EAST-WEST LABOUR MIGRATION AND INTEGRATION: TRENDS AND PROSPECTS FOR HEALTH PROFESSIONALS

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INTRODUCTION

The labour market situations in the East and West could provide an incentive for governments and employers to develop more extensive openings for migrants from Central and East European countries (CEEC) in the European Union (EU). This chapter will examine opportunities and obstacles for CEE health professionals during the transition period and beyond. The processes of enlargement to Central and Eastern Europe, and Cyprus and Malta, will eventually enable the people of twelve additional countries to move and seek employment freely within the enlarged EU labour market. East-West labour migration will therefore constitute, in the foreseeable future, a much grater element in the migration movements in Europe. Germany, and to a lesser extent, Austria and Italy have so far been the preferred EU countries for CEE migrants. They have developed various schemes to provide controlled admissions for temporary employment since 1989. The objectives of the schemes vary between countries and employment sectors, but on a broader level they aim to promote co-operation between East and West European employers and mutual benefits to the countries concerned (Werner 1996). On a smaller scale, programmes also exist between Central and East European countries (CEEC) and Belgium, Finland, France and Sweden. Other EU countries have so far shown little inclination to participate actively in the development of short-term employment opportunities for CEE migrants. However, reviews of immigration laws in a number of EU economies are underway because of changing trends in labour demand and supply.

Current and potential recruitment difficulties in the West open opportunities for skilled CEE migrants. Their geographical and cultural closeness, and their imminent membership of the EU, places them in an advantageous position in the pool of potential candidates. Employment growth in OECD countries is expected to be highest in the computer industry, followed by the health sector (Hilbert et al 2000). Although such demand will vary between countries, the need for medical, nursing and caring skills is unlikely to diminish in the foreseeable future. At the same time, health professionals in CEEC have been laid off due to the restructuring of the health sector, and others are willing to emigrate because of declining employment conditions (Heitlinger 1999; Heidenreich 2001). Moreover, the training systems of health professionals in CEEC have undergone many changes in the 1990s. They have been adapted to meet

EU and international requirements (Buchner-Jeziorska and Evetts 1997; Heitlinger 1999).

The chapter is divided into three sections: It begins with a brief overview of migration patterns since the late-1980s, and the restructuring processes in the health sector in CEEC. These sections will identify some of the main causes for temporary skilled migration to the West. The core of the chapter discusses the diverse factors and processes that may influence the incorporation of CEE health professionals in EU labour markets. Britain and Germany provide the broader societal-structural context, and the institutional arrangements and policy developments in the health sector the specific basis for the analysis. Germany has the highest proportion of CEE migrants residing and working in the EU. On the other hand, Britain has been reluctant to develop specific employment schemes for CEE migrants. Furthermore, the two countries differ in their employment and health care systems, and in the demand and supply factors among health professionals. The experiences of, and outcomes for, CEE migrants will be conditioned and shaped by these societal structural factors and developments and the regulatory system of the professions in the individual countries. Opportunities and obstacles to CEE health professionals will be discussed by examining four areas: labour demand and supply, legal framework, training and regulatory processes, and professional roles and work organisation. To ensure in-depth discussion, the analysis will, in part, focus on one profession (nursing) from two sending countries, the Czech Republic and Poland.

Patterns of East-West Migration

The current stock of CEE migrants in the EU is estimated at about 850,000 or 0.2 per cent of the EU population. The stock of CEE workers amounts to about 300,000 or 0.3 per cent of the EU workforce. Around 80 per cent reside in Germany and Austria. The majority of the existing stock immigrated before 1993. Since then net immigration from CEEC has been insignificant because of increasing restrictions in the countries of destination (Boeri and Brücker 2000). No EU-wide legislation on the employment of non-EU migrants exists. However, non-EU labour migrants usually enter member states via a work permit system. A number of countries, in addition, have signed bi-lateral agreements with their East European neighbours. Some agreements have existed for a long time, others are more recent. According to the classification of the UN agencies, this form of migration includes migration for training, migration for professional or business purposes, and contract migration (including temporary, seasonal and project-tied workers). Such migration movements are temporary, and vary in duration between the different types and countries (Werner 1996).

Migrants from Poland, the former Yugoslavia and, in recent years, the former USSR form the largest groups in Western Europe. Others include workers from the Czech Republic, Hungary, Albania and Bulgaria. The majority is young or middle-aged

and has tertiary or secondary level education. Most work as contract employees, and predominantly in agriculture, the building trades and nursing. There has also been an increase in 'brain drain' migration. In the 1970s and 1980s, such migration movements occurred mainly among students and researchers. In the 1990s, other professional groups in addition have increasingly taken up opportunities in the West, including physicians, computer scientists, engineers and technicians. Little is known about this migration path, as it is a fairly recent phenomenon. However, research undertaken on East European commuters and seasonal workers found that many East European university graduates were in jobs that did not require high level education, and Polish university staff and teachers worked in the service sector in Western Europe (Blaschke 1994; Molle et al 1994).

Many analysts predict that the flow to the West will probably grow in the foreseeable future (Molle et al 1994; Hönekopp and Werner 2000). There is, however, little agreement between them about the migration potential. Figures range from 590.000 to 1.18 million per year until the year 2010, declining to between 300.000 and 530.000 per year by the year 2030 (Franzmeyer and Brücker 1997). No figures are available on the migration potential of health professionals but, as already indicated, their migration may become more substantial because of labour shortages in the West and loss of jobs and poor employment conditions in the East. The following section looks at the transformation of the health sector in CEEC to identify some of the push factors for the emigration of health professionals.

Health Sector Restructuring in CEEC

Economic restructuring in CEEC has been accompanied by an increase in unemployment, a reduction in social and welfare services, a worsening of the working conditions, and major changes in the training, regulation and status of occupational groups. These developments, together with low incomes, lack of employment opportunities and poor prospects, are among the economic factors encouraging people to seek opportunities in Western Europe. Mistrust of new governments, poor housing, environmental conditions, the young age structure of the population, and cultural and geographical closeness to Western European countries are among the non-economic push factors (Golini et al 1993; Drbohlav 1997). The importance of each of these factors apply to some countries more than to others (Grečić 1993). Their significance is also likely to differ between occupational groups.

Since 1989 health care systems in CEEC have undergone complete reorganisation. The timing and the intensity of the reforms vary, but common among them has been the selection of the Bismarckian system of compulsory health insurance. The dismantling of the centrally planned system offering universal coverage and the introduction of a self-governing social health insurance system required changes to health care financing, management, planning, efficiency, and the organisation and employ-

ment of staff (Deppe and Oreskovic 1996). The impact of the reforms on profession-state relations and the conditions of employment have been wide-ranging. The process of restructuring has led to the creation of independent self-governing medical and nursing associations, a shift from political to professional control over the content of medical education and research, and modifications to medical and nursing training. Moreover, clinics, hospitals and health practitioners, including nurses, have been given permission to offer services privately (Heitlinger 1995; Deppe and Oreskovic 1996). As a result of the reorganisation, the majority of CEEC have experienced a slight but constant decline in the numbers employed by the health sector throughout the 1990s (European Training Foundation 2000).

The reorganisation of the health care system during a period of economic and social difficulties, including unemployment, has come under growing criticism in most CEEC. In the Czech Republic, for example, large-scale privatisation has been seen as the ultimate goal of health care and other reforms. The privatisation of many clinics and medical practices, however, has increased fears about gaps in regional and medical speciality provision. The fee-for-service scheme has been criticised for being too complex and expensive for it encourages professionals to provide more services in order to increase their salaries (Heitlinger 1995). Moreover, the introduction of self-governing professional associations has not achieved the desired goals. They have received educational, licensing, fee-bargaining and lobbying functions, and together with the trade unions, have exerted major influence on the debate and subsequent strategies about health care reforms and changes in the training of staff. However, as regards improvements to employment conditions, the medical and nursing lobbies have had limited influence, despite widespread industrial action. Salaries have remained very low compared to other occupational groups: for example, the average salary for a doctor was about 7,000 crowns a month whereas a metro driver earned 12,000 crowns in the mid-1990s (Heitlinger 1995). Nurses earn about 6,500 crowns a month, which is also below the average salary of employees (Heidenreich 2001). Perhaps not surprisingly, the demand for nursing training has declined. In 1995 the nursing high schools in Prague received one-half to one-third fewer application than in the previous year (Heitlinger 1999).

In Poland, health reforms, including the restoration of a health insurance system and the introduction of privatisation schemes, have only come into force in 1999. Despite re-examining the proposed structural changes and slowing down the process of reforms, dissatisfaction with the restructured health system is widespread (Deppe and Oreskovic 1996; Domagala 2000). Criticisms have been raised against the slow development of administrative decentralisation and the delivery of home-care through family doctors. District hospitals in cities have lost their district status in the transformation process. Their role and financial situation, and the surplus labour that will arise as a result of the change, have remained uncertain (Heidenreich 2001). First estimates predict job losses of 10 per cent, though the indications are that losses will be closer to 30 per cent (Domagala 2000). In 1989 all occupational groups with higher education, including doctors and nurses, obtained the right to self-government and

representation of their professional interests. Since 1992, most aspects of professional regulation have come to be influenced by the professional associations and, more so, by the market (Buchner-Jeziorska and Evetts 1997). Professional associations, in conjunction with independent examination boards, have begun to control registration, licensing and accreditation, and the monitoring of the curricula. The market is determining the numbers of students, professional career development and increasingly also pay. The growing privatisation of health care provision and the withdrawal of the state from its control and funding has led to a two-tier system in the occupational situation of professionals. Those working in the private sector operate according to different regulations and effectively determine their own fees for service provisions. Those working in the public sector have increasingly had to defend their interests through trade union activities (Buchner-Jeziorska and Evetts 1997). Strikes and demonstrations by health sector personnel in response to poor pay and growing job insecurity have become numerous (Domagala 2000).

Other CEEC have undergone similar changes (Deppe and Oreskovic 1996; Richardson 1996). As regards the workforce, the focus in CEEC has been on educational reform, the conditions of employment have been neglected. In fact, they appear to have worsened in the process of change. The migration potential among health professionals is therefore relatively high. In the short term, regulated East-West migration will continue to be influenced largely by the economic and institutional factors in the receiving and, probably to a lesser extent, the sending countries. The following section will examine the structures and processes that will influence the incorporation of CEE health professionals in EU countries, with specific reference to Britain and Germany.

OPPORTUNITIES AND OBSTACLES IN THE EU

Labour demand and supply

The ability of individual labour markets to absorb labour influences migration and the quota for the temporary employment schemes. Many EU countries are short of nurses, and Britain is also experiencing a severe shortage of doctors. In Britain, many hospitals claim a severe crisis in recruitment and retention of health professionals, particularly in large cities, and especially in London. Nation-wide, there are almost 10,000 nursing vacancies remaining unfilled for three months or more, and many hospitals have had to make increased use of agency staff and bank nurses.[1]

Bank nurses are estimated to fill about 10,000 nursing posts at any given time. Recruitment difficulties are likely to worsen in the future because of an ageing nursing workforce. The percentage of medical vacancies still unfilled after three months in

[1] Bank nurses register with the hospital (and not an agency) for temporary work. They are drawn on when there is an increase in the demand for staff.

some hospital-based specialities is seven per cent. Eleven per cent of general practitioner vacancies lie vacant for more than six months. Other developments will add to such trends. For example, a large proportion of overseas doctors who came to Britain in the 1960s and entered general practices will retire in the next few years, with some health authorities potentially losing 25 per cent of their general practitioners (Davies 2000). A series of cohort studies (1983-1993) on the intentions of newly qualified doctors identified a doubling of the percentage of 'undecided' graduates, and a significant increase in the number of newly qualified medical graduates not wanting to pursue a career in Britain (Lambert et al 1997). Staffing shortages have recently worsened, largely as a result of the government's increased investment in the National Health Service (NHS) (Davies 2000). It aims to bring the current funding level of the NHS (6.8% of GDP) closer to the European average (8.6%), to modernise the NHS and achieve a fully patient-centred health service within a 10-year period. As part of the NHS plan, published in 2000, the government promises 7,500 additional consultants, 2,000 general practitioners, 20,000 nurses and 6,500 therapists by the year 2004.

Germany has recruitment problems in nursing, though not in medicine. However, certain developments signal a change in the demand for doctors. Discontent among the medical profession is growing because of declining working conditions and poor pay. Increasingly, young doctors turn to alternative careers, and the numbers applying for medical training have declined over the past few years. Some areas of medicine are particularly affected, such as rehabilitation, radiology, neurology and general medicine (Wüsthof 2001). In addition, a recent ruling by the European Court on working hours will increase the need for additional medical staff throughout the European Union, as doctors' on-call hours in the hospital will be counted towards their full working time by employers (Weber 2000). Nevertheless, at present recruitment problems are restricted to nursing and caring staff. The reasons lie partly in the low staff-patient ratio and partly in high staff turnover and dissatisfaction. Until the early 1990s, the ratio was still based on a formula established in 1969, despite an increase in the number of patients with higher care needs (Schmidbauer 1992). Vacancies have declined since 1993, and official figures for May 1999 show 19,000 vacancies and 107,000 persons seeking work in the health services sector (Heidenreich 2001). Despite the decline, the situation has by no means eased. Hospitals have faced growing budgetary constraints since the 1993 reforms, which has limited the annual increase of their budgets (Dietrich 1995). Moreover, the fixed daily rate for care was replaced with a differential fee system in 1996. Responses to these budgetary reforms and the nursing care insurance of 1996 led increasingly to the provision of inadequate training programmes, and the recruitment of unqualified, assistant, and foreign staff. Shortages are expected to worsen because of the continuing increase in care needs and the decline of young people who opt for the profession (Becker 1996). A forecast by Prognos for the year 2010 shows an additional demand of 170,000 nursing and caring staff (Heidenreich 2001). The budgetary reforms to come into effect in January 2003 will introduce a flat rate fee system for groups of related diagnoses, which will impose further budgetary constraints on hospitals (Simon 2001).

Reducing staff shortages in the British and German health sectors will, therefore, be one of the key challenges of the next few years. Both countries have introduced initiatives to attract new staff and returnees. In Britain, new nursing categories have been introduced and pay also increased. The NHS Plan of 2000 sets out a number of new roles and responsibilities for nurses, offering a wider range of clinical practice, and improvements to continuing professional development (Bird, 2000/2001). In Germany, increased pay scales and fringe benefits and the provision of some university programmes in nursing studies have been introduced to improve the status of nurses (Wagner 1996). Despite these changes, nurse recruitment and retention have been insufficient to meet demands. Both governments have had to resort to foreign recruitment. Over 13 per cent of employed health associate professionals in Britain, among them mostly nurses, are foreign-born (Salt and Clarke 2001). The number of foreign nurses and midwives has increased by 48 per cent in the past year. Several large hospital trusts have signed agreements with the ministries of health of a number of countries to recruit nurses. Some hospitals offer special bonuses for weekend and night shifts to increase the earning capacity for these nurses. Others provide flexible work arrangements so that migrant nurses can work in different locations in Britain and take longer breaks for the purpose of travelling (Heitlinger 2000). About 28 percent of medical and dental staff in Britain obtained their primary qualification outside the European Economic Area (Department of Health, 1998). Despite the current shortage of doctors, health trusts have been reluctant to increase foreign recruitment, claiming that training outside the UK is inappropriate for the workload found in most hospitals (Davies 2000). Germany does not maintain statistics on foreign health professionals, and EU statistical sources do not categorise their samples into health personnel (Scar 2001). Estimates of foreign workers in the health sector therefore diverge widely. These range from four to forty per cent, with the highest share expected to be in large urban agglomerations (Heidenreich 2001).

It is evident that attracting foreign labour for shortage areas has been a common strategy adopted by both governments to solve past and current recruitment problems. Skill shortages and skill mismatch in European health sectors may open up employment opportunities for CEE migrants. Temporary migrants on work permits are particularly beneficial to employers because the quota admitted and the skills required can be adjusted flexibly according to the labour market needs (Werner 1996). Occupational deficits may contribute to a relatively smooth integration of foreign labour in the respective labour markets.

Legal Framework

Despite the opportunities that may arise as a result of the labour market situation in the West, migrants may face legal barriers in obtaining employment. Access to labour markets for third country migrants is regulated by a set of work or residence

permits defined by the existing national laws governing immigration. These vary between EU countries and also for different migrant groups within countries. With regard to the migration from CEEC to EU countries, entry rights and access to work operate either through bilateral agreements and the work permit system (eg Germany) or only through the work permit system (eg UK). Temporary migration laws offer short-term work opportunities, usually up to one year with possibilities of extension, and long-term permits, which are primarily for skilled and highly skilled workers. Many EU countries have adjusted their temporary migration laws and have introduced temporary work opportunities for seasonal workers, project workers, short-term workers, and occupational trainees. Moreover, long-term permits have increased with the change in skill demands (OECD 2001a). For example, in the UK, the number of work permits issued to non-EEA citizens increased by 63 per cent between 1995 and 2000 to almost 65,000, and all but a few issued in 2000 were to the skilled and highly skilled on longer term permits. However, the different response to recruitment problems between the medical and nursing professions is reflected in the proportion of work permits granted. More than eighteen per cent were issued to nurses and midwives, but only one per cent to medical practitioners (Salt and Clarke 2001). The number of decisions given to nurses and midwives from the CEE applicant countries for admission to a part of the professional register has increased from 64 in 1989/90 to 348 in 1999/2000. These decisions are valid for two years, but may be extended (UKCC 2000). Moreover, the British government has recently announced the introduction of a Green Card Scheme, including a fast-track work permit system with quotas in areas of severe labour shortages, including fields of medicine. Skilled workers from Eastern Europe are specified as one of the key groups to attract (OECD 2001a; Travis 2001). Given the current workforce shortage in the British health sector, it may only be a matter of time that a wider variety of professionals allied to medicine will be added to the 'shortage occupation list'.

In Germany, since 1991, CEE migrants can obtain temporary work opportunities through a variety of work permit mechanisms: as a border commuter, a guest worker, a seasonal worker, a project-tied worker, a nurse on job placement, or as trainee or worker through a specific bilateral agreement (Hönekopp 1997). In 1998, 234,600 CEE migrants entered Germany under these various schemes, including about 400 placements for nurses. Ninety-five per cent of all work permit holders work in the former West Germany. However, the numbers of non-EU foreign workers on work permits have declined since 1993, partly because of the deteriorating economic situation. Moreover, the permits are valid only for a specific activity, and are granted in many cases on the proviso that the existing labour force, German and foreign, will not be disadvantaged (Werner 1996). Exceptions to the rule of prior entitlement exist for the employment of contract labour and of guest workers from CEEC, though annual quotas are set for each nationality and occupation depending on the labour market situation. In addition to the 'ordinary' (general) permits, there are a small number of 'special' permits that give free access to the labour market for a limited or unlimited period without geo-

graphical or occupational restrictions. Furthermore, a Green Card work permit scheme was introduced in 2000. At present, the scheme is aimed at information technology specialists to allow employers to extend their recruitment catchment areas to non-EU countries in order to solve staffing shortages (OECD 2001a). However, a review of the Green Card scheme has been on the political agenda over the past few months. The scheme has been criticised by some for being inflexible. For example, the permit is restricted to a period of five years, and it requires the holder to be offered a salary of at least DM 100,000 per year (Haase 2001). The outcome of the review may lead to more flexibility and expansion of the scheme to other employment sectors. The revised scheme may offer additional opportunities of access to employment for CEE migrants.

Thus, the movement of labour from CEE (and other non-EU countries) to EU countries is tightly controlled. Regional, sectoral, numerical and durational restrictions usually apply for temporary employment opportunities. However, further deregulation of labour markets as a consequence of greater Europeanisation and globalisation can be expected. Changes in the demand for labour has already led governments to relax the regulations under which workers trained abroad can work in EU member states. Growing demand in skilled and highly skilled labour will further promote the expansion of the legal routes into national labour markets for non-EEA migrant groups.

Training and Regulatory Processes

Access to employment will be influenced by the institutional structure and organisation of labour markets and employment sectors in individual countries. Many occupations in the European health sector, including the medical and nursing professions, are regulated either by professional associations (eg UK) or by State bureaucracies (eg Germany). In Britain, self-regulatory professional associations operate license and registration systems, and thereby control the numbers and limit access to professional practice positions. They assess and accredit education and training courses.[2] Although

[2] Nursing training in Britain is the responsibility of the National Boards (England, Scotland, Wales and Northern Ireland) for Nursing, Midwifery and Health Visiting. The United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) administers the professional register for each qualification. First level nurse training takes three years. It consists of a common 18 month foundation programme for registered general nurses within the university system, which is followed by a choice of four specialisation programmes for another 18 months. Post-registration training is offered by the Royal College of Nursing, and other further education institutions approved by the individual national boards. The UKCC may set standards for such courses. A record of all courses undertaken must be kept in the personal professional profile for verification by the UKCC. To practice legally, nurses must be registered with the UKCC. To remain on the register, they must undergo a minimum of five days training every three years, and keep a record of reflection on learning in a personal professional profile. Health care assistants undergo work-based training of varying lengths and often hold National Vocational Qualifications (NVQs, levels 2 and 3), but have no professional qualification. The average training for level 2 takes 6-12 months, and for

the government has increasingly criticised, and intervened in, aspects of professional self-conduct, including training and supervision practices and structures, the professional associations have maintained their self-regulatory role. In contrast, in most mainland EU countries, with singular exception, professional associations do not exist in the same way nor perform the same functions as in Britain. In Germany, for example, the State accredits education and training courses. It operates the licensing and control procedures, and professional associations and the State negotiate over control of professional regulation (Buchner-Jeziorska and Evetts 1997).[3]

EU migrants are guaranteed equal access to employment and equal treatment in employment conditions in member states by various legal provisions implemented since the Treaty of Rome in 1957. Even though, in practice, they still encounter difficulties (see Ackers 1998; Zulauf 1998, 2001), the initiatives with regard to the mutual recognition of qualifications and diplomas have removed important formal obstacles to intra-EU mobility.[4] CEE migrants do not yet benefit from EU legislation on freedom of

level 3 it takes 9-18 months. Details on educational and training provision and the regulatory framework for first level registration and post registration qualifications can be found in a study commissioned by the Internal Market Directorate General of the European Commission (European Commission 2000). The medical training is described by Rogers (2000).

[3] In Germany, the Ministry of Health presides over the nursing schools that are eligible to provide training. Federal law regulates four nursing qualifications: general nurse, children's nurse, midwife and nursing assistants. The training for the two nursing qualifications takes three years, for midwives two years and for nursing assistants one year. The details of education programmes and regulations vary between the federal states. Post registration training is not regulated by federal law. Each regional government has its own regulatory framework and recognises different disciplines of post-registration training. The length of training for post-registration qualifications varies between disciplines, but most last a minimum of one to two years full-time or the equivalent part-time. The German Hospital Association provides guidelines and lists of recognised further training institutions which regional governments may or may not adopt. Training for management and teaching qualifications are not regulated at either federal or regional level. Applicants apply to the German Hospital Association for recognition of their qualification. However, there is no guarantee that certificates are recognised throughout Germany (Dietrich 1995). To be able to practice, nurses have to register with the regional governmental body (Regierungspräsidium) responsible for registration in the area of their workplace. Details on the educational and training paths and the regulatory framework for initial registration and post registration qualifications in the various regions can be obtained from the study commissioned by the Internal Market Directorate General of the European Commission (European Commission 2000). For the medical training, see Bundesärztekammer (2001).

[4] Medicine and nursing were among the first occupations to benefit from EU sectoral directives, which were implemented during the 1970s and 1980s. Directives 75/362/EEC, 75/363/EEC and 86/457/EEC for qualifications in medicine (in 1993 integrated into one directive 93/16/EEC); directives 77/452/EEC and 77/453/EEC for general nursing qualifications (in 1989 amended by directive 89/595/EEC); directives 80/154/EEC and 80/155/EEC for midwives; and directive 89/594/EEC for doctors, nurses responsible for general care, dental practitioners, veterinary surgeons and midwives (which made amendments to all the above directives) govern the recognition process within the Community. Groups not covered by the sectoral directives had to wait until the implementation of the General Directives in the 1990s to benefit from EU legislation on the mutual recognition of qualifications. Directive 89/48/EEC covers qualifications in regulated profes-

movement. Recognition of their qualifications and skills will be largely at the discretion of the regulatory bodies of the host country and the employers who take them on. A number of international conventions protect third country migrant workers, but they apply only to those countries that have ratified them. For example, convention 97 (1949) of the International Labour Organisation (ILO), which aims to ensure equality of treatment for migrant workers in respect of issues such as pay, working hours, overtime, has been ratified by many countries. Yet, other more far-reaching conventions have not been ratified by the majority of European countries. This includes the ILO's convention 143 (1975) concerning migrants in irregular situations with regard to their entry, stay or economic activity and the promotion of equality of opportunity and treatment of migrant workers, and the United Nation's convention of 1990 on the protection of the rights of all migrant workers and members of their families. Importantly for CEE migrants, some conventions do not cover the short-term employment of migrant workers, for example the 'European Convention on the Legal Status of Migrant Workers' of the Council of Europe (Werner 1996: 10-11). Outside these international provisions, CEE migrants depend on the provisions as laid down in the bi- or multi-lateral agreements or by the labour protection laws and agreements of the host countries. For example, employers of work permit holders in Britain have to guarantee that pay and conditions are the same as those of British employees (Findlay 1995). In Germany, foreign employees on the Green Card Scheme are guaranteed a minimum salary of DM 100,000 per year. Even though this requirement has been criticised by employers and others for a variety of reasons, it helps prevent that foreign employees are being recruited as cheap labour (Haase 2001). Moreover, the German government has allocated a large budget funding on an annual basis for measures that promote non-discriminatory practices in the recruitment of foreigners and their comparable standards of living to Germans (OECD 2001a). Thus, reforms in the past years have led to some improvements in the status of foreigners, and more attention is being given to integration measures in many countries. Despite such measures and controls, foreign workers are more vulnerable than native workers to being in less favourable employment situations.

Knowledge about training and employment in specific sectors in CEEC, including the variety and paths of training and further training, types of qualifications, nature of occupations and skills, different licencing, registration and certification arrangements, and the different bodies controlling access, as well as diverse professional culture and practices, in Western Europe is limited. The transferability of the acquired

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sions that require three or more years of full-time (or equivalent) higher education training. A second general directive (92/51/EEC), which complements Directive 89/48/EEC, covers all those regulated qualifications that require less than three years of post-secondary school training. In countries where an occupation for the second general directive is not regulated, two years experience on the job are required for recognition in another member state (Commission of the European Communities 1975a, 1975b, 1977a, 1977b, 1980a, 1980b, 1986, 1989a, 1989b, 1989c, 1992, 1993).

skills and experience in a West European context, where such factors are also diverse despite the changes that have come about with European integration, is difficult to assess without undertaking extensive empirical research. At the macro level, according to Iredale (1999: 94), the integration of skilled migrants in a labour market may be experienced at three levels. Firstly, migrants may experience a negative reception, and be confronted with closed shop practices of trade unions, racial discrimination or lack of legal status, and obtain employment at a level below their qualifications and skills. Secondly, they may find themselves in a neutral situation, and obtain employment in the primary labour market at a level commensurate with their qualifications and skills. Thirdly, employment may occur within an advantaged context, and they experience upward mobility in their profession because of political, social and economic factors.

Some evidence about CEE migrant nurses in Austria and Germany, for example, suggests that many are employed as nursing assistants rather than qualified nurses on the grounds that their training is not equivalent to that of the host country (Heitlinger 1995; Heidenreich 2001). Nursing in CEEC has undergone major changes in the 1990s. For example, in the Czech Republic the old system of four year specialised training into general, women's and paediatric nursing in nursing high schools has been abandoned. Instead, a two-year training course for general nursing in nursing colleges was introduced in 1994-95, and specialised training paths have become available only to those who have completed the general nursing training. New training centres have been set up to offer specialised post-graduate courses on aspects of nursing theory, clinical practice and management. Similarly, nursing schools in Poland replaced its two and a half-year training for nurses and midwives with a three-year programme in 1996-7 to bring the training into line with standards set by the European Union, the International Council of Nurses and the World Health Organization. Higher nursing education has been available since 1969, offering masters diplomas in nursing studies (Wrónska 1996; 1998). Recent reforms in CEEC show a move towards harmonising nursing education with countries in the EU. Therefore, eventually, nursing education, certification and licensing will resemble those of Western Europe (Heitlinger 1999). CEE migrants who obtained their qualifications post the reforms of the 1990s should thus have received training equivalent to EU standards in terms of content and length. While nurses who obtained their qualifications prior to the educational reforms may need supplementary skills training to be effectively incorporated into the EU labour market, the four-year training in the past, for example in the Czech Republic, suggests that nurses received extensive instruction and experience. Research into the labour market position of ethnic Germans from CEEC in Germany and CEE migrants in Austria suggests that the returns on human capital acquired are low, despite high education levels. Many work at the levels of other immigrants in the country, even if in possession of good language skills (Drbohlav 1997; Boeri and Brücker 2000). Interviews with employers and regulatory bodies in British nursing in the mid-1990s found that expectations concerning linguistic competence were very high and determined access to employment. However, Britain did not experience a shortage of nurses at the

time. German hospital employers showed significant leniency with respect to linguistic ability. The reasons given were severe labour shortages and not wanting to alienate foreign nurses (Zulauf 1998, 2001).

Nonetheless, research into the employment status among migrant professional workers in a number of advanced economies provides ample evidence of a decline in occupational status for migrants, at least in the short run (eg Bernstein and Shuval 1995; Kiehl and Werner 1999; Robinson and Carey 2000). In the case of non-EU foreign nurses, many have in the past been unable to find jobs in Germany in which to make use of their qualifications and experience (Schmidbauer 1992). Recent research on CEE nurses suggests that downgrading to assistant scales continues to be widely applied (Heitlinger 1999; Heidenreich 2001). Repeated findings on graduates from medical schools suggest similar problems concerning achievement for overseas doctors in Britain (Berlin et al 1997). Robinson and Carey (2000) report that Asian doctors have had it twice as difficult being shortlisted, and overseas doctors more generally have been less successful in reaching the upper grades of the occupational structure. A major study undertaken on ethnic minority nurses in Britain show similar results (Beishon et al 1995). Recent research on foreign nurses in Britain is mixed, highlighting positive (Daniel et al 2001) and negative experiences (Gow 2001).

Non-recognition of work experience by employers is by no means restricted to CEE migrants working in EU labour markets. The High Level Panel (1997) identified this obstacle for EU migrants working in a wide variety of employment sectors and member states. The new simplification directive, which is due to be implemented into national law by January 2003, amends the existing directives on the recognition of diplomas and professional qualifications. It aims to create a more transparent and flexible framework for the recognition of qualifications, and includes an obligation on EU countries to recognise work experience obtained in another member state (Commission of the European Communities 2001; Scatizzi 2001). CEE migrants will not be protected by the legislation for several years subsequent to its implementation. However, they may benefit from the standardisation of conditions brought about by the directive, and the increasing importance attached to the diffusion of good practice and peer pressure to promote greater convergence of policies within the EU.

There is also the danger that temporary foreign staff will be employed on pay below the collectively bargained or regular wage (Werner 1996). European countries generally push for greater rationalisation and competition within their individual health systems due to budgetary pressures and changing government ideology, and there is a growing emphasis on the privatisation of health services. These developments have increased the demand for less expensive health workers. Those who are trained and experienced are particularly sought after (Phillips 1996). Heidenreich (2001) claims that the employment of foreign labour has been used as a strategy to save costs in the German health sector. Heitlinger (1999) reports that the alleged discrepancies between Czech high school and West European nursing diploma training have been used by Austrian and German employers not to pay local wages to Czech nurses. An addi-

tional factor may be the knowledge among employers in the West that the salaries of health professionals in the Czech Republic (and other CEEC) are low compared to those of other professions (Lunts 1998), and much lower than the pay of their counterparts in the West. For example, the salaries of health professionals in CEEC bordering Western Europe are about one tenth of those in the West (Heitlinger 1999; Heidenreich 2001). Migrants may not oppose the conditions offered since remuneration will still be significantly above the accustomed pay they received in the country of origin (Wrónska 1996). Moreover, the aim of temporary migrants often is to maximise income during the short period abroad (Werner 1996). Equal opportunities policies and their monitoring are therefore of particular importance for the protection of temporary migrants. In the absence of such protection, third country migrants on short-term contracts may be particularly vulnerable to experiencing discriminatory treatment in working conditions and pay.

Professional Roles and Organisation of Work

Adjustment to the professional role and organisation of work influences the integration abroad. Variations in these areas exist between countries because of differences in the institutional arrangements of labour markets and the organisation of employment sectors. The institutional structure, patterns of government, professional associations and professional relationships, and political and economic circumstances all influence the role of occupational groups, their autonomy and power within a national context (Freidson 1986, 1994). The status and role of occupations are influenced, among other factors by the historical development of training systems and by forms of work organisations and practices. Skills, level of competence and responsibilities assigned to particular occupational groups will therefore also differ between countries. Aspects relating to the professional role and organisation of work include the care system, the role and status of qualified staff, the role boundaries between staff, professional specialisation, staff-patient ratios, and job routines such as shift patterns and medication administration (Döhler 1997; Daniel et al 2001). However, studies about foreign personnel in European health sectors have shown that the care system and the staff-patient ratio are particularly problematic issues in the integration processes.

In nursing, care delivery systems largely determine the organisation of work. Care systems may be largely holistic or task-oriented. Britain fully incorporated a holistic care system into nursing training with the implementation of Project 2000 in the late 1980s. Various care systems have been implemented over the past years, the main ones being patient allocation, primary nursing and team nursing. Under the system of patient allocation, the nurse is in charge of a group of patients, usually for a shift or several days. Under primary nursing, a nurse is also assigned a group of patients, but assumes 24-hour accountability from admission to discharge. In team nursing, care is

supervised by a team leader who assigns a number of nurses with different skill levels, determined by the needs of the patients, to the provision of care (Higgins and Dixon 1992). The development of these care systems, together with the shift to university training, has given nurses greater autonomy in their professional role and professional status (Walby et al 1994). Due to the reduction of working hours and shortages of medical personnel, clinical work previously done by doctors has increasingly been shifted to nurses. Moreover, patient-focused care has contributed to the development of multi-skilled job designs and work roles. Although still widely opposed as a desirable development, the utilisation of generic workers in the health sector, ranging from NVQ-trained health care assistants to cross-trained qualified professionals, is likely to grow. They may account for 48 per cent of the workforce by 2005 compared to the current 28 per cent (Hurst 1997).

In Germany, care delivery systems vary within and between regions, though functional care continues to operate in many hospitals. Functional care is a largely task-oriented approach under which work is highly fragmented and routinised. A change to a patient-focused system has been in the process of being implemented by an increasing number of German hospitals over the past years. However, a survey among nursing staff found that the adoption of holistic care was not as widespread in general hospitals (54 per cent) and university hospitals (47 per cent) as in other institutions, such as specialised hospitals (60 per cent) and old people's homes (82 per cent) (Dietrich 1995). Under the system of functional care, nurses receive responsibilities for tasks and not patients, and tasks are distributed on a rota basis and not by professional grades. Contrary to British nursing, there is no clear division of labour within the various nursing grades (Taubert 1994; Döhler 1997). Although one nurse will be in charge of a particular shift, it can be a nurse who has just qualified. Developments of new systems of care have remained underdeveloped in comparison to other countries (Philbert-Hasucha 1993). Nurses in Germany lack professional status and autonomy (Herbst 1995). The 1990s have seen a growing shift towards a holistic care system, an autonomous professional status and role for nurses, and university training for managerial positions. Moreover, regular updating of skills through continuous and/or further training has become a requirement. Despite these changes, management problems, authoritarian management styles and lack of communication influence the employment conditions in the hospital and geriatric sector negatively (Heidenreich 2001).

Shifting to a different care system can create adjustment problems for migrant nurses. A shift from a functional to a holistic care approach could create uncertainties, and a lack of confidence in performing the work role, particularly in combination with language impediments. In contrast, a shift from a holistic to a functional care system may create resentment among migrants because of a loss of status and a fear of de-skilling. The level of difficulties experienced by migrants will vary, and will be influenced by a number of factors. Of particular importance will be the organisations' response to the specific needs of foreign staff, the migrants' expectations, attitudes and values, and the time period following emigration within which the migrants find them-

selves (Hormuth 1998; Daniel et al 2001). However, Czech hospitals appear to use a task allocation system. A dialysis unit in a Prague hospital, for example, puts one nurse in charge of a shift who hands over to the nurse in charge of the next shift. Other nurses simply read the report of the earlier shift and the nursing instructions of the day. Among the 30 nursing staff on the unit there are about six experienced nurses with the remaining numbers comprising new and inexperienced staff. Junior nurses complete the tasks as specified in the nursing instructions, without taking or being given much responsibility. Nurses carry out their work according to doctors' orders, and have little professional autonomy (Lunts 1998). Thus, the care delivery system resembles that of the German nursing culture. Care delivery and the role of nurses in Poland appear to be closer to the British system. A law passed in 1997 recognised the nursing profession as an independent occupation with extended tasks and responsibilities. This law has given nurses greater autonomy in their work role and has contributed to the development of nursing practice (Wrónska1998). Health sector restructuring in CEEC has reformed and upgraded nursing training and has expanded the functions of professional associations (Heitlinger 1999). These changes may gradually shift more responsibilities and power from doctors to nurses (Lunts 1998). The above factors combined may ultimately lead to further improvements in the autonomy and status of the nursing profession. It will aid their adjustment process in the West, particularly in those countries where holistic care has been practised for some time.

The staff-patient ratio has been identified as another area where health professionals may experience adjustment problems in the work environment. OECD figures for 1998/9 show a similar average ratio of doctors per 1,000 inhabitants between Britain (1.7) and Poland (2.3), and between Germany (3.5) and the Czech Republic (3.0). The same applies to the average ratio of practising certified/registered nurses in hospitals per 1000 inhabitants, which was 5.0 for Britain and 5.1 for Poland compared to 9.6 for Germany and 8.2 for the Czech Republic. These figures indicate a higher workload for the first group of countries compared to the second. However, both Germany and the Czech Republic have a significantly higher number of in-patient care beds per 1000 inhabitants (9.3 and 8.9 respectively) than Britain (4.2) and Poland (5.3). Staff-patient ratios differ between wards according to care category and needs, but the average ratios influence the supply of personnel on wards, and ultimately the workload of doctors and nurses. For example, in 1997 the average number of nursing staff per bed in acute care was 1.0 in Britain, 0.58 in Germany and 0.44 in the Czech Republic (OECD 2001b).[5] No figure is available for Poland, but a similarity between Germany and the Czech Republic can again be identified. How closely the staff-patient ratios in the country of origin resemble those in the destination country will therefore play an important role in the integration process of health professionals abroad.

[5] The groups of countries are also similar in collecting statistical data. Figures for Britain and Poland refer to public sector institutions only, whereas those for Germany and the Czech Republic include the private sector.

Clearly, differences in staff cover are greater between the Czech Republic and Britain and between Poland and Germany. However, adjustment problems to workloads on hospital wards may turn out to be minimal for a number of reasons. The restructuring process in the Czech Republic has led to the privatisation of many hospitals. The workload of staff in state-run hospitals has increased tremendously as a result because of the pressure to maintain their funding. The average ratio of nurses per patient has been impossible to uphold, with the effect that nurses have little time to communicate with patients. Moreover, the professional status of doctors, and in particular of nurses, in the Czech Republic is low compared to many West European countries. As a result of poor pay and status and heavy workloads, turnover of staff is high. Shortage of personnel is therefore a common problem (Lunts 1998). In Poland, stress, exhaustion and absence through sickness have been common features among the nursing profession (Wrónska 1996). Recent reforms may have worsened the situation. Increasingly, employers try to employ health professionals outside the Labour Code. Individual contracts allow them to increase the working time according to the needs of the hospital rather than the time requirements for specific tasks. Moreover, conflicts between management and staff have increased because of differing opinions about the importance of financial considerations and the value of care to the patient in service delivery (Domagala 2000). Thus, a number of factors in both CEEC contribute to disillusionment among health professionals, leading to high turnover and exit from the sector. For some, the developments may provide incentives to search for opportunities abroad.

However, if decisions to migrate are primarily driven by specific occupational improvements, then the German and British health sectors may not be able to fulfil these aspirations. As shown earlier, staffing levels on wards in Germany are low. For a long time, hospitals have had to rely heavily on assistant nursing staff because of high staff turnover and exit (Jacobs 1992). In recent years, an increase in the recruitment of insufficiently qualified or unqualified staff can be observed, especially in the provision of long-term care needs (Becker 1996). Britain in the past decade has favoured qualified rather than support nursing staff for the delivery of care. However, with rising health care costs and severe staff shortages, a shift in the balance between the two categories of staff has become a growing tendency (Hurst 1997). Such developments in the two EU countries suggest a more problematic integration process for foreign staff. Time limits will affect not only the level of input expected of staff, but also staff mentoring, and ultimately the tasks allocated to newcomers. However, there is wide evidence that migration is often prompted by a set of economic and non-economic reasons. Short work periods abroad, the main route for CEE migrants into Western Europe, may offer benefits and rewards other than those directly related to careers.

CONCLUSION

The purpose of this chapter has been to examine the potential incorporation of health professionals from the accession countries of Central and Eastern Europe in EU labour markets during the transition period. The discussion shows that many factors inhibit the movement of CEE migrants to EU countries, and their integration into the labour markets. Admission to the West is strictly controlled, and is mostly short-term. Only a small number of EU countries have developed schemes offering temporary employment opportunities to CEE migrants. Employment systems and the organisation of specific employment sectors provide additional obstacles. A number of potential obstacles for health professionals have been identified in the regulatory system for training, qualifications and skills, and the professional role and organisation of work.

However, a few factors do promote the migration of CEE migrants, and their integration, to the West. The demand for specific skilled labour, including health professionals, in the EU is high, and several countries already look for solutions to meet skill shortages. Attracting labour from non-EU countries has become one attempt to solve shortages of labour. The European Commission favours the encouragement of intra-EU mobility to meet new labour demands (Vandamme 2000). Yet such mobility has remained low throughout the existence of the EU. Enlargement to Central and Eastern Europe is imminent, and the push factors of migration in the East are unlikely to diminish in the near and intermediate future. Demand for skilled labour in existing member states, and the growing need to recruit labour from abroad may lead to the increased acceptance and recruitment of staff from CEE countries, and to improved employment conditions for CEE migrants in the West. However, wide varieties are likely to remain, unless member states agree on greater convergence of short-term employment schemes offered to CEE migrants. While such agreements may have little impact on the actual experiences in workplaces, they would provide additional protection against unfair treatment due to their status as temporary migrants with work permits.

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POVZETEK

DELOVNE MIGRACIJE VZHOD - ZAHOD IN INTEGRACIJA: TRENDI IN IZGLEDI ZA ZDRAVSTVENE DELAVCE

Monika Zulauf

Svoboda gibanja ljudi je bila predmet razprav med EU in novimi potencialnimi članicami. Začasne delovne pogodbe za delavce iz Srednje in Vzhodne Evrope (CEE) so bile na voljo že vse od kasnih osemdesetih let. Ta ponudba odpira legalno pot v trg delovne sile držav EU za priseljence iz držav CEE v obdobju tranzicije. To poglavje raziskuje različne faktorje in procese, ki vplivajo na profesionalno vključevanje zdravstvenih delavcev iz Češke in Poljske v Veliki Britaniji in Nemčiji. Njihov sedanji in potencialni zaposlitveni položaj je obravnavan v odnosu na povpraševanje ter ponudbo za takšnimi zaposlitvami, legalni okvir tega trga dela, uvajanje v samo delo in proces reguliranja takšnih procesov ter profesionalno vlogo in delovno organizacijo v njem. V poglavju se napoveduje, da bo povpraševanje po specialni kvalifikaciji in visoki izobrazbi pri delu v mnogih državah EU lahko vodila v širitev zaposlitvenih priložnosti za priseljence iz držav CCE v naslednjih letih. Zagovarja se stališče večje konvergence pri izdajanju dovoljenj začasnih zaposlitev med državami članicami EU, v prid pridobivanja višje stopnje zaščite zaposlenih in pravičnejše obravnave začasnih priseljencev s takšnimi delovnimi dovoljenji.

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