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Comparative analysis of the migration paths of healthcare workers between European Countries: building a model for mobility choices

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Abstract

The growth of healthcare workforce mobility within the EU has represented an increasing concern in the last years; in particular, the two major questions regarded its impacts on quality of services due to the increasing of shortages and the ethical consequences derived from international recruitment. Understanding the determinants of healthcare professionals' mobility became a serious issue to be addressed by policy-makers, in order to avoid its backlashes on the quality of services' delivery. This work aimed at performing a both quantitative and qualitative analysis of the current mobility flows within the EU to frame the determinants in a general model. Abiding by a rational choice institutionalist approach, the hypothesis of this study is that macro-level national factors, such as shortages or oversupplies of professionals are not enough to explain healthcare professionals' mobility within the EU, which require a multi-level analysis. The first step of the study consisted in a quantitative overlook of available data; through two case studies on Italy and Belgium, it has been concluded that numerical aspects of the mobility flows are a necessary but not sufficient condition to explain the phenomenon. Rather, a stronger role is played by the EU legal framework, due to the freedom of movement of workers and the mutual recognition of diplomas and professional qualifications. Then, a qualitative analysis of migration paths was performed; abiding by the general theories of international migration, a focus was put on the push-pull factors outlined in the findings of the main EU funded projects and on some circumstances that affected mobility in the last years, namely the impact of the economic and financial crises, the EU enlargement and the demographic trends. Finally, these determinants were framed in the general theories of international migration, highlighting the importance of a multi-level approach entailing a macro-level based on the importance of the EU legal framework, a meso-level focusing on the importance of social networks and, most importantly, a micro-level stemming from individual preferences, which are the ultimate determinants of mobility decisions.

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Introduction

«Health-care delivery is highly labour intensive. To be effective, a health-care system must have the right number and mix of health-care workers» (McPake et al, 2013); this statement, written in the 2013 WHO Bulletin, allows to understand the importance of human resources in the healthcare sector. Among the most debated issues in this field, workforce mobility has represented a growing concern in the last years; in particular, the two major questions regarded its impacts on quality of services and the ethical consequences derived from international recruitment (Glinos A.I., 2015). As far as the latter is concerned, several efforts were undertaken, which culminated with the enactment of the WHO Global Code of Practice on the International Recruitment of Health Personnel in 2010. Although purely voluntary, this commitment represented the first collective action towards considering ethical aspects in recruitment practices (Glinos A.I., 2015). The main objective of the Code was to avoid that Countries experiencing lack of personnel could be subject to further outflows, which would have exacerbated the pre-existing shortages. As aforementioned, since human resources are the key actors of services' delivery, this aspect is strictly linked to quality issues of healthcare systems.

While ethical issues represented the main concern for the international community, at European level the focus was put on quality issues derived from shortages and oversupplies, which affect the majority of Member States (European Commission, 2012). Quantitative data helped to show the gravity of the situation; according to European Commission's projections, a lack of approximately 2 million professionals will affect the EU in 2020 (Malmström, 2010). Moreover, current demographic trends tend to exacerbate the situation: in particular, the ageing of population will probably increase labour demand, pushing further the need for adequate policy responses to expected shortages (European Commission, 2012). In the Commission Staff

Working document on an Action Plan for the EU Health Workforce, «Member States agreed on the added value of European cooperation to help tackle EU health workforce shortages» (European Commission, 2012).

Shortages' concerns in the EU started growing between 2004 and 2008 when two major events occurred, bringing to light the issue of professionals' mobility: the EU enlargement and the economic and financial crises. Since then, «health professional mobility in Europe has become a fast-moving target for policy-makers» (Wismar, 2014); while factors influencing international migration may be somehow managed by Countries, «in Europe [..] push and pull factors are co-determined by EU policies on free mobility, the qualifications directive and many soft law initiatives» (Wismar, 2014). As extensively underlined in the scientific literature, the EU is featured with some peculiarities that makes it a «unique» (Buchan et al, 2014) framework (Glinos, 2015; Wismar et al 2011) and fostered the growing concerns, particularly after the enlargements of 2004 and 2007. Moreover, workforce mobility assumed ever more relevance as far as the completion of Single Market was concerned (European Commission, 2011a). Several debates started revolving around the issue of international recruitment in the EU, especially with regard to the expected east to west exodus (Avgerinos et al, 2004; Costigliola, 2011; Ognyanova et al, 2014). For the first time, the European context began to pay serious attention on professionals' rather than patients' mobility (Glinos, 2012); as a result, a relevant number of studies and projects were financed and launched, in order to analyse in depth the phenomenon of healthcare professionals' mobility and provide policy-makers with more accurate pieces of information.

Among the projects funded by the European Commission, MoHProf and PROMeTHEUS stand as the most relevant; apart from final reports, findings of both studies constituted the basis for further publications[1]. The PROMeTHEUS project ran between 2009 and 2012 with the objective of better understanding professionals' mobility phenomena within the EU through 17

[1] See Buchan et al (2014), Tjadens et al (2013) and Wismar et al (2011)

Countries' case studies. In the final report, several insights highlighted common patterns, which were useful to draw some general conclusions (Wismar et al, 20111). Instead, the MoHProf project, which was carried out between 2008 and 2011, aimed at analysing figures and features of workforce migration paths involving EU Countries; its main outcome was an exhaustive list of the main factors influencing professionals' mobility, which were outlined according to a "push-pull" and "stick-stay" approach. Both the projects had to face a severe lack of data regarding mobility that restricted the scope, the accuracy and the reliability of the findings (Buchan et al 2014; Tjadens et al 2013; Wismar et al 2011); however, MoHProf and PROMeTHEUS represent the most exhaustive analyses of healthcare professionals' mobility within the EU.

The choice of limiting the analysis to the EU environment allowed for both practical advantages and improving efficacy: it would have been more difficult to gather data for non-EU States. Furthermore, focusing on the EU allows for an in-depth analysis of those peculiarities that profoundly influence mobility flows: the legal framework, the effects of the economic and financial crises, consequences of the enlargement and the impact of demographic trends. While apparently playing the role of intervening variables, these four elements will be treated as independent variable, since it will be showed their impact on mobility flows. This aspect brings to another limitation of this study, namely the time frame; this study chose to concentrate on the flows occurred in the last 20-25 years for a practical and a utility reason: the former is that databases from the EU do not include older figures, whereas the latter is related to the moment when professionals' mobility became a real issue within the EU. Finally, the last constraint of the analysis is linked to the definition of healthcare professionals, which, from now on, is restricted to physicians and nurses.

This study draws from the conclusions of both MoHProf and PROMeTHEUS projects, trying to frame the main findings on the motivations that push professionals to move abroad in a structured theoretical approach. The aim of this analysis is to contribute to the scientific literature on the field, organising in a single theoretical model the factors that affect

professionals' mobility choices within the EU. This tool would help policy-makers in formulating adequate responses to the aforementioned issues derived from workforce imbalances (Ono et al, 2014). Therefore, the general research question points at understanding the determinants of healthcare professionals' mobility choices and classifying them according to their respective level of analysis, in order to build a theoretical model that could explain migration paths within the EU. Determinants for mobility choices are classified according to their level of analysis: macro elements are those regarding the mobility profiles of Countries or the EU framework; meso aspects are those related to larger units of analysis or that take into consideration the importance of networks and, finally, factors regarding individual spheres are classified as micro. The hypothesis underlying this work is that healthcare professionals' mobility choices within the EU are determined by several elements that belong to different levels of analysis. In particular, the macro context constituted by the mobility profile of a Country and its national policies is not enough to explain why healthcare professionals decide to move; rather, a focus on the EU sphere is required. Moreover, other levels of analysis must be taken into consideration. It is useful to underline that posted workers are not included in this analysis, since they remain employed in their sending country, while practicing in another State.

The first Chapter will focus on the EU legal framework, exhaustively outlining the complete set of provisions that deal with healthcare professionals' mobility; in particular, the first section will focus on the freedom of movement for workers, whereas the second part will explain the importance of the Directives on the mutual recognition of diplomas and professional qualifications. This Chapter will help highlighting the pivotal role of EU legislation in fostering and regulating mobility within its borders.

Chapter 2 and Chapter 3 will be dedicated to the analysis of the flows within the EU; first, a quantitative analysis will be performed. The reason behind this choice is that changes in the structure of the workforce deeply affect healthcare systems; furthermore, «the larger these movements the greater the likelihood of tangible impacts» (Maier et al, 2011, p. 25). Hence, a quantitative outlook was fundamental. In this section, two case studies have been chosen to

show if mobility profiles of Countries based on numerical statistics are enough to explain professionals' choices to move; Italy and Belgium, a traditionally sending and recipient Country respectively, will be analysed, focusing on their healthcare systems and professionals' flows. This quantitative outlook will be carried out through the analysis of available data, scanning three different datasets: OECD health statistics, Eurostat database and The EU Single Market Regulated Professions Database. It is the case to underline that the lack of accurate and reliable data with regard to professionals' mobility constituted a limitation not only for this study, but also for the scientific literature in general (Buchan et al, 2014; Tjadens et al, 2013; Wismar et al, 2011). Chapter 3 will be instead dedicated to a qualitative analysis of the flows; first, a state of the art of the main general theories of international migration will be performed. Then, the main push and pull factors for healthcare professionals' mobility will be identified through a document analysis of the main EU funded projects on the field; these factors will also be classified according to their dimensions. Finally, the last section of Chapter 3 will focus on specific circumstances linked to the EU framework that affect healthcare professionals' mobility flows, namely the economic and financial crises, the EU enlargement and the demographic trends.

In conclusion, Chapter 4 will gather the findings on the factors and EU peculiarities that determine healthcare professionals' mobility and try to frame them in the general theories of international migration outlined in the first section of Chapter 3. Hence, each level of analysis will have its specific theory to explain healthcare professionals' mobility, tracing back to the hypothesis that sustained the need for a multi-level approach. However, in the concluding remarks it will be underlined how some factors are more decisive than others in affecting mobility flows; this will bring to light the importance of the theoretical approach used in this work: the rational choice institutionalism.

Trying to explain international migration through a single theory appears as an ambitious and hardly realisable task; hence, healthcare professionals' mobility was chosen as domain. The theoretical rationale behind this choice is that for general theories to be useful, a deep study on

specific flows is required (Massey et al, 1998); since the aim is to trace back mobility choices to a single model for migration, a restricted scope was necessary. Through the analysis of the main findings on the factors that influence healthcare professionals' mobility, two elements appeared as the most pivotal: the importance of the EU framework and the role of individuals. These aspects are strictly linked with the theoretical approach of this study; the choice of rational choice institutionalism stems from two fundamental assumptions: first of all, the fact that «mobility, particularly within the EU, hinges on an individual's decision to move» (Glinos et al, 2014). At the end of the day, deciding to leave the home country to practice abroad derives from migrants' evaluations. Hence, a specific focus on the individual was required; as a matter of fact, the main factors that determine mobility are referred to specific preferences' sets that suggest the rationality of the actors performing the mobility decision. The second assumption is related to the EU legal framework; «the EU constitutes a unique legal environment for health professionals' mobility» (Buchan et al., 2014) due to the freedom of movement of workers and the mutual recognition of diplomas and professional qualifications. Consequences of the EU enlargement and difference in magnitudes of flows due to the impact of the Directives on mutual recognition suggest the role of the EU framework in mobility choices. Hence, while it is true that individuals are rational actors that take their decisions to move on the basis of their preferences, the EU framework influence them, «leading actors toward particular calculations and potentially better social outcomes» (Hall & Taylor, 1996).

However, stating that only a single theoretical framework has been used in this study would be incorrect; as a matter of fact, the structure of the research question and hypothesis required a different theoretical basis. This study takes the shape of an enquiry on the determinants of healthcare professionals' mobility, assuming that, being a complex choice, a multi-level approach is required. Therefore, abiding by the rational choice institutionalism paradigm, other theoretical frameworks have been considered. In particular, while analysing meso-level determinants, sociological institutionalism has been taken into account in order to explain the importance of cultural inheritances.

To conclude, this work aims at providing policy-makers with a theoretical background for analysing healthcare professionals' mobility choices. This would enhance the effectiveness of policy responses to the current growing challenges that both the structure of the workforce and its mobility are posing on the quality of services' delivery.

Chapter 1: The EU framework for health professionals' mobility

Migration issues are nowadays a grave concern, both at the global and European level. The increasing flows are generating endless debates due to their severe impact on society; the key aspect is that migration is a complex phenomenon, which may have multilevel consequences. Currently, the most urgent issue is certainly its impact on security; nevertheless, backlashes on both social and economic spheres shall not be overlooked. Among these increasing flows, those regarding the workforce have progressively gained the attention of policymakers. At European level, the main reason for this focus is the importance of workforce mobility with regard to the correct and effective functioning of the Single Market. As a matter of fact, the European Commission included workers' mobility among the 12 priorities to solve the shortcomings[2] of the previous framework and «give the single market the opportunity to develop its full potential». (European Commission, 2011a).

1.1 "Skilled migration" and the case of healthcare professionals

Among workforce mobility, several studies have underlined the importance of the so-called "skilled migration", which has been amplified by mass-media and politicians through attractive and high-sounding terms, such as "brain drain", "brain waste" or "human capital flight". For the purpose of this study, it is intended as "skilled migration" the phenomenon that involves primarily people with tertiary level education, although sometimes specific non-graduated professionals are also included in the scope of the concept. For instance, mobile specialized

[2] In a letter of 20th October 2009, the former President of the European Commission José Manuel Barroso asked Professor Mario Monti to carry out a report highlighting the weaknesses of the Single Market to be addressed. The report, entitled "A New Strategy for The Single Market: at the service of Europe's economy and society", was released on 9th May 2010. Abiding by the work of Professor Monti, the European Commission adopted the Single Market Act I in 2011.

technicians or operators may be considered as skilled migration, even if they do not hold any university education (Coccia et al, 2016). The importance of this phenomenon is backboned by several data: figures show that at the global level, the rate of skilled migration in 2010/2011 was higher than the one of not-skilled migration, the extent of such difference varying from country to country. For instance, European skilled emigration rate was 5.8 %, lagging behind only Latin America (7.6 %) and Africa (9.6 %) and much higher than Asia (3.4 %) and North America (0.8 %) (Arslan et al, 2014).

Although workforce mobility has been identified as a crucial element for the functioning of the Single Market, there is still no common European framework, except the freedom of movement for workers, to regulate human capital flows inside the EU (Coccia et al, 2016). The lack of a comprehensive strategy, including coordinated policies and instruments, results in several challenges, whose urgency depends on the sector taken into consideration. According to the European Commission, workforce mobility strongly affects the health care occupations; moreover, «they are listed among the top bottleneck occupations[3]» (DG IPOL, 2015). Hence, foreign workers are pivotal for the sustainability of the system[4].

As a matter of fact, despite the technological and scientific developments that profoundly affected the health care systems, human resources still play a key role. The importance of the workforce has never been stressed enough by policy-makers, which usually take into little consideration those who are in charge of delivering care in favour of financial and economic aspects. At European level, human resources' debates revolve extensively around the issue of mobility, due to its importance for the Single Market and the impact of two major events that occurred in the last years: the process of EU enlargement and the economic and financial crises[5].

[3] According to the definition given by the European Commission in several reports, bottleneck occupations are those job positions featured by persistence shortages due to two factors: few and stable supply while high and increasing demand.

[4] See European Commission (2012), Commission Staff Working Document on an Action Plan for the EU Health Workforce, Strasbourg 18th April 2012

[5] See chapter 3

Their main consequence was the exacerbation of shortages in the healthcare workforce[6], with the European Commission expecting a lack of between 1 and 2 million professionals in 2020 (Malmström, 2010).

Furthermore, there are some macro trends that influence the current situation. The demographic transition is deeply affecting the health needs of the population; ageing and life expectancy increases are starting to pose new challenges to healthcare systems, boosting national request for long-term care personnel. Demographic changes have consequences for patients, but also for professionals: according to the European Commission,

> «The retirement bulge is drastically shrinking the EU's healthcare workforce. In 2009, about 30 % of all doctors in the EU were over 55 years of age and by 2020 more than 60 000 doctors or 3.2 % of all European doctors are expected to retire annually» (European Commission, 2012).

Together with demographic transition, another element that have a critical impact on human resources' mobility is the bottleneck effect that features occupations in the healthcare sector: current and expected shortages may not be offset by new workforce. Given this situation, the European Commission "Action Plan for the EU Health Workforce" (2014) aims at fulfilling the lack of a comprehensive strategy mentioned before, recommending recruitment and retention mechanisms in order to mitigate the consequences of these trends. However, the main objective remains to encourage intra EU mobility; in fact, among possible solutions, the Plan states:

> «Transnational mobility offers access to new jobs and new training opportunities to enhance skills. Intra-EU professional mobility [..] can help address the mismatches between labour supply and demand» (European Commission, 2012).

Nevertheless, professionals' mobility may also result in some shortcomings. In particular,

[6] In 2006, the World Health Organisation (WHO) estimated a lack of 4,3 million healthcare professionals. For further reading, see "*The World Health Report 2006 - working together for health*" (2006), WHO

extensive workforce migration can represent the main cause of severe shortages in specific sectors. This concern led to the adoption of the WHO Global Code of Practice on the International Recruitment of Health Personnel, where "fairness" is named as one of the principle that should drive international recruitment (WHO, 2010). At European level, the shortcomings of professionals' mobility are strictly linked with the issue of the EU enlargement, which will be discussed later in this study.

Therefore, human resources' mobility choices rapidly became one of the major concern for EU policy-makers. In order to fully understand and explain the main determinants of this phenomenon, it is of pivotal importance to give some insights of the peculiar legal framework constituted by the European Union, which has guaranteed the freedom of movement for workers since the Treaty of Rome in 1957.

1.2 The freedom of movement of workers

«The EU constitutes a unique legal environment for health professionals' mobility» (Buchan et al., 2014). As a matter of fact, freedom of movement for persons and indeed workers, was already enshrined in the Treaty of Rome establishing the European Economic Community, where Article 3(1)(c) laid down «the abolition, as between Member States, of obstacles to freedom of movement for persons, services and capital» (Treaty of Rome, 1957). Moreover, Title III of the same Treaty completely focused on workers, establishing in Article 48 that «Freedom of movement for workers shall be secured within the Community», abolishing « any discrimination based on nationality between workers of the Member States as regards employment, remuneration and other conditions of work and employment» (Ibidem).

The priority given to the freedom of movement for workers shall not surprise, the aim of the European founders being the establishment of an economic community. However, the provisions of the Treaty of Rome did not entail a full-fledged right of free movement, linking

the concept of mobility to individuals with two basic requirements: Member States' citizenship and engagement in an economic activity. Indeed, freedom of movement for workers lied at the bottom of a proper functioning of the single market. The full set of provisions entailed in Title III aimed at securing the mobility of factors of production, which should have solved possible shortages of workforce and «lead to an equalization in the price of labour across the EU» (Barnard, 2013). Nevertheless, this was not the case, because, as it will be shown in next chapters, mobility choices are more than a simple economic cost-benefit analysis. In this context, it is useful to provide a definition of 'worker', given that there is no such explanation in the Treaties. In Case *Lawrie-Blum*, the Court of Justice of the European Union (CJEU) has qualified a 'worker' as:

> any person performing for remuneration work the nature of which is not determined by himself for and under the control of another, regardless of the legal nature of the employment relationship. (CJEU, 1986).

Moreover, the CJEU has always privileged an 'inclusive' approach towards the definition of the economic activity carried out by the 'worker'; as stated in Case *Kurz*:

> neither the sui generis nature of the employment relationship under national law, nor the level of productivity of the person concerned, the origin of the funds from which the remuneration is paid or the limited amount of the remuneration can have any consequence in regard to whether or not the person is a worker for the purposes of Community law. (CJEU, 2002).

It is useful to notice that the inclusive approach of the CJEU does not entail the case of posted workers, who are employed in their home country, but sent in another EU state for a specific period of time. In this case, it is the employer exploiting its right to freely provide services in another country. Directive 96/71/EC of the European Parliament and of the Council of the European Union, and the consequent enforcement Directive 2014/67/EU addressed the case of posted workers, who are currently matter of debate in the framework of the revision of their

regulation.

It is widely acknowledged that, since 1957, the CJEU played an increasingly significant role in shaping EU legislation, with the four freedoms making no exception. The general approach of the CJEU towards the freedom of movement was to stick close with Article 3(1)(c), promoting the general removal of «discriminatory and non-discriminatory 'obstacles' or 'restrictions'» (Barnard, 2013), rather than focusing on the aforementioned requirements[7]. Following the same pattern of the CJEU, the European Commission enacted several directives that «demonstrated a gradual erosion of the link between *economic* activity and free movement». From this point of view, there was a shift in perception from freedom of movement of workers to freedom of movement for persons, which would have been entailed in the concept of European Citizenship with the Treaty of Maastricht in 1992. Despite the favourable approach of the CJEU, several obstacles or equivalent measures still prevent the complete freedom of movement. From this point of view, it is useful to analyse from a legal perspective, limits and restrictions to freedom of movement.

The Treaty of Rome has been amended several times; nevertheless, the original provisions regarding workers' mobility were preserved in Title IV of the Treaty on the Functioning of the European Union (TFEU), which was enacted in 2007. In particular, Article 45 lays down the general features of the freedom of movement for workers, as well as their rights and entitlements. It is true that in comma 3, it is stated that workers have the right to:

> «accept offers of employment actually made, move freely within the territory of Member States for this purpose, stay in a Member State for the purpose of employment in accordance with the provisions governing the employment of nationals of that State laid down by law, regulation or administrative action and remain in the territory of a

[7] In more recent cases, the CJEU enlarged the scope of the freedom of movement for workers: for the first time in *Baumbast* (2002), the Court untied the economic activity requirement from the right to move freely inside the EU, laying the foundations for the EU citizenship.

> Member State after having been employed in that State, subject to conditions which shall be embodied in regulations to be drawn up by the Commission» (TFEU, 2007).

Moreover, as aforementioned, freedom of movement is guaranteed without discrimination on the ground of nationality; nevertheless, this right can be «subject to limitations justified on grounds of public policy, public security or public health» (TFEU, 2007). Not only, it is also made clear that the non-discrimination principle is not to be applied «to employment in the public service» (TFEU, 2007).

A vast body of secondary legislation has been issued for ensuring the provisions of the Treaty of Rome, and then of the TFEU; together with Article 45, Regulation 492/11 constitutes the legal basis for the freedom of movement for workers. The provision concerns two distinct aspects that require further analysis: on the one hand the right of non-discriminatory access to a specific job; on the other, the right of equal treatment for those who chose to work in another EU country. As far as the former is concerned, the Regulation clarifies the aspect of non-discrimination, entailing both direct and indirect forms: while direct discriminatory measures occur when «a migrant worker is treated less favourably than the national worker» (Barnard, 2013), indirect measures implies discrimination through their effects. Some examples are laid out in Article 3, when there is a clear statement of a discriminatory measure; in fact:

> « [..] provisions laid down by law, regulation or administrative action or administrative practices of a Member State shall not apply where they limit application for and offers of employment, or the right of foreign nationals to take up and pursue employment or subject these to conditions not applicable in respect of their own nationals [..]» (European Parliament and Council, 2011);

Also, to include indirect discrimination, Article 3(1)(b) states that some measures,

> « [..] though applicable irrespective of nationality, their exclusive or principal aim or effect is to keep nationals of other Member States away from the employment offered

[..]» (European Parliament and Council, 2011).

Despite its inclusive approach, Regulation 492/11 introduces another limitation to the freedom of movement for workers, allowing linguistic discrimination, if «required by reason of the nature of the post to be filled» (European Parliament and Council, 2011). The linguistic requirement has often been subject of evaluation by the CJEU. For instance, in case *Groener*, the Irish government was authorised to demand the knowledge of gaelic in order to apply for a position as college teacher. The Court stated that the aim of encouraging the use of gaelic was enough to justify the Irish government, which was not breaching Article 3(1) of the TFEU. However, it is once again the role of the CJEU that has to be highlighted, in order to comprehend the path towards the removal of obstacles and barriers to freedom of movement for workers.

The field of the freedom of movement for workers was involved in a broader change of approach by the Court. Although, both direct and indirect discriminatory measures were recognised by the TFEU as the only criteria to define if there was a breach of the law, the CJEU increasingly showed a more active role. The consequence was a new focus on removing obstacles and barriers to free circulation; rather than concentrate on discriminatory measures, the CJEU started to analyse whether or not freedom of movement is prevented and, if so, whether this prevention constitutes a breach of the law. Following this path, the Court has very often run into violations of the Treaty; nevertheless, «occasionally it considers that the rule does not restrict free movement» (Barnard, 2013).

This change of approach deeply affected Member States' also the aforementioned derogations in preventing both free circulation for reasons of public policy, public security and public health and equal access for migrant workers to employment in the public service. Several Directives enacted in the 1990s, and grouped together in the Citizens' Rights Directive 2004/38,[8]

[8] The Citizens' Rights Directives was enacted in 2004, repealing Directives 64/221/EEC, 68/360/EEC, 72/194/EEC, 73/148/EEC, 75/34/EEC, 75/35/EEC, 90/364/EEC, 90/365/EEC, 93/96/EEC, Regulations 1251/70 and 1612/68. Hence, Article 45 of the TFEU, Regulation 492/11 and the CRD constitutes the legal framework for free circulation of workers.

contributed to enlarge Member States' discretion in resorting to such derogations. Nevertheless, «the limitations and conditions laid down by these directives have been subject to an increasingly strict proportionality review» (Barnard, 2013). Restrictions of access to employment in the public service are of particular interest for health professionals' mobility, due to the presence of National Healthcare Systems in the EU. Therefore, this issue will be further analysed in next section.

Non-discriminatory access to employment, with the partial exception constituted by the language requirement, was only the first Section in Chapter 1 of the Regulation 492/11 on freedom of movement for workers within the Union. Employment and equality of treatment is the core of Section II, where Article 7(1) states:

> «A worker who is a national of a Member State may not, in the territory of another Member State, be treated differently from national workers by reason of his nationality in respect of any conditions of employment and work [..]» (European Parliament and Council, 2011).

The equality of treatment must be ensured in each of its declination, starting from remuneration, both for private contracts and collective agreements [Article 7(4)]. The most controversial aspect of Section II is where the Regulation confer to migrant workers the same social and tax advantages of nationals, due to its overlapping of competence in two critical fields of national legislation: welfare state and fiscal rules. This issue has produced a vast amount of case law, which is better dealt elsewhere[9]; nevertheless, it is useful to highlight that the general approach of the CJEU was in favour of moving «far beyond what was necessary to ensure the mobility of workers» (Barnard, 2013).

Also, equality of treatment must be guaranteed for «access to training in vocational schools and

[9] For further readings, see Chapter 9 of Barnard C. (2013), The Substantive Law of the EU: The Four Freedoms, Oxford University Press, Fourth Edition, pp. 704

retraining centres» (European Parliament and Council, 2011) and, finally

> « [..] as regards membership of trade unions and the exercise of rights attaching thereto, including the right to vote and to be eligible for the administration or management posts of a trade union or [..] for workers' representative bodies in the undertaking[10]» (European Parliament and Council, 2011).

To sum up, the completion of the Single Market required the free circulation of workers, which was already enshrined in the Treaty of Rome in 1957. The provisions of both primary and secondary legislation, such as Regulation 492/11, furnished workers' rights to free movement; moreover, the approach of the CJEU lead the way to a progressive removal of obstacle and barriers; nevertheless, Member States have continuously tried to exploit the grey areas of EU legislation, in order to retain some degrees of national sovereignty, as it was the case for welfare and taxation treatments reserved to residents and non-residents. In conclusion, a lot has been done to ensure the free circulation of workers; despite the attempts of Member States, it is possible to highlight a progressive path towards the removal of barriers. A clear element that points in this direction is the vast amount of EU secondary legislation, which has been enacted to deal with critical issues preventing the free circulation. In the next paragraph, several provisions will be analysed, focusing on those which play a key role in favouring health professionals' mobility.

1.3 EU legal context for health professionals' mobility

Abiding by the general framework of EU freedom of movement for workers, it is now time to analyse those provisions enacted with regard to health professionals' mobility. Since 1957, EU policies have progressively affected this field, defining its exclusive, shared and supportive

[10] Undertaking referring to "bodies or offices governed by public law"

competencies. In general, «the organization and financing of health care within the EU is the responsibility of the Member States» (Baeten & Jorens, 2006); therefore, the Community can only intervene on the basis of the so-called principle of subsidiarity stated in Article 5(c) TEU:

> «[..] the Union shall act only if and in so far as the objectives of the proposed action cannot be sufficiently achieved by the Member States, either at central level or at regional and local level, but can rather, by reason of the scale or effects of the proposed action, be better achieved at Union level [..]» (TEU, 2008).

Nevertheless, there are several EU provisions that have affected Member States' competences in governing health professionals' mobility, mainly linked to the aim of establishing a single market. Even if Member States have always claimed that such provisions concern social protection systems and consequently fall under their area of exclusive competence, CJEU decisions have pushed for the enlargement of the EU area of influence.

1.3.1 Restrictions to free circulation of healthcare professionals

Starting with Treaties' provisions, Article 45(4) TFEU empowers Member States to restrict free circulation of workers as far as access to Public employment is concerned. The CJEU has always attributed a limited scope to Article 45(4), coherently with its approach towards the freedom of movement for workers; therefore, in Case *Commission vs Belgium* (C-149/79), the Court has stated that it is intended as Public employment a job which:

> « [..] involve(*s*) direct or indirect participation in the exercise of powers conferred by public law and duties designed to safeguard the interests of the State or of other public authorities» (CJEU, 1982).

Moreover, the CJEU restricted the derogation entitled to Member States to those job posts effectively involved in the activities aforementioned, adopting a functional approach for its

definition of public employment and formulating its decisions on a case-by-case basis.

The CJEU definition of Public employment plays a key role in the healthcare professionals' mobility framework, since several European healthcare systems are part of the national Public Administration. Through its interpretations, the Court has increasingly restricted the scope of Article 45(4); in particular, as far as health care personnel is concerned, Case 307/84 represents a milestone. In the decision, the CJEU affirmed that Member States cannot preserve job posts as state nurses to their own nationals, since this would result in a violation of the principle of freedom of movement for workers. Case 307/84 is an example of the functional approach of the CJEU towards the definition of Public employment: state nurses do not carry out any function featured by the two requirements stated in the aforementioned C-149/79. Therefore, Member States are unable to discriminate foreign workers in the selection for state nurses' positions.

Abiding by the approach of the CJEU, the Commission aligned itself and further restricted the derogation of Article 45(4): in Communication 88/C 72/02, it stated that many sectors of the Public employment are considerably distant from the functional definition expressed by the Court. Hence, the derogation shall not apply to the following areas:

> «[..] bodies responsible for administering commercial services (e.g. public transport, electricity and gas supply, airline and shipping companies, posts and telecommunications, radio and television companies), public health care services, teaching in State educational establishments, research for non-military purposes in public establishments [..]» (Official Journal of the European Community, 1988).

According to the Commission, each of these exceptions are justified by the fact that they also have a private dimension that does not lay within the scope of Article 45(4). As already underlined, the constraint to the concept of Public employment with regard to public health care services is particularly important because it ensures the freedom of movement for all kinds of professionals. Therefore, Member States can no longer restrict access to foreign workers in their

public healthcare systems.

1.3.2 Mutual recognition of diplomas and professional qualifications

Another fundamental element to ensure an effective health professionals' mobility, both in the public and private sector, is the mutual recognition of diplomas and professional qualifications. Since Member States own the competence to legislate regarding the admittance to health care careers, the EU was always featured with high inhomogeneity. As a matter of fact,

> «[..] national regulations on structures and conditions for access to health care professions can create de facto barriers for migrant professionals coming from another Member State» (Baeten & Jorens, 2006).

Consequently, one of the most urgent issue for the EU was to establish a common regulatory framework, pursuing two objectives: on the one hand, ensuring the quality of health care services, while, on the other, removing obstacles to the free circulation of health professionals. Therefore, as stated in Article 53 TFEU (former Art. 47 of the Treaty of Rome):

> «In the case of the medical and allied and pharmaceutical professions, the progressive abolition of restrictions shall be dependent upon coordination of the conditions for their exercise in the various Member States» (TFEU, 2007).

The path towards the mutual recognition of diplomas started in the 1970s; as aforementioned, the European Community was aware of removing any possible barrier towards the free movement of workers. Hence, it enacted sectoral directives, with the aim of regulating mutual recognition of professional qualifications in key areas, such as healthcare and justice. In particular, Council Directive 77/452/EEC concerned nurses responsible for general care, whereas Council Directive 93/16/EEC, which amended several previous directives, was about doctors. Both provisions aimed at securing the right to move, establish and provide services in

an EU Country different to the one where their diplomas were carried out, while at the same time ensuring quality standards.

Sectoral directives laid down the list of national diplomas to be recognised; abiding by Article 53 TFEU, the list was based on a simple criterion: «minimum periods for educational and training programmes» (Baeten & Jorens, 2006). Once the qualification figured in such list:

> «Each Member State shall recognize the diplomas, certificates and other evidence of formal qualifications awarded to nationals of Member States by other Member States [..] by giving such qualifications [..] the same effect in its territory as those which the Member State itself awards» (Council of the European Community, 1993)[11].

Even if these provisions appear to imply the automatic recognition of professional qualifications, the reality was different. The "automatic" procedure consisted in a request, often accompanied by administrative charges, submitted to the authority in charge of examining the applications, usually national Ministers; then, according to the Directive 93/16/EEC, Member States had three months to take their decision, which, if rejected, may be appealed by the applicant in the national courts (Baeten & Jorens, 2006). The implementation of such provisions gave rise to widespread criticism.

Some Member States claimed that the process of automatic recognition would have led to several shortcomings in the short-medium period. In particular, those countries with higher educational and training standards argued against the rigidity of the process, which would have caused critical quality issues. This position was supported by two main elements: the first was that the automatic recognition of professional qualification did not assess the effective expertise of the applicant; the second was related to the possibility of updating the process of recognition with scientific and technological development. As far as the former is concerned, sectoral directives focused only on «the length of training (in years or hours) [..] at the expense of

[11] The same text applies for Directive 77/452/EEC

content and scope» (Baeten & Jorens, 2006). This principle was also clearly expressed in the provisions of the directives, where it is stated that coordination between Member States will concern:

> «the right to take up specialized training, the minimum training period, the method by which such training is given and the place where it is to be carried out, as well as the supervision to which it should be subject» (Council of the European Community, 1993).

It is true that the same Directive does not exclude further coordination, but no specification is provided about which area should cover.

The second element of criticism regarded the lack of adaptive measures for the sectoral directives; in particular, the healthcare sector is highly sensitive to scientific and technological progress. Therefore, standards and criteria for mutual recognition of professional qualification, such as minimum training periods, should be kept up to date. Moreover, it is often the case that developments in the healthcare sector may result in relevant changes for medical professions. For instance, Directive 77/452/EEC did not take into account the evolution faced by nurses, which were moving in the direction of a more restricted expertise. As a matter of fact: «the directive for general care nurses ignores the current trend for specialized nurses» (Baeten & Jorens, 2006).

Finally, another thorny issue concerned the possibility for Member States to ask the migrant doctor to provide a certificate from its country, «as proof of good character or good repute» (Directive 93/16/EEC, 1993). Under the umbrella of good character or good repute, the directive included physical and mental health,

> «measures or disciplinary action of a professional or administrative nature taken in respect of the person concerned or criminal penalties imposed on him when pursuing his profession in the Member State of origin or in the Member State from which he came» (Council of the European Community, 1993).

Nevertheless, the vagueness of these provisions, together with the inhomogeneity of national regulations concerning the punishment of professional mistakes, resulted in a poor outcome, fostering the sense of inadequacy of the legal framework for mutual recognition of professional qualifications.

These shortcomings were exacerbated by the process of EU enlargement, which fomented Member States' concerns regarding the quality of healthcare services. On the one hand, increasing mobility was seen as positive for the completion of the Single Market; on the other hand, it was considered as a threat to quality standards. Hence, the issue of reforming the system laid down by the sectoral directives became even more pressing. In 2005, the revision process of the legal framework gave birth to Directive 2005/36/EC, replacing previous sectoral directives and introducing new rules for the mutual recognition of professional qualifications.

The aim of the Directive was to overcome the shortcomings of the previous framework, in order to remove barriers to free circulation of professionals. It was enacted on 7th September 2005, with the time-limit for transposition set at October 2007; «however, it was not until September 2010 that all 27 Member States had complied with the Directive» (Merkur, 2014). The new framework established by Directive 2005/36/EC clearly addressed some of the issues raised with regard to the sectoral system, while leaving some others aside. For instance, the process for automatic recognition remained the same. A new element was the registration with national professional organizations, which was set as a requirement for the applicants in case their profession was «regulated in the host Member State by an association or organization» (Merkur, 2014).

As far as minimum training and educational requirements are concerned, the aim was to harmonise the framework within the EU, updating the provisions of the previous sectoral directives. Therefore:

> «Directive 2005/36/EC went further to specify both the minimum number of years and the minimum number of hours for training doctors and general care nurses (the sectoral

directives only specified the former) » (Merkur, 2014).

Together with Directive 2005/36/EC, mutual recognition of professional qualifications is ensured by a system of "acquired rights" that applies for new Member States. Several critics were raised at EU level with regard to the recognition of qualifications for the EU12; in particular, quality concerns were the key issues of debate. The solution found was a new system, namely "acquired rights", which relied on «a combination of pre-harmonisation qualification and years of experience» (Tjadens et al., 2013)[12]. Moreover, in some cases transitory programmes were set up, in order to facilitate recognition during accession negotiations. Nevertheless, several issues were still debated, mainly linked to the assessment of applicants' previous experience.

Directive 2005/36/EC also coped with workers who travel to another Member State to provide services temporarily; the provisions do not restrict Countries' legitimacy to deal with these cases, as long as they do not restrict the fundamental freedom of provision of services. Nonetheless, according to data, this is not a relevant issue for healthcare professionals (Tjadens et al., 2013)[13].

To sum up, Directive 2005/36/EC improved the situation as far as health professional's mobility is concerned, establishing a clearer and better-defined framework for mutual recognition of qualifications inside the EU. According to the Directorate-General for the Internal Market and Services of the European Commission, the provisions laid down by the Directive, based on the harmonisation of minimum requirements, a total of 6.4 million citizens benefit from the system in 2008. Among these, the vast majority are healthcare professionals, which account for 5.77 million (European Commission, 2010)[14]. Despite what may seem a satisfying result, a general

[12]For a better definition of "Acquired rights system" see Peeters M. & McKee M. & Merkur S. (2010), "EU law and health professionals" in "Health systems governance in Europe: the role of EU law and policy", Health economics, policy and management. Cambridge University Press, Cambridge

[13] See also European Commission (2012), MoHProf Report Summary

[14]Healthcare is not the sector that benefits the most from mutual recognition of professional qualifications.

consensus emerged on the need for updating the system. Therefore, in 2010 the European Commission initiated an evaluation of Directive 2005/36/EC in order to assess the effectiveness of the mutual recognition of professional qualifications.

The evaluation report was published by the Commission on 5th July 2011 highlighting strengths and weaknesses of the Directive; the general tone was fairly positive, as underlined in the executive summary:

> «This system is appreciated by competent authorities and professionals because it allows for efficient treatment of requests for recognition» (European Commission, 2011).

Moreover, data point out that mobility of health professionals has undergone a substantial increase in its numbers, strongly fostered by the automatic recognition of qualifications.

Nevertheless, the evaluation report also pointed out several shortcomings. In the process, the European Commission gathered the opinions of the main stakeholders of the healthcare sector, ranging from national competent authorities, such as ministries or external agencies, to other key actors, like professional orders. Several negative elements emerged from the consultations and found their place in the evaluation report.

The most relevant issue regarded the minimum training requirements; first of all, since national academic paths and qualifications may vary, for instance with the introduction of new diplomas, the Commission must be notified in due time of any change. The evaluation report pointed out the negative consequences of possible delays, which may act as a barrier to the automatic recognition of qualifications. Moreover, disparities in national training curricula may led to adaptation periods for migrant workers, *de facto* limiting mobility opportunities for professionals. These discrepancies were addressed by Directive 2005/36/EC, which left to

According to the same data, teachers, social and cultural professions have been the most mobile categories between 1997 and 2008, even if they do not fall under the regime of automatic recognition.

Member States the regulation of the so-called continuing professional development (CPD). Nonetheless, the lack of a European coherent framework may result in a major shortcoming; for instance, those who do not succeed in their CPD could have «*lost* their right to exercise the profession for which they were qualified in their home Member State» (European Commission, 2011). Finally, especially for doctors, the consultations brought about a widespread criticism towards the focus of training requirements, which was extensively on their length rather than their contents, with non-harmonised national CPDs playing an increasingly important role and resulting in the aforementioned shortcomings.

Apart from training requirements, one of the most relevant issues was the language criterion. As a matter of fact, Directive 2005/36/EC dealt with the concern in Article 53, requiring

> «persons benefiting from the recognition of professional qualifications [to] have the knowledge of languages necessary for practising the profession in the host Member State» (European Parliament and Council, 2005).

According to the Directive, receiving countries have the competence to assess the applicant's level of knowledge of their language, though they can impose tests or evaluations only in exceptional cases. During the consultations, some actors protested against the fact that this assessment was only mentioned in the framework of the exercise of the profession, rather than in the automatic recognition process, leading to a situation where Countries shall recognise diplomas and qualifications even if the applicant was not able to speak their language.

On the grounds of the consultations and the evaluation report, the European Commission published its Green paper on "Modernising the Professional Qualifications Directive" on 22nd June 2011, which resulted in a legislative proposal at the end of the same year[15]. Recognising the important role of professionals' mobility with regard to the completion of the Single Market, the Commission aimed at improving the framework of mutual recognition of qualifications in

[15] The European Commission proposal was presented on 19th December 2011.

order to overcome many of the limits pointed out in the evaluation report. The outcome of the legislative process was the enacting of Directive 2013/55/EU amending Directive 2005/36/EC in November 2013, which was published on the Official Journal of the European Union on 28th December 2013[16]. Nowadays, the provisions laid out by Directive 2013/55/EU constitutes the current framework for the mutual recognition of professional qualifications.

The Directive entailed many of the measures proposed by the Commission in its Green Paper, introducing new elements in order to address the limits of the previous framework. For instance, the introduction of the European Professional Card (EPC) should guarantee a smoother and clearer procedure for the mutual recognition of qualifications. This electronic process is dedicated to those professions that are regulated both in the sending and receiving country; moreover, these provisions will not apply to all careers; rather, according to Article 4 of the Directive, the Commission will enact specific implementing regulations for those professions that meet the following criteria:

> «there is significant mobility or potential for significant mobility in the profession concerned; (b) there is sufficient interest expressed by the relevant stakeholders; (c) the profession or the education and training geared to the pursuit of the profession is regulated in a significant number of Member States» (European Parliament and Council, 2013).

As far as the healthcare sector is concerned, nurses for general care is currently the only category that falls under the scope of Article 4.

The issue of the harmonisation of minimum training requirements was addressed by several amendments that try to cope with the aforementioned widespread criticism. First of all, sectoral

[16] For a thorough description of the legislative process, see Merkur S. (2014), *Policy responses facilitating mobility or mitigating its negative effects: national, EU and international instruments* in "Health Professionals' Mobility in a Changing Europe: New dynamics, mobile individuals and diverse responses", European Observatory on Health Systems and Policies, Observatory Studies Series, Vol. 2

professions, such as those in the healthcare sector, start having competence and knowledge-based training requirements abiding by the European Qualifications Framework (EQF). The minimum length of training curricula changed for both doctors of medicine and nurses for general care, with the former switching from 6 to 5 years, while the latter being fixed at 12. Together with time frame, the European Credit Transfer and Accumulation System (ECTS) is established as a way to express training requirements. Moreover, each Member State has to notify in due time any change in the procedures for issuing diplomas and qualifications[17], as stated in Article 21bis.

Secondly, Article 21 also ensures the possibility of updating the minimum training requirements for sectoral professions. According to the Directive, the European Commission has the power to issue delegated implementing acts[18] in order to align minimum skills and competences with the scientific and technological development.

Language requirements are addressed by the amendments to Article 53. As far as the healthcare sector is concerned, Directive 2013/55/EU clarify the role of Member States with regard to language tests. The new provisions allow receiving countries to carry out controls as long as

> «the profession to be practised has patient safety implications [..]» or «in cases where there is a serious and concrete doubt about the sufficiency of the professional's language knowledge in respect of the professional activities that that professional intends to pursue» (European Parliament and Council, 2013).

Finally, Article 56bis introduces a new alert mechanism specific for the healthcare workers with regard to penalties and sanctions imposed during the performance of their functions. According

[17] This procedure was also entailed in Directive 2005/36/EC but Directive 2013/55/EU introduces the Internal Market Information system (IMI); the notification procedure must now be submitted through the IMI, which will avoid delays and unclarities.

[18] With the Lisbon Treaty, Art. 290 of the TFEU introduces the so-called "Delegated Acts". The Commission is entitled with the power of issuing non-legislative acts that can act as legislative acts in accordance with the legislative act that allow her to do that.

to the procedure, Member States' competent authorities shall notify to the other countries any sanction, whether temporary or permanent, imposed on a professional. Such notification, shall be carried out within three days and must entail all the relevant information regarding identity of the recipient, role of the authority that is imposing the sanction and duration and features of it.

In conclusion, mobility of workforce within the EU is considered a key step towards the completion of Single Market. In this framework, the provisions regarding free movement and mutual recognition of qualifications play a pivotal role, as underlined by the 12 priorities laid out in the Single Market Act in 2011. Moreover, as far as the healthcare sector is concerned, mobility has become an urgent issue to be addressed, since a shortage of professionals is expected in the short-medium term both at global and European level. Therefore, after having analysed the peculiar framework of workforce mobility inside the EU, it is now time to carry out a quantitative analysis of the flows, before trying to understand their determinants and lay down a general model for mobility choices.

Chapter 2: A quantitative analysis of the flows inside the EU: Sending vs Receiving countries

Understanding the determinants of mobility choices is crucial for designing adequate policy responses to the challenges posed by possible shortages or oversupplies of workforce; a key step in this process is certainly the collection of data. It is of pivotal importance to perform a quantitative analysis of migration flows, in order to better assess their determinants. Despite the growing concern that healthcare workforce mobility is causing, availability of accurate data still represents a serious challenge to face. Several international organizations, such as the International Labour Organization (ILO), the World Health Organization (WHO) or the Organization for Economic Cooperation and Development (OECD) have called upon their Member States to collect reliable data to be used for monitoring healthcare professionals' mobility, because «in times of crisis, accurate, up-to-date data and intelligence are even more important» (Maier et al, 2014). Consequently, international databases strongly rely on national statistics, which are often unreliable or, worse, not available.

There are several elements at each level of analysis that may affect the reliability of data. First of all, from a conceptual point of view, mobility is a dynamic notion; it can vary very rapidly due to a very broad spectrum of reasons. Hence, collecting accurate and up-to-date data often results in an impractical exercise. This is particularly evident in periods of economic or social changes, which usually increase the scale of the phenomenon analyzed (Maier et al, 2014). Secondly, from a practical point of view, national databases, when presents, are often incomplete, not updated or not comparable with other Countries' data sets (Buchan et al, 2014). For instance, there may be a difference in the scope of the concept of "mobile healthcare professionals" or in the years of data collection. Moreover, there is little or no information with regard to the private sector (Dussault et al, 2009). Thirdly, and finally, from a national point of view, there might be several circumstances that limit the possibility to gather accurate data,

which range from the lack of political will to the scarcity of resources, both economic and practical.

As aforementioned, several international organizations have committed to solve these limitations, encouraging Member States to provide accurate databases. For instance, the WHO highlighted the importance of data in Article 6 of the Global Code of Practice on the International Recruitment of Health Personnel, stating that:

> «Member States should recognize that the formulation of effective policies and plans on the health workforce requires a sound evidence base»; therefore, «[..] Member States are encouraged to establish or strengthen and maintain, as appropriate, health personnel information systems, including health personnel migration [..]» (WHO, 2010)

Also, the OECD has recently launched its personal database[19], where there are statistics regarding both stocks and flows of mobile healthcare professionals, namely doctors and nurses. Nevertheless, since international organizations have to rely on national data, both OECD and WHO face several difficulties in building accurate databases. Fortunately, at least for mobility, the EU is the most reliable source for data gathering through its information system on mutual recognition of professional qualifications. Therefore, it is now time to analyze the European context.

2.1 Data and figures inside the EU

At European level, the estimated lack of one million healthcare workers by 2020 exacerbated the need for accurate data, in order to design a general plan for healthcare workforce. Expected shortages were not the only reasons that justified this urgency; as aforementioned, the

[19] Reliable data on healthcare workforce migration lacks in several Countries. The OECD has committed to gather accurate statistics with regard to mobility since 2008. The OECD database is regularly updated with data made available by Countries.

importance of workers in the framework of an effective Single Market fueled the process of improving data collection methods. Moreover, the relevance of the healthcare sector for reasons of public security gave the final push for a serious intervention. In 2012, the European Commission enacted the Action Plan for the EU health workforce. The objective was to improve EU capacity of planning the management of healthcare human resources and forecasting future needs for the sector: it goes without saying that accurate data played a key role in this process.

The "Action Plan for the EU health workforce" identified the main challenges posed by the human resources environment and proposed to face them at European level. Concretely speaking, it resulted in a three-years funded project, namely the "Joint Action on European Health Workforce Planning and Forecasting". Launched in 2013, the program was articulated in 7 working packages, which ran until June 2016. Among these, the working package number 4, entitled "Data for health workforce planning", contributed with the analysis of data already gathered at international level[20]. Also, it aimed at:

> «[..] providing policy recommendations to improve health workforce data collection in EU Member States» in the framework of reaching the « [..] overall aim of the Joint Action to support Members States in developing a reliable health workforce planning system that enables the fulfillment of national healthcare needs» (Semmelweis University, 2015)

The working package on data for healthcare workforce planning concluded that, nowadays, the EU and its features constrain policy-makers to take into account the level of integration between Countries. As a matter of fact, national healthcare systems are profoundly interrelated due to the legal framework analyzed in the previous chapter. Above all things, freedom of movement

[20] The European Commission, through EUROSTAT, together with the OECD and WHO, have performed a joint data collection which resulted in the report "Health at a Glance: Europe 2010", published by the OECD and the EU in 2010.

and mutual recognition of professional qualifications inextricably link Member States; hence, improving the collection of European data represents a key step towards the formulation of effective policy responses. From this point of view, the working package recommended Member States to harmonize their data collection strategies, in order to facilitate comparisons between Countries. Moreover, it called for increasing cooperation both at national and international level: as far as the former is concerned, national stakeholders «should work together to achieve better healthcare workforce data» collection, whereas international organizations should collaborate «to facilitate the understanding of the usefulness of international healthcare workforce data collection» (Semmelweis University, 2015).

As aforementioned, both in the EU and international context, mobility rapidly became a critical issue, particularly in recent times[21]. The peculiarity of this phenomenon is its ambivalence, since it has been regarded as both a policy problem and solution (Buchan, 2006). The practice of international recruitment has been broadly used by Countries to solve their internal shortages: for instance, the UK strongly relied on foreign workers in the last years, in order to cope with several pressures that used to affect its health system[22]. Also, international recruitment may represent a relief for Countries dealing with situations of oversupply, as it is the case for Italy and its enormous number of doctors[23]. Finally, practicing abroad may represent an opportunity «for individual health workers to improve their skills and standard of living» (Buchan, 2006). Nevertheless, healthcare workforce migration also poses several challenges to the sustainability of national health systems. In particular, excessive outflows may affect the quality of health services when it happens to aggravate already existent understaffing issues. The gravity of this phenomenon was highlighted by the WHO in its 57th General Assembly; indeed, the final

[21] See Introduction and Chapter 3

[22] For further reading, see: Jinks C. & Ong B.N. & Paton C. (2000), Mobile medics? The mobility of doctors in the European Economic Area, Health Policy, Vol.54, Elsevier, pp. 45-64 and Young R. (2011), *A major destination country: the United Kingdom and its changing recruitment policies* in "Health Professional Mobility and Health Systems: Evidence from 17 European Countries", Observatory Studies Series, No. 23, pp.597

[23] This issue will be better analysed further in the chapter

resolution called upon Member States: «to develop strategies to mitigate the adverse effects of migration of health personnel and minimize its negative impact on health systems» (WHO,2004).

In this sense, the WHO underlines the main policy challenge for Countries with regard to healthcare professionals' migration; at the end of the day, human resources' flows are not good or bad on their own. Indeed, it is their efficiency that should concern policy-makers the most (Buchan, 2006); if there are excessive inflows or outflows of workforce, the main objective should not be to eliminate them, but to adjust their negative consequences on national healthcare systems. It comes without saying that data and figures are crucial for policy-makers that have to counteract possible backlashes of professionals' migration: as a matter of fact, any policy response needs a proper assessment of the determinants of the flows; nevertheless, a reliable and accurate data collection represents the *conditio sine qua non* of a qualitative analysis.

The EU strongly committed to increase efforts for gathering accurate data with regard to healthcare professionals' mobility; nevertheless, there are some limitations that derive from the peculiar framework constituted by the European environment. For instance, the freedom of movement for workers has a negative consequence on the validity of data. As underlined in the final report of the MoHProf project[24]:

> «sending countries often lack information concerning the whereabouts of their diaspora health workers as freedom to move stands in contrast with possible requirements to detail one's whereabouts» (Tjadens et al, 2013).

Another limitation is the lack of harmonization of data; at European level, as well as at

[24] The MoHProf was a three years project funded by the European Commission within the 7th Framework Programme, which ran from 2008 to 2011. It aimed at analysing the mobility of healthcare workforce in the EU, highlighting trends and features. The leading organisation of the project was Scientific Institute of the Medical Association of German Doctors (WIAD), but many regional research partners participated in the study. The outcome of the study consisted in National reports highlighting the main findings of the restricted analysis; a general final report was also published. For further informations, see Tjadens et al, (2013)

international, there is no coherent framework for data collection with regard to healthcare professionals' mobility. This is the main backlash of relying on national statistics, which can differ for time framing, focus or several other features[25].

EU efforts in promoting reliable data collection resulted in several funded projects, such as the MoHProf or the collaboration with OECD and WHO in the annual reports entitled "Health at a Glance". Moreover, the official statistical source of the European Commission, namely Eurostat, provides accurate figures of the main indicators for national healthcare systems, ranging from its status to its resources. Nevertheless, Eurostat faces the same challenges derived from relying exclusively on national data. Fortunately, as far as professionals' mobility is concerned, the Directorate General for Internal Market and Services contributes with a fundamental tool, namely the Regulated professions database, which registers the number of healthcare workers that ask for the recognition of their diplomas and qualifications in another EU Country. It is true that there are several limitations that alter the validity of the Regulated professions database; for instance, it does not show the real movements of professionals; rather, it provides the number of those with the intention of practicing their job abroad (Maier et al, 2014).

To sum up, data and figures inside the EU have strengths and weaknesses; since healthcare professionals' mobility has become a serious concern for policy-makers, the EU has multiplicated its efforts for ensuring accurate and reliable data. The cooperation with International Organisations, such as the OECD and WHO, resulted in a significant improvement of the situation. Moreover, figures from its own institutes and bodies have contributed with a European framework of data gathering. Nevertheless, as highlighted by the "Joint Action on European Health Workforce Planning and Forecasting", Member States still represent the main source of accurate and reliable statistics.

[25] See Tjadens et al, (2013)

The quantitative analysis of migration flows is largely based on the data collected by the OECD, together with the statistics provided by the EU Regulated professions database. At first glance, it is possible to identify two main categories: source or sending Countries are those where outflows of healthcare professionals exceed inflows; oppositely, receiving or destination countries experience more inflows than outflows. From another point of view, migration of healthcare professionals can also be cumulatively described by the national rate of reliance on foreign workers, which is expressed by the ration between the total number of foreign workers and the workforce (Maier et al, 2011).

The study carried out by Maier et al.[26] is the most comprehensive quantitative analysis of the healthcare professionals' flows within the EU. Although it has focused on 17 Member States, it provides a reliable sample of Countries to draw significant conclusions as far as healthcare workforce mobility in Europe is concerned (Maier et al, 2011). The research employed both rates of reliance and direct measurements of the flows, in order to give an accurate quantitative analysis. Nevertheless, there are also some limitations that should be taken into account. First of all, data for physicians are usually more available than those of nurses; moreover, registration in national registers may create some issues. For instance, while some Countries include in national registers the total number of professionals, others may exclude those who do not practice their job anymore. Despite several limitations, several conclusions of this analysis may be drawn from this analysis, helping to give a realistic illustration of the significance of healthcare professionals' flows inside the EU. Among these, two should be highlighted: first, according to the study, which covers until 2008, the general trend reflects a sound increase in mobility in the last years. Second, the process EU enlargement had a crucial impact on

[26] "Health Professional Mobility and Health Systems: Evidence from 17 European Countries" is one of the outcome of the PROMeTHEUS project, which ran from 2009 to 2012. It was funded by the European Commission through the 7th Framework Programme and aimed at providing a clearer figure of healthcare mobility paths inside the EU through the quantitative analysis performed in several case studies. The leading organisation was the European Observatory on Health Systems and Policies.

workforce migration[27], which increased the concerns of policy-makers and brought mobility issues on the top of the agenda.

Among the 17 case studies analysed in the study, Italy and Belgium can be considered as two representatives of distinct categories, respectively sending and receiving Countries. Although the difference between the features may seem clear and definite, several studies claimed that the borders of these categories are becoming increasingly fine and «blurred» (Glinos et al, 2014). The reasons underlying this assumption are mainly three: firstly and as aforementioned, migration is a dynamic process; hence, from one year to another, a sending Country may switch itself a recipient one and vice versa. This is particularly relevant in the EU, where freedom of movement and automatic mutual recognition of professional qualifications facilitate and smooth mobility of workers. Secondly, healthcare professionals' groups may be differently affected by mobility flows; for instance, a given Country can experience a severe outflow of medical doctors, while receiving a significant inflow of nurses. This is exactly the case for Italy, which will be analysed later in this chapter. Finally:

> «[..] the implicit suggestion that countries actively "send" or "receive" health professionals neglects the fact that mobility often happens independently of any deliberate policy action; mobility, particularly within the EU, hinges on an individual's decision to move [..]» (Glinos et al, 2014).

This aspect is exactly the focus of next sections, where this study will concentrate on Italy and Belgium; abiding by three different data sources, which were integrated in a single label[28] to compose a clearer framework for analyzing mobility flows, a description of the national contexts will be given. The quantitative aspect will show that Italy and Belgium may belong to the two distinct categories aforementioned (sending vs receiving *ndr*). Nevertheless, the study of both the healthcare system and human resources' situation will introduce a first qualitative

[27] See chapter 3
[28] See appendix I

point of view to the analysis of the determinants of healthcare workforce migration. As a matter of fact, the aim of the next sections will be to demonstrate the hypothesis underlying this work, namely that national contexts are not enough to explain mobility choices, as underlined by Glinos et al.; rather, a multilevel model is required to give an exhaustive description of healthcare professionals' mobility.

2.2 From quantitative to qualitative analysis: a case study on Italy and Belgium

If we try to infer the determinants of mobility choices on the basis of a quantitative analysis of the flows, it goes without saying that national contexts would be identified as the main cause of healthcare professionals' migration. This is a direct consequence of the idea that, taking into account only the magnitude of mobility, Countries may be divided in two distinct categories: sending and receiving. Nonetheless, as shown in the last section, the differences between the two groups are becoming ever more blurred. As aforementioned, one of the main reasons behind this process is that national contexts and policies does not decisively affect mobility choices. Clearly, this is a qualitative inference that requires a strong background. Therefore, in this section Italy and Belgium will be analysed from the point of view of their health systems and policies. Then, in the final paragraph, some conclusions will be drawn from the findings. From a quantitative perspective, they will be presented as representatives of senders and recipients respectively; However, it will be shown that neither of the two Countries can be categorised, sustaining the hypothesis that a quantitative perspective does not fully explain healthcare professionals' mobility. Rather, a qualitative analysis is required, starting with the conclusion of this chapter: national contexts and policies are a necessary but not sufficient element to explain healthcare professionals' mobility.

2.2.1 Italy: a sender Country?

The Italian Republic is one of the founding Countries of the European Community, together with Belgium, France, Germany, Luxembourg and the Netherlands. Italy is divided into 20 regions that, together with provinces and municipalities, constitute the administrative and political system. Nowadays, as far as population is concerned, it stands at the sixth place in Europe, counting nearly 61 million people in 2016. From the economic point of view, Italy has been deeply affected by the economic and financial crises in 2007 and 2008; as a result, specific weaknesses were exacerbated: for instance, youth unemployment reached a peak of 37,8% in 2016 (OECD, 2017). Health indicators show that Italy has improved its statistics in the last years, ranking high on the list for average life expectancy at birth, behind only Switzerland in Europe (Eurostat, 2016). Another important indicator, such as mortality rate, also ranks Italy at the top in the OECD Countries (OECD, 2014). Despite what may seem a good performance, satisfaction towards the National Healthcare Service (NHS[29]) has generally decreased due to the quality gap between different areas. As a matter of fact, with the so-called devolution process, several healthcare competences were transferred to the regional level, laying the foundations for the inhomogeneity of the Country with regard to the delivery of services.

The *Servizio Sanitario Nazionale* (SSN) is the body in charge of guaranteeing the right to health for the population, which is entailed in Article 32 of the Constitution. According to the law, the Ministry of Health manages the system, determining aims and general guidelines[30]. The delivery of services is carried out by ASL[31]s (*Aziende Sanitarie Locali*), which are the regional structures of the SSN. Funded by the regions, the Local Health Authorities (LHAs) can provide

[29] Servizio Sanitario Nazionale (SSN) in Italian

[30] Among the main responsibilities at the national level, the most important is the setting of LEA (*Livelli Essenziali di Assistenza*), which are minimum healthcare services whose availability must be ensured to everyone.

[31] Local Health Authority (LHA) in English

services by themselves or through both public and private facilities[32]. Overall, the Italian Healthcare System «provides universal coverage, largely free of charge at the point of service» (Ferrè et al, 2014). Given its public nature, the SSN is financed through the revenues of national and regional taxes, which accounted for the 78,2 % of the Italian healthcare expenditures in 2012; among the rest, the 17,8 % was made up of private expenses, whereas «only about 1% of total healthcare expenditure is funded by private health insurance» (Ferrè et al, 2014). The devolution process that started at the end of 1990s led the way to a differentiation in financing between regions. In particular, regions became free to choose how much budget allocate to their healthcare structures, using national guidelines only as a reference. As a consequence, nowadays both the level of expenditures and quality of services are significantly inhomogeneous throughout the Country.

As far as expenditure is concerned, a brief focus is required. Despite the high performance on health indicators, Italy stands slightly below the EU average for health expenses as a percentage of the GDP. According to the WHO[33], in 2012 they accounted for the 9,2%, against the 9,6% of the EU average. Health expenditures experienced a significant growth in the 2000s, both in Italy and in the EU; therefore, containing excessive costs rapidly became a primary concern for policy-makers. In particular, Italy had to face serious regional deficits that have been addressed placing stricter controls on regional budgets (Ferrè et al, 2014); as a result, the growth rate of health expenditures significantly decreased between 2010 and 2012. This reduction had a dual reading: on the one hand, it may have been caused by a low growth of the GDP; on the other hand, interventions by the Government might have been considered as effective. The dual reading was fuelled by the Italian economic and political context; Italy has been one of the EU Countries that suffered the most after the economic and financial crises. Following high international pressures, especially by the Commission, the Italian Government was forced to take severe austerity measures, in order to reduce national public debt. In these efforts, the

[32] Every Healthcare facility must be registered with the NHS through the accreditation system.
[33] WHO Health Data and Statistics, 2012

political authorities fail to cope with the growing pressures, leading the way to a technical Government headed by the economist Mr. Mario Monti in 2011.

The backlashes of the economic and financial crises particularly relapsed on the healthcare sector. Throughout the EU, austerity measures translated in significant cuts to health expenditures, with Italy making no exception. According to data provided by the regions, between 2010 and 2015, the central government, through the annual stability laws, has cut the healthcare budget by almost 26 billion euros (Conferenza delle Regioni e delle Province Autonome, 2012). Given the decentralised structure of the system, the effectiveness of these measures strongly differed in the Country, variations being wider or smaller depending on the region considered.

To sum up, the key features of the national healthcare service (SSN) are: first, a universalistic and public system, with a regional structure based on local health authorities (ASLs) that are differently funded as established by the fiscal devolution process; secondly, a solid performance in general health indicators that ranks Italy at the top places in Europe. Thirdly, an inhomogeneous quality of healthcare services' delivery due to differences in regional budgets and, finally, a general trend towards the containment of healthcare expenditures after the 2007-2008 economic crises.

Human resources' situation clearly reflects the features of the SSN; since the delivery of services is carried out by public authorities, mainly through public facilities, the vast majority of healthcare professionals are «employed by the National Health Service (SSN) [..] and have civil servant status» (Ferrè et al, 2014). The only exception is constituted by General Practitioners (GPs) and paediatricians, who are salaried with a different system[34]. Although all professionals are publicly employed, they can also offer private services: moreover, in case they do that «within National Health Service facilities», they have to «pay a proportion of their

[34] In particular, GPs are salaried on a capitation fee basis

income to that facility» (Ferrè et al, 2014).

Switching to a quantitative analysis of data, Italy has one of the highest number of medical doctors in the EU; with a population of almost 61 million people (Eurostat, 2016), it counts about 240.000 physicians, with a growth rate that shows no sign of abating (OECD, 2016). This exaggerate amount is probably due to the massive enrolment at University level; nevertheless, despite a clearly saturated situation, «shortages are expected when the current cohort retires» (Bertinato et al, 2011). To understand the disproportionality of these data, it is useful to draw a comparison with neighbourhood Countries; for instance, France has a slightly bigger population, counting about 66 million people. Nevertheless, the number of its physicians is smaller, since France employs less than 210.000 medical doctors (OECD, 2016). As a matter of fact, according to a 2008 OECD analysis,

> «Italy has one of the highest ratios of medical doctors in the world – 4 medical doctors for every 1000 citizens. This compares with the OECD average of 3 doctors per 1000» (Bertinato et al, 2011).

As far as nurses are concerned, the lack of accurate data makes comparisons particularly difficult; however, according to existing statistics, Italy counts about 326.000 officially registered nurses. In contrast, Germany, which has a significant but not exaggerate bigger population, computes more than triple the number of nurses, attesting at slightly more than 1 million in 2015 (OECD, 2015). In Italy, despite the evolution of their role and competences highlighted in the previous chapter, nurses' careers are still underestimated. Compared to the other OECD Countries, Italy experiences a low ratio of nurses for 1000 citizens, standing below the EU average (WHO, 2014).

Despite the efforts of national associations of professionals, namely the *Federazione Nazionale Collegi Infermieri* (IPASVI) and the Federazione Nazionale degli Ordini dei Medici Chirurghi e degli Odontoiatri (FNOMCeO), a severe lack of data with regard to professionals' mobility affects the national level. Nevertheless, through the help of OECD Eurostat and the

PROMeTHEUS project, it is possible to perform a quantitative analysis of the flows. The first thing to underline is that the mobility profile of the Country is strongly affected by the national statistics on human resources laid out in the previous paragraph.

The high number of medical doctors generates a situation of over-supplying of physicians, which prevents the development of inflows of foreign professionals. According to data gathered by the PROMeTHEUS project, this resulted in an exiguous rate of reliance on migrant doctors, namely about the 4%. This result appears even more striking if compared to other realities in the EU that often exceed 20 % (Bertinato et al, 2011). From a European point of view, Italy welcomed only 1429 doctors of medicine through the automatic recognition of diplomas between 1997 and 2016, issuing 112 rejections (European Commission, 2016)[35]. Overall, EU nationality professionals represent a great percentage of total foreign medical doctors in Italy, together with those Countries that present a significant Italian migrant community. (Bertinato et al, 2011).

Now, from a quantitative point of view, if the over-supplying of medical doctors prevents inflow phenomenon, as it is actually the case, it should encourage the development of outflows of physicians. Nevertheless, Italy does not experience such a strong phenomenon: according to the Osservatorio Internazionale della Salute (OIS), only 4,7 % of medical doctors decides to emigrate and, often, not on a stable basis (OIS, 2016). Moreover, as far as national data are concerned, there are several biases that affect the reliability of statistics. For instance, «medical doctors [..] working abroad can be commuters» (Bertinato et al, 2011) to border Countries. Therefore, despite recent data that highlight the growth of the "brain drain" phenomenon in Italy (Coccia et al, 2016), physicians are not affected by these trends.

The situation is clearly different for nurses, where, given the low ratio, Italy is experiencing a

[35] Disparities between data may depend on definitions; for instance, there is no agreement on the concept of "foreign". Some data count as foreign doctors also those who have double nationality; instead, if only those with foreign nationality are taken into account, the percentage of migrant medical doctors fall to about 1 %

severe shortage of about 70.000 workers (Bertinato et al, 2011). The needing situation is exacerbated by the demographic profile of the Country, where the ageing of population is a key feature and average life expectancy at birth is one of the highest in the EU. According to data gathered by PROMeTHEUS project, which relied on IPASVI statistics, the inflow of foreign nurses has been a relevant phenomenon in the last years; while they accounted for the 2 % of the workforce in 2005, they rose to the 11 % in 2008 (Bertinato et al, 2011). At European level, the regulated professions database counts more than 7.000 recognitions of diplomas between 1997 and 2016. These data confirmed that most of the inflows came from the European Union and, particularly, from EU enlargement Countries[36] (Ferrè et al, 2014). In the last years, Italy faced an increasing need for long-term care nurses, the so-called *badanti*, to cope with the ageing of population. Nowadays:

> «the elderly care and home-care sectors rely heavily on foreign carers, who nevertheless are mainly undocumented workers working in the grey economy»;

therefore:

> «Recent legislation has sought to regularize the immigration status of care worker and partly reflects the needs of the health and long-term care systems» (Ferrè et al, 2014).

Nonetheless, the EU Single Market area continues to represent the main provider of workforce due to advantages such as the mutual recognition of diplomas and professional qualifications and access to job in the public sector (Ferrè et al, 2014).

[36] EU enlargement Countries, also known as EU12, are those which joined the European Union in 2004 and 2007, namely Hungary, Poland, Slovakia, Latvia, Lithuania, Estonia, Czech Republic, Slovenia, Cyprus, Malta, Romania and Bulgaria.

2.2.2 Belgium: a receiving country?

The Kingdom of Belgium is, together with Italy, one of the sixth founding Countries of the European Community; its political system consists of three stages of power: starting from the top, the federal government, the federated regions and communities and, at the bottom, local authorities such as provinces and municipalities. Brussels is the Capital of the Country and it is considered the core of the EU, since it hosts the headquarters of the European Commission, Council of the European Union and European Parliament. Nowadays, Belgium has a population of about 11 million people (Eurostat, 2016) and it experiences a strong division between the French-speaking community, Wallonia, and the Flemish one, the Flanders. Although the rift between the two factions is deep and historical, it does not result in great differences between regions, as it is the case for Italy. This is due to the highly centralised National Healthcare System, which will be analysed in the next paragraph. Nevertheless, national health indicators are featured with significant rates of variation between regions; for instance, life expectancy at birth is considerably lower in Wallonia than the Belgian average (Gerkens & Merkur, 2010). Overall, Belgium's National Healthcare System performs quite well, experiencing a constant increase in life expectancy indicators and resulting above the EU average in 2007 (OECD, 2009). Nonetheless, the rate of dissatisfaction of citizens is stable and significant, reaching a peak of 48 % in people of 75 years or more (IPH, 2010).

The key actors in the healthcare policy sector are the federal government and the federal regions, which share the main competences and responsibilities; the former is in charge of the general management of the system. Among its duties, the most relevant concerns the financing and regulation of the compulsory health insurance (Gerkens & Merkur, 2010), which is the basic element of the system. Instead, federated entities regulate all the aspects that lay closer to the citizens. Finally, the collaboration between these two actors is ensured by interministerial conferences, which systematically gather representatives of both levels of power (Gerkens &

Merkur, 2010).

Overall, Belgium spends a significant amount of money in the healthcare sector; according to available data, it stood at the third place in the EU as far as the percentage of the GDP is concerned. With a score of 10,2 % in 2007, Belgium was above the EU average of 6,1 % and behind only France and Germany. The increasing level of expenditures in the healthcare sector that involved the Country is in line with the broader European trend and it is due to several elements common to all the EU area. Among these reasons, ageing of the population, increase of life expectancy and growth of the GDP represent the main figures.

As aforementioned, the compulsory health insurance is the pivotal element of the Belgian healthcare system; it guarantees to almost all the population a vast set of services that are established at the national level. Citizens help to maintain this generous system through a scheme of co-payments which, together with other forms of contribution, account for about the 20 % of the total expenses (Gerkens & Merkur, 2010). The rest of the expenditures is burdened by the National Institute for Health and Disability Insurance (NIHDI)[37], which funds the Belgian sickness funds in charge of paying for the health services of their clients. To benefit from the national healthcare system, «all individuals entitled to health insurance must join or register with a sickness fund» (Gerkens & Merkur, 2010). Given the generous services' package guaranteed by the State, private insurance companies' market constitutes just an exiguous part of the business. Thus, sickness funds play a recognised pivotal role in the Belgian system; also, they take part in the decision-making processes with the Government and the representatives of both civil society and healthcare services' providers.

Horizontal and vertical solidarity are the two principles underlying the financing of the National Healthcare System; as a matter of fact, the main sources of funding are progressive contributions based on income and not on risk, through the forms of both social security inputs

[37] In official Belgian languages: *Rijksinstituut voor Ziekte- en Invaliditeitsverzekering* (RIZIV) or *Institut national d'assurance maladie-invalidité* (INAMI).

and direct taxation (Gerkens & Merkur, 2010). Payments for services are charged to patients, which are then refunded by their respective sickness fund; the NIHDI used to be responsible of providing the whole resources for reimbursement. Nevertheless:

> « [..] since 1995, they (*sickness funds*) have been held financially responsible for a proportion (25 %) of any discrepancy between their actual spending and their budget, for which 30 % is determined according to a normative risk-adjusted allocation» (Gerkens & Merkur, 2010).

Human resources in the healthcare sector have undergone a significant transformation in the last years; at the end of the 20th century, Belgium ranked among the advanced Countries with the highest physician/population ration, standing at 3,6 per 1000 inhabitants (Gerkens & Merkur, 2010). The risk of oversupplying of medical doctors, together with the inhomogeneous distribution between internal Communities raised the concern of federal policy-makers, both from a social and economic point of view; consequently, the issue was addressed by several interventions, with the aim of planning the supply-side organisation of the workforce. In 1996, the Federal Government settled the *Commission de planification médicale*[38] in order to elaborate a proposal to cope with national priorities. The Committee gathered together the stakeholders of the sector, such as representatives of health professionals and experts in labour planning; the outcome of its work was a quota system which was introduced by federal authorities in 1997. The mechanism, which underwent an adaptation period of 7 years[39], consists in a threshold on the number of specialization posts. Such threshold is set every year at the national level and contains two qualitative elements: the first concerns the equilibrium between the two Communities; according to the system, the 60 % of available places is reserved to Dutch-speaking applicants, whereas the 40 % is destined to French-speaking trainees. The second entails a division between specializations: on the one hand, those who apply for General

[38] In English: Committee for Medical Supply Planning

[39] The adaptation period was planned to allow those who have already started their academic path to conclude it with the same rules.

Practitioners posts; on the other hand, all the other specializations.

To be effective, the efforts undertaken at the Federal level should have been combined with an intervention on the academic side of the healthcare sector; since education falls under the competences of the Communities, national authorities called upon French and Flemish policy-makers to cope with the new quota mechanism. The former introduced a procedure to skim aspiring doctors of medicine at the end of the third year of studying; the criterion of the selection procedure was their academic performance. Since 2006, the selection is carried out at the end of the first year. As far as the Flemish Community is concerned, an entry test was established in 1997; however,

> «It is an exam and not a competition: everyone who passes the exam is eligible to register for university training, without any number restriction. [*Moreover*], each student can try to pass this exam more than once» (Gerkens & Merkur, 2010).

Despite the efforts of the Belgian authorities, the number of physicians in the healthcare system has undergone a progressive and constant increase since 2000; according to OECD data, it reached a peak of 34.020 units in 2015. Even if the physician/population ratio has significantly decreased, attesting at the 13th place in the EU (OECD, 2006), the concerns of policy-makers remained present, switching to another important focus that partly explains the numerical growth of statistics: healthcare professionals' mobility.

Before going further with the analysis, it is necessary to highlight that Belgium experiences a severe lack of data with regard to the mobility of health professionals. Moreover, some peculiarities of the Country, such as the particular regime of diplomas' recognition with the Netherlands that will be analysed later, influence the reliability of the data gathered. Moreover, the frequency of double nationalities, people who graduate and complete their training but then go back to home countries and the vast presence of commuters are significant issues to be taken into account. Abiding by these considerations, the data used in this analysis consist of an integration of national Belgian sources, the European regulated professions database and the

OECD health statistics updated to 2016[40]. As it was the case for Italy, human resources' statistics profoundly affect the mobility profile of the Country; nevertheless, limiting the analysis to quantitative aspects might be misleading. The analysis of flows laid out in appendix 1 shows that Belgium is mainly a receiving Country, with an inflow of approximately 7.000 medical doctors and 5.000 nurses from the EU, compared to an outflow of respectively about 2.500 and 1.000 units.

Despite outflows represent the less frequent phenomenon of Belgian mobility, the oversupplying of medical doctors aforementioned suggests a closer analysis. Following the adoption of the quota system for specialization in 1997, many medical doctors decided to emigrate; data from the competent Belgian authority for professionals who apply in order to see their diplomas recognised in the EU[41] show that, in the last years, «for every 10 specialists who enter the Belgian labour market nearly two (plan to) emigrate» (Safuta & Baeten, 2011).

The most striking feature of the outflows is certainly the relationship between Belgium and the Netherlands. According to the European regulated professions database, approximately the 75 % of emigrates chose the Netherlands to establish and practice their profession; this figure acquires more importance when compared to other Counties' percentage; as a matter of fact, the second preferred destination is the United Kingdom, which accounts for only the 11 % of the total. One of the reasons underlying this feature is certainly the particular regime of diplomas and professional qualifications' recognition that exist between the Netherlands and Belgium. According to Dutch law, both Belgian medical doctors and nurses do not need any certificate of conformity to practice in the Country; therefore, data from the EU database must be compared with the statistics provided by the Netherlands' authorities.

Besides the Netherlands, France also accounted for a large share of Belgian emigrants, even if it cannot be evinced from the EU data. As a matter of fact, France requires a specific conformity

[40] For further analysis, see appendix I

[41] This Authority is part of the Federal Public Service for Health, Food Chain safety and Environment

certificate for those healthcare professionals who wish to practice in the Country. According to available data on conformity certificates, France should be the first destination for Belgian medical doctors; nevertheless, several biases must be taken into account. For instance, the analysis does not make any distinction between those who have Belgian nationality and those who simply have graduated in the Country. However, what is clear is that, as claimed by the PROMeTHEUS project, «language and geographical proximity appear as the crucial facilitating factors [*of mobility*] » (Safuta & Baeten, 2011).

The magnitude of healthcare professionals' inflows makes Belgium prevalently a receiving Country; according to the European regulated professions database, Belgium experienced a relevant increase of foreign healthcare personnel in the last 20 years (appendix I). In particular, data collected by the Federal Public Service for Health, Food chain safety and Environment show that the number of EU medical diplomas recognised in Belgium almost doubled between 2005 and 2008, while performing a modest increase in the previous years. From a qualitative point of view, it is useful to split physicians' migration in two groups: on the one hand, Doctors of medicine without specialization; on the other hand, general practitioners and specialists. The differences between the two can be evinced by national data gathered by the FPS, which collected the relevant numbers between 2005 and 2008. The percentage of foreign Doctors of basic medicine annually registered in Belgium grew from 11,5 % in 2005 to 25,3 % in 2008; by contrast, the corresponding values for general practitioners and specialists show only a moderate increase, from 7,8 % to 12,2 % in the same years.

As far as sending Countries are concerned, France and the Netherlands are the main sources of medical doctors (FPS, 2009), confirming the trend, already registered for outflows, that geographical factors play a key role in explaining mobility phenomena. Nevertheless, with its EU accession in 2007,

> «Romania became the third most frequent country of origin (267 recognitions) overtaking both Germany (213) and Italy (187), which were the third and fourth source

countries until 2006» (Safuta & Baeten, 2011).

Thus, together with geographical factors, the EU framework strongly affects the mobility profile of Belgium. It is true that flows from Romania were relevantly present also before 2007; however, Belgian legislation with regard to immigrants restricted their establishment (Safuta & Baeten, 2011). These limitations were prolonged until 2011; but, «since the first day of accession, there have been no limitations on self-employment» (Safuta & Baeten, 2011). Given that the majority of health professionals in belgium belong to such category, it is easy to recognise the impact of EU free movement and mutual recognition of diplomas and professional qualifications.

Although mobility data of medical doctors are more relevant and explanatory for the analysis that will be carried out in next section, nurses' statistics deserve a brief focus. According to the EU regulated professions database approximately 5.000 units reached Belgium between 1997 and 2016. National data, which concentrate on a smaller time frame, suggests that in 2008, the percentage of foreign nurses was 4,4 %. It is useful to remind that this statistic includes also non-EU workforce, even if the vast majority are from the Single Market Area, with France accounting for more than the half. Moreover, the same data show that after 2005, Belgium experienced a relevant increase in the percentage of foreign newly licensed nurses, with a shift from 5,8 % in 2005 to 13,5 % in 2008 (Safuta & Baten, 2011). The EU regulated professions database provides some insights about the composition of the inflows: as it was the case for medical doctors, France and the Netherlands are again the first source Countries; nevertheless, the presence of Portugal as a strong supplier of nurses raises some questions. A plausible explanation may be the bilateral agreements between Belgian University and Institutes in order to encourage international recruitment in fields featured by shortages.

To sum up, healthcare professionals' mobility became an issue when federal authorities faced an increasing in the number of medical doctors and a shortage in nursing workforce. Given the quota system introduced in 1997, the inflows experienced by Belgium can be considered the

primary cause of the numerical growth of medical doctors. As a matter of fact, foreign applicants for training as specialists or General practitioners are not included in the quota mechanism. Thus, in this case, national policies have significantly affected mobility choices, encouraging outflows of medical doctors and inflows of nurses. Nevertheless, the increasing rate of physicians with basic training who seek to practice in in Belgium suggests that other factors are more relevant when deciding to migrate. This and other conclusions regarding the Italian case will be discussed in the next section, which aims at inferring some qualitative considerations from the quantitative analysis carried out in this chapter.

2.3 National contexts and flows: drawing qualitative conclusions from the case

The quantitative analysis of mobility flows was necessary in order to better understand the determinants of healthcare professionals' migration. These case studies started with two assumptions: first, from a quantitative point of view, Italy and Belgium shall be the representatives of two categories: the former takes the shape of a sender Country, whereas the latter stands for a recipient Country. Differences between the two groups trace back to the magnitude of mobility flows: if a Country is mainly featured with inflows, it belongs to the recipients; in contrast, if it is characterised by significant outflows, that Country is a sender. The second assumption was that, since labelling States on the basis of quantitative considerations is too simplistic, a qualitative analysis of the flows is required. The hypothesis was that national contexts and policies are not enough to explain healthcare professionals' mobility choices. In this section, through the analysis of the Italian and Belgian case, some conclusions regarding these two assumptions will be drawn.

2.3.1 Considerations from the Italian case: oversupply and shortages as drivers of mobility?

The Italian mobility profile is strongly affected by national statistics concerning human resources in the healthcare system. Oversupply of doctors and shortages of nurses are the keys to understand the magnitude of outflows and inflows that features the Italian case; as shown by the data in appendix I, there is a high number of medical doctors, which ranked Italy as one of the top EU Countries for the physician/population ratio. Thus, a relevant emigration rate should be expected. By contrast, the acknowledged shortages in the nursing sector shall translate in relevant inflows of professionals. Mobility data show that Italy actually experienced a significant rate of nursing immigration in the last years, particularly from the EU enlargement Countries. Nonetheless, outflows of Italian physicians, though existing, are smaller than expected; according to the OIS analysis, newly registered medical doctors easily find a stable job: as a matter of fact, the rate of Italian employed physicians between 25 and 40 years old reaches a peak of 92 % in the northern part of the Country (OIS, 2016). This is probably due to the generational turnover that is affecting the «current cohort» (Bertinato et al, 2011).

If oversupply of medical doctors is not enough to explain the existing outflows, there are several other determinants that might be taken into account; for instance,

> «The President of the Italian Society of Psychiatry (Società Italiana Psichiatria) has cited "ridiculous salaries" and punishing working conditions as reasons why young specialists leave the country» (Bertinato et al, 2011).

Moreover, data collected in appendix 1 show a significant outflow of doctors towards the EFTA[42] Countries, with the vast majority choosing Switzerland for language and geographical

[42] The mutual recognition of Diplomas and Professional qualifications applies also to the EFTA (European Free Trade Association) Countries, namely Iceland, Lichtenstein, Norway and Switzerland.

proximity (Regulated Professions Database, 2016).

Consequently, the first lesson learned is that quantitative data are not enough to explain healthcare professionals' mobility. Despite the importance of oversupply and shortages, qualitative insights are necessary to understand the phenomenon. The qualitative analysis of inflows brings about other considerations regarding our assumptions; according to data, the migration phenomenon related to Italy involve mostly EU Countries (Maier et al, 2011). This comes as a surprise, given the large amount of long-term care nurses (so-called *badanti*, who are often from non-EU areas. In this field, the Italian government committed to ease the procedures for those professionals who cannot benefit from the EU regulations of free movement and diplomas' recognition. Despite these efforts, the magnitude of inflows coming from the Single Market area remains bigger.

In conclusion, Italy cannot be labelled as a sender Country, as suggested by a mere quantitative analysis; qualitative considerations show that such a categorization may be misleading. It is certainly true that national quantitative data are important to understand the mobility profile of a Country; for instance, shortages of nurses in Italy brought to significant inflows. Nevertheless, the lack of a relevant outflow of medical doctors due to the national oversupply shows that numerical aspects are not enough: after all, the categorization would imply that national contexts and policies represent the main determinants of healthcare professionals' migration. Rather, given that qualitative analyses show that the EU framework is still more important than national measures and data, a different approach is required to build a model that explain mobility choices. This is also confirmed by the existing outflows of physicians that are mainly due to individual considerations.

2.3.2 The Belgian case: do national policies affect mobility?

As it is the case for Italy, the mobility profile of Belgium is influenced by national data

regarding healthcare human resources. The high number of physicians that featured the Country during the 1990s represented a serious concern for national policy-makers; also, severe shortages affected the nursing professions, laying the foundations for a relevant inflow of foreign nurses. As it can be easily acknowledged, Belgium faces an environment similar to the Italian one; nevertheless, outcomes were different. As a matter of fact, while the arrival of foreign nurses is common to both Countries, Belgium also experienced a significant inflow of medical doctors.

There are several reasons underlying this difference; first of all, Belgium took an important action to tackle its situation. In 1997, a quota system was introduced to moderate the oversupply of medical doctors; despite this intervention, the Country faced an increase in the numerical presence of physicians, due to a significant inflow of foreign workforce. This outcome was prompted by the quota system, which did not include foreign professionals in the limitations; moreover:

> «migration flows seem rather natural as Belgium is a country with generally high levels of individual and professional mobility[43] – a country with permeable borders» (Safuta & Baeten, 2011).

Consequently, Belgium, as Italy, show that quantitative data are not enough to explain professionals' mobility; but, in the Belgian case, a national policy profoundly affected the mobility profile of the Country.

Despite this influence, there are other factors that can be considered more pivotal to explain healthcare professionals' mobility choices. From a qualitative point of view, the analysis of the flows show that geographical and cultural proximity are the key features of Belgian mobility profile. This is reflected in the percentage of mobile professionals that come from France, Germany or the Netherlands. Nevertheless, nurses' mobility represents an explicative

[43] According to statistics, Belgian foreign population represents nowadays the 16,4 % of the total (Eurostat)

exception; in this case, since the EU enlargement in 2007, Romanian inflows have rapidly become the third most significant behind France and the Netherlands. Moreover, according to data, Belgium experienced an increase in professionals' mobility after the enactment of the EU Directive on mutual recognition of diplomas and professional qualifications. Therefore, while national policies and context surely have an impact, the EU framework and other factors have a stronger influence on healthcare professionals' mobility choices.

2.3.3 General conclusions

To sum up, the quantitative analysis of mobility flows provides an incomplete picture of the determinants of healthcare professionals' migration; as shown also by the conclusions of the MoHProf project, there are no sending or receiving Countries, because «realities are more complex» (Tjadens et al, 2013). Moreover, it would suggest that national contexts, through statistics and policies, affect mobility choices of medical doctors and nurses. Hence, a macro approach would be enough to build a thorough model for explaining healthcare professionals' migration. Nonetheless, findings from the case studies raise doubts about these assumptions.

First of all, the categorisation of Countries based on the quantitative analysis of the flows is misleading: from a qualitative point of view, Italy and Belgium cases show that sender and recipient labels cannot be conferred so easily. However, these two Countries are actually representatives of two different groups; indeed, while Italy is a clear example of the ineffectiveness of national contexts and policies, the Belgian experience illustrates that federal authorities succeeded in influencing migration flows. Nevertheless, despite the quota system affected the mobility profile of Belgium, the European framework, with the freedom of movement and the mutual recognition of diplomas and qualifications, represented a stronger determinant for healthcare professionals' migration choices.

From a theoretical point of view, this is a key finding; it suggests that a macro approach is

necessary to build a model that could explain healthcare professionals' mobility choices. On the one hand, the case studies have highlighted that national contexts partly influence mobility flows; on the other hand, data show that the EU context is a stronger determinant for healthcare workforce migration. Driven by Single Market considerations, through the legislative work and the ruling of the CJEU, the European Union sought to overcome national barriers and play a key role in regulating mobility inside its territory; therefore, from this point of views, a suitable macro approach should focus on the EU, rather than Member States. Consequently, further aspects should be taken into account; in particular, given that the EU have committed to the integration of national labour markets through its regulation on mutual recognition and freedom of movement[44], the importance of other factors, such as geographical and languages proximity (Safuta & Baeten, 2011) or salary considerations (Bertinato et al, 2011) should be analysed. This underlines the importance of a micro and meso approach[45], because, after all, «mobility, particularly within the EU, hinges on an individual's decision to move» (Glinos et al, 2014).

[44] See Chapter 1
[45] See Chapter 4

Chapter 3: A qualitative analysis of the flows inside the EU: understanding the determinants of mobility

So far, the previous chapters acknowledged several key elements; first of all, the structure of the European legal framework concerning the mobility of healthcare professionals. In this field, the freedom of movement for workers and the mutual recognition of diplomas and professional qualifications constitutes the pillars of the system. In particular, the EU have always highlighted the importance of workers' mobility for the completion of an effective Single Market; therefore, the aim of its efforts has always been to eliminate any national restriction: the first chapter showed all the progresses achieved in this domain. Secondly, the importance of accurate data at the European level; nowadays, mobility is becoming a key issue for National Healthcare Systems: the lack of reliable statistics endangers the effectiveness of policy-makers in planning adequate solutions. Thirdly, quantitative aspects do not provide a complete picture of the healthcare professionals' mobility phenomenon; the case studies showed that a qualitative analysis of the flows brings out new and fundamental aspects. Finally, the importance of the EU framework has been underlined by the findings of the case studies; explaining healthcare professionals' mobility partly requires a macro approach. However, EU efforts in removing barriers to migration, brought Brussels to play a stronger role than national authorities. Hence, a model that sought to individuate the determinants of healthcare professionals' mobility must entail a macro approach, with a focus on the EU framework.

Abiding by these findings, it is now time to concentrate on two aspects: the qualitative analysis of the flows and the levels of approach for explaining healthcare professionals' mobility. While the latter will be better dealt in the last chapter, the former is the object of next sections. First of all, the general theories of international migration will be presented: it will be demonstrated that, also at the international level, a multilevel approach is required to explain mobility; then, narrowing down to the healthcare sphere, conclusions and considerations with regard to

professionals' mobility inside the EU will be discussed, analysing the European projects that focused on these aspects. Finally, the last section will deal with the EU peculiarities that influenced mobility paths, namely the impact of the Economic and Financial Crises, the enlargement process that occurred between 2004 and 2007 and the demographic challenges that the EU is currently facing.

3.1 The need for a new theoretical framework

Since ancient history, migration has always been a phenomenon that concerned humankind, even if with different features; leaving aside the nomadic phase, between the 16th century and the end of the 20th century, there are four main periods in which the history of migration can be split: the mercantile and industrial stage, the period of limited migration and, finally, the post-industrial migration period (Massey et al, 1998). Within this framework, Europe has always played a key role, whether as a sender or receiving area. As a matter of fact, the continent has been the core of migration flows, since the mercantile period, which ranged from the beginning of the 16th century to the end of 19th century. During these three centuries, Europe acted as a powerful source Country, mainly due to the colonization of Africa and Americas; the need for labour force, which was dictated by the capitalist paradigm of economic development, constituted the main driver for European migration. Between 1800 and the First World War, the only thing that changed were destination Countries, with the United States of America (USA) receiving the lion's share of total inflows; apart from the USA, European migrants concentrated on the paths towards America and Oceania. The period of limited migration that covered approximately 40 years and the two World Wars represented a turning point for Europe's role, which would have completely changed its mobility profile in the last stage of the aforementioned division: the post-industrial migration period.

The post-industrial migration period saw a complete transformation of the key features of

migration's phenomena, which started to involve the whole international sphere, rather than concentrate on colonization's paths. Moreover:

> «whereas migration during the industrial era brought people from densely settled, rapidly industrializing areas to sparsely settled, rapidly industrializing regions, migration in the post-industrial era brought people from densely settled Countries in the earliest stages of industrialization to densely settled post-industrial societies» (Massey et al, 1998).

In this framework, Europe ceased to be a source of migrants and rapidly became the recipient of increasing inflows from newly sender Countries, ranging from Africa to Asia and South America; even historical sources such as Southern European Countries began to experience significant immigration phenomena, particularly from Northern African States. This transformation was rooted in the economic development that occurred in the 19th century, when Europe was the core of the two industrial revolutions. The technological progress was featured with a shift in the demographic profile of the continent, which experienced a significant growth in the birth rate. Initially, this phenomenon increased outflows from Europe; nevertheless, starting from the 1960s, migration paths started to reverse and, with them, also demographic indicators.

From a qualitative point of view, the post-industrial migration towards Europe was featured with many peculiarities; first of all, in contrast to the mercantile and industrial period, destination Countries were not intensive in land. Due to the industrial revolutions, Europe reached a situation of «capital abundance and labour scarcity» (Massey et al, 1998), which led the way to the massive inflows of migrants, even in traditionally sender Countries. This situation also affected the modalities of the phenomenon; as a matter of fact, receiving States sought to fill their labour scarcity with temporary inflows of workforce. However, immigrants started to establish themselves, generating the integration problems that still represent one of the main concern of policy-makers. On the other side, the post-industrial migration also showed

a transformation in the sender Countries, which tended to be featured with a vast workforce, but low capital and job opportunity levels. Finally, the last element to be highlighted is the importance of migrant workforce for receiving Countries; although States strongly rely on immigrants, this is often not acknowledged at the national level, with *de facto* Countries of immigration that do not even consider themselves as such (Massey et al, 1998). To sum up, the post-industrial period of migration developed in a completely new context, different from previous stages; this new context was featured with strong imbalances in labour demand and supply within sending countries and limited labour supply due to ageing population and low birth rate in receiving countries (Massey et al, 1998).

The features of migration during the post-industrial era challenged the old theories that sought to explain the phenomenon in the industrial era; rooted in the standard economic models, they rely on two assumptions that laid on a micro and macro level. The former was that migrants were conceived as rational actors, who took their mobility decisions on the basis of economic preferences between Countries; the latter was the transposition of the assumption at the macro level. It consisted in the so-called "push-pull" approach, which claimed that migration phenomena were dictated by the imbalances in labour supply and demand between Countries (Massey et al, 1998).

As far as the micro assumption is concerned, evidences clearly show that «economic disparities alone are not enough to explain international movement» (Massey et al, 1998). As a matter of fact, standard economic theories present several pitfalls; for instance:

> «Although there is still a substantial wage differential between Northern and Southern Europe, [..], little migration occurs between Spain, Portugal and Italy, on the one hand, and Germany, Belgium and Denmark, on the other» (Massey et al, 1998).

Moreover, while economic material development does reduce outflows in the long run, it encourages migration in the short run because it increases displacement of people from agriculture and rural life.

Standard economic models also assume that the greater the economic disparities, the greater the migration flows from the poorer to the richer Country. In particular, it was believed that the more a migrant expected to increase his income, the more likely is migration phenomena. Nonetheless, data have showed that some Countries experienced relevant inflows, despite their economic performance, from the point of view of average incomes, was deteriorating. Furthermore, according to these theories, the lack of economic disparities should have translated in the end of migration phenomena. Clearly, this assumption is wrong:

> «Migration typically has not ended with the equalization of wages, but with the attainment of bearable conditions of life in areas of origin, after which people find migration not worth the effort» (Massey et al, 1998).

This element allows to look at the larger picture; standard economic theories do not gather the complexity of individual motivations: it is always more common that a migrant chooses to move not to improve its condition, but because it assess his situation as intolerable. This perspective should be used also when looking at migration costs. It is often assumed that the lowering of material costs for travelling from one Country to another increases international movement; nonetheless, data show that when these costs are approximately non-existent, sometimes no migration flows occur. This finding suggest that migration cost may include those of leaving the native Country, risk-aversion features or any other element related to the individual sphere.

The theories developed in the industrial era also took into account the demographic aspect; according to the old models, migration phenomena were deeply affected by demographic forces. In particular, it was assumed that sender Countries were featured with high birth and population growth rates, whereas recipients with opposite trends. According to old theories, this situation produced a direct impact on international movement; nonetheless, «demographic disparities *per se* are irrelevant» (Massey et al, 1998); migration is a far more complex phenomenon.

Finally, old theories have always tended to disregard political obstacles derived from national authorities. Migration phenomena have been analysed from a potential point of view; as a matter of fact, nation states do play a role in influencing international movement. However, as we saw in previous chapters, Europe stands by itself from this perspective. The EU has sought to remove any national barriers to free movement; consequently, it represents a particular environment that have already been discussed and will be further analysed in next sections.

Challenges to the second pillar of the old industrial era theories, namely the "push-pull" approach, were rooted in those which regarded the first assumption. In particular, it was claimed that the imbalances between labour demand and supply are not an exhaustive explanation for international movement. It was analysed that «in the post-industrial period [..], the forces of expulsion seem to have gained the upper hand»; consequently, push factors should generate a constant incentive to move. However, migration flows do not reflect this tendency. This do not translate in the abruption of the push-pull model; rather, there still are two forces, but they have not equal weight, due to other intervening variables that affect mobility choices.

To put all this in a nutshell, the complexity of migration phenomena does not allow to frame the whole set of determinants within economic considerations, as theories used to do in the industrial era. The post-industrial period brought to light several new elements that must be taken into account when trying to explain mobility; overall:

> «thinking has moved away from reified, mechanical models towards more dynamic formulations that allow micro-level decisions to affect macro-level processes and vice versa» (Massey et al, 1998).

As a result, the focus was switched from economic disparities between Countries to the migrants' sphere, highlighting the importance of aspects such as personal perspectives or contexts in which decisions are taken. Moreover, quantitative considerations started to become more tailored to individual features, rather than relying on macro data (Massey et al, 1998). Nonetheless, while underlining the importance of a micro-approach based on migrants' sphere,

macro-level considerations shall not be neglected; rather, «the need to combine macro- and micro-level approaches into coherent multilevel models is a clear desideratum» (Massey et al, 1998). In conclusion, there is the need for a reconceptualization of the determinants of mobility; a new approach is required to combine the analysis of the decision-making process of migrants with their economic and social situation, without abandoning the macro level of political and legal variables.

Once acknowledged the need for a multi-level theoretical framework in order to explain international movement, it is now time to draw a state of the art of the main single theories that sought to represent a model for understanding the determinants of migration phenomena. According to several studies:

> «[..] there is no single theory widely accepted by social scientists to account for the emergence and perpetuation of international migration throughout the world, only a fragmented set of theories that have developed largely in isolation from one another» (Massey et al, 1998).

Therefore, an overview of the main general theories is required before turning to specific frameworks that seek to explain healthcare professionals' mobility inside the EU. The analysis will be carried out as follows: first, the description of theories regarding the reasons underlying the beginning of migration and then a focus on those which justify its continuation.

3.1.1 Why migration begins?

As aforementioned, Neo-classical economics provide both a macro and micro theory to explain international movement. The main arguments are the two pillars discussed above: from a macro point of view, migration processes result from imbalances between labour demand and supply. People tend to move from a labour intensive Country, featured with a situation of capital

scarcity, to Countries with the opposite situation. As a matter of fact, abundance of workforce associated with capital exiguity result in situation of low market wages; Consequently, migrants move to seek higher salaries. In this framework, wages' differentials constitute the determinant of international movement. The macro approach necessarily relies on a micro theory, which represents the second pillar of Neo-classical economics: people tend to move for obtaining higher wages because they act as rational economic actors. According to this assumption, in taking their decision, migrants perform a cost-benefit analysis, considering every aspect of their choice. In particular, among migration costs are included material expenses such as those for travelling and establishing, but also those related to the individual sphere. For instance, learning a new language, leaving home and family and integrating into a completely new culture or environment. Therefore, while constituting the basis for the macro level, the micro-approach of Neo-classical economics introduces some elements that refers to individual features; nonetheless, it framed everything within an economic logic, without taking into consideration the contexts where a migrant decides. Furthermore, assuming that choosing to move is an individual decision arose several critics.

In particular, the New Economics of Migration challenged the individual approach of the Neo-classical economics theories, which took the single migrant as unit of analysis; instead, the key element of this new approach was to focus on households, rather than individuals. The fundamental assumption was that:

> «Unlike individuals, households are in a good position to control risks to their economic well-being by diversifying the allocation of resources at their disposal, such as family labour» (Massey et al, 1998).

The New Economics of Migration claimed that households could decide to diversify their workforce across different labour markets, in order to avoid possible negative consequences from market failures. According to this approach, the relationship between the household and the various markets, such as unemployment insurance or capital and credit markets, rather than

differences in wages, are the real determinants of mobility choices. Thus, the need for diversification of risks for households drives international movement.

The approaches discussed until now share the view that mobility decisions are taken by individuals through a rational choice model; moving away from this perspective, the Segmented Labour Market Theory changes the focus of the approach and «argues that international migration stems from the intrinsic labour demands of modern industrial societies» (Massey et al, 1998). This means that migration is not determined by micro/meso-level actors, such as individuals or households, but it derives from macro-level processes; in particular:

> «International labour migration is largely demand-based and is usually initiated through recruitment by employers in developed societies, or by governments acting on their behalf» (Massey et al, 1998).

Therefore, migration is dictated by the needs of national economy and depends on international recruitment, rather than on individuals' choices.

The macro-level approach of the Segmented Labour Market theory is shared by the Historical-Structure and World Systems theory, which claimed that migration phenomena are driven by the differences between Countries generated by the level of development of capitalism. While Historical-Structure's studies did not particularly focus on international movement,

> «world systems theory argues that the penetration of capitalist economic relations into non-capitalist or pre-capitalist societies creates a mobile population that is prone to migrate. [..] International migration thus emerges as a natural outgrowth of disruptions and dislocations that inevitably occur in the process of capitalist development» (Massey et al, 1998).

According to the main World Systems' theorist, namely Immanuel Wallerstein, among the capitalist system, «one could speak of core, periphery and semi-periphery» States (Wallerstein, 1974); through the investments of core states' businesses, periphery Countries get in touch with

the global economy, generating «flows of labour in the opposite direction» (Massey et al, 1998). Thus, the main determinant of migration phenomena is simply the different stage of capitalism that a Country is experiencing.

3.1.2 Why migration continues?

The previous section dealt with those theories that seek to explain why migration phenomena begins; nonetheless, they provide an incomplete picture, since they rely on contextual elements that might change over time. Furthermore, new conditions may emerge that can affect mobility choices, ensuring the perpetuation of migration phenomena. Therefore, several other theories have sought to study how new contexts generated by international movement, may or may not affect the permanence of such phenomenon.

The Social Capital theory claimed that the continuation of international movement relies on two strong forces, namely migrants' networks and supporting institutions (Massey et al, 1998). Pierre Bourdieu and Loïc Wacquant asserted that:

> «Social Capital is the sum of the resources, actual or virtual, that accrue to an individual or a group by which of possessing a durable network of more or less institutionalized relationships of mutual acquaintance and recognition» (Bourdieu &Wacquant, 1992).

Social capital plays a key role in the analysis of migration phenomena, because it ensures the perpetuation of movement by means of the social networks it creates. Therefore, according to social capital theorists, the real determinant for mobility is not related to economic features, both at individual or Country level; rather, it is the institutionalization of migrants' networks that guarantees the continuation of international movement, which «becomes progressively independent of the factors that originally caused it» (Massey et al,1998).

Similar to the Social Capital theory, Cumulative Causation approaches turned their focus on

those elements that step in once migration phenomena have initiated; according to these theories, international movement is fuelled by the consequences that a migrant's decision bring. In a nutshell:

> «Causation is cumulative in the sense that each act of migration alters the social context within which subsequent migration decisions are made, typically in ways that make additional movement more likely» (Massey et al, 1998).

Thus, these alterations that might concern different levels of context, whether economic or cultural, constitute the real determinant of migration phenomena's continuation, regardless of the initial causes of mobility.

To sum up, several theories have sought to explain international movement; among these, a general distinction has to be made: on the one hand, those that focus on the beginning of migration phenomena. On the other hand, theories that analyse the continuation of mobility, highlighting the independence from the elements that have generated it. The general theories of international migration differ with respect to their approach; for instance, Neo-classical economics rely on the idea that mobility choices are taken by individuals, which act according to a rational choice paradigm. By contrast, Segmented Labour Market and World Systems theories privileged another approach, claiming that migration phenomena are dictated by macro-processes, such as capitalism stages of development or the needs of national economic systems. Finally, the theories that sought to explain the perpetuation of international migration adopt a meso-approach, asserting that a key role is played by social, economic and cultural networks between migrants.

Every theory analysed so far stands at a different level of analysis; clarifying which model is the most appropriate should rely on a thorough, as well as challenging, empirical analysis of specific migration paths. Therefore, it is now time to focus on the healthcare sphere; in the next sections, theories explaining healthcare professionals' mobility within the EU will be discussed. After that, a specific paragraph will be dedicated to the peculiarities that stem from the

European environment, such as the enlargements of 2004 and 2007 or the severe impact of the economic crises. In the end, the final chapter will combine these elements: the aim is to link every specificity of the EU framework to the general theories of international migration, in order to build an exhaustive theoretical model for mobility choices inside the EU.

3.2 Healthcare professionals' mobility theories in the EU

Currently, explaining healthcare professionals' mobility choices through one single theory is something that has not been achieved; the lack of reliable and accurate data on migration flows between EU countries prevents the formulation of specific theories. Nevertheless, abiding by general approaches towards international migration, several attempts were made to build a theoretical framework tailored to the healthcare professionals' mobility. As aforementioned, a thorough model that aims at explaining such phenomenon requires an empirical analysis of the specific migration flows; at European level, the most comprehensive endeavor resulted in the MoHProf project, which included a significant number of EU Member States and aimed at understanding which determinants mainly affected the mobility of healthcare professionals. It is necessary to underline that the analysis of the MoHProf findings requires a certain degree of approximation due to the structure of the project. In particular, the sample of the study includes 25 Countries of which only 12 are EU Member States; consequently, the resulting factors affecting mobility will entail also outcomes from non-EU Countries. Clearly, the whole set of findings will be discussed in this section; nonetheless, the last paragraph will be dedicated to EU peculiarities that will be extrapolated both from the MoHProf and the PROMeTHEUS projects. In this way, the determinants derived from the MoHProf will be double checked with exclusively EU findings, allowing a smaller degree of approximation. To give an example, it is clear that "health treats" among those factors which contribute to mobility is probably associated with non-EU Member States; hence, the last section of this chapter is indispensable.

According to the MoHProf project, mobility choices are mainly individual decisions, which are influenced by a wide set of factors that belong to different levels of analysis. In general, the analysis relied on the aforementioned "push-pull" approach, where determinants of migration are divided between those elements that encourage to move and those that keep the possible migrant in her/his native Country. However, these factors are not exclusively related to the imbalances of labour supply and demand between states; this would have been the case, if mobility choices were dictated by quantitative aspects. As shown in the previous chapter, such assumption does not hold in the EU framework; the categorisation of Member States based on the magnitude of both in- and outflows does not work. Although the MoHProf project rely on the division between sending and receiving Countries, findings have shown that the dichotomy is more apparent than real, confirming the conclusions of the cases' study in Chapter 2; as written in the final report:

> «A surprising outcome is that push factors are not restricted to countries that are generally perceived to be sending countries, nor are pull factors solely restricted to countries that appear to be receiving countries» (Tjadens et al, 2013).

Nonetheless, findings from the project allow to produce an exhaustive set of the factors that affect mobility choices, which, together with the peculiarities of the EU environment that will be analysed in next section, will provide a complete framework to build a model for understanding the determinants of healthcare professionals' mobility. Dividing the key factors according to their level of analysis (ex. micro/meso/macro) will partly anticipate the fourth chapter, where they will be framed in the general theories that share their same level of analysis.

The "push-pull" paradigm traces back the determinants of mobility choices to the presence or absence of specific factors, which relate to different spheres at distinct levels of analysis. For instance, elements attributable to individual preferences belong to the micro level, whereas factors linked to the health systems or policies stand on the macro one. Among the first group, the most cited factors are linked to individual self-realization; the possibility of career's

development strongly affects migrating professionals. Such development may consist in further professional or training opportunities, but also better working conditions or higher salaries. It is useful to highlight that in some small countries, such as Ireland, «studying abroad is sometimes the only option in order to qualify in [*some*] medical specialties» (Tjadens et al, 2013). Moreover, less-developed Countries generally offer poorer career prospects with respect to more advanced States, such as France, Germany or The United Kingdom; career opportunities can also take the form of higher remunerations or better social security systems. For instance, historical welfare state Countries, typically those in Northern Europe, experience higher degrees of attraction. As far as salaries are concerned, relative, rather than absolute wages, have a stronger weight on migrants' choices; this is strictly linked with another micro-level factor, namely perceived living and working conditions. As aforementioned, perceived present situations rather than future opportunities are more relevant for mobility choices.

Factors related to the personal sphere also influence migration's decisions. For instance, self-perception in the society may play a key role: this is not always related to economic considerations. As a matter of fact: «low social status or professional prestige can push health workers abroad» (Tjadens et al, 2013). Furthermore, elements such as low risk-aversion and high propensity to new experiences and adventures or reasons of personal safety can have their weight on the decision to leave. Finally, personal circumstances are also important; for instance, as shown in the Belgian case study, many healthcare professionals migrate with the aim of coming back home in the future; this idea may be premeditated, or it may emerge during the mobility period due to several factors such as discrimination or unhappiness (Tjadens et al, 2013). Also, gender considerations are often taken into account: female professionals experience higher propensity to move if gender equality is better guaranteed in the receiving Country (Tjadens et al, 2013).

To sum up, factors that relate to the individual sphere belong to the micro-level of analysis; this may be due to several features: they can interfere with personal preferences and choices or simply be linked to individuals' perception of their situation. Micro-level elements are framed

in the general theories analysed in the previous section; after analysing some EU peculiarities in the next section, the following chapter will deal with the question of how much they affect healthcare professionals' mobility choices inside the EU.

Factors that relate to larger units of analysis, such as households and families, or do not derive from strictly individual processes, such as social networks, belong to the meso-level. As confirmed by the case studies, geographical and cultural proximity are pivotal for mobility choices; flows between Belgium, France and Netherlands, as those between Italy and Switzerland are the most significant for the Countries analysed. Also, Austria, which was one of the MoHProf project State, highlighted a relevant and stable migration path with neighbour German-speaking Countries, namely Germany, Lichtenstein and Switzerland (Tjadens et al, 2013). As a matter of fact, language plays a key role in mobility choices; in the framework of mutual recognition of diplomas and professional qualifications, chapter 1 have shown the importance attributed to adequate language tests for allowing foreign healthcare workforce to establish and practice their profession[46].

As we saw in the previous section, migration choices are not always individual; as a matter of fact, they might be related to households' considerations. For instance, when deciding to move, opportunities for family members, being them better education for children or career prospects for spouses, are always taken into consideration. To sustain this hypothesis, according to the MoHProf findings: «Bulgaria reports training possibilities and a better educational future for the children and career opportunities in receiving Countries» (Tjadens et al, 2013). Generally speaking, such considerations are reflected in mobility flows between less-developed Countries to more advanced States, namely UK or Germany. Another familiar consideration might be to move to a specific Country because of the presence of relatives or friends; even if this might be more linked to individual features, such as risk aversion or propensity to adventures, it traces

[46] See section 1.3.2 for a better description of language requirements

back to the importance of social networks.

Among the determinants of mobility choices, social network is the most important meso-level consideration and it may take different shapes. For instance, the presence of a structured and of excellent quality professional environment represents a strong incentive to move, especially for highly-specialized professionals (Tjadens et al, 2013). Moreover, hierarchical organisation of specific sectors may play a double role, depending on the rigidity: on the one hand, it may push professionals to leave, because of the difficulty in advancing to higher grades. On the other hand, it can attract workers because of career prospects. However, social networks may refer to something that is independent from the employment sphere; for example, apart from the aforementioned family and friends, also «immigrants of the same background [..], cultural enclaves [..] and migrant communities» (Tjadens et al, 2013) play the role of a safety net, affecting mobility choices of potential migrants. This is particularly relevant in explaining the massive outflows from EU enlargement Countries to particular Member States, such as Italy and Belgium[47]. Finally, cultural considerations shall be taken into account:

> «In some Countries, migration is, to some extent, a fact of life. Ireland, for instance, mentions its long-lasting tradition of emigration to English-speaking Countries» (Tjadens et al, 2013).

Historically migrants' States, such as Italy, will probably experience more outflows than traditionally recipient Countries such as Belgium. Even if this might be related to the macro-level[48], from a cultural point of view, it should be included among the meso-aspects.

There are some factors that relate to a sphere that has nothing to do with individual preferences or social processes; together with micro and meso, also macro-level elements such as political institutions and health systems' structures affect migration choices of healthcare professionals.

[47] See Chapter 2

[48] This may be linked to the concept of "path dependency" in historical institutionalism or rather to sociological institutionalism. For further reading, see Hall & Taylor (1996)

As we saw in Chapter 2 with the case studies, national statistics often determine the mobility profile of Countries; in particular, shortages and oversupplies of professionals intervene on two different levels: on the one hand, they address the individual who takes the decision on the basis of the labour market situation. On the other hand, they refer to the political authorities that take actions in order to solve national imbalances; these interventions may take the shape of planned international recruitment, as it was the case for the UK in the 1990s (Jinx & Ong, 2000), or national quota systems, as described in Belgium's case study (Safuta & Baeten, 2011). Hence, from a macro-perspective, the situation of the labour market affects mobility choices in two distinct ways: directly, through the lack of work opportunities and indirectly, through consequent following national interventions.

Apart from labour market imbalances, mobile professionals also take into account other aspects derived from the healthcare systems' structures; according to the findings of the MoHProf project, the lack of financial resources is a relevant issue, especially in Countries with public healthcare systems. This problem is reflected in low salaries, poor research opportunities and inadequate «infrastructures, equipment and supplies» (Tjadens et al, 2013). Although this issue is more relevant for specific Countries, the EU has registered a general decrease in healthcare spending, due to the necessary cuts derived from the impact of the economic crises[49]. Furthermore, several Countries experience a poor organisational management of their healthcare systems; in particular, the lack of an effective human resources' administration mechanism has brought most of the EU Member States to suffer from oversupplies or shortages.

Macro-level factors are not limited to the healthcare systems; professionals moving abroad obviously consider national features. In particular, the socio-economic situation of the Country, though not strictly related to healthcare professionals' mobility, can prove itself as particularly important in migrants' decisions; among these factors, tax burden and social instability are often

[49] For instance, as we saw in Chapter 2, Italy has registered significant cuts in the healthcare sector since 2009. Further analysis on the impact of economic crises on healthcare professionals' mobility within the EU is provided in next section

presented as pivotal elements. Also, corruption in the professional environment is sometimes perceived as insupportable; for instance, the succession of scandals in the Italian tests for medical specialties has led to increasing outflows. Despite such cases, corruption factors, together with health treats and political instability, belong to those MoHProf findings from non-EU Countries (Tjadens et al, 2013). Finally, as we saw in the Italian case, national demographic profiles influence several aspects of mobility choices: for example, the ageing of population may exacerbate shortages of long-term care nurses, or, at the same time, prolonging the working age and consequently push young professionals to leave in order to find a stable job.

The last macro-level factors to be analysed are national policies, particularly those that relate to migration and professionals' establishment. Since social security falls under Member States' competences, welfare benefits also represent a macro-level factor that affects mobility decisions. Nonetheless, the most important thing in to highlight in this framework is that EU legislation, particularly with the ruling of CJEU concerning the freedom of movement and Directive 2013/55/EU[50], sought to eliminate any national barrier for healthcare professionals' mobility. Hence, while bilateral agreements and recruitment and the slowness of bureaucracy still play a role in non-EU migrants' decisions (Tjadens et al, 2013), the same cannot be said for EU Member States' professionals, who, as aforementioned, move within a «peculiar environment» (Buchan et al, 2014).

To sum up, according to the MoHProf project, healthcare professionals' mobility develops in the framework of a "push-pull" paradigm; as a matter of fact, the theoretical approach of the project included also a whole set of "stick-stay" factors, which referred to those elements that come into play once the mobility decision has already been taken and the professional is already established abroad. However, this analysis has not performed such division for two main reasons: first, the objective is to build a theoretical model to explain mobility choices; second, despite the decision to stay might also represent a mobility choice, the difference between

[50] See Chapter 1

"push-pull" and "stick-stay" factors is only linked to perceptions. Indeed, the former «are more related to personal or social aspects», whereas the latter «relate to more objective factors» (Tjadens et al, 2013). Hence, in this study the dichotomy between "push-pull" and "stick-stay" was replaced by the division in micro, meso and macro-levels of analysis. Once attributed all these factors from the MoHProf findings to their respective level, it is now time to analyse some peculiarities that emerged from the analysis of EU flows, abiding by the PROMeTHEUS project.

3.3 Peculiarities of EU context

Apart from the distinctive legal framework that was analysed in Chapter 1, the European Union presents some contextual features, which strongly affect migration choices. In the process of building a model for understanding the determinants of healthcare professionals' mobility, discerning these features appears a key stage. The EU healthcare workforce is currently facing several challenges, which derived from distinct spheres: in the economic field, the crises of 2007 and 2008 have brought down more than one Member State; as we saw in the Italian case study, consequences invested also the healthcare sector, which have experienced unprecedented expenditure cuts. Then, from a political point of view, the enlargement process brought 12 new Countries in the European Union, with the following impact on the labour market. Last, but not least, from a social perspective, demographic trends affect the EU healthcare professionals' mobility, both in direct and indirect ways: as far as the former are concerned, the ageing of population influence the need for specific professionals, but also the structure of the workforce. Instead, among the indirect ways, the most important is the change in population's needs. From a theoretical point of view, these elements might play the role of intervening variables, since they belong to the changing environment where the professionals take their decision: their temporary feature should affect their importance. However, given that the aim of this study is to provide policy-makers with a model to better manage current mobility issues, EU contextual

factors will be treated as independent variables; finally, in the last chapter, these determinants will be framed in their specific level of analysis and ascended to the general theories described in the previous section.

Abiding by the available data, the overall impact of EU enlargement, economic crises and demographic trends seems to have increase the magnitude of professionals' flows within the EU. In particular:

> «most of the EU-15 countries for which data were available show a rise in yearly inflows [..]. Outflows from the EU-12 countries appear to have increased [..]. Moreover, even some of the EU-15 countries have experienced increasing outflows. All three of these developments point towards increasing levels of mobility on the whole» (Maier et al, 2011).

The aim of this section is to analyse each of the aforementioned factors, underlining their specific impact on mobility choices and highlighting their level of analysis. Once carried out this task, it will be possible to build a theoretical model to understand the multi-level determinants of healthcare professionals' mobility, focusing on which paradigm is more influencing.

3.3.1 The economic crises and their impact on mobility

The economic and financial crises that broke out in 2007 and 2008 represented a major shock throughout the world; the severity of their impact varied across EU Member States, depending on the stability of national economies. There are two main ways in which the economic crises affected healthcare workforce mobility; the first belong to a macro-level of analysis and is strictly related to the impact on the healthcare system in general, whereas the second is linked to the micro-world of individual preferences.

As aforementioned, the healthcare sector did not remain unscathed from the backlashes of the crises; rather, according to OECD data, Germany is the only Country that have not experienced a decline between *pre* and *post* healthcare spending. Obviously, Member States reacted differently to the crises, depending to their structural economic situations; for instance, Greece, Spain and Italy, which were (and are) featured with high public debts, strongly intervened on national expenditures. The amount of cuts in the healthcare spending rapidly affected the workforce:

> «being the key expense in health care, health workforce raises temptations to restrict it in its growth or even achieving its contraction as that can bring about significant savings[51]» (Albreht, 2011).

While it is difficult to assess the extent to which the reduction in the stock of professionals is directly linked to the economic and financial crises, the features of the healthcare labour market, particular its labour-intensity, suggest that, at least, their impact plays a role (Dussault & Buchan, 2014). Triggered by the economic crises, changes in the stocks of healthcare professionals clearly affect the both the magnitude and the paths of migration flows. The lack of accurate data does not allow to exhaustively explain how national cuts to healthcare expenditure have influenced mobility; however, as aforementioned, the EU experienced an overall increase in migration flows. By contrast, as far as paths are concerned:

> «the key is to recognize that the actual impact on different flows may be in different directions in different Countries, and that it is important to consider the impact – if any – on each component flow in order to make an overall assessment» (Dussault & Buchan, 2014).

As confirmed by the case studies, national mobility profiles are pivotal for understanding

[51] Apart from staff reduction, there are several other ways in which cuts to healthcare expenditures may affect the healthcare workforce. For instance, reducing social security benefits for professionals or lowering salaries may represent alternative solutions.

migration flows; as matter of fact, findings from the PROMeTHEUS project reported that pre-existing employment's situation act as a key determinant for the impact of the economic crises.

At a macro-level, together with cuts to healthcare expenditures, governmental authorities responded also with some protectionist measures, particularly in the national labour markets. In this framework, for instance, EU Member States have decided to adopt stricter immigration policies; consequently, as highlighted also by the OECD, a slowdown in overall migration was experienced between 2008 and 2010 due to the effects of the economic and financial crises (OECD, 2012). This new element seems to clash with the previous finding about the increase in EU flows' magnitude; however, this difference provides the chance for a new interpretation of the results. Indeed, as highlighted in the PROMeTHEUS project, «a pattern of relatively more inter-EU mobility, combined with lower levels of into-EU mobility» (Dussault & Buchan, 2014) has emerged after the economic and financial crises. As a matter of fact, Member States were constrained by supra-national considerations, namely EU legislation; due to the freedom of movement of workers, restrictive measure could have been implemented to non-EU migrants only.

The difficulty to assess the extent to which the effects of the economic crises impacted on mobility choices reflects also at the micro-level of analysis; the obvious methodological problems were faced also by the MoHProf project, which, however, partly succeed in providing a reliable amount of accurate data. As seen in the previous section, economic considerations play a key role in individual mobility choices, particularly with regard to the perception of personal situation (Tjadens et al, 2013). Furthermore, findings from the PROMeTHEUS project show that:

> «the global financial crisis may have intensified motivations for migration or may have slowed them if fewer job opportunities were available in destination Countries» (Maier et al, 2011).

This statement cope with the conclusions from the MoHProf project and provide another

important conclusion for this analysis: the economic crises had surely an impact. Quantifying this impact appears an extremely difficult task; nonetheless, several studies pointed out that:

> «Where a feasible end-destination exists, this has meant that the flow has been towards perceived "better" employment and career prospects. As such, this is no different from other periods. What the crisis has done is sharpen the relative differences between prospects in the current location and the potential destination, and to increase the "push" factors to motivate individual health workers to move» (Dussault & Buchan, 2014).

This means that the impact of the economic and financial crises at the macro-level is important for mobility choices, as long as consequent policy responses affect micro-level elements, such as personal motivations for leaving.

To sum up, the economic and financial crises influenced healthcare professionals' mobility within the EU both at a macro- and micro-level of analysis; as far as the former is concerned, the impact increased the magnitude of flows inside the Single Market Area, confirming the finding of the second chapter of this study: the freedom of movement for workers, and EU legislation in general, limiting Member States' immigration restrictive policies, played a major role in influencing healthcare professionals' mobility. However, national policy responses are important, because they may produce consequences that impact on individual preferences' frameworks. The second key finding concerns the micro-level of analysis: according to the available data from the EU projects, the economic and financial crises affected individual motivations in taking mobility choices, directly influencing their economic considerations. Combining these two outcomes, a key conclusion come into play: given the pre-existing situation of freedom of movement for workers, the increased magnitude of mobility of flows must be significantly related to the impact of the crises; hence, the economic and financial crises affected mainly the micro-level of analysis in both direct and indirect ways. As summarized by the PROMeTHEUS project:

> «there is more evidence suggesting that the impact of the crisis has been a net increase

in health worker flows at national level, rather than reduced flows. In part, this reflects free mobility for doctors, nurses and midwives across the EU, which cannot be constrained by governments, who may increase barriers to entry for non-EU health workers. In part, it reflects diminishing job and career prospects and a related increase in "push" factor for health workers in some health systems, most notably in countries of the south and east of the EU» (Dussault & Buchan, 2014).

3.3.2 EU enlargements: new flows within the EU

Between 2004 and 2007 the EU experienced two enlargements that almost doubled the number of Member States, which shifted from 15 to 27. The total population increased by approximately 100 million citizens, strongly impacting the EU labour market (Ognyanova et al, 2014). From a geopolitical point of view, the two enlargements were a consequence of the dissolution of the USSR and involved most of the Eastern European Countries that once were under the aegis of the Russian Federation. According to the Eurostat database, the economic performance of the new Member States was well below the average of the EU15[52]; as far as the healthcare sector was concerned,

> «in many Countries, the crisis in public finance has led to a lack of resources in the health sector. On average, pay and working conditions for health workers in the new EU Member States are still considered to be worse than those of the old Member States [..]. Because of this income gap [..] many expected a mass migration [..] from the new EU Member States» (Ognyanova et al, 2014).

As aforementioned, the lack of a complete and accurate database on healthcare professionals' mobility exacerbated the difficulties in assessing the extent to which an event, namely the

[52] EU15 refers to the EU Member States before the enlargements of 2004 and 2007, whereas EU12 are those which accessed the EU in the same years

economic and financial crises in the previous section and EU enlargement now, affect migration flows; however, findings from the PROMeTHEUS project constitute a good approximation.

The first thing to say is that the magnitude of healthcare professionals' mobility flows has increased after the EU enlargements of 2004 and 2007; in particular, «the PROMeTHEUS data show that outflows from the new EU Member States towards the western region of the EU increased» (Ognyanova et al, 2014). As shown by the data of those EU15 Countries involved in the study, the number of both physicians and nurses experienced a relevant growth between 2004 and 2008; also, the Regulated Professions Database confirm this finding, reporting a significant increase in the recognitions of diplomas and professional qualifications in the same years.

Once acknowledged that EU enlargements fueled mobility from EU12 to EU15 Countries, there are two elements, which deserve more attention in the framework of this study. On the one hand, from a macro point of view, analysing the possibility for EU15 Member States to enact temporary restrictive policies with regard to EU12 migration inflows; on the other hand, from a micro point of view, verifying the impact of EU enlargements on mobile individuals and their motivations.

According to the transitional arrangements agreed in the accession treaties, EU15 Member States were provided with the authority of enacting restrictive measures in their national labour markets. However, the European Commission has circumscribed the scope of these interventions to the transitional period[53]; as a matter of fact, the last restrictions for those Countries that accessed in 2004 were lifted in 2011[54], whereas in 2014 for those which entered in 2007[55]. Concretely speaking, these measures consisted in the need of obtaining work permits

[53] The period that intervenes before a Country gets full accession to the EU

[54] See also European Commission (2011), "Free movement: workers from eight Member States that joined EU in 2004 finally enjoy full rights", EU Press Release IP/11/506, Brussels, 28 April 2011

[55] See also European Commission (2014), "End of restrictions on free movement of workers from Bulgaria and Romania - statement by László Andor, European Commissioner for Employment, Social Affairs and Inclusion", EU Press Release, Brussels, 1 January 2014

for healthcare professionals, but also in the incomplete application of Directive 2005/36/EC on mutual recognition of diplomas and professional qualifications[56]. Evidences from the PROMeTHEUS project showed a striking difference between EU15 Countries' inflows which restricted their labour market and those which did not; for instance:

> «In Germany[57], one of the Countries that delayed full labour market access for the longest period possible, the restrictive labour market approach may have been one of the reasons why, against expectations, the migration of health professionals from Eastern Europe did not produce a mass exodus right after the 2004 EU enlargement» (Ognyanova et al, 2014).

The fact that temporary labour market restrictions played a role in constraining migration flows after the EU enlargements confirm previous findings of this study; while national policies may affect mobility flows, EU legislation, whose aim was (and is) removing any internal barrier to the free circulation of workers, plays a stronger role. In this case, the temporary feature of allowed labour market restrictions represented the brawn of EU's brain.

As far as the micro-level of analysis is concerned, economic considerations played a key role also in those healthcare professionals who decided to move due to the EU enlargements. There are two evidences from the PROMeTHEUS project that confirm this trend; the first is directly linked to the micro-level aspect of mobility flows, whereas the second has a secondary impact. The former consists in a simple acknowledgement of the importance of economic aspects for individuals' choices: among the EU12 Countries, the worse the economic condition, the higher the outflows towards EU15 Countries. For instance, «in Romania, the substantial rise in mobility resulting from both EU enlargement and the financial crisis *appeared* to be of critical

[56] As witnessed by Italy, one of the possible consequences of the labour market restrictions was the development of a partly non-legal migration of some categories of professionals, especially long-term care nurses. For further reading, see Ferrè et al (2014)

[57] The opposite situation was registered by the United Kingdom; for further reading, see Young R. (2011)

concern» (Ognyanova et al, 2014).

The latter evidence requires a further step; as aforementioned, national statistics of healthcare workforce are a major driver for mobility choices. In this framework, the role of international recruitment in order to cope with professionals' shortages has already been highlighted. However, especially after the EU enlargements of 2004 and 2007, several challenges emerged; in particular, the expected massive outflows from EU12 towards EU15 Countries raised serious concerns about the ethical aspects of international recruitment. The main issue was related to the risk of causing, or worse, exacerbating shortages in new EU Member States. Consequently, various efforts were undertaken both at European and International level, with the WHO Code of Practice for the International Recruitment of Health Personnel adopted in 2010 representing the main result. Despite these commitments, as aforementioned for Romania, other EU12 Countries were forced to intervene in order to avoid a massive exodus of their healthcare workforce. The most common measures consisted in increasing wages and improving working conditions (Ognyanova et al, 2014); as a result, according to the PROMeTHEUS project: «In several Countries, including Estonia, Poland and Lithuania, return migration was observed, presumably as a result of policy changes» (Ognyanova et al, 2014). In this case, national policies decisively affected mobility flows of healthcare professionals; however, as it was the case for policy responses to the economic crises, their effectiveness was mainly due to the fact that they have touched the sphere of individual preferences. Indeed, micro-level of analysis plays once again a stronger role in understanding mobility choices of healthcare professionals. To sum up:

> «recruitment activities of national, regional and private institutions in response to the emerging shortage of health professionals in the destination countries greatly foster migration [*but*] higher remuneration, better working conditions and training opportunities are the main incentives for health professionals to move» (Ognyanova et al, 2014).

Finally, in this section, it is only the case to recall the importance of migrants' networks; as highlighted by the push factors for healthcare professionals' mobility outlined in the previous sections and confirmed by the findings of the case studies, the presence of a relevant migrants' community fuels new inflows, especially of compatriots.

3.3.3 Demographic trends: the changing healthcare workforce

As aforementioned in the section about the economic and financial crises, also non-direct effects on healthcare professionals' mobility must be taken into account. In that case, it was highlighted how the impact on national economies and health systems was reflected in professionals' migration choices; as far as demographic trends are concerned, the same procedure occurs. In particular, there are several indirect ways in which workforce mobility can be influenced by demographic considerations, especially in the healthcare sector; however, before proceeding with the analysis, it should be explained why the EU is featured with a peculiar demographic situation.

Throughout this work, it has been underlined that two main trends are affecting EU demographic profile: ageing of population and low birth rates. Each European indicator shows a critical situation: in particular, the percentage of people aged between 65 and 79 years old has undergone a constant increase since 2005, shifting from 12,6 % to 13,8 % in 2016. The same applies for the percentage of population over 80 years old, which went from 4 % to 5,4 % (Eurostat, 2016). Also, life expectancy at birth experienced an increase in the same years, ranging from 78,4 in 2004 to 80,6 in 2016; all these data are reflected in the sharp growth of European median age, which raised from approximately 37,5 in 2001 to more than 42,5 in 2016, increasing *de facto* the old-age dependency ratio[58] that stems today at more than 52 % (Eurostat,

[58] «This indicator is the ratio between the number of persons aged 65 and over (age when they are generally economically inactive) and the number of persons aged between 15 and 64» (Eurostat, 2016)

2016).

Likewise, the situation for birth rates shows no reasons to be optimistic; data highlight that total live births declined from approximately 7,5 million in 1961 to slightly more than 5 million in 2015 (Eurostat,2016). Furthermore, according to existent statistics, there is no single EU Country that get close to national birth rates' levels of 1960s; in particular, nowadays the average live births per woman does not exceed the value of 1,96 registered in France, attesting at 1,58 for the EU28 (Eurostat, 2016).

While in the previous section these features were framed in the general theories of international migration, it is now time to focus their impact on healthcare professionals' mobility choices. As aforementioned, the ageing of population produces a double effect: on the one hand, it directly affects the structure of the workforce, raising retirement ages and lengthening individuals' working age. On the other hand, it changes patients' needs, shifting the focus of health services to long-term care. Both these phenomena may affect workforce mobility: the former can induce sectoral oversupplies, pushing young professionals to move abroad looking for job opportunities. This was the case for the outflows of Italian medical doctors, who chose to live their Country due to the lengthening of current professionals' careers (Bertinato et al, 2011). However, as shown by the case study, data provide a different picture, with no massive outflows experienced due to other individual considerations, mainly economic (OIS,2016). By contrast, new requirements in the health services' sphere had a strong impact in Italy, exacerbating the pre-existing shortage of long-term care personnel (Bertinato et al, 2011). The increasing need for specialised nurses generated massive migration also in the other case study analysed, namely Belgium, which experienced high inflows, especially from Romania (Gerkens & Merkur, 2010).

To sum up, peculiar demographic trends of the EU affected healthcare professionals' mobility; nonetheless, the two discernible effects provided a key finding, which confirmed the importance of micro-level factors in migration choices. As a matter of fact, the Italian case

showed that economic considerations related to career possibilities preponderate on any other aspect, which in this case are represented by demographic trends. Moreover, the inflows of long-term care and specialized nurses confirm the importance of shortages and oversupplies in determining professionals' migration already acknowledged in Chapter 2. However, individual considerations still play the key role in mobility choices, as underlined by the findings of the case studies; moreover, the fact that ever more professionals migrate and establish themselves in partly non-legal ways (Ferrè et al, 2014), underlines the importance of micro-level considerations.

Chapter 4: Towards a multi-level approach for understanding mobility choices

Building a single model for explaining a complex phenomenon such as international migration is certainly an ambitious, and still not realised, project (Massey et al, 1998); the objective of this study was to restrict the scope of the analysis, in order to carry out a more effective result. Hence, as outlined in the introduction, several boundaries were set up; among these, the most important for this last chapter is that limiting the analysis to healthcare professionals' mobility within the EU allowed for both practical advantages and improved efficacy. In particular, the chronical lack of reliable and accurate data at the national level was partly overcome through the use of EU databases; moreover, as aforementioned, the EU framework is featured with some peculiarities that were worth analysing. Together with the freedom of movement for workers and mutual recognition of diplomas and professional qualifications, also those elements highlighted in the last section of Chapter 3 contributed to perform a more efficient analysis.

So far, this study has highlighted several findings; abiding by the analysis of the legal framework carried out in Chapter 1, the following sections showed that a quantitative analysis of the flows is necessary but not sufficient for understanding mobility choices. Moreover, the case studies drew attention on the importance of the EU, rather than national, framework. Then, Chapter 3 started with a description of the general theories of international migration, which was followed by the analysis of the main determinants that explain healthcare professionals' mobility. Finally, the last section focused on three current circumstances that made the analysis more updated; the key findings will be now framed in the general theories of international migration, in order to provide a stronger theoretical basis for understanding mobility choices: the aim is to show that a multi-level approach is required. This chapter is structured as follow: the first section will focus on the macro-level of analysis, underlining those aspects that play a role in mobility choices and attempting to frame them in the general theories outlined in the

previous chapter. Then, the same procedure will be performed with meso and micro-level elements. In the end, some concluding remarks will help to sum up all the findings.

4.1 Macro-level

To fully comprehend the importance of macro-level aspects in mobility decisions, it is useful to recall one of the key findings from the case studies: a macro-approach must focus on the European rather than national level. Several elements provide a strong background for this assumption, with the EU legal framework explained in Chapter 1 playing the leading role. As a matter of fact, the freedom of movement for workers and the mutual recognition of diplomas and professional qualifications have proved to be crucial in affecting healthcare professionals' mobility. Overall, available data have shown that the EU framework, together with the particular circumstances outlined in the previous chapter, have increased the magnitude of flows. Moreover, as acknowledged by Dussault & Buchan (2014), mobility within the EU experienced a more relevant growth with respect to non-EU paths of migration. In fact, while any Member State may enact labour market restrictive policies towards third Countries, Single Market provisions, such as freedom of movement for workers and mutual recognition, prevent to do the same with fellow Member States[59]. Consequently, especially during periods of crises, non-EU flows experience a significant reduction in magnitude with respect to intra-EU paths.

Several quantitative elements support the importance of the EU framework; in particular, this study has highlighted two main evidences. The first was among the findings of the case studies; both Italy and Belgium, in order to face national shortages, tried to facilitate workforce immigration, simplifying bureaucratic paths and, consequently, alleviating migration costs. Nonetheless, according to available data, the majority of flows involve EU rather than non-EU Countries (Bertinato et al., 2011; Gerkens & Merkur, 2010). The second evidence stems from

[59] Unless, as aforementioned, established by the transitional measures agreed in the accessions' Treaties

the discussion about the EU enlargement and relates to the effectiveness of agreed transitional measures for the EU12; as aforementioned, the fact that these restrictive interventions succeeded in reducing flows, confirmed the importance of Single Market provisions for healthcare professionals' mobility choices. Given that transitional measures must be allowed by the EU, which also sets their expiration dates, this finding also certify the stronger role that Brussels plays in influencing migration choices[60]. In sum, «national policies for human resource planning are often bypassed, neutralized or overridden by EU law» (Baeten & Jorens, 2006).

This conclusion should not come as a surprise; the EU has always sought to remove any internal national barrier for the completion of the Single Market, aiming at replacing Member States' authorities for regulatory issues[61]. As stated in the TFEU,

> «the European Parliament and the Council shall, acting in accordance with the ordinary legislative procedure and after consulting the Economic and Social Committee, issue directives or make regulations setting out the measures required to bring about freedom of movement for workers [..], in particular: [..] by abolishing those administrative procedures and practices and those qualifying periods in respect of eligibility for available employment, whether resulting from national legislation or from agreements previously concluded between Member States, the maintenance of which would form an obstacle to liberalisation of the movement of workers» (TFEU, 2007).

However, Chapter 3 have shown the extent to which some national interventions succeeded in influencing healthcare professionals' mobility flows; in particular, it was demonstrated that policies affecting economic parameters, such as wages and working conditions, produce decisive backlashes on individuals' migration choices. Hence, the second key finding is that

[60] This was also made clear by the Belgian case study, where the quota system was able to influence migration flows, but less than the European framework; for further information, see Chapter 2

[61] As aforementioned, the Single Market has always been a key concern for European authorities; even the issue of workers mobility was mainly seen as part of the bigger picture

macro-level elements are relevant as long as they affect the micro-sphere where migrants take their decisions.

Apart from national policies, another macro-element that might influence mobility choices of professionals trace back to cultural features; in particular, as shown in Chapter 3, propensity to move is also something that relies on historical inheritance. Data have shown that Countries that are featured with a sending tradition, are more likely to experience outflows; on the other hand, traditionally recipient States have high probability to be exposed to inflows (Tjadens et al, 2013).

Finally, the last macro-element that must be taken into consideration is the mobility profile of the Country; as aforementioned, shortages and oversupplies are pivotal features for understanding mobility flows. Although Member States cannot be categorised on the basis of quantitative considerations, the lack of personnel usually generates inflows, whereas high number of professionals induce outflows; therefore, a reliable model that sought to explain mobility choices cannot ignore this aspect. Nonetheless, this is not over; as a matter of fact, the individual decision is not strictly dictated by national statistics. The Italian case study sheds some light on this element: the massive outflow of medical doctors, due to the high number of registered professionals, did not take place; at least not with the expected magnitude. According to OIS (2016), sometimes other considerations, such as higher career prospects due to the probable retirement of the current workforce, have a greater influence on migration choices. Hence, as aforementioned, imbalances in labour supply and demand are necessary but not sufficient conditions to explain healthcare professionals' mobility within the EU.

This brings us to the general theory linked to the macro-level, namely Neo-classical economics. As shown in the previous chapter, it relies on the assumption that migration is generated by imbalances between labour demand and supply; according to the main theorists, individuals are rational actors that take their decisions on the basis cost-benefit considerations. Hence, as aforementioned, Neo-classical economics is also built on a micro-level assumption. According

to this theory, «international movement does not occur in the absence of differences in earnings levels and/or employment rates between countries» (Massey et al, 1998). This assumption clearly clashes with our finding from the previous paragraph; nonetheless, Neo-classical economics helps partly explains professionals' migration, taking into account the importance of national workforce statistics.

As far as the other findings are concerned, no general theory of international migration fully catches both the importance of the EU framework and national policies in shaping individual choices. However, rational choice and historical institutionalism paradigms provide useful insights; while sharing with Neo-classical economics the assumption of individuals as rational actors, rational choice institutionalism highlights the importance of institutions in shaping the environment where personal choices are made, «leading actors toward particular calculations and potentially better social outcomes» (Hall & Taylor, 1996). By contrast, sociological institutionalism helps to comprehend the importance of cultural inheritances in shaping phenomena, such as migration.

To sum up, the macro-level of an ideal model that sought to explain intra-EU healthcare workforce migration must include four key elements: first of all, the legal framework constituted by EU legislation, whose pillars are freedom of movement for workers and mutual recognition of diplomas and professional qualifications; second, national policies shall be taken into account only if they touch the micro-sphere of individual preferences. Third, historical Countries' features may influence current mobility profiles. Fourth and lastly, imbalances between labour supply and demand are pivotal conditions for mobility flows, as suggested by Neo-classical economics. however, other levels of analysis are necessary to build an exhaustive model. As far as these elements are concerned, rational choice and sociological institutionalism provide a solid theoretical background.

4.2 Meso level

As seen in chapter 3, when choosing to move, meso-level factors play a significant role; from, this point of view, there are two key aspects: the first one is related to the unit of analysis, whereas the second one is linked to the concept of social network. According to the findings of the MoHProf project, mobility choices are often taken by larger actors, such as households or families; this brings into play new factors with regard to what really drives migration flows. In particular, to cite some of the push factors highlighted in Chapter 3, considerations about educational future for children or career prospects for spouses are involved in mobility choices; hence, while the focus continues to be on individuals as rational actors, which take decisions on a cost-benefit analysis basis, some meso-elements come into play. In this case, these aspects are linked to the individual sphere through informal relations (Liu et al, 2017) that make the «actors and their actions [..] interdependent rather than independent, autonomous units» (Wasserman & Faust, 1994).

As suggested by the first element, the most important meso-level aspect is the role of social networks in affecting phenomena, such as healthcare professionals' mobility; generally speaking, the key feature of a social network perspective is «the importance of relationships among interacting units [*which*] «are linked to one another by social ties» (Wasserman & Faust, 1994). Generally speaking:

> «A social network consists of a finite set or sets of actors and the relation or relations defined on them. The presence of relational information is a critical and defining feature of a social network» (Wasserman & Faust, 1994).

According to the analysis carried out in this study, two main kinds of interactions affect healthcare professionals' mobility choice; the first one is featured by «association or affiliation» (Wasserman & Faust, 1994) relationships, whereas the second one relies on cultural or affective

linkages.

As shown in Chapter 3, among the factors individuated by the MoHProf project, a more developed working environment, is one of the elements that push healthcare professionals to move. This consideration is valid from different point of views; for instance, a more advanced and ambitious context results as more attractive for inflows, but also the possibility to reach higher degrees in the professionals' hierarchy plays an important role. However, in the same section it was acknowledged that migrants often choose to move pushed by past experiences of relatives, friends or simply compatriots.

The importance of social networks' considerations when trying to explain mobility choices becomes much clearer through the analysis of migration paths that have followed the EU enlargement. As seen in Chapter 2, both Italy and Belgium experienced significant inflows from a restricted set of sending Countries; in particular, it is true that Romanian nurses penetrated in the Belgian labour market due to language proximity and bilateral agreements (Gerkens & Merkur, 2010), but, as highlighted by the MoHProf project, the presence of migrants' communities increases the individual propensity to move, especially if composed by a large share of compatriots.

These elements ring a bell with regard to the general theories that try to explain international migration; in particular, the importance of migrants' networks is highlighted by the Social Capital Theory. According to this approach, the independent variable of mobility phenomena is the cost of migration that may be lowered by the presence of migrants' networks;

> «migrant networks are sets of interpersonal ties that connect migrants, former migrants, and non-migrants in origin and destination areas through ties of kinship, friendship, and shared community origin. They increase the likelihood of international movement because they lower the costs and risks of movement and increase the expected net returns to migration. Network connections constitute a form of social capital that people can draw upon to gain access to various kinds of financial capital» (Massey et al, 1998).

The Segmented Labour Market Theory also come into play as far as flows deriving from the EU enlargement are concerned; according to this approach, migration is driven by labour-demand mechanisms in advanced Countries. This may occasionally lead towards massive inflows and the formation of «ethnic enclaves» (Massey et al, 1998) for specific sectors; As shown by the Belgian case study, this was exactly what happened with Romanian nurses (Gerkens & Merkur, 2010). Nevertheless, the Segmented Labour Market Theory does not take into consideration the individual aspect, asserting «that international migration stems from the intrinsic labour demands of modern industrial society» (Massey et al, 1998); having already acknowledged that national statistics regarding shortages and oversupplies are not enough to explain professionals mobility and established that migration choices are mainly individual, the Segmented Labour Market Theory cannot be taken into account, neither for the meso-, nor for the macro-level.

To sum up, meso-level considerations underline two key aspects for building a model to explain healthcare professionals' mobility; the first one is related to the unit of analysis: since migration choices take into account larger units, an exhaustive model seems to involve a different focus. However, the ultimate decision traces back to individuals, who perform a cost-benefit analysis evaluating a larger spectrum of motivations, including, for instance, familiar considerations; hence, the unit of analysis of the final model will remain the individual. As far as the importance of social networks is concerned, social capital theory will constitute the theoretical approach to entail meso-level aspects of healthcare professionals' mobility choices within the EU.

4.3 Micro level

What should be clear at this point of the analysis is that micro-level elements are those that mostly affect healthcare professionals' mobility choices. As previously highlighted, migration decisions are taken by individuals, which represent the key unit of analysis; moreover, Chapter

3 shed some light on the most important micro-level aspect that play a role in influencing mobility flows: individual self-realization. According to the MoHProf and PROMeTHEUS projects, considerations regarding wages, career prospects in terms of hierarchy, working conditions and social status are the main factors that push EU professionals to leave their Country for another Member State.

If self-realization represents the lowest common denominator among the micro-level elements that influence mobility choices, money is the factor that weights the most. According to the findings of the EU projects, «income is the most cited factor in deciding whether or not to migrate, and influences leavers, returnees and those who remain» (Glinos et al, 2011). However, self-realization display itself also through other elements:

> «The other most often mentioned motivation in the country case studies is working conditions. This includes the working environment, terms of employment, work relations and access to infrastructures. Low social recognition and/or low esteem were also mentioned relatively frequently» (Glinos et al, 2011).

The importance of perceived self-realization is reflected in the incidence of specific national policies that touched either salaries or working conditions on migration; as seen in Chapter 3, government interventions on these two elements generated immediate impact on mobility flows (Ognyanova et al, 2014).

The fact that individuals take their mobility decisions on the basis of such considerations should easily link micro-level aspects to the already known theory of Neo-classical economics. As seen in the analysis of general theories of international migration, while the Neo-classical economics' macro-theory assumes that mobility is determined by imbalances in labour demand and supply, its micro-level equivalent links migration choices to individual perceptions and analysis. Migrants are seen as rational actors that take their decision evaluating possible costs and expected returns (Massey et al, 1998); however, according to this general theory, the only two parameters that individuals take into account are «earnings and employment rates». Hence,

seeing the results of previous section, Neo-classical economics is another necessary but not sufficient condition to explain healthcare professionals' mobility choices.

Concluding remarks

This study aimed at understanding which are the determinants of healthcare professionals' mobility within the EU and frame them in a theoretical model in order to provide policy-makers with a tool to improve the effectiveness of policy-responses to the issues generated by mobility phenomena inside the EU. The hypothesis underlying this work was that a single, macro-level approach, based on Countries' mobility profiles and policies is not enough to explain the phenomenon; rather, a multi-level approach is necessary in order to fully understand why healthcare professionals choose to move abroad to practice their profession. This study adopted an abductive reasoning: it started with the observation of the phenomenon of professionals' mobility, then proceeded confronting the main findings on determinants with the general theories and finally went back to the empirical context, analysing the peculiarities of such phenomenon. At the end of the analysis, the study traced the findings back to the general theories, in order to provide a strong theoretical background.

Chapter 1 outlined the main features of the legal framework where professionals choose to move. In particular, through the legislative analysis of the freedom of movement of workers and the Directives on mutual recognition of diplomas and professional qualifications, the first chapter aimed at explaining why the EU legal framework does play a key role in mobility choices.

Chapter 2 performs a quantitative analysis of the flows inside the EU, coping with the limited data available. After having acknowledged the increasing magnitude in the last years and the growing concerns that the issue is generating, a case study is performed on Italy and Belgium. The main finding is that the macro-context constituted by national workforce statistics and policies does not decisively affect mobility flows within the EU; rather, at a macro-level of analysis the legal framework outlined in Chapter 1 plays a stronger role. Hence, a quantitative analysis of the flows is not sufficient to explain healthcare professionals' mobility.

Chapter 3 provide the analysis with some qualitative aspects; through a deductive approach, it focuses firstly on the general theories of international migration, then on the specific factors that affect healthcare professionals' mobility and finally on the peculiar circumstances that have influenced the flows within the EU in the last years, namely the EU enlargement, the impact of the economic and financial crises and the demographic trends. The main finding of this chapter is that both push-pull factors and EU peculiarities play a role in determining healthcare professionals' mobility choices; since they belong to different levels of analysis, a multi-level model is required to understand mobility flows within the EU.

Finally, Chapter 4 attempts to frame the findings from the previous chapter in the general theories of international migration, in order to provide a strong theoretical background for explaining mobility choices. Macro and micro level factors are framed in the Neo-classical economics theory; however, at the macro-level of analysis the role of the EU framework must be taken into account. Abiding by rational choice institutionalism, it is useful to underline that the environment where individuals take their decisions is profoundly shaped by EU legislation, which plays a stronger role in affecting mobility choices. Meso-level factors are instead framed in the social capital theory, which entails the importance of social networks in affecting migrants' decisions.

To conclude, the quantitative and qualitative analysis of healthcare professionals' mobility flows within the EU highlighted that national mobility profiles and policies are not enough to explain the phenomenon, validating the hypothesis of this work. However, several evidences showed that the EU legal framework must be taken into consideration when discussing the macro-level factors that influence professionals' mobility. Furthermore, the analysis has underlined the importance of micro and meso-level factors, because, as outlined by the conclusions of the PROMeTHEUS project, «one must look at the individual migrant in order to fully grasp health professional mobility and its diversity». Hence, a model aiming at explaining the phenomenon of healthcare professionals' mobility within the EU must entail a macro-level of analysis, where the focus is on the EU rather than national point of view, a meso-

level, entangling the pivotal role of social networks and a micro-level based on individual preferences, without forgetting that, after all, «mobility, particularly within the EU, hinges on an individual's decision to move» (Glinos et al, 2014).

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Appendix I

//	**Italy**	**Belgium**
Total number of doctors (OECD, 2015)	233.102	34.020
Total number of nurses (OECD, 2015)	330.602	122.127
Total number of inflows of doctors (Regulated Professions Database, 2016)	1.409 + 49 (EFTA Countries)	5.747 + 74 (EFTA Countries)
Total number of inflows of nurses (Regulated Professions Database, 2016)	4.094 + 18 (EFTA Countries)	4.868 + 22 (EFTA Countries)
Total number of outflows of doctors (Regulated Professions Database, 2016)	5598 + 4451 (EFTA Countries)	2.517 + 611 (EFTA Countries)
Total number of outflows of nurses (Regulated Professions Database, 2016)	4.500 + 1.147 (EFTA Countries)	1.358 + 262 (EFTA Countries)

This table integrates three different sources of data, which were put together in order to cope with the lack of reliable and accurate statistics at the national level. Stock of medical doctors

and nurses were taken from the OECD and Eurostat online database that were updated to 2015. Unfortunately, data on mobility flows consist in an approximation drawn by the European Regulated Professions Database; these statistics cannot be considered as an accurate quantitative description, since they only took into account the intention of a professional to move abroad. Nonetheless, it is the most reliable source with regard to mobility flows.

Summary

Human resources are pivotal in the healthcare sector which is clearly labour intensive. Among the most debated issues in this field, workforce mobility has represented a growing concern in the last years; in particular, the two major questions regarded its impacts on quality of services and the ethical consequences derived from international recruitment.

At European level the focus was put on quality issues derived from shortages and oversupplies, which affect the majority of Member States, as highlighted in the Commission Staff Working Document on an Action Plan for the EU Health Workforce (2012). Quantitative data helped to show the gravity of the situation; according to European Commission's projections, a lack of approximately 2 million professionals will affect the EU in 2020. In the Commission Staff Working document on an Action Plan for the EU Health Workforce, «Member States agreed on the added value of European cooperation to help tackle EU health workforce shortages» (European Commission, 2012).

Shortages' concerns in the EU started growing between 2004 and 2008 when two major events occurred, bringing to light the issue of professionals' mobility: the EU enlargement and the economic and financial crises. Together with worries about demographic trends, they exacerbated the situation and, since then, «health professional mobility in Europe has become a fast-moving target for policy-makers» (Wismar, 2014). While factors influencing international migration may be somehow managed by Countries, in Europe push and pull factors are codetermined by EU policies on free mobility, the qualifications directive and many soft law initiatives.

As extensively underlined in the scientific literature, the EU is featured with some peculiarities that makes it a unique framework, as highlighted in chapter 1; moreover, workforce mobility assumed ever more relevance as far as the completion of Single Market was concerned. Several debates started revolving around the issue of international recruitment in the EU and, for the first time, the European context began to pay serious attention on professionals' rather than

patients' mobility; as a result, a relevant number of studies and projects were financed and launched, in order to analyse in depth the phenomenon of healthcare professionals' mobility and provide policy-makers with more accurate pieces of information.

This study draws from the conclusions of European projects, trying to frame the main findings on the motivations that push professionals to move abroad in a structured theoretical approach. The aim of this analysis is to contribute to the scientific literature on the field, organising in a single theoretical model the factors that affect professionals' mobility choices within the EU. This tool would help policy-makers in formulating adequate responses to the aforementioned issues derived from workforce imbalances. Therefore, the general research question points at understanding the determinants of healthcare professionals' mobility choices and classifying them according to their respective level of analysis, in order to build a theoretical model that could explain migration paths within the EU.

Determinants for mobility choices are classified according to their level of analysis: macro elements are those regarding the mobility profiles of Countries or the EU framework; meso aspects are those related to larger units of analysis or that take into consideration the importance of networks and, finally, factors regarding individual spheres are classified as micro. The hypothesis underlying this work is that healthcare professionals' mobility choices within the EU are determined by several elements that belong to different levels of analysis. In particular, the macro context constituted by the mobility profile of a Country and its national policies is not enough to explain why healthcare professionals decide to move; rather, a focus on the EU sphere is required. Moreover, other levels of analysis must be taken into consideration.

The first Chapter will focus on the EU legal framework, exhaustively outlining the complete set of provisions that deal with healthcare professionals' mobility; in particular, the first section will focus on the freedom of movement for workers, whereas the second part will explain the importance of the Directives on the mutual recognition of diplomas and professional qualifications. As far as the freedom of movement for workers is concerned, the completion of the Single Market required the free circulation of workers. The provisions of both primary and

secondary legislation, such as Regulation 492/11, furnished workers' rights to free movement; Member States have continuously tried to exploit the grey areas of EU legislation, in order to retain some degrees of national sovereignty, as it was the case for welfare and taxation treatments reserved to residents and non-residents. Despite the attempts of Member States, it is possible to highlight a progressive path towards the removal of barriers, strongly led by the work of the Court of Justice of the European Union (CJEU). The importance of mutual recognition is instead reflected in the continuous updating of the concerning directives.

Chapter 2 and Chapter 3 will be dedicated to a state of the art of the flows within the EU; first, a quantitative analysis will be performed. The reason behind this choice is that «the larger these movements the greater the likelihood of tangible impacts» (Maier et al, 2011). In this section, two case studies have been chosen to show if mobility profiles of Countries based on numerical statistics are enough to explain professionals' choices to move; This quantitative outlook will be carried out through the analysis of available data, scanning three different datasets: OECD health statistics, Eurostat database and The EU Single Market Regulated Professions Database. It is the case to underline that the lack of accurate and reliable data with regard to professionals' mobility constituted a limitation not only for this study, but also for the scientific literature in general.

The main finding is that the categorisation of Countries based on the quantitative analysis of the flows is misleading: from a qualitative point of view, Italy and Belgium cases show that sender and recipient labels cannot be conferred so easily. Moreover, on the one hand, the case studies have highlighted that national contexts partly influence mobility flows; on the other hand, data show that the EU context is a stronger determinant for healthcare workforce migration. Driven by Single Market considerations, through the legislative work and the ruling of the CJEU, the European Union sought to overcome national barriers and play a key role in regulating mobility inside its territory; therefore, from this point of views, a suitable macro approach should focus on the EU, rather than Member States. However, further aspects should be taken into account; this entails the importance of a micro and meso approach, because, after

all, «mobility, particularly within the EU, hinges on an individual's decision to move» (Glinos et al, 2014).

Chapter 3 will be instead dedicated to a qualitative analysis of the flows; first, a state of the art of the main general theories of international migration will be performed. Abiding by the analysis made by Douglas Massey, the theories will be presented dividing between those which regard the initiation and those which regard the perpetuation of international movement. clarifying which model is the most appropriate for health professionals' mobility should rely on a thorough, as well as challenging, empirical analysis of specific migration paths. The main push and pull factors for healthcare professionals' mobility will be identified through a document analysis of the main EU funded projects on the field; these factors will also be classified according to their dimensions, namely macro, meso and micro. factors that relate to the individual sphere belong to the micro-level of analysis; this may be due to several features: they can interfere with personal preferences and choices or simply be linked to individuals' perception of their situation; Factors that relate to larger units of analysis, such as households and families, or do not derive from strictly individual processes, such as social networks, belong to the meso-level; then, There are some factors that relate to a sphere that has nothing to do with individual preferences or social processes; together with micro and meso, also macro-level elements such as political institutions and health systems' structures affect migration choices of healthcare professionals.

Finally, the last section of Chapter 3 will focus on specific circumstances linked to the EU framework that affect healthcare professionals' mobility flows, namely the economic and financial crises, the EU enlargement and the demographic trends. To sum up, the economic and financial crises influenced healthcare professionals' mobility within the EU both at a macro- and micro-level of analysis; as far as the former is concerned, the impact increased the magnitude of flows inside the Single Market Area, confirming the finding of the second chapter of this study: the freedom of movement for workers, and EU legislation in general, limiting Member States' immigration restrictive policies, played a major role in influencing healthcare

professionals' mobility. However, national policy responses are important, because they may produce consequences that impact on individual preferences' frameworks (Ex. Estonia). The second key finding concerns the micro-level of analysis: according to the available data from the EU projects, the economic and financial crises affected individual motivations in taking mobility choices, directly influencing their economic considerations. Combining these two outcomes, a key conclusion come into play: given the pre-existing situation of freedom of movement for workers, the increased magnitude of mobility of flows must be significantly related to the impact of the crises; hence, the economic and financial crises affected mainly the micro-level of analysis in both direct and indirect ways.

As far as the EU enlargement is concerned, once acknowledged that EU enlargements fuelled mobility from EU12 to EU15 Countries, there are two elements, which deserve more attention in the framework of this study. On the one hand, from a macro point of view, analysing the possibility for EU15 Member States to enact temporary restrictive policies with regard to EU12 migration inflows. It was found out that national restrictive policies did play a role in influencing mobility; however, it is once again the EU that goes stronger, forcing Member States to lift such policies after a maximum of 7 years; on the other hand, from a micro point of view, verifying the impact of EU enlargements on mobile individuals and their motivations. In this case, it emerged that interventions on specific aspects of individuals' choices, for instance salaries, did influence mobility.

Peculiar demographic trends of the EU affected healthcare professionals' mobility; nonetheless, the two discernible effects provided a key finding, which confirmed the importance of micro-level factors in migration choices. As a matter of fact, the Italian case showed that economic considerations related to career possibilities preponderate on any other aspect. Moreover, the inflows of long-term care and specialized nurses confirm the importance of shortages and oversupplies in determining professionals' migration already acknowledged in Chapter 2. However, individual considerations still play the key role in mobility choices, as underlined by the findings of the case studies; moreover, the fact that ever more professionals migrate and

establish themselves in partly non-legal ways, underlines the importance of micro-level considerations. To sum up the conclusions from the last paragraph of Chapter 3: EU peculiar circumstances highlight the importance of micro-level determinants.

In conclusion, Chapter 4 will gather the findings on the factors and EU peculiarities that determine healthcare professionals' mobility and try to frame them in the general theories of international migration outlined in the first section of Chapter 3.

The macro-level of an ideal model that sought to explain intra-EU healthcare workforce migration must include four key elements: first of all, the legal framework constituted by EU legislation, whose pillars are freedom of movement for workers and mutual recognition of diplomas and professional qualifications; second, national policies shall be taken into account only if they touch the micro-sphere of individual preferences. Third, historical Countries' features may influence current mobility profiles. Fourth and lastly, imbalances between labour supply and demand are pivotal conditions for mobility flows, as suggested by Neo-classical economics. however, other levels of analysis are necessary to build an exhaustive model. As far as these elements are concerned, rational choice and sociological institutionalism provide a solid theoretical background.

The meso-level considerations underline two key aspects for building a model to explain healthcare professionals' mobility; the first one is related to the unit of analysis: since migration choices take into account larger units, an exhaustive model seems to involve a different focus. However, the ultimate decision traces back to individuals, who perform a cost-benefit analysis evaluating a larger spectrum of motivations, including, for instance, familiar considerations; hence, the unit of analysis of the final model will remain the individual. As far as the importance of social networks is concerned, social capital theory will constitute the theoretical approach to entail meso-level aspects of healthcare professionals' mobility choices within the EU.

What should be clear at this point of the analysis is that micro-level elements are those that mostly affect healthcare professionals' mobility choices. As previously highlighted, migration

decisions are taken by individuals, which represent the key unit of analysis; moreover, Chapter 3 shed some light on the most important micro-level aspect that play a role in influencing mobility flows: individual self-realization. According to the MoHProf and PROMeTHEUS projects, considerations regarding wages, career prospects in terms of hierarchy, working conditions and social status are the main factors that push EU professionals to leave their Country for another Member State.

If self-realization represents the lowest common denominator among the micro-level elements that influence mobility choices, money is the factor that weights the most. According to the findings of the EU projects, «income is the most cited factor in deciding whether or not to migrate, and influences leavers, returnees and those who remain» (Glinos et al, 2011). The importance of perceived self-realization is reflected in the incidence of specific national policies that touched either salaries or working conditions on migration; as seen in Chapter 3, government interventions on these two elements generated immediate impact on mobility flows.

The fact that individuals take their mobility decisions on the basis of such considerations should easily link micro-level aspects to the already known theory of Neo-classical economics. As seen in the analysis of general theories of international migration, while the Neo-classical economics' macro-theory assumes that mobility is determined by imbalances in labour demand and supply, its micro-level equivalent links migration choices to individual perceptions and analysis. Migrants are seen as rational actors that take their decision evaluating possible costs and expected returns (Massey et al, 1998); however, according to this general theory, the only two parameters that individuals take into account are «earnings and employment rates». Hence, seeing the results of previous section, Neo-classical economics is another necessary but not sufficient condition to explain healthcare professionals' mobility choices.

In conclusion, a multi-level approach is required, but some factors are more decisive than others in affecting mobility flows; the quantitative and qualitative analysis of healthcare professionals' mobility flows within the EU highlighted that national mobility profiles and policies are not

enough to explain the phenomenon, validating the hypothesis of this work. However, several evidences showed that the EU legal framework must be taken into consideration when discussing the macro-level factors that influence professionals' mobility. Furthermore, the analysis has underlined the importance of micro and meso-level factors, because, as outlined by the conclusions of the PROMeTHEUS project, «one must look at the individual migrant in order to fully grasp health professional mobility and its diversity». Hence, a model aiming at explaining the phenomenon of healthcare professionals' mobility within the EU must entail a macro-level of analysis, where the focus is on the EU rather than national point of view, a meso-level, entangling the pivotal role of social networks and a micro-level based on individual preferences, without forgetting that, after all, «mobility, particularly within the EU, hinges on an individual's decision to move» (Glinos et al, 2014).