# MINUTES

## 'Mobility of Health Professionals in the EU: Ethical Recruitment and Policy Coherence'

## 5 May 2015, European Parliament, Brussels

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The meeting was opened by host **Nessa Childers MEP** (S&D, Ireland) who welcomed the participants and underlined the importance of the health workforce debate at a time when professional mobility flows are becoming more complicated in Europe, not only because increasing numbers of individuals are taking advantage of the opportunities available to them in other Member States but also because of economic developments, which in smaller countries like Ireland could be quite fast-moving and exert an important impact on the health system, which in turn influences the magnitude of health workforce flows. She also specified the dilemma between the right to mobility in the Internal Market and the need for equity in the distribution of health workers.

**Caroline Hager**, Policy Officer at the European Commission's Directorate-General for Health and Consumer Policy, put the theme of the event into context and explained that the implementation of the 2010 WHO Global Code of Practice on the International Recruitment of Health Personnel was an integral part of the Commission's Action Plan for the European Health Workforce adopted in 2012. She stated there were 17 million health workers in Europe, but numbers are shrinking as a result of retirement and insufficient influx of newly trained health workers. Such problems can be solved at national level by more training, better retention, better skills mix & recruitment from other countries, but the latter also causes problems in source countries.

She stressed that although data are increasingly being gathered, more information is needed & data collection should be more systematic, as well as its analysis, e.g. what do we see in the data and what does it mean. She also emphasised the need to learn from policies aimed at retaining health professionals. And – not unimportant – she encourages Member States to make use of cohesion funds for training, capacity building, new hospitals, and such, in order to become more self-sufficient.

**Linda Mans**, Coordinator of the Health Workers for All (HW4All) project and Global Health Advocate at HW4All partner organisation the Wemos Foundation, Netherlands introduced the pan-European HW4All consortium funded by EuropeAid (2013-2015). She explained that the aim of the project was to contribute from Europe to a sustainable health workforce worldwide, using a rights-based approach which emphasises the right to health on one hand, and the rights of internationally mobile health workers on the other. HW4All also developed

and shared tools for policy analysis and (inter)action to increase knowledge and understanding of human resources from a global health perspective. Both global and European aspects of the WHO Global Code are closely interlinked.

Mans also explained the voluntary nature of the WHO Global Code, the implementation of which depends on political will and commitment of all stakeholders. It contains principles for ethical international recruitment and strengthening health systems, taking into account the rights, obligations and expectations of source and destination countries, and migrating health personnel. In support of the proper implementation of the WHO Global Code in Europe, HW4All launched a Call to Action for European decision-makers 'A Health Worker for Everyone, everywhere!', and Mans informed participants that it was available for signatures during and after the event.

Ms Mans reported on the various efforts made by civil society across Europe to raise awareness of equitable distribution of health workers and migrant workers' rights, stating that the specific problems were often different from country to country but the overall problem of insufficient recruitment and retention strategies remained the same. Hence it is important to share lessons learned, increase mutual learning, and spread innovation among stakeholders. As the collection of case studies compiled by HW4All revealed, the Code is already being translated into practical measures in many local and national contexts. Mans also stated that the multi-stakeholder approach promoted by the Code was key to its implementation.

One prime challenge is policy coherence since various government ministries, including those responsible for health but also employment, education, trade, and development co-operation, need to collaborate at national and supranational level in order to shape sustainable, mutually beneficial mobility and migration patterns. In 2015, HW4All would bring these issues to WHO, during the monitoring process of Code implementation, and there would also be a side event organised by HW4All at the 2015 World Health Assembly about the WHO Global Code's initial achievements and future challenges.

This was followed with a presentation by **Sascha Marschang**, Policy Manager at the European Public Health Alliance (EPHA) who linked the ongoing out-migration of health workers from Southern and Central/Eastern European countries with the findings of EPHA member organisations working on the impacts of the economic crisis across Europe. In this context he made reference to the 2012 report by the European Federation of Nurses Associations (EFN), 'Caring in Crisis', and the 2013 report by Médecins du Monde, 'Access to Healthcare in Times of Crisis and Rising Xenophobia', which depict the severity of the crisis both for nurses and for patients and people in need of healthcare. He also provided an overview of EPHA's work on health workforce and of its collaboration with HW4All and EPSU.

Moreover, he pointed out the pioneering work undertaken by Action for Global Health on the implementation of the WHO Global Code in five European countries, and by the Royal College of Nursing in the UK on ethical recruitment and comprehensive data collection of stocks and flows.

He also stressed the valuable contributions by the European Observatory on Health Systems and Policies in this area, stating that the two volumes published by the Observatory encouraged thinking about the nuances of health worker migration and about the value of complementing quantitative data with qualitative evidence. Mobility and migration being dynamic by nature, categories such as 'source' and 'destination' countries are not fixed.

Marschang noted that the root causes of migration included chronically underfunded health systems, the effects of the economic crisis and austerity measures, lack of training and education opportunities and personal motives, the latter being more difficult to identify and control through policies. Listing a number of public health concerns arising from unbalanced health workforce mobility, including the need to cater to an ageing population and cope with the associated chronic disease and care burden, Mr Marschang concluded his presentation by proposing a number of questions to guide the subsequent policy debate.

## 1st Panel – EU implementation of WHO Global Code: Equitable distribution of health workers

Moderator **Remco van de Pas** (Institute of Tropical Medicine, Antwerp) opened the first panel by stating that the issue of health workforce mobility had worsened since the onset of the economic crisis. Austerity measures were implemented in the health and social care sectors, including budget and salary cuts, and an increased amount of workload was shifted to health workers in many Member States. In addition, he stated there was also health worker migration from third countries, hence the relationship and interactions with the European Union (EU) are quite complex.

Overall, van de Pas underlined the need for bigger investments in health workforce and social policies in times of crisis, citing the work of David Stuckler / Sanjay Basu and James Galbraith. This needs to occur even though the possibilities for reserving fiscal space are restrained. If Europe is an open market place, it needs to reinforce social protection. Identifying key actors for change is crucial, including the role of MEPs in this process.

**Réka Kovács** (Ministry of Human Capacities & Semmelweis University, Hungary) presented the report she drafted for the Joint Action on Health Workforce Planning and Forecasting (Work Package 4 re: mobility data) on the applicability of the WHO Global Code in the European context. She explained that the report arose out of information gathered during meetings and workshop discussions that took place in Bratislava and Lisbon in 2014. The method deployed by the Work Package members was to formulate, discuss and vote on 12 statements related to health workforce 'Code' issues in the EU context. The final report was adopted by the JA Executive Board in March 2015 and would feed into other JA deliverables and policy recommendations.

Implementation of the Code in relation to non-European countries is considered a priority. But the report findings confirm that the principles of the WHO Global Code also make sense in the European context and need to be implemented there, too. The statements receiving most endorsement by stakeholders relate to retention policies, compensation, and circular migration. Kovács also said that it was important to collect relevant data and monitor it well. Hence the EU had launched several other initiatives as part of the Commission's Action Plan for the EU Health Workforce.

Kovács provided the example of Hungary, which, although not the most affected source country, nonetheless struggles to manage the detrimental consequences of steady out-migration of health workers coupled with an ageing domestic health workforce. The top three motivations for migrating Hungarians are hopes for better salaries, quality of life and working environments.

She proposed that the EU could implement a tailored version of the code, focusing on different topics, including the following:

- Examining health workers' intentions to leave and their reasons;
- Examining individual country practises re: integration, the regulation of recruitment agencies, financial compensation of source countries, retention policies and stakeholder engagement;
- Organising meetings and events for sharing knowledge and increasing awareness and networking; and
- Exchanging and in-depth investigating of mobility data

The most feasible area of action concerns retention policies; migrant 'source countries' need to offer fair working conditions to their health workers. Dissemination of good practices is particularly important in countries strongly affected by out-migration.

Ms Kovács also suggested encouraging circular migration in order to stimulate returns to home countries following periods working abroad. The next JA Conference would take place on 18-19 February 2016 in Varna and has 'mobility of health professionals in the EU' as major theme.

**Biljana Borzan MEP** (S&D, Croatia), who is herself a medical doctor, stated that since 2013, over 300 health workers have left Croatia, while another 673 have applied to leave. Worse still, these numbers only concern employed people for whom a lot of resources are being expended into their training.

Although 17 Member States still require work permits for Croatian workers, this is not the case anymore for health workers able move freely thanks to the mutual recognition of their professional qualifications in the EU. MEP Borzan stated that the Croatian government is often criticized of not doing enough to retain health workers and pointed out that the problem was not only concerning salaries since remuneration in Croatia is on a par with that of some destination countries. Beyond financial reasons, health worker migration also occurs to take advantage of other personal and professional opportunities, such as career development, the possibility to do a specialisation, etc.

Moreover, she noted that the maldistribution of health workers between different regions within her country – with the well known problems in rural and non-touristic areas – was also a problem.

According to Ms Borzan, the EU can be seen as both the cause and the solution to these issues. Quality of life, working conditions and living standards need to be harmonised among all Member States in order to prevent migration. While this will still take many years, in the meantime concrete actions are required to ensure equitable distribution. On top of that, she recalled that the European population is ageing and that health workforce shortages are only getting worse. Therefore, she argued in favour of investing into information systems and in other initiatives to stimulate the implementation of sustainable health workforce actions.

MEP Childers then gave the example of Ireland, which is both a source and a destination country for migrants. There is broad agreement that migration was a very good phenomenon, something useful that could strengthen economies. But it is equally important to achieve a harmonised distribution of health workers among EU Member States.

Childers explained that Ireland has traditionally had a lot of emigration, but since the 'Celtic Tiger' years of the 1990s, and especially following the accession of Central and Eastern European Member States in 2004, it also became one of Europe's premier countries for migrants both from within and outside of Europe. However, some of these workers saw

themselves forced to leave Ireland again in the wake of the economic crisis. Since 2009, 5,000 Irish nurses have lost their jobs with obvious negative repercussions for the health system. Childers stated that it was difficult to establish a notion of sustainability for the healthcare system under these conditions, and because Ireland is a small county this is even more difficult.

Childers echoed her colleagues' comments and affirmed that the focus should be on retention and health workforce distribution planning. Since the crisis, this problem has not only become worse but it has also been removed from the priorities of many Member States putting more emphasis on other problems.

**During two Q&A rounds,** a number of issues were brought to discussion:

- **Mariana Pinto da Costa of the European Federation of Psychiatric Trainees (EFPT)** shared information about the study her organisation has undertaken in 33 European countries on trainee doctors' motives for leaving (2013-14). A majority of respondents stated that migration was primarily influenced by academic reasons, while income dissatisfaction in home countries was cited as the main reason for not returning there (only 8% of survey participants planned on moving back home). Others were also moving for personal reasons.
- **Thomas Schwarz of Medical Mundi International Network / HW4All, Switzerland** asked about the WHO Global Code's applicability in Europe in the context of the upcoming 2015 World Health Assembly. The WHO Code's principles were related to international migration whereas within the EU, the focus of the debate was on internal mobility. It was important to decide whether the EU should be considered as a region or as one country. Moreover, it was important to find an approach to fair compensation of source countries.
- **Susan Williams, Royal College of Nursing (UK),** stressed the importance of getting governments think in a long-term, sustainable fashion rather than only in the short term, which could also be quite expensive. While on one hand, data are being gathered on a long-term basis to put the accent on that component of the strategy, if there was a need for more nurses and none were available, the UK would still recruit from abroad in spite of ethical principles. This behaviour revealed a rather short-sighted way of acting.
- **Sandra Hočevar of the European Pharmaceutical Students' Association (EPSA)** highlighted the fact that some graduates were forced to move to other Member States because there were no jobs for them available in certain countries. Some students wished to move for personal reasons but others simply had no other option. For example in the field of pharmaceuticals, there was a general lack of health workers except for the UK and France. She stated that people should have the right to work in their own countries.

Responding to (3), MEP Childers stated that unfortunately, people only became concerned since the crisis has occurred, with its palpable negative impact on the economies and labour markets in the majority of EU Member States. Hence it is crucial to stimulate further awareness-raising, and it is the role of the different organisations involved in this debate to enhance knowledge of these issues. She also agreed that it is important to take a long-term view including for financial measures for health, something that should be independent from electoral promises.

Ms Kovács responded to the first two questions, noting that the implementation of the WHO Global Code in Europe could be achieved even with a different functioning than mentioned in the WHO Global Code. She agreed that the issue of compensation is important but it is particularly difficult to implement in practice. Who should be responsible for compensating source countries if people are leaving? Compensation is included in the mechanisms for sustainability, however it is equally important to try and increase circular migration to avoid permanent loss of trained health workers.

She stated that coordination should take place at EU level, and pointed out that an EU statement on the WHO Global Code was agreed by the WHO Executive Board in January.

She agreed that taking a long-term view is necessary, and dialogue over professional mobility must go on. There should be a planning system for the retention of health workers, and more awareness raising programs. In addition, stronger commitment to health workforce planning and recruitment and retention measures at national level is required.

## 2nd panel – EU implementation of WHO Global Code: Sustainability and rights of internationally mobile health workers

Moderator **Heino Güllemann** of terre des hommes / HW4All (Germany) opened the second panel by pointing out the necessity to return to the wording of the WHO Global Code. Regarding sustainability, a country needs to be able to establish a sustainable health system based on its own resources. When it comes to health workers' rights, the WHO Code states that migrant workers should have the same legal rights as the domestic health workforce of the destination country. However, a number of studies show that, in some institutions, migrant workers' rights are poorly protected, including in some EU countries. Güllemann stated the best known example was that of Spanish nurses working in Germany[1]. They are required to take a language course – which should be paid for by the institution – however, after the course is completed, the nurses have seen these expenses deducted from their salary, which is not legal. What is more, some Spanish nurses had to learn that they earned about 20 – 40% less than German trained nurses. And if they wanted to break their short term contract (usually 1-2 years), the employer obliged them to pay penalties as high as 10,000 Euros. In the two federal states of Berlin and Brandenburg alone, already 400 such cases of unfair working conditions have been reported.

Güllemann also stated that it makes sense to include the issues of sustainability and rights in the same panel because they are closely linked. Germany is also a source as well as a destination country since German trained nurses are leaving while Germany is hiring from abroad. This creates a vicious circle which cannot be resolved until and unless the health system is adjusted in a more sustainable way.

**Gerd Dielmann** of German trade union Ver.di / EPSU explained that in 2008, EPSU and HOSPEEM had negotiated and agreed on a joint Code of Conduct on Ethical Cross-border Recruitment. The starting point was the request for and provision of high quality medical care accessible to all citizens in the EU. From a policy perspective, this called for effective

[1] More information can be accessed via the EPSU webpage in the articles http://www.epsu.org/a/10619 and http://www.epsu.org/a/10605

planning and human resources policies at local, regional and national levels to meet the needs of safe staffing and the right mix of qualifications in the health sector.

He stated it was grossly negligent that for example in Germany, a few years ago jobs in hospitals and positions to train workers in nursing professions were cut in order to save costs: Between 1995 and 2007, 52,000 of 350,000 jobs in nursing were cut in German hospitals. The staffing level of 1995 could not be reached again in 2015, even though the length of hospital stays has been shortened, and the total number of treatments/cases has increased. This is not a shortage of skilled workers, but a shortage of posts due to insufficient funding. Between 1998 and 2008, the number of places for the training of nurses was reduced by about 10,000 (from 65,000 to 55,000). Only in 2012 the number of 60,000 training places could be reached again. At the same time employers are complaining about the shortage of skilled health professionals and they forecast supply gaps for the near future. Ver.di has assessed the current staff shortage in the hospital sector in Germany through a survey of its members (in 2014) which found that hospitals are short of about 160,000 health workers (of a total of 500,000 women and men working in hospitals). To change this situation, ver.di is currently running a campaign for the introduction of legally fixed standards for safe and effective staffing in Germany.

In addition, different workplace-related aspects need to be taken into account when recruiting health workers from another EU country (this being the scope of this Code of Conduct. These include fair and transparent contracting and proper training; equal treatment and non-discrimination with regard to employment conditions and coverage by social protection; promoting ethical recruitment practices and the use of agencies with demonstrated good practice; and the right to organise in trade unions.

He pointed out the distinction between different categories of migrant health (and elderly) care workers in Germany, which include nursing/personal care and household workers (mostly women from Central/Eastern European countries), crisis-induced migration of Southern Europeans, and nurses and elderly carers from developing countries based on bilateral government agreements (e.g. Philippines, China, Vietnam). Ver.di is represented in a board set up by the Federal Ministry for Labour and Social Affairs to accompany the elaboration and use of such bilateral agreements and has been involved in the elaboration of model work contracts for these health workers that comply with the EPSU-HOSPEEM Code of Conduct and the WHO Global Code.

Mr Dielmann made the following recommendations, directed at Member States and the EU, from a trade union perspective:

- Creation of economic conditions enabling all EU MS to provide for quality health care for their population with systems pursuing public policy & general interest objectives
- Governments, public authorities and the EU institutions to cooperate with the social partners on policies, strategies and financial support for recruitment & retention

Trade unions could help migrant health workers by:

- Facilitating bilateral cooperation/agreements and mutual support (membership; access to TU services) between EPSU members to mitigate the negative effects of brain drain and ‘care drain’

- Increasing own efforts to improve training for shop stewards or representatives of staff in work councils and their awareness on questions and challenges related to ethical recruitment practices, to the employment, contractual issues, working and pay conditions as well as to the induction of migration workers
- Supporting the provision of counselling of migrant workers in case of problems with employers when it comes to pay, working time and contractual arrangements. This is done by service centres of the German Trade Union Confederation (DGB) with whom Ver.di (staff) cooperate.

The need for associations of migrant workers or social economy organisations (providing support or counselling services to them) to get involved with trade unions and authorities was also pointed out.

**Ismail Ertug MEP** (S&D, Germany) argued in favour of equal rights of migrant health workers in terms of salaries and treatment, based on capacity and qualification, stating that discrimination was unacceptable. He emphasised the importance of implementing the WHO Global Code and also called for better information dissemination regarding health workers' rights. Until now planning for demand and supply has been inadequate in Germany.

He also stated that, while health workforce financing was a national issue, health policy development is a shared competence and responsibility and insofar also an EU issue, which included for example the Professional Qualifications Directive and the Posted Workers Directive. Member States should adapt national legislation to achieve better distribution of health workers. However, a common EU approach with the support of the Commission is needed to tackle recruitment problems and reinforce health workers' rights as there is no 'one size fits all' solution.

Finally, Ertug stated that the use of EU Structural Funds is possible and could help to build up and strengthen health infrastructure. He noted that Commission President Juncker focused on financing infrastructures in the EFSI (European Fund for Strategic investments), but not on healthcare infrastructure and the health workforce. A lot could be achieved through proper use of these financial instruments, in the sense of improving the recruitment and retention conditions in source countries and thereby reducing the pressures and incentives for outward migration.

**Razvan Gae** (Sanitas / EPSU, Romania) provided data and information about the health workforce situation in Romania. He noted that, while it was important to for trade unions in Romania and Europe to defend the fundamental right of freedom of movement of workers across Europe, the health workforce requires particular consideration. He stated that Romania had a low capacity for healthcare compared to other Member States; there is an imbalance of health workers and hospitals among regions. Although accurate data collection remains difficult, between 2007 and 2013 about 20% of doctors left Romania, and in 2014 over 2,000 doctors requested certificates that would allow them to leave the country, which is bad news for sustainability. In the same period, 28% of nurses left the Romanian health care system, and in 2014, about 3,650 submitted requests to move abroad, with higher numbers effectively leaving as not all would notify the relevant professional body about their intention to leave Romania.

Mr Gae described the collaboration between Sanitas and CPSS, the Romanian partner in the HW4All project, to shed light on the health worker situation and suggested that an expanded partnership of 'source' countries could generate viable solutions. This required recognition and prioritisation at EU level and financial support to countries affected by out-migration,

including for establishing registers of mobility / information systems, continuous professional development, better education infrastructures and increased professional qualifications, and other financial and non-financial incentives. To create a coherent, national health workforce registry, Structural Funds could be used. At national level, Romania should establish a Health Pact to acknowledge that the lack of human resources is a critical and urgent health problem for its population, and a long-term strategy must be put in place to more effectively address the problem. European funds coulds be dedicated for creating sustainable health systems as regards human resources, e.g. by using them for continuing medical education and training, better infrastructure in education (undergraduate and postgraduate studies) or improved professional qualifications. A Public Health Programme of the European Commission (or a similar initiative) dedicated to "source" countries with a lower GDP could contribute to reducing inequalities in access to the health system and in view of the quality of the services provided. Financial support from the EU level dedicated to health systems could thus contribute to a stabilisation of medical staff levels or to an increase in the number of training positions for medical staff.

Regarding the rights of migrating health workers, Gae proposed that a governmental decision could regulate the authorisation of recruitment companies and oblige them to notify the professional health bodies about the personnel leaving based on a contract. In addition, health professional organisations should advocate that those who are leaving are treated on equal terms in destination countries. They can establish bilateral relations with other EU countries to establish how many health workers are registered abroad and promote common principles to ensure fair and equal working conditions.

Finally, Gae stated that Member States had to recognise that this issue required evidence-based plans of actions. A guide of good practices by both source and destination countries should be published. The EU should make ethical recruitment a priority given that the repercussions of unbalanced mobility were worse for poorer countries.

**Soledad Cabezón Ruiz MEP** (S&D, Spain) shared her views on the health workforce experience in Spain stating that until a short time ago, Spain used to be an important destination country, but since the economic crisis it has become a source country for health workers.

She stated that the Spanish health system used to be very efficient, one of the oldest public systems providing free and universal healthcare for its population. For a few years now the system has undergone changes, including more privatisation. There has been a notable lack of investment in innovation and research since the disengagement of investors. This was followed by brain drain of researchers, with the massive emigration of health workers as a final consequence.

Cabezón Ruiz also stated that planning needed to be modified and improved in Spain. The Spanish health sector budget has decreased significantly; there should have been a maximum 10% cut, but the government went up to 20%, creating a loss of 5,000 jobs, shortages and new healthcare access problems, e.g. for migrants.

She explained that Spain is comprised of 17 communities which operate different policies. Andalusia remains a model for public healthcare provision as it has kept the old universal system, and they are also carrying out pilot trials for retention policies. Germany and other EU countries should also focus their efforts more on retention.

At EU level, health system sustainability and mobility of health workers should be real priorities as pointed out by the Council in 2006 and 2008. After the economic crisis struck, these concerns were put aside. Instead, health should be at the centre of the EU model as a principle.

Ms Cabezón Ruiz affirmed that the right for free movement is necessary, but there should be compensation measures for countries losing health workers. Certain Member States are providing a direct service to others through this loss. She also spoke in favour of promoting circular migration and encouraging the return of health professionals.

The final panellist, **Filiz Hyusmenova MEP** (ALDE, Bulgaria) revealed that, according to the Bulgarian Medical Association, since 2009 between 400 and 500 doctors applied for certificates to work abroad every year. According to representatives at the Medical University of Sofia, nearly 80% of graduating young professionals intended to leave the country.

She stated there were two main reasons Bulgarian medical professionals gave as motives for their decision to leave the country: low salaries and few opportunities to obtain specialisations. In addition, Western European countries offered better equipment, technology and opportunities for innovative research, as well as less overtime and better working conditions. Partly this is a result of these countries' approaches to healthcare financing - while Bulgaria spends only 4%, Germany devoted about 11% of its GDP to the health sector. Another reason is of a social nature: the reduction of medical staff and increased workloads are creating growing tensions between doctors and patients in Bulgaria. Patients complain about specialists being too busy, lack of prevention and lack of health security.

Moreover, Hyusmenova deplored that, according to information obtained from the Federation of German Trade Unions (DGB) which is supporting migrant workers, employers often exploit Bulgarian nurses including by deducting costs for language courses (done prior to departure, but also after arrival in Germany) from their salaries and appointing them to positions incommensurate with their professional qualifications, e.g. as health care assistants or interns. She also condemned the anti-Bulgarian and anti -Romanian sentiment found in many Western European countries, which fuelled discrimination and prevented full integration of health workers.

Hyusmenova affirmed that there is a clear need for coordination at European level for the sustainable development of this sector in 'source' countries. In October 2014, she submitted a question to the European Commission regarding the actions it intended to take in this direction. The Commission response stressed, *inter alia*, that it encourages Member States to enhance awareness regarding mobility flows, to take advantage of training opportunities through bilateral agreements, and make best use of the EU structural funds for 2014-2020 and other programmes and opportunities supporting the Europe 2020 strategy.

MEP Hyusmenova concluded her intervention by maintaining that cross-border cooperation, as well as the use of Structural and Cohesion Funds must be increased and that they should be at the disposal of all Member States to provide quality healthcare across the entire EU.

**During the ensuing rounds of Q&A / comments,** the following points were made:

- The importance of recognising diplomas across Europe and the standardisation of training contents and quality was stressed by Ms Pinto da Costa.
- Ms Williams, Royal College of Nursing (UK), saw a key role for the EU not only for passing legislation but also for implementing and monitoring it. Some data were more

difficult to collect than others, especially if small institutions are involved, which made it harder to monitor and supervise how they were implementing policies. Moreover, she pointed out that homecare workers, providing medical and/or social care, are particularly vulnerable to various forms of exploitation and facing the risk of indecent working and pay conditions and contractual agreements.

- Remco van de Pas stated that social protection mechanisms are prerequisites for reducing mobility flows and retaining workers. For example, establishing a minimum salary also for health workers in all EU Member States could be a feasible retention measure.

In response, Mr Dielmann noted that for nurses, diploma recognition is quite easy to implement but that this is more difficult for doctors with medical specialties. In his view it is the task of the Commission to harmonise diploma recognition.

Nessa Childers agreed that lack of implementation and monitoring are not specific to the health sector, but in general when laws are passed implementation should be better monitored.

MEP Hyusmenova added that there should be clearer definitions of all these problems. There should also be more meetings on health workforce, organised by the European Parliament but also the Commission and the European Council to clarify their different roles and solutions, and to multiply the contacts with external experts such as NGOs. This would help the representatives of EU Institutions better understand the reality of these problems.

Mr Dielmann stated that trade unions and their employers' counterparts need to work to raise the awareness regarding this situation. He stated that a political framework was needed for protecting migrants' rights, with appropriate financing by the Member States and the EU.

Mr Gae spoke in favour of common initiatives between the Member States and for establishing partnerships to be able to better address the problems of transnational health worker migration. The results of this cooperation need to be disseminated in the European Parliament in order to receive more political support from MEPs, in line with a co-responsibility of the European Institutions for measures to alleviate the problems stemming from cross-border migration.

**Hosting MEP Nessa Childers** concluded the discussion by pointing out the need for another meeting to follow up on these issues because they are so broad. A political framework was necessary, and that European Parliament ought to remain on guard to ensure that nothing escapes the EU political agenda. European solutions are needed but they are not easy to achieve since they are also related to the political will for a closer Union, and achieving policy coherence across different Committees.