Observatory for Sociopolitical Developments in Europe

Migration of health-care workers from the new EU Member States to Germany

Major trends, drivers and future perspective

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Summary

Since the 2000s, transnational migration of health-care workers to EU Member States in Western Europe has significantly helped relieve shortages of professional personnel in this sector. Given the importance of migration for the sustainability of formal health-care provision, several institutional measures for the recruitment of foreign professional health-care workers have been taken in Germany. The present working paper examines the main migration trends from the new EU Member States to Germany in the health-care sector. It also sheds light on how the need for health-care services in selected regions of Eastern Europe is likely to evolve and discusses the key factors responsible for intra-European migration in the health-care sector. The following results are worthy of note:

- The number of migrant workers in the health-care sector in Germany is growing disproportionately compared to the group without a migration background. Health-care workers from the new EU Member States constitute the main driving force behind this development.
- Poland is the most common country of origin of migrant workers in the German health-care sector: every fifth migrant employed in the health-care sector comes from Poland. The other Visegrád countries (the Czech Republic, Hungary and Slovakia) are nowhere as significant in comparison. Most health-care workers from the Visegrád countries who migrate to Germany are unskilled.
- Demographic indicators currently show below-average demand for health-care services in the Visegrád countries compared to other EU Member States. This need, however, will increase rapidly in the coming years. Compared to western and northern EU Member States, the Visegrád countries have a significantly lower proportion of medical and health-care professionals to the overall population.
- Germany is currently one of the EU countries in which the largest proportion of foreign-trained medical and health-care professionals work.
- In most EU Member States, the number of foreign-born professional medical and health-care workers is significantly higher than the number of foreign-trained medical and health-care workers. Providing training for migrant health-care workers is thus in many cases being assumed by the receiving countries. In some EU Member States, therefore, we see a gradual substitution of foreign-trained by locally-trained foreign health-care workers.
- Significant migration factors that influence the migration of health-care workers from the Visegrád countries to Germany are, inter alia, geographical proximity, ease of transnational transport and communication as well as social and cultural acceptance of health-care workers coming from Germany's eastern neighbours. Legislative development towards an integrated labour market in the EU also encourages inflows of Central and Eastern European health-care workers to Germany and at the same time promotes intra-European competition for health-care workers.

1 Introduction

In several EU Member States, demand for professional health-care workers has been rising disproportionately against labour market expansion in the formal health-care sector (Reymen et al. 2015: 47).[1] It is well known that Germany is not an exception to this increase in demand, and that it suffers from a continuously growing shortage of qualified personnel: on the basis of model calculations, Germany's Federal Statistical Office and the Federal Institute for Vocational Education and Training (BIBB) have predicted a shortfall of 135,000-214,000 full-time trained health-care workers by 2025 (cf. Afentakis et al. 2012).[2] Various measures have been agreed within the scope of the federal government's "Training and Qualification Initiative in Elderly Care", a programme run by the German Federal Ministry for Family Affairs, Senior Citizens, Women and Youth (BMFSFJ) with the primary objective of increasing the appeal of health-care professions and improving conditions so that more young people in Germany might opt for careers in this field. There is, however, broad consensus in the professional community that Germany's existing potential to cover the need for professional health-care workers will not be sufficient to meet demand (BMWi 2012: 10). The BMFSFJ initiative therefore includes funding for concrete measures and pilot projects to recruit professional health-care workers from other EU Member States and from non-EU countries (BMFSFJ 2015: 124).[3]

The importance of transnational migration, particularly from EU Member States, for the sustainability of formal health-care provision in Germany becomes self-evident in this context. EU labour market integration measures and pertinent EU-level actions to promote intra-European recognition of qualifications and facilitate placement of professionals have helped counteract the shortfall of qualified personnel in the German health-care sector. The new EU Member States in Central and Eastern Europe have traditionally been important countries of origin of professional or informal health-care workers, either for permanent employment in Germany or for postings brokered by employment agencies.[4] Migrants from former socialist countries, in particular Poland, currently represent the majority of migrant workers in formal health-care provision in Germany. But at the same time, health-care systems in these Central and Eastern European Member States are also facing demographic and health-care policy challenges with regard to ensuring their own supply of professional workers. Despite the fact that population in these regions is often relatively young in comparison with other European countries, demographic change, here too, has been fuelling increased demand for health-care workers. In addition, care systems in the new EU Member States are still under-

1 According to the European Parliament study quoted here, EU Member States Austria, Belgium, Croatia, Denmark, Germany, Finland, Ireland, Lithuania, Malta, the Netherlands and Sweden currently suffer from an acute lack of skilled workers in the health-care sector.

2 The lack of qualified personnel varies significantly from region to region, but there is no doubt that the bottleneck is a nationwide phenomenon.

3 These measures and pilot projects are based on the WHO Global Code of Practice on the International Recruitment of Health Personnel, a set of guidelines adopted by the *World Health Organization* (WHO) in 2010. The WHO Global Code of Practice recommends that Member States discourage the recruitment of medical and health-care workers from countries who themselves face critical shortages of personnel in these areas (cf. Angenendt et al. 2014)

4 Migrant carers, who are almost exclusively female, often also work as domestic help within the context of all-round home care. The number of unreported cases of undeclared work among this group of migrants is significant (cf. Kniejska 2015; Körner 2014).

developed and fragmented. This means that health-care systems in the new EU Member States need to be reformed, and working conditions in care professions need to be improved there as well, among other reasons to improve retention of care workers (cf. Perek-Białas/Racław 2014). This means that there is a growing competition within the single European labour market for potential professional health-care workers between Germany and other receiving and sending countries (cf. Royal College of Nursing 2015; OECD 2015). The present working paper looks at the development of migration among professional and casual health-care workers with a special focus on Central and Eastern Europe, in particular the so-called Visegrád countries.[5] It aims to examine the main migration trends in the health-care sector and to identify the demographic and social factors that currently affect flows of professional health-care workers within the EU internal market which all together will continue to shape the European health-care labour market.

The paper begins with a quantitative examination of migration of professional and informal health-care workers to Germany. Several official sources of secondary data on the employment of foreign health-care workers have been consulted and assessed. It then outlines the demographic trends in the Visegrád group which in the long term will determine the need for health-care services and for professional and casual health-care workers in these countries (chapter 3). And finally, the main factors fuelling migration among health-care workers are examined as part of a *push and pull* analysis (chapter 4). This analysis examines on the one hand the factors that make the German health-care sector attractive for health-care workers from other EU Member States, and on the other hand it identifies the factors which – in addition to economic reasons – are responsible for the migration flows of professional health-care workers.

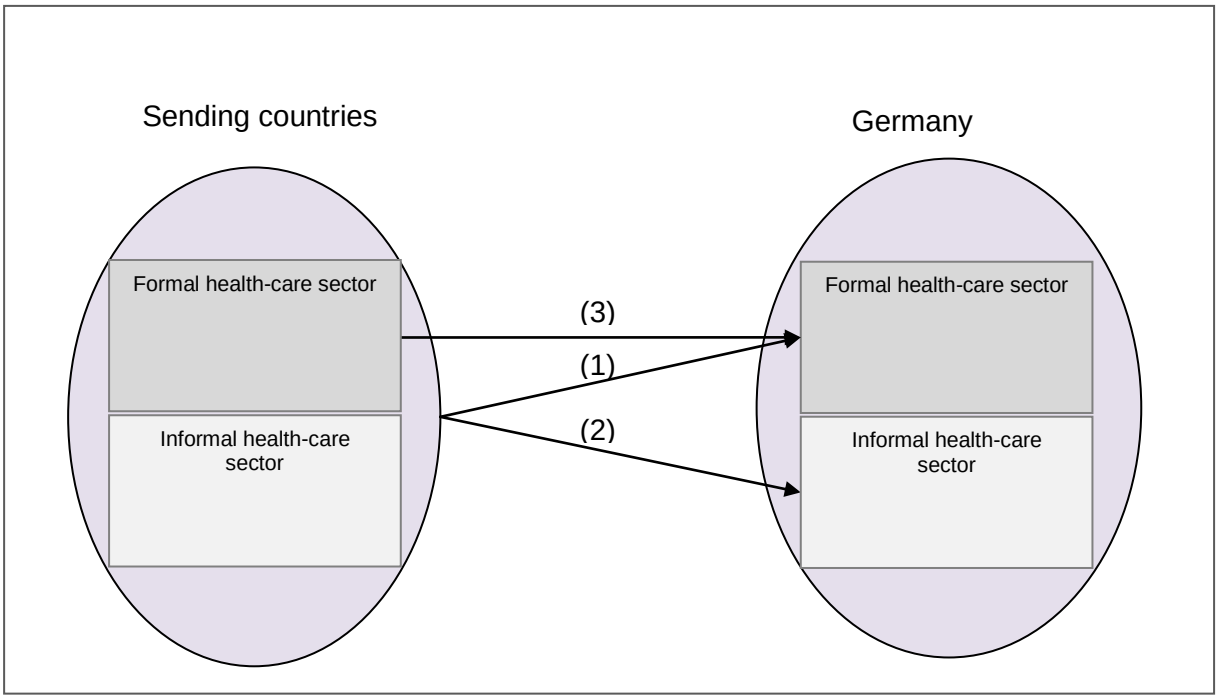
2 Migration in the health-care sector from a quantitative perspective

The present chapter evaluates various types of data at national level providing a quantitative overview of migration in the health-care sector in Germany. The aim of the chapter is to analyse existing quantitative secondary data on migration in the German health-care sector. To this end, this paper presents the current scope of migration and the development of three selected migration patterns in the health-care sector. The analysis is based on the research model of migration flows in the medical and health-care sector proposed by Diallo (2004) considering the following migration patterns (cf. fig. 1):

(1) Migration to exercise health-care activities in the *formal* health-care sector
(2) Migration to exercise health-care activities in the *informal* health-care sector
(3) Migration of foreign *professional health-care workers* to exercise care activities in the *formal* health-care sector

5 Countries to be examined were selected according to the *most similar system* design: the EU 2004 accession states of the Visegrád group (Poland, the Czech Republic, Slovakia and Hungary) share a common socialist history and regularly exchange information in their efforts to modernise their economic and social systems.

Figure 1: Migration patterns in the health-care sector



Source: Own presentation based on Diallo (2004).

The quantification of the first migration pattern (1) – migration in the formal health-care sector (section 2.1) – is based on evaluations of a microcensus carried out by the German Federal Statistical Office and on labour-market data collected by the Federal Employment Agency. These statistics quantify gainful employment of migrant workers in the health-care professions as well as employment of foreign workers in elderly-care jobs that are liable to social security. No official data are available to quantify the second migration pattern (2) – migrants in the informal labour market (section 2.2). Secondary data from various research projects on this topic have been used. To draw a quantitative picture of the third migration pattern (3) – migration of trained health-care professionals (section 2.3) – we have examined official records of applications for qualification recognition on the basis of the Professional Qualification Determination Act that came into force in 2012 (Berufsqualifikationsfeststellungsgesetz, BQFG). The BQFG regulates recognition of foreign professional qualifications on the basis of reference professions underlying German federal law. These qualification recognition procedures are available to foreign-trained professional health-care workers who wish to have their qualifications recognised according to German standards. The final section of this chapter analyses migration in the formal health-care sector from a European comparative perspective (section 2.4). The working paper then makes comparisons and draws conclusions to identify the special quantitative characteristics of migration in the health-care sector.

2.1 Migration to exercise health-care activities in the formal health-care sector

According to the microcensus of the Federal Statistical Office, more than 3.1 million people were employed in professions of the medical and health-care sector in 2015, including some 419,000 persons with direct experience of migration.[6] This means that currently more than every tenth person employed in the health-care sector (we refer to them as “Pflegekräfte”, or “health-care workers”)[7] are migrants to Germany; 88 % of these are women. The proportion of women among migrant health-care workers who are gainfully employed in Germany is 5.5 per cent higher than among employed health-care workers without a migration background or experience of migration.

Roughly 183,000 of the 419,000 health-care workers who migrated to Germany in 2015 came from other EU Member States. This means that approx. 44 % of migrant health-care workers are from other EU Member States. Of these, the vast majority migrated from the new EU Member States: some 147,000 are from countries that joined the EU after 2004.[8] This represents over 80 % of employed migrant health-care workers from the EU and 35 % of total figures for employed migrant health-care workers (cf. fig. 2). In spite of the restrictions that applied to free movement within the EU single market for workers from the new EU Member States between 2004 and 2011 – from Romania and Bulgaria until 2014 and from Croatia until 2015 –, most migrant health-care workers in the formal health-care sector came from the new EU Member States.

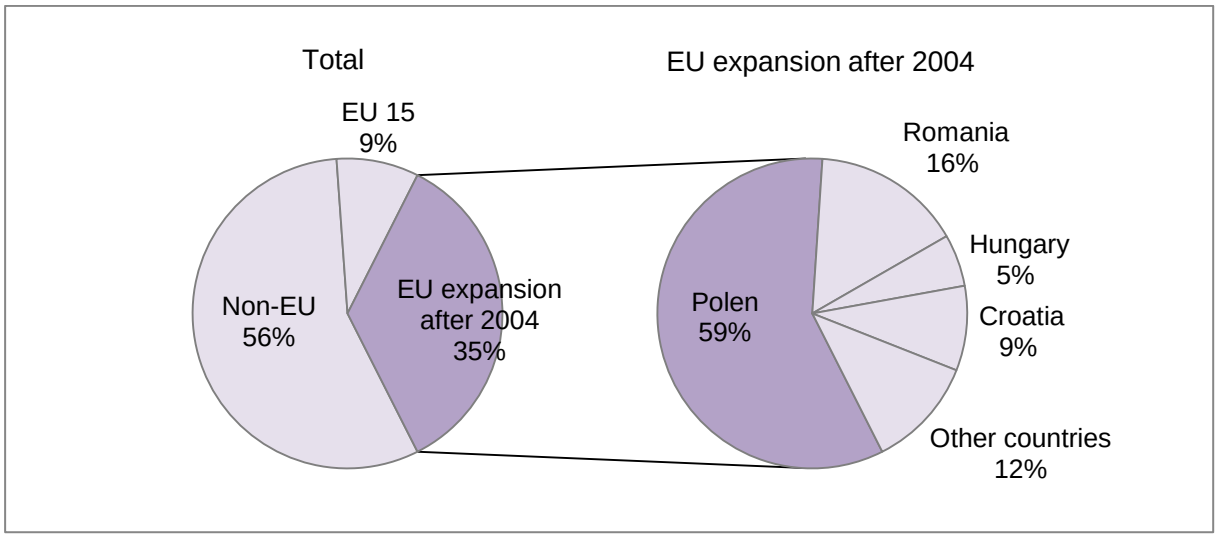
With a share of nearly 60 % of migrant health-care workers from the new EU Member States and a share of approximately 20 % of all migrant health-care workers now in employment, Poland represents the most common country of origin of migrant health-care workers: at present, roughly every fifth migrant health-care worker comes from Poland. Compared to Poland, the other Visegrád countries (the Czech Republic, Hungary and Slovakia) are nowhere as significant in terms of employment numbers in the health-care sector. The number of employed migrant health-care workers by country of origin also shows that other traditional sources of foreign workers in Germany, countries such as Turkey, currently have no significant weight within the group of employed migrants in the health-care sector.

6 These data cover gainfully employed migrants in the formal health-care sector, i.e. all those born abroad who have migrated to Germany, do not have German citizenship, and exercise occupations in the German health-care sector. According to the definition used by the International Labour Organization, employed persons are all persons 15 or older who work at least one hour per week for payment, or are in an employment relationship, have a business of their own or exercise a liberal profession (Federal Statistical Office, no date). Health-care professions are defined on the basis of the umbrella list of medical and health-care professions proposed by the Federal Employment Agency which is normally used to define “health-care workers” in official statistics. Basically, the umbrella lists includes all activities dealing directly with patients: medical care and nursing and therapeutic activities as well as non-medical care and social support of persons in need of care (cf. Federal Employment Agency 2013).

7 The data-analysis of the German Federal Statistical Office refer to this occupational group as “Pflegekräfte”, or “health-care workers” (cf. Federal Statistical Office 2015).

8 This group of countries includes Cyprus, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia and Slovenia.

Figure 2: Migrant workers in the health-care sector by country of origin (2015)

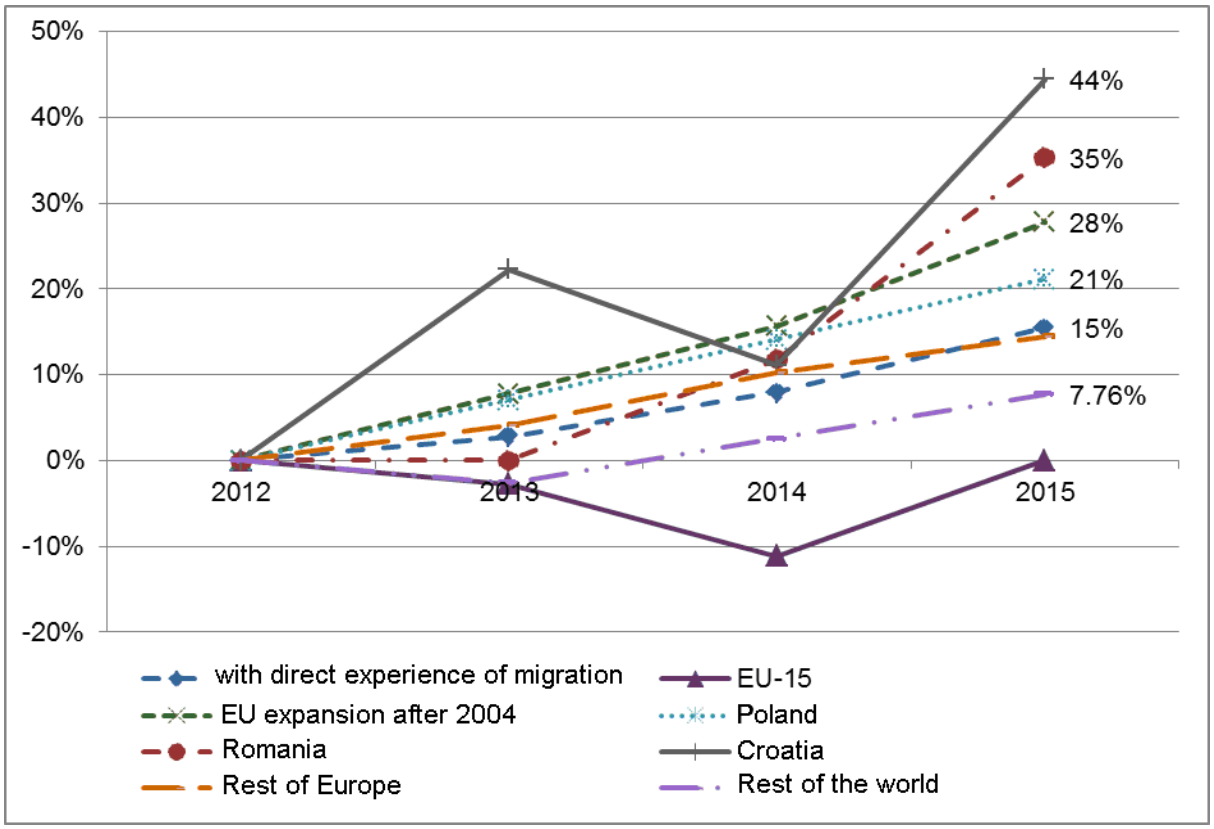


Source: Own calculations based on special evaluations of the microcensus of the Federal Statistical Office

In recent years, there has been a significant increase in migrant workers in the health-care sector. Between 2012 and 2015 numbers in this group increased by 15 %: from 363,000 in 2012 to 419,000 in 2015. This means that the ratio of migrants to total employment figures in the health-care sector grew by a whole percentage point within this short period of time: from 12.4 % in 2012 to 13.4 % in 2015. The number of persons employed in health-care professions who do not have a migration background or migration experience, on the other hand, shows only a moderate increase of approximately 5.3 % over the same period. The proportion of women in both groups – migrant health-care workers (88 %) and health-care workers without migration background or migration experience (84.5 %) – has remained constant over this period. It can therefore be stated that employment the German health-care sector is increasingly dominated by migrant female workers.

As shown above, the number of migrant health-care workers is currently growing disproportionately compared to the group of health-care workers without a migration background. The microcensus data show that migrant health-care workers from the new EU Member States constitute the main driving force behind this development. Between 2012 and 2015, this group increased by 28 %, almost twice as much as the entire group of migrant workers employed in the health-care sector. On the other hand, the number of employed migrant workers from non-EU countries is growing at a much slower pace. The highest growth among migrant health-care workers in Germany is attributable to migrants from Croatia (44 %) and Romania (35 %). After the removal of restrictions on the free movement of workers from Romania in 2014, this country recorded its highest growth in the period under review as country of origin of migrant health-care workers in Germany. In Croatia, restrictions on free movement of workers were abolished in July 2015, which also affected growth in numbers of migrant health-care workers. Workers from countries in Eastern Europe that joined the EU in 2004, 2007 and 2013 have so far had not only a structurally greater weight in the health-care sector than workers from the EU-15; their migration figures have also shown significantly higher growth in recent years (cf. fig. 3).

Figure 3: Growth rate in numbers of migrants employed in health-care professions (index 2012 = 100)



Source: Own calculations based on special analysis of the microcensus of the Federal Statistical Office

A quantitative analysis of the official microcensus evaluations allows a comprehensive overview of the importance and development of migration in the formal health-care sector. The criteria used – for the delimitation of the medical and health-care sector on the basis of the umbrella definition drawn up by the Federal Employment Agency as well as for what constitutes employment according to the Federal Statistical Office – are suitably broadly defined. However, this limits the analysis of other relevant factors affecting the migration patterns considered in the present paper: qualification levels, concrete care activities being exercised and employment relationship. To allow a closer focus on the quantitative aspect of this migration pattern, data of the Federal Employment Agency for employment in elderly care was consulted – i.e. jobs that provide care and other services for elderly people who are in need of care or assistance, and that are categorised on the basis of required qualifications, nationality of the worker and employment relationship.

In Germany, shortfalls in skilled personnel in the health-care sector are particularly acute in the elderly-care sector. If a distinction is made between overall health-care and elderly-care professionals, vacancy times[9] in the latter group have, since 2011, become longer: vacancy periods for qualified nurses and qualified elderly-care workers were 78 and 73 days respectively in 2009. By 2014, these figures had risen to 111 and 122 respectively. At 79 days, the average time until a vacancy for qualified personnel is occupied – all professions included –

9 Vacancy times are average times reported by employers until a position can be occupied.

is significantly shorter (Bonin et al. 2015: 21). Elderly care constitutes the only professional category where shortages in skilled personnel are being felt in every one of Germany's states (Federal Employment Agency 2015: 14). Covering the need for skilled elderly-care workers therefore plays a particularly important role in meeting increasing demand for formal health-care provision in Germany.

In contrast to the effect of migration on employment in the overall health-care sector, foreign workers[10] carry little weight in terms of employment figures for elderly-care jobs that are liable to social security.[11] According to job statistics of the Federal Employment Agency, there were more than half a million people employed in elderly-care jobs that are liable to social security in 2015. Of these, more than 45,000, or approximately 9 %, were foreign health-care workers. EU Member States and the Visegrád group were the countries of origin of 54 % and 22 % respectively of foreign elderly-care workers (cf. fig. 4: Structure by nationality 2015). Currently, about one in fifty workers who are subject to social security contributions in the elderly-care sector is a national of one of the Visegrád countries.

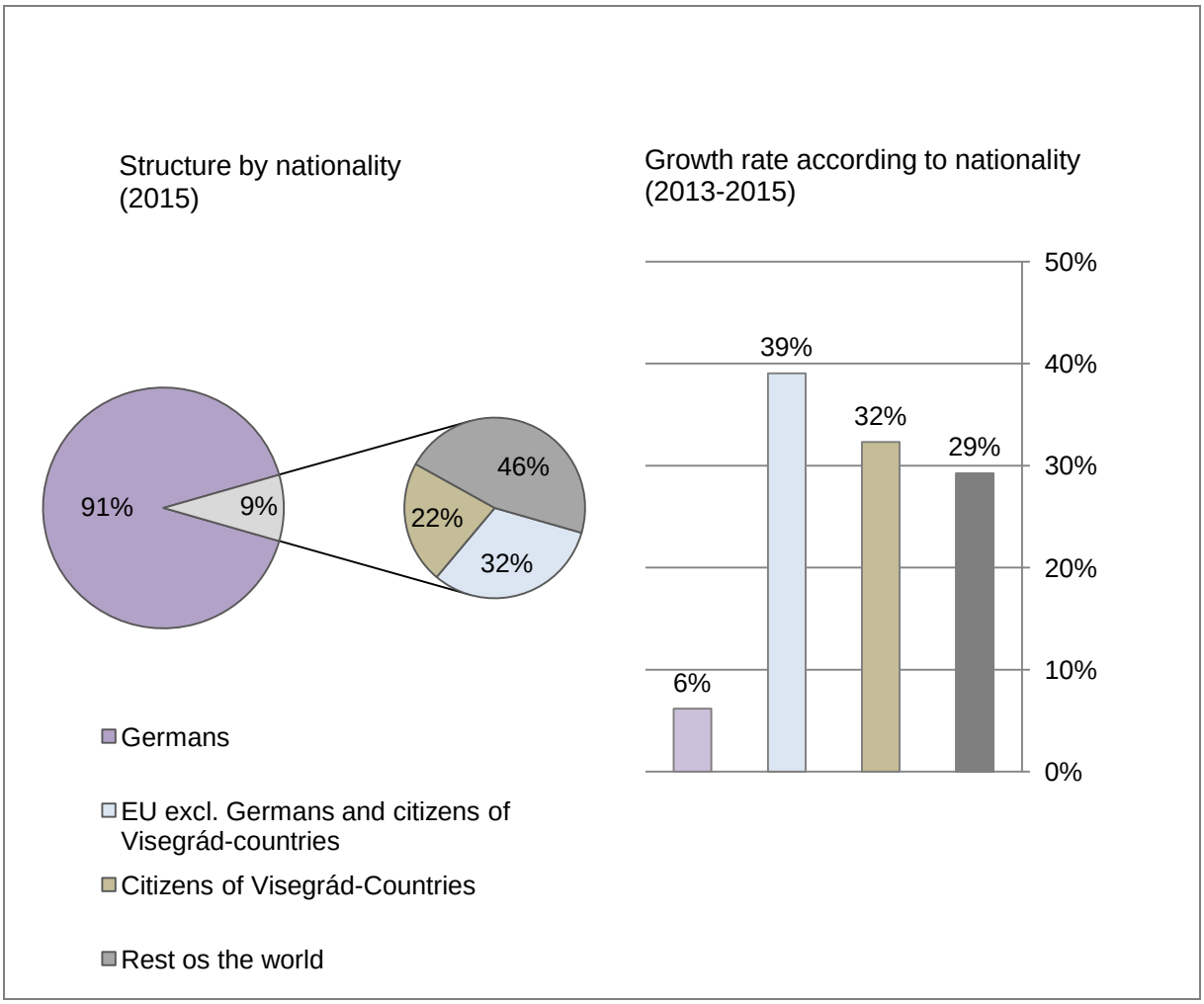
Despite the low numbers of foreign elderly-care workers employed in jobs that are liable to social security, official data in the last few years show above-average growth of foreign elderly-care workers when compared to German workers:[12] while numbers of German elderly-care workers grew by only 6 % in the past three years, numbers of elderly-care workers from other EU Member States and from the Visegrád countries grew by 36 % and 32 % respectively (cf. fig. 4: Growth rate by nationality, 2013-2015). The growth in employment of foreign elderly-care workers in jobs liable to social security is thus mainly attributable to health-care workers from EU Member States. An analysis by nationality of the structure and growth of marginal part-time employment in elderly-care professions produces analogous results.

10 Foreigners in the job statistics of the Federal Employment Agency are defined as persons working in Germany who are not German within the meaning of Article 116 of the Basic Law.

11 While the statistics of the Federal Agency refer to the concept of nationality and thus differentiate between foreigners and Germans, the microcensus evaluations are based on the concept of migration background and/or experience of migration. The terms "foreigner" and "direct experience of migration" are similar.

12 Due to a re-classification of health-care professions (KldB 2010) and a revision of the data of the Federal Employment Agency, only data from 2013-2015 can be evaluated over time.

Figure 4: Elderly-care workers employed in jobs liable to social security



Source: Own calculations based on special evaluations of the Federal Employment Agency

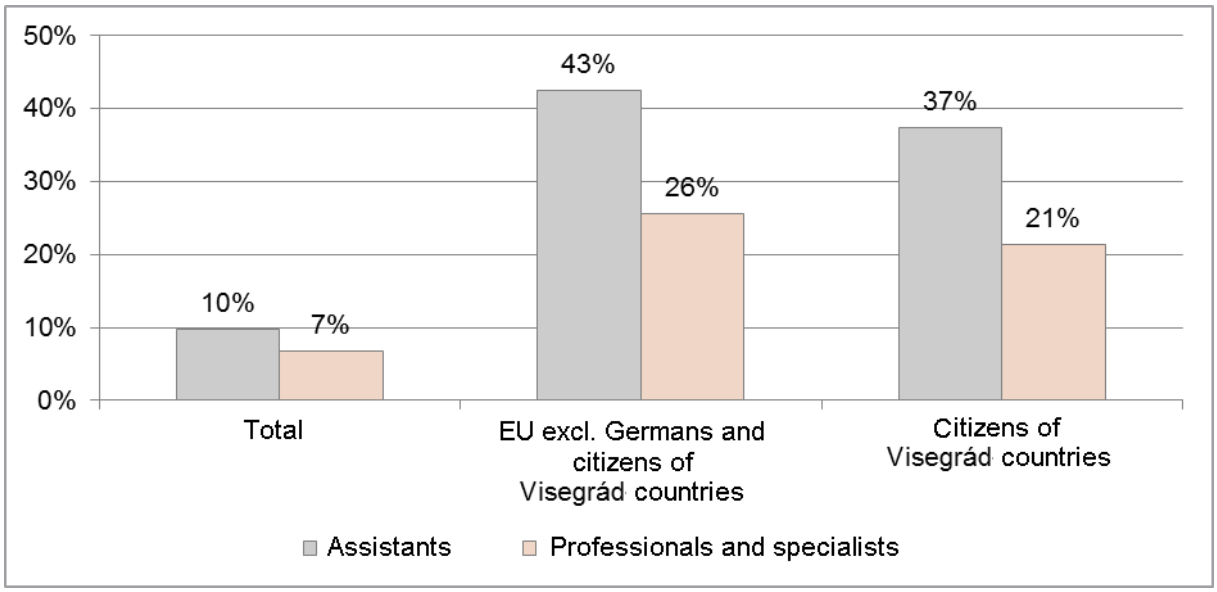
Looking at the care activities of this group, we see that there is an inverse correlation between numbers of foreign health-care workers employed in elderly-care jobs liable to social security and qualification requirements and/or professional qualifications of the foreign health-care workers. In other words, the higher the requirements and professional qualifications, the lower the number of foreign elderly-care workers, particularly from the new EU Member States. According to special evaluations of the job statistics of the Federal Employment Agency, the proportion of foreign elderly-care workers who are classified as "elderly-care assistants"[13] and come from the EU and from the Visegrád countries is 7 % and 3 % respectively of all elderly-care assistants in jobs liable to social security, while elderly-care professionals or specialists[14] from the EU and Visegrád countries account for only 3 % and 1 % respectively of all elderly-care professionals and specialists. This observation is also

13 Workers classified as "assistants" in the employment statistics of the Federal Employment Agency exercise activities of lower complexity. This requirement level therefore includes all assisting and semi-skilled activities and involves one year of regular vocational training.

14 Workers classified as professionals or specialists in the employment statistics of the Federal Employment Agency exercise activities for which in-depth professional knowledge is required. This requirement level is usually associated with the completion of two- to three-year vocational training (or a technical college or university degree in the case of specialists).

reflected in growth figures for foreign employment according to requirements. Accordingly, growth rates (2013-2015) among elderly-care workers who are classified as “assistants” and come from the EU or Visegrád countries are twice as high as growth rates for elderly-care professionals and specialists from the same two areas (cf. fig. 5). Migration from (Central and Eastern) Europe in the health-care sector therefore breaks from the traditional migration theory within the EU as it applied prior to enlargement, namely that intra-European migration mainly involves a young and skilled workforce (cf. Heinz/Ward-Warmedinger 2006).

Figure 5: Growth rate (2013-2015) among elderly-care workers subject to social security – according to qualification requirements and nationality



Source: Own calculations based on special evaluations of the Federal Employment Agency

2.2 Migration to exercise health-care activities in the informal health-care sector

Of the three migration patterns considered here, migration for undeclared care work, i.e. work in the informal employment market, is the one that attracts the most attention in the public debate. It is, however, particularly difficult to quantify this type of employment – for two reasons: first, care workers in the informal market generally exercise a whole range of diverse activities that might include elderly care, child care or domestic services. It is impossible to clearly delimit the scope of actual health-care activities in this migration pattern. Secondly, illegal employment is by its very nature undocumented and hidden. Therefore, and in spite of research interest in quantifying this migration pattern, only vague estimates are possible. These estimates are not based on a statistical model that can be reproduced over varying periods of time. As a result, migration trends for health-care workers in the informal care sector are not researchable from any perspective, be it nationally or comparatively across Europe.

Extensive examination of secondary data on employment in the informal care sector uncovered two pertinent quantitative estimates. In a study in 2009, the German Institute of Applied Nursing Research [Deutsches Institut für angewandte Pflegeforschung] postulated a potential figure of approximately 145,000 domestic workers from Central and Eastern Europe em-

ployed in an irregular work situation involving predominantly care activities. This estimate was based on a model computation involving user characteristics of private households extrapolated from secondary statistics (Neuhaus et al. 2009) However, Lutz and Palenga-Möllenbeck (2010a) proposed an even higher estimate: they assumed a figure of 150,000-200,000 carers from Central and Eastern Europe working in informal care arrangements in German households. The most common form of employment for these migrant care workers is 24-hour care. However, the above estimates apply to the period prior to a judgment handed down by the Munich Local Court in 2010 which ruled that employing Eastern European home helpers as independent care workers is illegal. But although this ruling is expected to have an impact on future numbers in this type of home care, this impact cannot be backed up with data at present.

Nor are there reliable data available in any of the other EU Member States. From a comparative European perspective, however, it can be observed that the German care sector displays a number of factors that encourage the employment of illegal caregivers in households with persons requiring care. Low financial support, uncontrolled direct transfers to families and an increasing shift of care work responsibility to family members have been identified by experts as the main reasons for migrant care workers being illegally employed in private households (Lutz/Palenga-Möllenbeck 2015). Moreover, German migration regulations for care workers are more stringent than those in southern EU Member States (cf. section 2.4). Besides, Germans with relatives who need care are more likely to be employed than the EU average: according to figures of the Federal Statistical Office for 2010, 63 % of female and 73 % of male caregiver relatives aged 25 to 64 years in Germany were employed, while the EU average was 58 % and 71 % respectively (Federal Statistical Office 2014). The need to reconcile career and care duties and the scarce resources of private household budgets often tempt families to seek cost-effective solutions such as the illegal employment of 24-hour long-term care workers, often with no health-care training requirement (Kniejska 2015: 4).

2.3 Migration of professional health-care workers to exercise care activities in the formal health-care sector

The quantitative analysis of the first migration pattern – migration in the formal health-care sector – was based on official employment data that do not reveal where migrant workers trained prior to coming to Germany or what their previous professional activities were. In other words, this information does not allow an analysis of whether migrant workers were already professionally active in the health-care sector in their countries of origin or had completed training in a health-care profession prior to migrating. The following analysis seeks to quantitatively reproduce this specific migration pattern, i.e. migration of trained foreign health-care professionals to exercise care activities in the formal health-care sector. One condition migrant professional health-care workers must fulfil in order to exercise their profession in Germany is recognition of their foreign qualifications. This means that quantifying qualification recognition procedures in the health-care sector can provide conclusive information about numbers of migrant health-care professionals. These data are available from evaluations carried out by the Federal Statistical Office on the basis of the Professional

Qualification Determination Act that came into force on 1 April 2012 (BQFG).[15] Recognition applications under this law can be initiated both in Germany and abroad.

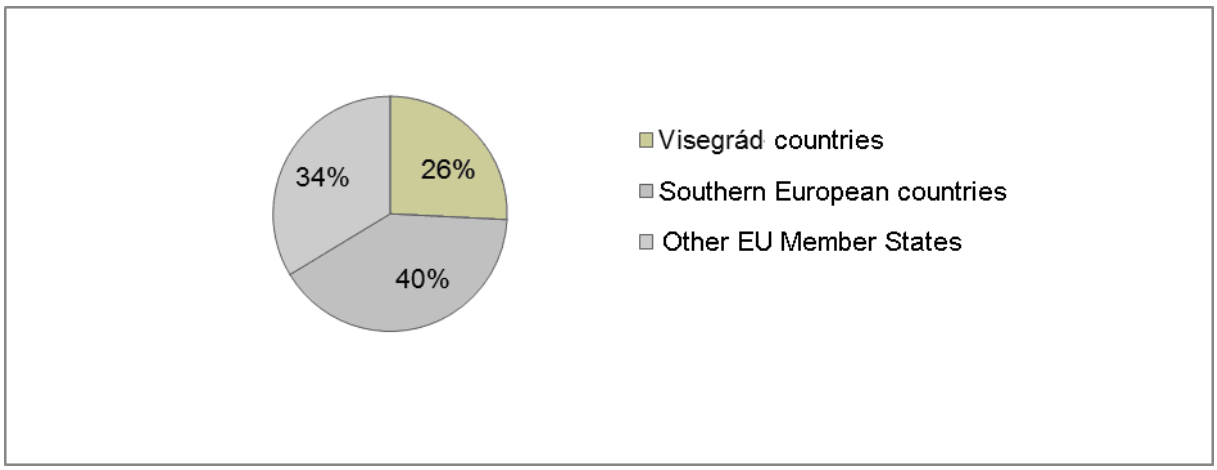
15 This limits the period of available data, as only information for the years 2013 and 2014 was available for evaluation.

In 2014, more than 13,200 professional qualifications acquired abroad were accepted – in full or with some constraints – as being equivalent to qualifications acquired in Germany. Among the successful applications for recognition of foreign professional qualifications were 3,300 involving medical and health-care workers[16], or roughly one quarter of all successful recognition applications for 2014. Most recognition applications in the medical and health-care sector were submitted only once the applicants had arrived in Germany (91 %). In 2013, some 2,400 successful recognition applications were reported for professional health-care workers, which means that between 2013 and 2014 the number had increased by approximately 27 %. It should be noted, however, that the numbers of (still) unprocessed applications for 2013 and 2014 are 1,250 and 1,900 respectively. Recognition procedures of foreign medical and health-care qualifications show a high success rate: in 2014 there were negative decisions in only about 120 cases. Despite the increasing number of recognition procedures involving professional health-care workers, we see from the low absolute numbers that these health-care workers will not contribute significantly to meeting demand for professional health-care workers in Germany.

Overall, some 87 % of recognition applications for foreign medical and health-care workers involve qualifications acquired within the EU. The importance of non-EU countries for migration of trained health-care workers is lower, and significantly so, than in the migration patterns analysed earlier in the present paper. Looking at the EU Member States, we also note significant differences between this migration pattern and the others. With regard to migration in the formal health-care sector (migration pattern 1), countries of the Visegrád group, Poland in particular, were one of the most significant regions of origin of health-care workers who migrated to Germany. For migration of trained health-care professionals from EU Member States, it is southern Europe the main source with a share of 40 % of all successfully recognised qualifications in health-care professions from EU countries (cf. fig. 6), that is obviously the most important region. Spain, with a share of 25 %, is the most common country of origin and training for EU health-care professionals migrating to Germany. This can be partially attributed to recruitment programmes carried out within the scope of the “Training and Qualification Initiative in Elderly Care” launched by the federal government during this period.

16 As for the evaluations of the Federal Statistical Office on employment in health-care professions, health-care workers were identified on the basis of the umbrella list of medical and health-care professions of the Federal Employment Agency (cf. explanation of the professional activities of this umbrella category on p. 6).

Figure 6: Recognised foreign qualifications of medical and health-care professionals on the basis of place of qualification in the EU (2014)



Source: Own calculations based on special evaluations of the Federal Statistical Office

According to evaluations of the Federal Statistical Office microcensus, in 2015 there were approximately 5,000 more migrant health-care workers from Poland gainfully employed in Germany than in the previous year. However, only 260 successful recognition applications from health-care professionals trained in Poland were recorded in 2014, a significantly lower number than for professional health-care workers trained elsewhere. If we compare the quantitative data from the first two migration patterns presented earlier with the numbers of recognised qualifications in the medical and health-care sector (as an indicator of migration flows of health-care professionals), we note that potential health-care workers from Poland and the other Visegrád countries migrate predominantly without qualifications.

2.4 Migration in the health-care sector: an EU-comparative perspective

In spite of the relevance of migration to maintain a supply of health-care services, migration flows of professional or casual care workers in the EU can be quantified only up to a certain point and subject to significant simplifications. One obstructive factor for comparing countries in this regard is the great variety of migration patterns that need to be taken into account for the care sector, for instance migration of foreign-trained professional health-care workers to exercise care activities in the formal care sector or migration of workers to exercise informal household and care activities. Besides, talking about *professional health-care workers* within European comparative analyses of quantitative migration is difficult because so far the term has no uniform or universally accepted definition in the EU, and it is used differently depending on context and EU Member State. The term *professional health-care worker* is usually interpreted or statistically defined on the basis of either qualification obtained or activities exercised. There are, however, a great number of educational or training options leading to professions in the health-care sector in the various the EU Member States. Subsuming the three basic health-care professions – elderly care, general nursing and paediatric nursing – under a single concept as it is done in Germany, for instance, is not done in most EU Member States (Waldhausen et al. 2014). From one EU Member State to the other, the job of *(health-)care workers* can therefore include different activities in the health, social or care sector for a broad range of target groups, for instance from health-related activities in a nurs-

ing context to household and social services for children, the sick, the elderly or similar groups. European comparative statistics on migration flows of professional health-care workers within the EU should therefore be viewed with reservation due to these methodological challenges.

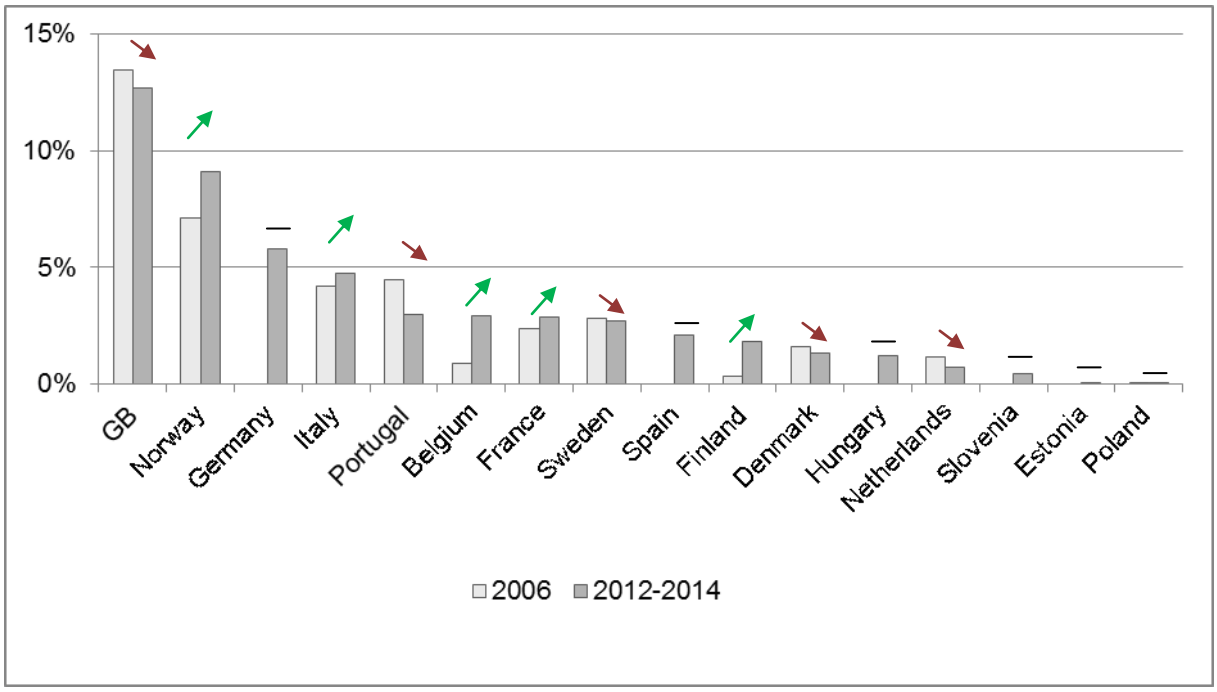
Against the backdrop of increasing shortages of medical professionals in Western countries – especially doctors and nurses –, the issue of migration flows in the medical and health-care sector has been of increasing interest to research institutions since the early 2000s. The first detailed quantitative country comparison in this area was published in the 2007 edition of the OECD's annual migration study *International Migration Outlook*. For the first time, and on the basis of a great variety of data collections, this study showed how important migration was in the 2000s to increase numbers of medical and health-care professionals in OECD countries. The 2015 OECD study is once again dedicated to this topic, and it presents comparisons between countries within a broad time span. Two basic categories are proposed for the analysis of these migration flows: foreign-trained and foreign-born health-care workers. In most OECD countries the latter group is larger, suggesting that receiving countries tend to assume the task of training migrants. The professional group *nurses*, which nearly corresponds to the German term *Pflegefachkräfte*, is examined separately in the study.[17]

As explained above, migration plays a large and increasing role in the German care sector. Germany is therefore one of the EU countries that employs the largest proportion of foreign-trained medical and health-care professionals (cf. fig. 7). This proportion can be compared across Europe in the last ten years, where trends have differed according to EU Member States. While in most EU Member States the proportion of foreign-trained health-care workers to total numbers of health-care workers either has remained constant or decreased, it increased in Italy, Belgium, France and Finland. The increase of foreign-trained health-care professionals in Italy is due to migration from Romania. In spite of the fact that free movement of workers from Romania to Italy was not granted until 2012 the largest influx occurred after Romania's accession to the EU in 2007. And although the proportion of foreign-trained health-care workers to total numbers in Belgium, France and Finland is low, absolute numbers have roughly doubled over the past decade.

In Denmark – as in other EU Member States where the proportion of foreign-trained professional health-care workers declined – there has been a trend towards replacing foreign-trained by locally-trained health-care professionals. Although migration trends in the health-care sector vary from one EU Member State to another, we can see that the increase in foreign-trained health-care workers took place mainly between 2000 and 2006 (OECD 2015).

17 The professional group *nurses* is defined on the basis of the ILO classification of professions, which is similar to the umbrella category "medical and health-care workers" of Germany's Federal Employment Agency. It includes activities involving medical nursing care, but also care activities for people with disabilities and for the elderly.

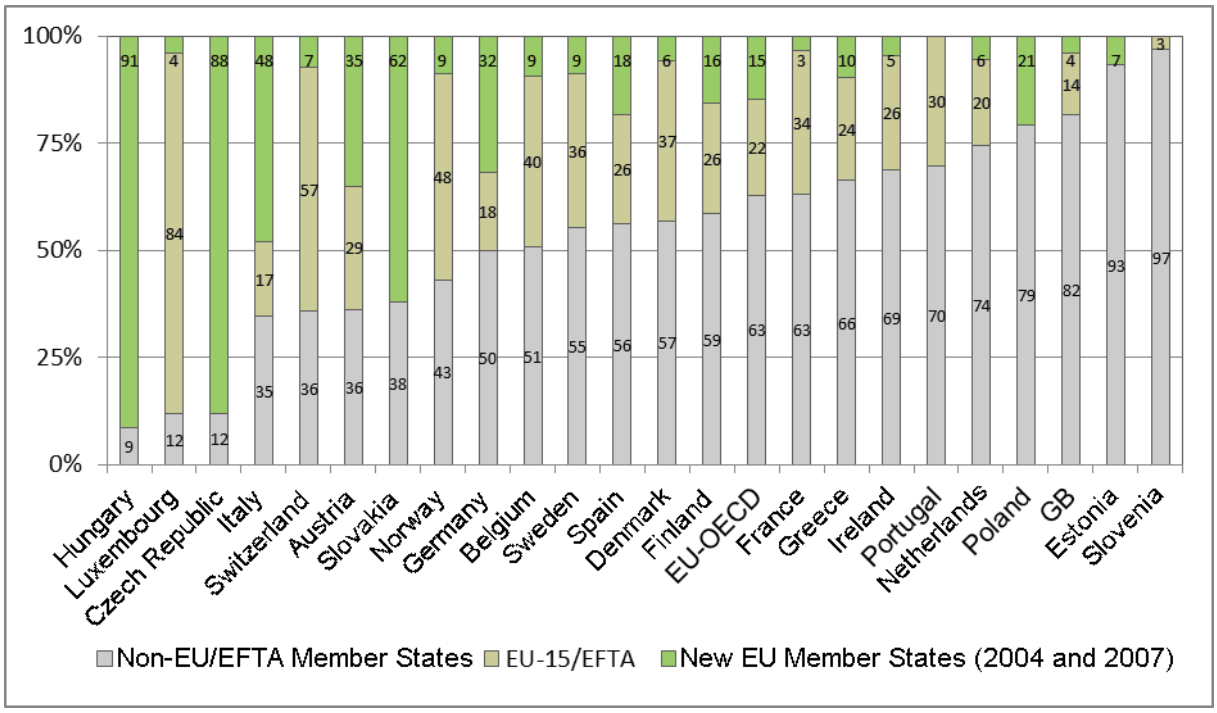
Figure 7: Proportion of foreign-trained to total numbers of professional health-care workers in selected European countries



Source: OECD (2015) – The data for Germany apply to 2010.

Geographical correlations with respect to health-care migration into EU Member States can be identified particularly in terms of the countries of origin of foreign health-care workers. Although the proportion of health-care workers from third countries (excluding EFTA members states) to foreign health-care workers overall has the greatest weight in most EU Member States, the distribution of intra-European migration in the health-care sector is heavily influenced by the geographical proximity of the migrants. Italy, Austria and Germany are thus the main receiving countries of health-care workers from the new EU Member States. At the same time, health-care migration to Hungary, the Czech Republic and Slovakia consists almost exclusively of workers from other new EU Member States (cf. fig. 9). Migration of health-care workers from the new EU Member States is therefore concentrated on Central and Eastern Europe, which in turn suggests that cross-border self-employment and posting in the health-care sector is the most common form of employment for health-care workers from the new EU Member States.

Figure 8: Foreign-born employed health-care workers by nationality (2010/11)



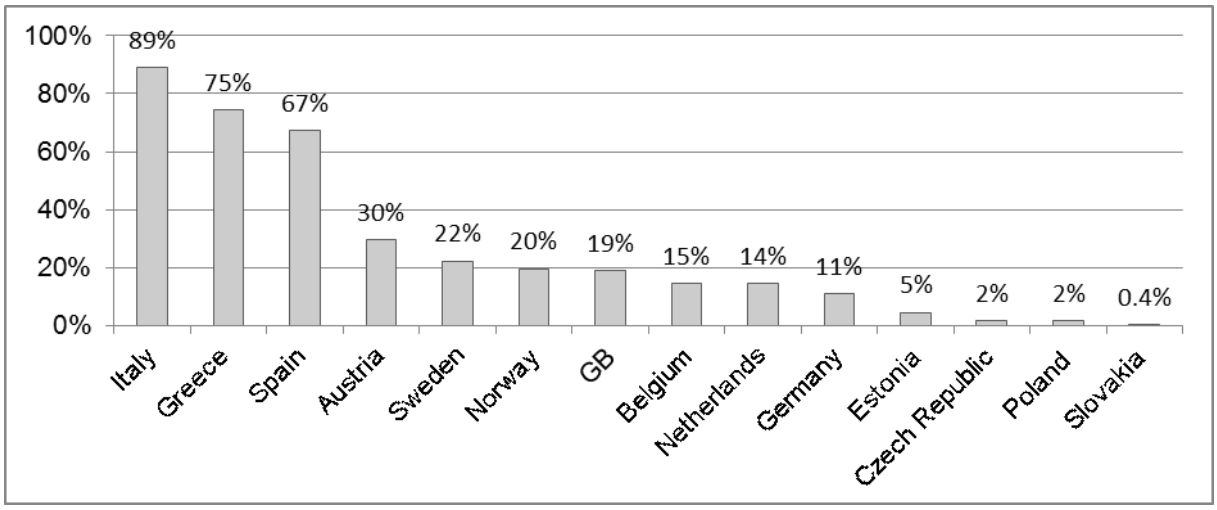
Source: OECD (2015).

As a result of the expansion of home-care services over in-patient care, 24-hour long-term care plays a particularly important role in the provision of care in EU Member States. In western EU countries, this type of care is provided predominantly by foreign carers working either legally or illegally.[18] These carers usually have no professional qualification and carry out diverse activities ranging from household duties to care. Within the EU there are different migration regulations applying to this type of care work, stricter or looser depending on the Member State concerned.

In southern EU Member States, where until now care had been provided mainly within the family, a paradigm shift towards care by persons outside the family has been observed since the early 2000s (Ambrosini 2015). While home-based care had traditionally been provided by family members, it is increasingly being assumed mainly by foreign non-qualified carers. Several measures have been taken to regulate the grey zones in this care area: Spain for instance has introduced special work permits for this purpose and in Italy pertinent regulations were successively adopted in the years 2002, 2009 and 2012 (OECD 2015). This may explain why the proportion of registered foreign-born 24-hour long-term care workers to the whole of the formal care sector in Italy, Greece and Spain is about 60%. This differs significantly from figures in other EU countries (cf. fig. 9).

18 It is estimated that up to four million German households employ household help in some form or other. In contrast, current statistics show only 43,000 jobs liable to social security and roughly 380,000 so-called “mini-jobs” in private households (DGB 2016).

Figure 9: Proportion of registered foreign-born home-based long-term workers in the care sector (2012/13)



Source: OECD (2015).

3 Care needs in the Visegrád countries

The recruitment of foreign skilled workers to fill gaps in the health-care area has given rise to intense and controversial debate (cf. Döcker 2014; AWO 2013). Migration flows of professional health-care workers to Germany have implications not only for receiving and sending countries, but also for the recruited workers and their families. Experts refer to these demographic phenomena as *care chains* and *care drain*.

The ***care drain*** concept refers to the loss of human resources and qualified professionals in the health-care sector of the countries of origin. Migrating health-care workers have been trained at the cost of their countries of origin, whose supply structures are then not able to benefit from this investment. The ***care chain*** concept refers to transnational supply chains: situations in which people, especially women, migrate to care for patients in other families, creating a supply gap in their own families back home. This care work is then usually taken over by other family members in the home country or outsourced to other migrants or other women in the country of origin (Waldhausen 2011; Lutz/Palenga-Möllenbeck 2015). One example of transnational supply chains are the health-care migration flows from Ukraine to Poland and from Poland to Germany: Polish migrant women do care work in Germany, and the resulting supply gap in the Polish family is then often filled by Ukrainian women working in an illegal employment context (Golinowska 2010: 15).

The so-called *global care chains* and intra-European migration in the health-care sector can have both negative *(care drain)* and positive *(brain gain)* consequences for sending countries and receiving countries. Looking at migration flows in the German care sector we see from the above quantitative analysis, for example, that the *care drain* phenomenon does not directly concern the new EU Member States, particularly the Visegrád countries. Migrants to Germany from this region generally have no health-care training. It can even be argued that

the new EU Member States could in future experience a *brain gain*, when the countries of origin begin benefitting from the acquired knowledge and working experience of returning care workers. However, this requires certain conditions: for sending countries to benefit from *brain gain*, there must be training opportunities available to migrants in their receiving countries, and the health-care workers must then return to their countries of origin. From an economic perspective it could also be argued that the monetary remittances of migrant health-care workers to their home countries represent an important drive for these countries' economic development (cf. Lubambu 2014).

Intra-European migration in the health-care sector can therefore have a variety of impacts. The central question of the debate on effects on the countries of origin, however, is the following: to what extent are the new EU Member States, as traditional countries of origin of health-care workers, affected by the ageing of their own societies and therefore by increasing demand in their own health-care sector? Addressing this issue provides conclusive answers not only about the legitimacy of recruiting health-care workers from the new EU Member States, but also about the potential contribution of migration from this region to fill the gap in health-care needs in Germany in the coming years.

3.1 Demand for care services

In research, prognoses regarding demand for care services are normally determined by the proportion of elderly people to the population as a whole, since this ratio is closely correlated with the general health of the population (Przywara 2010; Lipszyc et al. 2012: 21). At the moment, the population of the Visegrád countries is ageing at a slower pace than the population of northern and western European countries. Their dependency ratio[19] is therefore significantly lower. This indicator is used to assess the potential dependency of the older population (65+) on the population of working age. It is thus closely related to the burden placed on health-care systems. In the Visegrád countries, the dependency ratio in 2014 was 22.9, while in the EU-27 and in Germany it was 28.1 and 31.5 respectively (cf. table 1). In other words, Poland, Hungary, the Czech Republic and Slovakia have significantly more people of working age per older person than in most EU Member States. This suggests that the need for health-care services in the Visegrád countries is lower than in EU Member States in Western Europe.

The current demographic differences between the Visegrád countries and the EU-27 are principally due to political, socio-economic and demographic developments during the communist regime (cf. Hoff 2008). After the baby boom, birth rates in most western and northern European countries were already below replacement rate, while the strong family-oriented and pro-natalist policies of the communist regimes kept birth rates far above replacement rates in the Czech Republic and Hungary until approximately 1980 and in Poland and Slovakia until approximately 1990 (cf. Kacerova/Ondačková 2015: 50).

19 The dependency ratio is the ratio of people over 65 to people of working age (16-64).

Table 1: Key indicators of ageing in the societies of the Visegrád countries in 2014

EU Member State	Population over 65 in %	Population over 80 in %	Life expectancy (2013)	Dependency ratio (15-64)	Healthy life years at birth		Healthy life years at 65	
					Women	Men	Women	Men
EU-27	18.5 %	5.1 %	80.6	28.1	61.8	61.4	8.6	8.6
Visegrád group	15.8 %	3.8 %	77.0	22.9	60.8	59.4	6.8	6.6
Poland	14.9 %	3.9 %	77.1	21.2	62.7	59.8	8.1	7.5
Hungary	17.5 %	4.2 %	75.8	25.8	60.8	58.9	6.1	6.0
Czech Republic	17.4 %	3.9 %	78.3	25.7	65.0	63.4	9.3	8.5
Slovakia	13.5 %	3.0 %	76.6	19.0	54.6	55.5	3.6	4.3
Germany	20.5 %	5.4 %	80.9	31.5	56.5	56.4	6.7	6.8

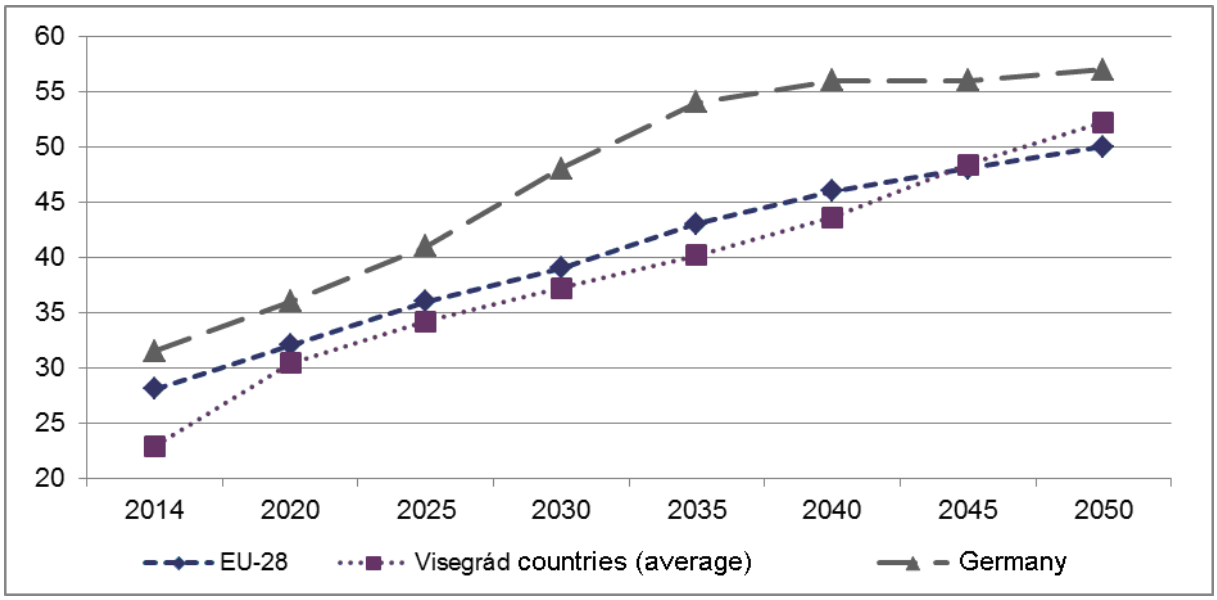
Source: Own calculations and Eurostat (2015). The individual values for the Visegrád group correspond to the average of the four states.

The moderate and constant fertility development in the Visegrád countries, together with lower life expectancy and the emigration controls that applied until the end of the communist regime, contributed significantly to the fact that the populations of the Visegrád countries are currently much younger than in Western EU Member States. The year 1989 was a radical turning point in their demographic development. The phenomena which then began appearing were extremely low birth rates, a western reproductive behaviour (e.g. late procreation and family formation), rising life-expectancy rates and high emigration rates of young workers, all facilitators of population ageing (cf. Hoff 2008). The remaining demographic advantages of the Visegrád states against Western EU Member States have therefore been declining continuously, so that predictions for the year 2050 assume that by then the populations of the Visegrád countries will be among the oldest in the EU (cf. fig. 10).

In addition to population ageing, the development of care needs among older population groups is a critical factor for mapping potential demand for health care. The indicator for *healthy life years*, HLY, reflects the number of years that are likely to remain to a person living in a private household at a specific age without being affected by severe or moderately serious health problems or disabilities. This indicator is determined on the basis of EU-wide statistics on mortality as well as from self-assessments of health restrictions in everyday life as collected in population surveys.[20]

20 Data on self-perceived activity limitations have been gathered from a European health module integrated into the collection of EU Statistics on Income and Living Conditions (EU-SILC).HLY thus depend to some degree on the subjective perception of the respondent and on their social and cultural background. In addition, the statistical methods of EU-SILC are set by the individual EU Member States, potentially causing distortions in the context of cross-national analyses.

Figure 10: Predicted development of the dependency ratio (2014-2050)



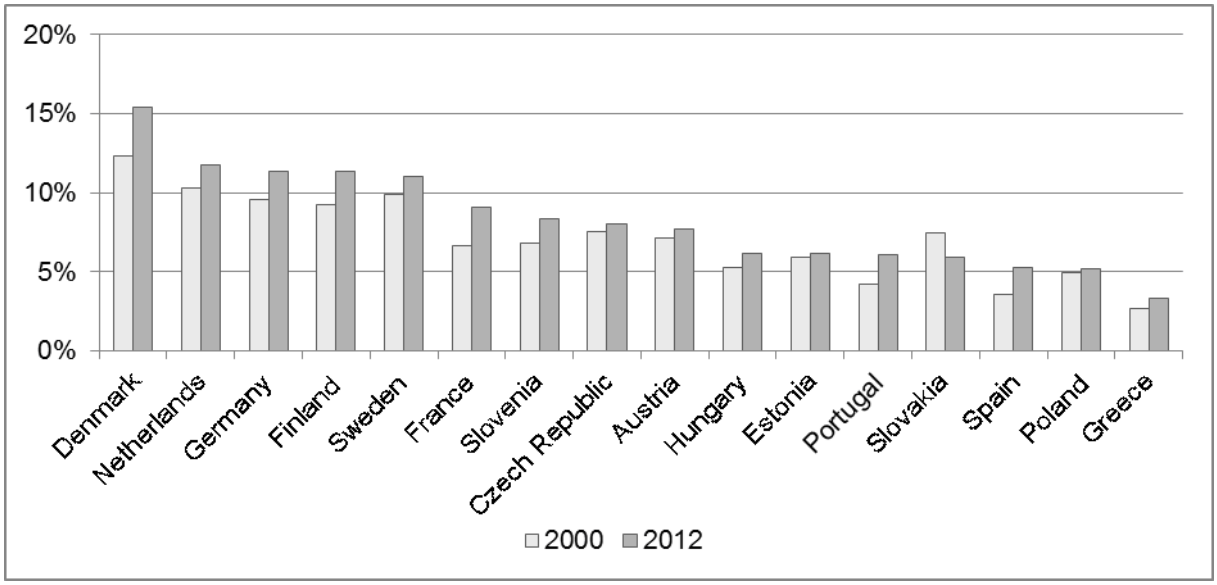
Source: Own calculations on the basis of EU Commission data (2015). The values for the Visegrád countries correspond to the average of the four states.

With the exception of the Czech Republic, the number of expected healthy life years at birth and at the age of 65 in the Visegrád countries is slightly below the EU average. For 2014, approximately 62 years of healthy life can be expected at birth and nine at 65 for the population of the EU-27. The average values for the Visegrád countries are approximately 61 and seven respectively (cf. table 1). We can therefore see that the Visegrád region currently has no above-average demand for health-care services. The demographic indicators examined, however, suggest that the need for care in the Visegrád countries will increase in the coming years.

3.2 Supply of medical and health-care professionals in the health-care labour market

A cornerstone of the debate about intra-European migration flows is the development of the supply of trained health-care workers in the formal labour market of individual EU Member States. The supply of professional health-care workers is determined by institutional factors such as the organisation and financing of health-care systems. Starting in the 1990s, the health-care sector of many Western countries was reorganised: in many of these countries measures have been adopted to regulate, finance and support the health-care sector, for instance in Germany with the introduction of a separate nursing care insurance. Compared to other EU Member States, care services in the Visegrád countries are still provided in the context of underdeveloped and fragmented health-care systems (Österle/Mittendrein 2012). Since the 2000s, the health-care systems of the Visegrád countries have been undergoing a process of development, partly in an effort to improve the formal sector (Szüdi et al. 2016; Perek-Białas/Racław 2014: 256-259). Between 2006 and 2012, the number of health-care workers in relation to population size has risen in all EU Member States except Slovakia (cf. fig. 11). Nevertheless there are important differences between the eastern and southern regions of Europe on the one hand and the western and northern regions on the other. The proportion of medical and health-care professionals to the population in Germany for instance (11.4 %) is almost twice as high as in the Visegrád group (6.3 %).

Figure 11: Medical and health-care professionals in the formal sector per thousand of population in selected EU Member States



Source: OECD (2015).

Although the short- and medium-term impact of ageing on demand for health-care services in the new EU Member States can be expected to be lower than the EU average, care systems in these countries also have a significantly lower supply of health-care professionals.

4 Push and pull factors of intra-European migration in the health-care sector

A *push and pull* analysis is a methodological research approach to explain international and interregional migration. The analysis examines factors that encourage people to leave their countries of origin (*push* factors), and factors that attract migrants and have a positive effect on immigration in receiving countries (*pull* factors). The aim of this analysis is to better understand the factors for migration in the care sector discussed previously and uncover interdependencies of the European labour market in the health-care sector. Focus is on general health-care migration from the new EU Member States to Germany, without differentiating between the various migration patterns.

The primary factors for intra-European migration in the health-care sector are socio-economic in nature: for example, differences in demographics and income structures, or career opportunities in the EU Member States. Employment of Central and Eastern European health-care workers in informal or formal care arrangements in Germany is therefore not due to economic factors only. The *push* factors in the Visegrád countries are primarily the relatively precarious living and working conditions of care workers, their low pay and heavy workload. Lutz and Palenga-Möllenbeck (2015) identify the following specific *pull* factors for migration of care workers to Germany: “The increasing dependence on foreign care workers in informal care arrangements in Germany has been growing due to, among other reasons, demographic (declining birth rates and ageing societies), socio-economic (increasing numbers of women in the workforce) and political (reduction of welfare services) factors.”

Table 2 presents an overview of the main factors affecting intra-European migration of health-care workers to Germany that are also discussed in professional circles. Two levels have been considered: the micro level, which examines the reasons for health-care workers emigrating to Germany, and the macro level, which considers the legal and policy framework within the EU internal market.

Table 2: Push and pull factors of intra-European migration in the health-care sector

Pull factors	Push factors
Micro level	
Good pay	Poor pay and working conditions Social insecurity
Transnational movement and communication possibilities	
Geographic proximity	
Social and cultural acceptance	
Transborder networks of contacts between Poland and Germany	
Macro level	
Greater care needs and greater demand for care services	Free movement of workers
Harmonisation of professional qualifications	Underdeveloped care systems

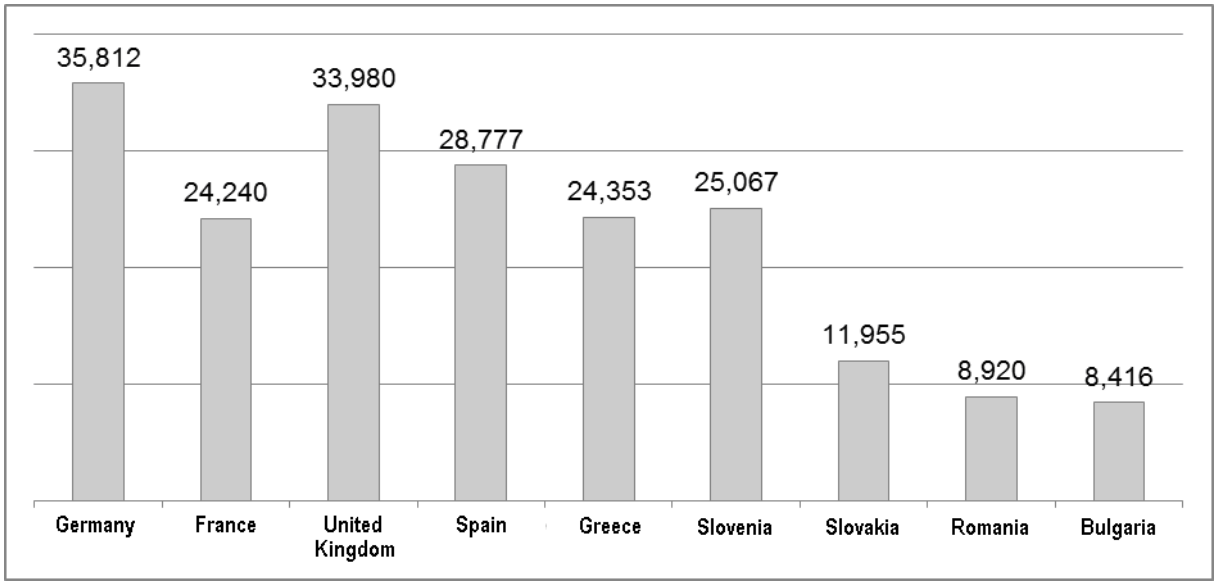
Source: own presentation

4.1 The micro level – health-care workers' reasons for migration

An important *pull* factor is the geographical proximity between Germany and the new EU Member States, which offers migrant care workers the option to commute from border regions. It is more specifically from regions like Upper or Lower Silesia, where labour migration has meanwhile become an "earning tradition", that women (for the most part) commute to do care work in the neighbouring country (Kniejska 2015: 2). In both the formal and informal care sector, this type of work offers additional earning opportunities for people like pensioners or homemakers who can work on a part-time basis or during short periods spent abroad. Empirical data analysed by Lutz and Palenga-Möllenbeck (2010b) revealed that mothers from Eastern Europe prefer a three-month rotation system that enables them to return to their families every two months. In the formal care sector, contact networks in border regions can influence health-care migration between Poland and Germany. In recent years, welfare associations have carried out numerous *win-win* cooperation projects with health-care training institutions in the new EU Member States along the German border: foreign health-care workers are trained and given the opportunity to gain work experience in Germany while German institutions benefit from these workers' contribution (Stifler 2011). Geographical proximity and modern transport and communication options can also facilitate working placements abroad for health-care workers, who do not have to lose all contacts with their families. In addition, there is widespread social acceptance in Germany for care workers from Eastern Europe. "The private employment of Polish care workers seems to be an optimal solution for many German families; this is reinforced by the fact that not only do they belong to the same culture, but they also cater to certain stereotypes of Eastern European women ("capable, loving, affordable and hard-working")" (Kniejska 2015).

In addition to the migration causes discussed above, however, the wage gap between Central and Eastern EU Member States and Germany in the health-care sector also represents a strong *pull* factor for the migration of trained health-care workers. Germany offers better wage conditions in the medical and health-care sector than other traditional EU receiving countries, such as France. German wage levels in the medical and health-care sector can be up to three times as high as wages in Central and Eastern European Member States. This gives Germany a comparative advantage for the recruitment of health-care workers. There are, however, no major differences to other important receiving countries of European health-care workers, such as the United Kingdom (cf. fig. 12).

Figure 12: Average gross earnings in the health and social services sector in selected EU Member States in Euro, 2009 (taking purchasing power parity into account)



Source: BMWI (2012).

4.2 The macro level – health-care migration in the EU context

Inner-European migration flows of health-care workers are also influenced by the legal framework and by legislative measures taken in this area. The European project of labour market integration has two pillars that have a direct influence on migration in the health-care sector: the reduction of administrative barriers to the free movement of workers – these barriers have been cut back successively in all new EU Member States since 2011 – and the harmonisation of vocational training across the EU. Other EU regulations also play a role in this context, for instance Directive 2014/67/EU, which regulates the posting of workers. However, the prosecution of illegal health-care work in EU host countries is the responsibility of the national legal systems of these host countries. Here EU regulations affect only the formal care sector.

The harmonisation of vocational training in the various countries and the regulation of training recognition procedures is currently the central element of the EU policy to promote intra-European labour migration. Significant steps have been taken in this area in recent years. The implementation of Directive 2005/36/EC created a first pan-European legal regime within

which countries can recognise professional qualifications. Directive 2013/55/EU will even, in the coming years, provide automatic recognition of health-care training for citizens of EU or EFTA Member States. According to the German Nursing Act (Section 2 (1) no. 4), however, nursing migration requires language skills, so that professional recognition cannot be automatic in Germany. The effect of the intra-European legal framework can be observed empirically by studying the recruitment trends of skilled workers in German nursing homes. The problems involving the recognition of foreign qualifications in Germany are considerably lower in recruitment procedures for EU health-care workers than when health-care workers from third countries are recruited (Bonin et al. 2015: 45).

5 Conclusions and prospects

Formal care in Germany increasingly depends on the contribution of female migrants from the new EU Member States, particularly Poland. But while it is true that there are many migrant health-care workers from the new EU Member States working in Germany, they are rarely employed in jobs liable to social security. Most of them are contract workers or posted workers from foreign companies who work in Germany within the framework of the EU freedom to provide services. Furthermore, the quantitative analysis of health-care sector migration figures shows an inverse correlation between numbers of professional workers employed in Germany and their qualification levels. This means that the number of Central and Eastern European care workers in Germany continues to increase, but most of these migrants have had no health-care training.

The EU legal framework and EU legislative measures have a central influence on intra-European labour migration, and this also applies to the health-care area. There have been several legislative measures towards an integrated EU labour market taken in recent years – especially in the health-care sector. Measures on the mutual recognition and harmonisation of health-care professions in EU Member States have been introduced, so that currently the only remaining barrier to recognition of EU health-care qualifications in Germany is the lack of language skills. The competition for health-care workers is therefore meanwhile EU-wide, and this trend is supported by concrete institutional measures. Because of the bottlenecks in meeting the increasing demand for medical and health-care services, measures for the recruitment of foreign health-care workers have, since the early 2000s, gained in importance in the political agenda of Western EU Member States (cf. OECD 2015: 122-151). Within the context of this transnational competition, Germany has important comparative advantages to offer, in particular good wages as wells geographical proximity to the main countries of origin of health-care workers in some Eastern European regions. Germany is therefore one of the EU countries that employs the largest proportion of foreign-trained health-care professionals.

Nevertheless, recruitment of foreign-trained health-care workers from other EU Member States is very challenging. It is common practice that companies recruit trained workers in other EU countries. However, this requires resources that are often not available to smaller health-care companies or institutions. In several EU Member States, the number of foreign-born professional health-care workers is significantly higher than the number of foreign-trained health-care workers (OECD 2015: 114-118). It thus seems that in many cases the training of migrant health-care workers is being assumed by the receiving countries. In some

EU Member States, there is a gradual substitution of foreign-trained by locally-trained health-care workers.

Recruiting trained health-care workers from the new EU Member States poses significant potential challenges. The analysis of demographic indicators in a European comparative perspective shows that population ageing in the new EU Member States is currently less pronounced than in Western Europe. Compared to Western EU Member States, the new EU Member States still have what can be termed a moderate need for health-care services. For the next few years, however, predictions show that the population structure in several Central and Eastern European Member States will become one of the oldest in the EU and therefore that the need for care services will become acute. Against this background, the question of how health-care workers from the new EU Member States can in future contribute to meet the increasing need for care in Germany needs to be addressed. Training Central and Eastern European health-care workers who are currently working in the German informal care sector without vocational qualifications and in illegal employment offers significant potential to address shortages of skilled labour in the health-care professions: Not only because do these care workers already have work experience in the care sector, but because they have then also acquired language skills that other potential foreign-trained health-care workers – for instance from southern EU Member States – do not usually have. Qualification measures targeting migrant care workers in informal care arrangements in Germany can therefore, on the one hand, help reduce employment in the “grey” market while on the other hand counteracting the shortage of trained workers in the health-care field. Qualification measures of this type would also be desirable for the sending countries, which could then eventually benefit from the training investment and accumulated work experience of returning health-care workers.

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