recruitment of health professionals, and studying formal inter-country agreements within the European Union for health workforce exchange and mobility.
2. **Create networks and platforms.** This involves strengthening or broadening existing alliances of collaborating civil society organizations, trade unions, and professional associations. Such a network could focus on developing strong health systems while addressing the negative implications of excessive health worker mobility. It could foster the development of a broader

European health movement and develop alternative policy options with a gender equity perspective for a fairer and more equitable distribution of health professionals on the continent. Such a platform would provide for necessary policy dialogue and knowledge translation in bridging evidence with politicians and policy makers.

3. **Advocate and campaign.** This includes advocacy at the national, European, and global level to guarantee essential public health functions and demand decent employment, labor rights, and social protection policies for migrant health workers.

4. **Support health workers to organize.** This involves supporting health workers to represent themselves at the EU level, while also in originating and receiving countries. This could be particularly important for nurses, and could take a gender dimension by emphasizing women and nurses, a large migrating population.

Conclusion

An open society is one in which people can live and work in freedom and dignity in their country of origin or their chosen country of destination. This principle is fundamental both to a united Europe, as well as to the ability of individual states to deliver the fruits of social democracy and solidarity. In the 21st century, the health care sector plays a major role in European economic cooperation. A public-oriented, equitably distributed health workforce is of crucial importance to sustaining the European dream. This requires solidarity, a commitment to human rights, and shared governance that recognizes the interdependence of all countries.

The Open Society Foundations aim to contribute to a Europe where human rights, social justice, equity, and solidarity govern public policy. In order to reap the benefits and mitigate the risks of health workforce migration, civil society, trade unions, health professional organizations, and patients themselves need to be supported and engaged. These groups can build the evidence and capacities, create the networks and platforms, and expand the advocacy and campaigning that promote fairness and solidarity in health systems, decent employment and wages for health workers, equitable allocation of public health goods, and social protection mechanisms for all Europeans.

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