HEALTH WORKFORCE MOBILITY IN THE SOUTH-EAST EUROPEAN HEALTH NETWORK REGION (SEEHN)

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Executive Summary

Dynamic health-related demographic and migratory trends are creating new challenges for health systems across Europe – nationally and regionally. The increasing out-migration of health professionals from low- and middle-income countries towards high-income countries of the European Union (EU) is becoming a crucial problem facing the health systems of the sending countries. The Council of the European Union recognizes that the ageing of the population and the health workforce, coupled with the growing number of major and chronic diseases, the changing needs of patients and of the health systems, the increasing mobility of patients and health care professionals, and the emergence of new technologies pose new challenges for all Member States, and require innovative approaches in training and supplying the health workforce of the future[1].

In recent years, many of these health workforce needs in the EU have been met by increasing numbers of migrating non-EU health professionals, including those from South-Eastern Europe (SEE). The situation in the SEE is alarming, due to substantial loss of qualified, trained health professionals from the Region. Through its collaborative efforts with the South-Eastern European Health Network (SEEHN), the International Organization for Migration (IOM) administered a survey, developed within the framework of the MoHProf Project[2], on the mobility of health professionals involving the member states of the SEEHN (Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Israel[3], the Former Yugoslav Republic of Macedonia, Moldova, Montenegro, Romania and Serbia), in order to determine the gravity of the situation.

Overall, the surveys reveal that the out-migration of highly trained and qualified health professionals is a prominent concern throughout the Region. With the EU as the primary destination for SEE health workers, the sending states recognize the need for the establishment of greater collaboration, data collection, formal agreements and codes of best practice between sending and receiving countries. Ensuring the best, most effective, and most equitable exchange between health systems in the present will not only facilitate the resolution of current healthcare needs within Europe, it will also promote the development of sustainable healthcare systems for the future needs of all.

[1] Council of the European Union. "Council Conclusions on investing in Europe's health workforce of tomorrow: Scope for innovation and collaboration." 3053rd Employment, Social Policy Health and Consumer Affairs Council meeting. Brussels, 7 December 2010.
[2] See project website for more information: http://www.mohprof.eu/LIVE/
[3] The survey was administered in 2010. Israel joined the SEEHN as the tenth Member State on 12 October 2011.

Introduction

In recent years, the issue of health professional mobility has received increased attention on the global scale. An international seminar on the "Migration and Human Resources for Health: From Awareness to Action" was held in Geneva, March 23-24, 2006 organized jointly by the International Organization for Migration (IOM), the World Health Organization (WHO) and the International Labour Organization (ILO), and recommended the establishment of an observatory to track and monitor the global migration of health workers as well as the development of Codes of Practices for International Recruitment of Health Care Workers.

Subsequently, this issue has received increased attention in Europe, as in the Council of Europe's 8th Conference of Ministers of Health "People on the Move: Human Rights and Challenges for Health Care Systems" held in Bratislava, November 22-23, 2007. The conference drew attention to the fact that "[t]he growing mobility of health care workers including mobility within the 47 Council of Europe member states favours some countries while at the same time deprives selected countries of highly trained and much need professionals"[4]. Therefore, the Ministers recommended a greater level of management, surveillance and cooperation between governments and organizations on public health issues related to international migration, at the international, national and community level[5]. On 24 May 2008, the Sixty-first World Health Assembly (WHA) called on all United Nations (UN) member states "to contribute to the reduction of the global deficit of health professionals and its consequences on the stability of health systems and the attainment of the Millennium Development Goals"[6]. These actions further increased the global visibility of health professional mobility in the face of drastic demographic changes across the world and particularly in Europe.

The ageing populations of industrialized countries are rapidly increasing the demand for skilled healthcare workers in both the public and private healthcare sectors, effectively overburdening the health systems. The need to urgently address these issues was acknowledged by the European Commission's Strategy for Action on the Crisis in Human Resources for Health in Developing Countries[7] in 2005 and in the Green Paper on the European Workforce for Health[8] in 2009. Furthermore, in order to ensure that the health systems of sending countries do not permanently lose some of their best trained health professionals, the EU has expressed a desire to promote and encourage circular migration and support the WHO Global Code of Practice on the International Recruitment of Health Personnel and work on the implementation of the Code

[4] Petrova-Benedict, Roumyana. *Multi-country Workshop on Health Workforces Needs and Mobility in the EU and SEE Countries*. 11 July 2008. Migration of Human Resources for Health: Perspectives from the Field. IOM - Migration Health Department, Brussels.
[5] Committee of Ministers. "8th Conference of European Health Ministers (Bratislava, 22-23 November 2007)." *Council of Europe - Committee of Ministers - CM Documents*. Council of Europe, 12 Mar. 2008. Web. 8 Oct. 2011. https://wcd.coe.int/wcd/ViewDoc.jsp?Ref=CM(2008)29&Language=lanEnglish&Ver=original&Site=CM&BackColorInternet=9999CC&BackColorIntranet=FFBB55&BackColorLogged=FFAC75.
[6] Resolution WHA61.17 on the Health of Migrants, 24 May 2008.
[7] Commission of the European Communities. *EU Strategy for Action on the Crisis in Human Resources for Health in Developing Countries.* COM(2005) 642 final. Brussels: Commission of the European Communities, 12.12.2005. Communication from the Commission to the Council and the European Parliament.
[8] EC. "Green Paper on the European Workforce for Health – COM(2008)725." *EUROPA – EU Website.* European Commission, 26 Jan. 2009. Web. 25 Aug. 2011. http://europa.eu/legislation_summaries/public_health/european_health_strategy/sp0005_en.htm.

specifically for the EU context[9]. The 2010 Belgian Presidency to the Council of the European Union recognized health workforce needs as a key issue area, organizing a Ministerial Conference in La Hulpe, 9-10 September 2010 “Investing in Europe’s Health Workforce of tomorrow: Scope for innovation and collaboration”[10]. The Presidency also called for the development of a joint action and an action plan by 2012 to tackle the issue of health workforce planning, which culminated in the abovementioned Council conclusions on “Investing in Europe’s health workforce of tomorrow”[11].

Given the situation within the health systems of EU Member States and neighbouring non-EU candidate countries, such global and regional actions are becoming increasingly more important for Europe. The migration and mobility of health professionals into, out of and within the EU is also exacerbating shortages in some countries and regions, while alleviating the pressure on health systems in others. Some of the most negatively affected countries are those of the South-East European (SEE) region, due to the large resource differentials between these countries and the neighbouring Western European EU states[12]. However, despite the substantial regional, national and personal impacts of this phenomenon, there is a paucity of data and policies exploring the issues.

Currently, the International Organization for Migration (IOM) is participating in the project Mobility of Health Professionals (MoHProf), funded by the European Commission DG Research under the Seventh Framework Programme, to explore the issues surrounding migration and mobility of health professionals. The general objective of MoHProf is to research on current trends of mobility of health professionals to, from and within the EU, as well as in non-European sending and receiving countries. The focus of the project lies on the EU, determining the impact of different types of migration on national health systems through comparative studies conducted in a selected range of representative states from five continents. Specifically, MoHProf explores the importance of *migration management*, or “the shaping of clear and comprehensive policies, laws and administrative arrangements to ensure that population movements occur to the mutual benefit of migrants, societies and governments”[13]. Furthermore, within the analytical confines of the MoHProf project, the surveys investigate the impact of different types of migration on national health systems in sending, transit and receiving countries, as well as detailed qualities such as professions, motives, circumstances and the social context, i.e. push, pull, stick and stay factors.

Migration of health professionals from the SEE, when effectively regulated, can have positive effects such as reducing staff shortages in some countries, while relieving other countries of the oversupply of staff; it also allows, *inter alia* for further professional development and improved standards of living for individuals. Nevertheless, differentials in wealth and opportunities between countries can exacerbate existing staff shortages, undermine the quality of and access to health care and affect the morale of the health

[9] DG SANCO. *Report on the Open Consultation on the Green Paper on the European Workforce for Health*. Rep. Luxembourg: European Communities, 2009.
[10] Belgian Presidency of the Council of the European Union: Priorities on Health. “Health Policy Forum.” 21 October 2010.
[11] Council of the European Union, 2010.
[12] EC, 2009.
[13] Petrova-Benedict, 2008.

workforce in SEE sending countries[14]. This report demonstrates the gravity of the health professional migration phenomenon in the Region as expressed by the surveyed, and emphasizes the importance of monitoring and managing migration in order to prevent deterioration of health standards in the region.

Method

The questionnaire used in the study was developed within the MoHProf framework by the Scientific Institute of the German Medical Association (WIAD), with inputs from the International Council of Nurses (ICN), the International Hospital Federation (IHF), the World Medical Association (WMA) and the IOM. The IOM subsequently administered the survey in the nine SEE region countries[15] – Albania, Bosnia-Herzegovina (BiH), Bulgaria, Croatia, the Former Yugoslav Republic of Macedonia (FYR Macedonia), Moldova, Montenegro, Romania and Serbia – apart from the original project plans. The study included responses all nine South-East European Health Network (SEEHN) members, with Romania sending six separate responses. In total, fourteen surveys were received from health experts from the Ministries of Health (MoHs), National Institutes for Public Health (NIPHs) and several universities.

The first part of the survey explores the current situation of health professionals in the country, including the balance of supply and demand and the monitoring systems regulating it; the professional distribution and receiving countries for national emigrating health workers; and the professional backgrounds and sending countries for immigrating health workers. The second part of the survey focuses on the professional and personal motives, circumstances and social context acting as push, pull, stick, and stay factors influencing migrating health professionals. Finally, the third part of the survey addresses the existence of and need for legal and regulatory frameworks in the field at national, EU and international levels.

Limitations: Due to the incomplete nature of some of the surveys, the different country health system situations, and the limited number of expert respondents within each country[16], this report presents a general overview of the trends within the Region, rather than a comprehensive study of the phenomenon of health worker mobility. Of the six Romanian respondents, the primary data used was from the National Institute for Public Health; the discrepancies between Romanian respondents are indicated in the results section. Where countries formed clear outliers in relation to the regional trend, they were identified throughout the report.

[14] Buchan, James. "How can the migration of heath service professionals be managed so as to reduce any negative effects on supply?" World Health Organization, on behalf of the European Observatory on Health Systems and Policies, 2008.
[15] See note 3.
[16] Each of the participating SEEHN member states submitted one survey, from the respective ministries of health. As noted above, Romania submitted six separate surveys: four from the public health network; two from Faculties of Medicine. Where relevant, sources of discrepancies in responses from the Romanian sample will be noted.

Results

Current trends of health professionals' emigration and immigration

International migration of health professionals is regarded as an important issue in virtually all countries of the region; Albania, BiH and Montenegro, however, do not indicate that this is a significant phenomenon in their countries. These three countries acknowledge that there is some indication of health professional out-migration, but they do not report having precise data or research on the number of migrants or the countries of destination. The out-migration of young, qualified, trained health professionals is considered a disadvantage not only for the health system of the country, but for society in general, due to the loss of the most educated cadres. Given the experiences of Bulgaria and Romania since the 2007 EU accession, the other SEE countries fear the deleterious effects future EU membership would have on the national health systems.

According to the findings of the overall MoHProf research, the health sector in Bulgaria and Romania is found to be below EU standards in terms of the social status of their medical personnel, remuneration of staff across all categories of health workers, and the lack of opportunities for further professional development. These factors, combined with the geographic and socio-political proximity to the more rewarding EU health-sector employment options has stimulated a substantial outflow of health workers from the newest EU member states that is threatening to destabilize national healthcare systems – if left unmonitored and unregulated. The removal of legal and social barriers to migration has the potential to further accelerate the out-migration of the health workers from the Region – especially, most immediately, from Croatia, which will formally join the EU on 1 July 2013.

There is a general imbalance between the supply and demand of most health professionals in all SEE countries[17]; the notable outliers are Albania and Serbia, which report a surplus of professionals across the entire health sector, and exceptionally high country-wide unemployment rates. Throughout the region, nurses working in the health profession are indicated to be in universal short supply, regardless of geographic or rural-urban factors; the demand for nurses exceeds the available supply in all countries, except Albania and Serbia. The situation of medical doctors is slightly more varied, as BiH and the FYR Macedonia report having a balance between the supply and demand, and one of the Romanian respondents (from the public health institute) joins Serbia in claiming an overabundance of supply. The remainder of the countries[18], however, indicate the same overall shortage situation for doctors as for nurses. Conversely, there is a general excess of dentists in the region, with all countries (except three respondents from the Romanian sample) reporting either a surplus or a balance within the dental workforce. Apart from the three largest professional groups, some countries also report having an oversupply of pharmacists (Serbia) and auxiliary and administrative staff (the FYR Macedonia), while others report understaffing for lab technicians (the FYR Macedonia) and psychologists (RO).

[17] Montenegro did not comment on this question.
[18] Albania, BiH, Bulgaria, Croatia, Moldova, and five of the Romanian respondents.

However, these trends may have been underestimated or overestimated by survey respondents, and the strength of the claim cannot be validated quantitatively due to a lack of national-level monitoring infrastructure and instruments[19]. According to the results, the monitoring of supply, demand, immigration and emigration of health professionals within the countries of the region is sporadic, unsystematic and primarily provisional. Respondents report that the supply and demand in the health sector is not monitored in a systematic, centralized manner. Some countries report no reliable methods for estimating supply and demand (Bulgaria, BiH, Montenegro, Romania[20] and the FYR Macedonia) while others (Albania, Croatia, Moldova, Romania[21] and Serbia) are able to make estimates based on figures from the MoH, other ministries and health insurance funds. Only Moldova reports that its MoH receives quarterly demands for health professionals from medical institutions, and that its MoH is engaged in the active distribution of new graduates to these institutions[22]. Montenegro, on the other hand, indicates that a register of human resources is planned in the near future, but, for the moment, the country collects aggregated data on the health workforce. Similarly, the SEE countries tend to employ only indirect monitoring systems regarding the emigration and immigration of health professionals, involving inferences based on professionals' requests for documents necessary for emigration. Of the eight respondent countries, Albania and Croatia are the only ones that require foreign professionals to register and obtain working permits and licences from the MoH/Ministry of Education and the Croatian National Chamber, respectively.

In contrast to the socioeconomically disadvantaged SEE sending countries, the main receiving countries for migrating health professionals include the most socioeconomically developed Western European nations, such as Belgium, France, Germany, the Netherlands, Norway, Sweden, Switzerland and UK, as well as non-European destinations, such as Canada, New Zealand and the United States. Other declared destinations for SEE health professionals include countries which facilitate the adaptation process due to geographic and linguistic proximity and/or the presence of an already-substantial Diaspora, such as Greece, Hungary, Ireland, Italy, Portugal, Romania (especially for Moldovans), Serbia (especially for Montenegrins), Slovenia, Spain, and South Africa (especially for Serbs). In contrast, the vast majority of immigrating health professionals comes from within the SEE region, or geographically proximate countries of the CIS and the Middle East (e.g. Turkey, Syria, Jordan). An especially important percent of these professionals are foreign medical students who studied in the SEE country (especially foreigners in Moldova and Serbia) and decided to remain and work in the country after completing their medical training.

There are also reported substantial differences across different health professions within the region, both in terms of emigrating and immigrating health professionals. The large population of emigrating professionals are most frequently doctors and nurses; apart from a significant loss of general practitioners (GPs), new graduates, anaesthesiologists, surgeons, psychiatrists, emergency and intensive care specialists, orthopaedics,

[19] The difficulties in obtaining consistent, reliable data are evidenced in the current study, through the example of the differences in reporting within the Romanian sample.
[20] This includes two Romanian respondents from the public health network.
[21] This includes four Romanian respondents, two from the public health network and two from Faculties of Medicine.
[22] An electronic Human Resources for Health (HRH) database was developed within the IOM Chisinau project "Managing the Impact of Migration on the Health-care System of Moldova".

radiologists, gynaecologists, neurologists, urologists, pharmacists and occupational health workers make up the largest portion of the regional health professional "brain drain".

In contrast, all nine respondent countries report a small, negligent overall number of immigrating health professionals, with a prevalence of doctors (predominantly GPs, some specialists), with fewer nurses and dentists coming to the SEE. The vast majority of foreign health professionals, however, are employed in private hospitals and clinics, and do not significantly influence the understaffed situation within the public health sector. The identified immigrating medical specialists include GPs, paediatricians, interventional cardiologists, anaesthesiologists, ophthalmologists, oncologists, urologists and general surgeons.

In recent years, according to respondents, another notable trend has been the abandonment of the health sector (in whole or in part) by trained health staff in search of more lucrative employment opportunities. Although there is a paucity of official data regarding health professionals working outside of public health, unofficial sources suggest that the majority tend to concentrate in pharmaceutical sales and other financially attractive sectors.

Push, pull, stick and stay factors[23]

Overall, the low salaries and a lack of job opportunities are seen as the most important push factors for health professionals emigrating from their home countries. Other important factors include: a lack of appreciation for the medical profession; the low level of development of the home country; a lack of opportunities for more specialized training and education; the high unemployment rates of health professionals; and the inefficient organization of health services. Of moderate importance are factors such as appreciation from the employer, the difficulty and security of family life, the political situation of the home country, the efforts of active recruitment agencies and too much hierarchy of social organization. Least important push factors are the number of working hours and any discrimination, ethnic or religious concerns of the health professionals.

However, some health professionals choose to remain in the home country, primarily due to personal considerations such as the undesirability of starting the professional career from the beginning in a new country, and the family bonds and dependencies of the home country. Other important stick factors are professional issues such as satisfying working conditions and salary levels, as well as general difficulties associated with migration and uprooting. The least importance is given to the likelihood of a brighter future in the home country regarding the eventual development and improvement of health services.

Those choosing to emigrate have as their primary motivation the possibility of obtaining a satisfying salary level, followed by considerations of working conditions such as the effective organization of health services, the availability of jobs, career advancement opportunities and the high level of general development of the receiving country.

[23] Montenegro did not provide responses to this section, due to the stated lack of research regarding the migration of its health workforce.

Personal factors concerning the facilitation of family life in the receiving country are also regarded as extremely important. Other significant pull factors include professional and interpersonal concerns such as the ability to apply learned skills; the high value placed on the medical profession; the availability of further education and training opportunities; family security in the receiving country; and the employer's expressed appreciation of professional performance. Least important pull factors are workplace egalitarianism, a satisfying number of working hours and the actions of recruitment agencies.

Once employed in the receiving countries, economic and integration factors become crucial determinants of professionals' desire to stay. The most important stay factors are the ability of the receiving country to meet health professionals' expectations; the objective improvement of material standards; the acquisition of the receiving country language; and successful integration into the new environment. Slightly less important are skill acquisition and the familiarization with receiving country health system organization and regulation. An unchanging situation in the home country, requiring returning professionals to restart at the lowest levels in health care, without recognizing the skills and qualifications they acquired while abroad is also deemed of low overall importance.

Legal and regulatory frameworks

In terms of laws and regulations, only four countries (Croatia, Montenegro, Romania and Serbia) report having specific international agreements relating to the migration of health professionals. As of May 2011, Croatia and Slovenia entered into a multilateral agreement with Italy for the exchange and specialization training of physicians in Italian universities, potentially facilitating future international employment for the graduates. The MoH of Montenegro has signed a Memorandum of Cooperation in the 'Healthcare and Medical Science' field with Serbia and Slovenia, and is in the process of negotiating the same with BiH and Croatia[24]. Similarly, Romania is party to the 2005/71/CE Directive of the Council, regarding applications for the deployment of scientific activities. On the other hand, Serbia reports a past bilateral agreement with Libya, but its continued validity is unclear due to the current political situation in Libya. Nevertheless, the SEE countries are of the unanimous opinion that international agreements are necessary and desirable – especially for the regulation of circular migration and the ethical recruitment of health professionals – and that they should involve state and non-state actors, such as ministries of health, IOs (primarily the WHO), and neighbouring and EU destination countries.

All countries, except Albania and BiH, indicate being aware of the WHO "Global Code of Practice on International Recruitment of Health Personnel", and see it as a useful tool in helping to regulate, improve and set standards for the migration process. The countries recognize that the Code is important for the development and strengthening of education and training of health personnel; the establishment of healthcare professionals information systems; and for addressing the misdistribution and retention of health professionals. Similarly, all countries, except BiH and Romania, are aware of the Council

[24] One of the provisions of the Memorandum states that the signatory countries will be subject to cooperating on: "Direct contracts between health institutions, meical faculties and associations of health professionals and cooperation in the training of health workers."

Conclusions on “Investing in Europe’s health workforce of tomorrow: Scope for innovation and collaboration”. The document stresses the importance of improving qualitative and quantitative data, as well as the need to develop (comparable) country databases for health-related human resources. Subsequently, a cross-border exchange of good practices can be used to produce recommendations for continuing professional development. The positive outcomes of these policies include an improvement of national and international policies, regulations and retention systems, as well as an opportunity for health professionals to gain valuable skills and competences internationally. However, there are fears that facilitating migration might further exacerbate the regional problem.

All countries (except BiH, which did not respond) are of the opinion that the EU needs to play a strong role in the monitoring and improvement of the conditions for migrating health professionals. The more developed EU countries are the main recipients of SEE health workers and, as such, need to play a strong leading role in promoting the development of concrete frameworks and policies regarding working conditions, education and acceptable remuneration of health professionals across the Region. Furthermore, the EU should develop a common policy to address this problem and avoid exacerbating the “brain drain” from SEE countries, by promoting circular migration and regulating the ethical recruitment of health professionals. Health professional out-migration is not purely a free market phenomenon, for it has many adverse effects on sending country social systems and the overall status of the population.

Despite the gravity of the situation, virtually no policy recommendations exist in the SEE at the national or Regional level. Several countries mention the EU Directive (2005/36/EC) on the recognition of professional qualifications, but out of the non EU countries, only Croatia has adopted it into its national laws (OG 124/09, 45/11). Other countries are aware of the EU-level initiatives such as the European Hospital and Healthcare Employers’ Association (HOSPEEM), the European Federation of Public Service Unions (EPSU), and the UK Code of Conduct for International Recruitment of Health Personnel, as examples of positive actions on the EU and country levels. Moreover, all respondents expressed a need for national and international planning, and a particular willingness to participate in EU level actions to create and promote good practice.

Examples of good practice were offered by less than half of the respondent countries (excluding ALB, BG, BiH and RO[25]), focusing primarily on professional training and migration and mobility management. Croatia is involved in the IPA 2008 project on “Rising the knowledge and skills of nurses and midwives and harmonization of educational curricula with Directive 2005/36/EC” which aims to facilitate the mobility of professionals to the EU for further training. The Former Yugoslav Republic of Macedonia is implementing a national project that offers scholarships for Roma students entering the medical professions, desiring to remain and practice in underserved Roma communities. Montenegro has signed two Memoranda of Cooperation in Healthcare and Medical Science (with Serbia and Slovenia) – and is planning to sign two more (with BiH and Croatia) – in order to promote circular migration of health professionals and reduce “brain drain”. Similarly, Serbia is developing a National Strategy for Health and

[25] These four countries did not respond, including five of the six respondents in the Romanian sample.

Education, while Moldova and Romania[26] are engaging in National projects on "Better managing the mobility of health professionals in the Republic of Moldova" (IOM Chisinau) and "Migration Tendency of Medical Staff", respectively.

Discussion

As evidenced by the aforementioned documents, conferences and resolutions, recent years have seen an increase in the attention directed to the health needs of the ageing European population, and the considerable demand this will continue to place on health care systems, in terms of both structural and human resources. The increasing demand for health workers in the EU is being met from various source countries, including the geographically and socio-politically proximate South-eastern European region. The effect of this emigration on the source countries remains one of the most significant and understudied issue areas in the global mobility of health professionals[27]. This report summarizes the findings of a short survey of the views of national experts regarding the migration of health professionals within and outside SEE countries and identifies some key issues for the region.

In accordance with the objectives of the aforementioned directives, conferences and other political actions[28], the current report demonstrates the importance of the "Mobility and migration of the health workforce" issue in the SEE Region. It has been recognized that the "mobility of health professionals has a dual effect. A positive effect because it can allow supply to be adapted to demand. Professionals can indeed go where they are most needed. This free circulation can also have negative effects in that it can create imbalances and inequalities in terms of availability of health staff"[29]. However, the EC recognizes the negative effects migration has on sending countries, and proposes that mechanisms of circular migration be put in place to ensure mutual benefits for the sending countries and the receiving countries of the European Union.

The situation is particularly alarming in the relatively poor, geographically proximate countries of SEE. Despite the general lack of official monitoring mechanism across the region, SEE countries are able to gauge the gravity of the situation and the substantial brain drain across the region based on data from informal and unofficial channels. Based on the responses from government respondents and officials in the region, migration estimates are based on analyses of health insurance funds and professional registration, the output of professionals registered by Ministries of Education, and requests for official documents that would be necessary for professionals intending to migrate. Currently, only Albania and Croatia require the registration of foreign professionals working in the countries, but none of the countries claim to have a system fully equipped to monitor the supply, demand, immigration and emigration of health professionals in the country. Thus, in order to effectively address this phenomenon, SEE countries would have to establish bodies and mechanisms to monitor and regulate health worker migration, as well as establishing multisectoral cooperation for the purpose of information gathering.

[26] As indicated by one of the Romanian public health network respondents.
[27] See also HEALTH PROMeTHEUS Project (http://www.ehma.org/index.php?q=node/46).
[28] EC, 2009.
[29] Ibid.

Similarly, within the individual SEE countries there is a notable disparity between the health sector human resources in urban versus rural areas. As expected, rural and poorer areas of all eight respondent countries are chronically understaffed, underfunded and underserved. Moreover, the SEE region is home to a substantial Roma minority within most countries; the health status of these communities is reportedly the worst of all the groups in the region. To address this problem, the Ministry of Health and the Ministry of Education of the Former Yugoslav Republic of Macedonia have initiated an innovative project to address at once the need to increase the number of rural health professionals and to provide better public health care for underserved Roma communities. The programme offers 138 scholarships for Roma students wishing to enrol in education for health professionals. As of the 2010, 120 scholarships were awarded to Roma students entering secondary medical school and 18 scholarships for Roma students entering the Medical, Pharmaceutical and Dental Faculty. The scholarships are granted under the requirement to sign a contract to work in the public health system in the Roma community, as a retention measure for the workforce.

Roma health has also received significant attention and funding in other SEE countries, although this information was not included in the surveys. Most notably, the OSI Public Health Program published *How the Global Fund Can Improve Roma Health*, a report assessing the impact of Roma-related projects in Bulgaria, the FYR Macedonia, Romania and Serbia, sponsored by the Global Fund. Although the projects are largely devoted to disease prevention and control, a significant aspect of the OSI report examines the involvement of Roma civil society in healthcare, and the need for capacity building in terms of health professionals for the Roma community.

However, projects such as those above, focusing on the need to train, redistribute and retain health professionals are the exception rather than the rule in the region; the SEE continues to suffer from the double burden of training highly skilled health professionals and investing in human resources early in the professional career only to lose new graduates to more inviting Western European markets. Due to the stressors of migration – such as restarting a career and life from the beginning, breaking family bonds, uprooting, and adapting to a new language and culture – most of the migrating health professionals tend to be young and/or newly graduated. This leaves the SEE countries with an overwhelmingly older, and ageing, health workforce. For example, Romania estimates that the vast majority of its remaining health professionals are 10 to 15 years away from retirement, while the younger health worker cadres increasingly opt to emigrate. This finding is corroborated by most of the other respondent countries. The trends suggest that the situation within the public health sector of SEE countries will become significantly exacerbated within the next two decades, and that concrete, organized action is urgently needed to address these issues.

In the region, only Albania and Serbia indicate that the emigration of health professionals is not a significant issue, and that the public health systems are overstaffed due to a high output of health staff from private universities and overall high unemployment among all skilled workers, respectively. However, given the regional migration trends and the high demand for skilled health workers in the neighbouring countries of SEE and the EU, the situation in Albania and Serbia could quickly begin to resemble that of the rest of the

region. Unfortunately, despite the urgent need for action, there have been scant developments in terms of legislation, policies and agreements between the main sending SEE countries and the (largely EU) receiving countries. While most respondents recognized the existence of the WHO "Global Code of Practice on International Recruitment of Health Personnel" and the Council Conclusions on "Investing in Europe's health workforce of tomorrow: Scope for innovation and collaboration", they continued to express concerns that the situation in the Region might be further exacerbated – especially if and when the seven non-EU members join the Union. Therefore, all SEE countries concur that agreements regulating health professional migration are needed, especially with the EU and individual destination countries.

Conclusions

The results of the survey reveal the perceived importance of the migration of health professional migration in the SEE region, and the urgent need to develop policies and practices to address concerns surrounding the Region's decreasing health workforce within national, European and international fora. The input and guidance of the European Union is both strongly desired and perceived as necessary for the region, in order to ensure a more equitable exchange of costs and benefits between the main sending and main receiving countries for South-East European health professionals.

On the basis of qualitative data of the study provided by expert opinions from across the SEE, it can be concluded that highly trained health professionals from the eight surveyed SEE countries will continue to migrate to the more developed countries of the EU and abroad, in a desire for improved professional, personal and family circumstances. Therefore, policies governing human resource development and migration management need to be established, both within the region and at the EU and international levels, in connection to the SEE. Only through such measures could the sending countries of the SEE hope to regain their investment in public health workforce development, as well as guarantee opportunities for its migrating citizens in terms of improvement of remuneration and employment conditions, career development, and the overall standard of living. Similarly, the SEE governments would be better able to plan their national health policies and improve the health standards across the region, particularly in the poorest, most underserved areas.

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