



From international competition to united action

White paper on how to solve Europe's health workforce crisis

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Executive summary

With this white paper, the [Pillars of Health](#) coalition aims to:

- present findings and conclusions of their research work on health worker mobility and migration in the European Union (EU).
- provide inspiration and talking points for the numerous occasions where EU level stakeholders discuss matters related to access to healthcare in general and access to health workers in particular, in the EU context. These occasions include for instance: the ongoing discussions on the future of the European Health Union; conferences in the context of the current Belgian EU Presidency, and meetings with (new) Members of European Parliament, in the run-up to and after the European Parliament elections on 6 June 2024.

Access to health workers in the EU

When you are ill or injured, you want to receive the medical care you need. This requires that you have access to skilled health workers who are enabled to do their job well. Unfortunately, this is not a given everywhere in the EU.

Our analyses show that health workers in particular from countries in Eastern and Southern Europe are leaving for other, richer parts of Europe, in search of better working conditions, career prospects and work-life balance. The countries they leave behind are left with fewer health workers and score below EU average on the Universal Health Coverage index. .

The current situation also shows that the so-called destination countries do not have a sustainable response to health worker shortages within their borders and are unable to educate, recruit and retain sufficient health workers domestically.

Responsibility of EU Member States

Health is a fundamental need and is embedded as a human right in international treaties. In the European Union, the right to health has been enshrined in principle 16 of the European Pillar of Social Rights Action Plan: “everyone has the right to timely access to affordable, preventive and curative healthcare of good quality.”

This means that EU Member States are responsible and accountable for ensuring all its inhabitants the conditions to achieve optimal access to healthcare. This includes access to sufficient health workers.

Moreover - and perhaps most importantly – Europe’s health workforce crisis and persistent unequal availability of health workers weakens the region’s health systems. This goes against the EU’s ambition of shared prosperity and solidarity. If the EU wants all its Member States’ citizens to prosper, be healthy and have access to a health worker whenever and wherever needed, then the EU should step in and make an overarching plan to tackle the crisis. Member States cannot solve the interconnected health workforce crisis on their own; the EU should support its Member States in this urgent endeavour.

Call for united action

Each EU Member State faces challenges regarding health worker shortages and lack of access to healthcare, and these challenges are interlinked. Most EU countries face an ageing population, an ageing health workforce and increasing challenges in training, recruiting and retaining sufficient health and care workers. Ever higher shortages of health workers in some countries result in higher economic demand and a stronger 'pull' effect on health and care workers in other countries. As a consequence, richer countries, who will have more to offer, end up with more of the scarce health workers, to the detriment of the countries in the economic periphery, thus increasing the inequalities in health systems’ capacities.

Therefore, we need to move from international competition for skilled health workers, towards united action from all EU Member States to enable health workers across Europe to deliver high-quality healthcare, to all who need it and commensurate to their health needs.

For this united action by EU Member States, we recommend the following:

- EU Member States must invest in robust, attractive health systems by increasing the education and training of health workers, increasing health worker retention and recruitment efforts, optimizing health workers’ performance and enhancing planning and forecasting capabilities.
- The European Commission should disseminate existing examples of how different EU funding sources (Recovery and Resilience Funds, Cohesion Funds, European Structural and Investment Funds, and others), can be used by Member States to

boost health systems performance and provide more attractive working conditions for the scarce health and care workers.

- The incoming Members of European Parliament should use the upcoming 2025 revision of the European Pillars of Social Rights Action Plan to develop and start monitoring health workforce targets indicators and equitable access to health services. This could be achieved through dedicated actions and funding in a (new) EU Action Plan for the EU Health Workforce. We thereby also propose a workstream on strengthening the nursing workforce and primary healthcare, given the evidence that investing in the development of the nursing workforce is a solution to increase access to health services, and that strengthening primary health care contributes to improving population health.
- The European Semester process should make it mandatory for Member States to report on health workforce shortages, in combination with data on the recruitment of doctors and nurses from abroad and their reliance on foreign-born, foreign-trained doctors and nurses. These reports should become publicly available and serve as conversation starters on how said indicators could be improved.
- Policy makers involved in the European Health Data Space (EHDS) should make an effort to expand the EHDS's remit, to include a standardization of indicators for health worker mobility, and to ensure regular reporting and integration of data from various sources and data collection bodies. Both more qualitative *and* quantitative data are needed; they complement each other and can provide deeper insights into health worker mobility and migration.
- EU duty bearers, institutions and dialogues should ensure that more non-state actors are invited in debates about Europe's health workforce crisis – and most importantly, about the solutions to this problem. Space for civic involvement has been decreasing at EU and national levels. By giving non-State actors a voice – in research, knowledge generation and advocacy in their countries – they can provide a valuable contribution to the discussion, as the last decades (pre-Covid pandemic) have also shown that Member States have had fluctuating interest in the topic.

Pillars of Health coalition

The Pillars of Health coalition – consisting of Wemos (lead organization, the Netherlands), Center for Health Policies and Services (Romania), Media Education Centre (Serbia) and VU Athena (the Netherlands) – has conducted research in select countries in Europe (i.e. France, Germany, the Netherlands, Romania and Serbia) that adds to the existing body of knowledge about Europe’s health workforce challenges, their root causes and how health worker mobility and migration play a role in either worsening or alleviating these challenges. We have conducted an in-depth situational analysis in the project countries and enriched current knowledge with extensive qualitative research.

In short, our findings illustrate:

- the diversity and similarity of the challenges in the health workforces in EU Member States.
- the considerable dimension of health worker migration in Europe and its neighbouring countries. Although it is a complex pattern, with no country being just country of origin or destination country, the patterns show how especially countries from the South and East lose, while countries in West and North win health workers. These patterns follow economic gradients.
- that health worker migration is not a problem in itself, but rather the symptom of a larger crisis: EU national governments’ underinvestment in their health systems have resulted in underfunded health sectors, making them an unattractive employment sector for health workers. This creates a vicious cycle: health workers become overburdened, leave the sector in their country of origin, and/or migrate elsewhere for e.g. better career opportunities, salaries and professional development. In turn, the colleagues they leave behind risk becoming even more overburdened due to an increased workload and patient-to-health worker ratio, and increasing the risk of them leaving the sector and country, too. Ultimately, neither health workers nor patients/populations benefit from such situations.
- that health workers quitting their jobs and health workers migrating are two sides of the same coin: due to job dissatisfaction, they either leave the healthcare sector and switch to another sector, or leave their country of origin altogether, seeking better professional prospects in a destination country’s healthcare sector.
- the difficulty in retrieving quality data on the healthcare workforce in general, and on health worker mobility in particular.
- that, although unprecedented funding is available from the European Commission, for example for the National Recovery and Resilience Plans, not all EU Member States dedicate

proportionate investments to strengthening their health workforce.

Introduction

All European citizens, including health and care professionals, have the right to decide where to make a living. Nevertheless, the existing data indicate that the excessive migration and mobility of the health workforce over the last decades have imbalanced health and care worker availability among the EU Member States, jeopardizing the equitable access to quality healthcare services and deepening the already existing structural inequalities in healthcare resources.

The Covid-19 pandemic exposed the fragility of the European health systems with acute health workforce shortages in many EU countries, as well as the limited EU health competences, and the need to build a robust European Health Union. A public opinion survey commissioned by the European Parliament during the pandemic showed the support for such a Health Union: for most Europeans (55%), EU spending on public health was their most important priority [1].

Still, data on access to health services in the EU revealed unmet medical care needs as high in spring 2022 as in spring 2021 [2]. Access to medical care requires (among other things) a sufficient number of doctors and nurses, their appropriate geographical distribution, and a strong network of primary healthcare professionals to deliver first-line services to people.

Context

Promoting stronger health systems in Europe and around the world has become a strategic priority for the EU following the Covid-19 pandemic. The Commission supports Member States with unprecedented funds for reforms and investments in line with the European Pillar of Social Rights, with a total of EUR 1.8 trillion to recover from the Covid-19 crisis and become greener, more digital and socially just, including a new financial instrument: the Recovery and Resilience Facility [3]. These funds are meant to, among others, enhance health systems resilience and capacities, focusing on primary health care, mental health, improved access to quality healthcare for all and reduced social, territorial and economic inequalities in health. None of the focus areas can be achieved without sufficient, skilled and motivated health professionals.

The Commission has launched important strategic documents like the Pharmaceutical Strategy for Europe, Europe's Beating Cancer Plan, and the European Health Data Space for better monitoring tools of access inequalities. Simultaneously, Member States are encouraged to invest in health and care workforce, improving their working conditions and access to training. Numerous recommendations are available to support policy makers, based on previously funded Joint

Actions [4], project grants under the 3rd EU Health Programme and other sources. Also, several EU funding sources can be, and have been, used to contribute to resilient health systems, such as Structural and Investment Funds, Cohesion Funds, and European Investment Bank funding.

The report *Health at a Glance: Europe 2022* indicates that most European countries increased the number of medical students and nurses due to the pandemic, but some have increased the recruitment of doctors and nurses from other countries as a quicker way to address current shortages, while the demand for nurses is expected to continue to rise in the coming years due to population ageing while many nurses are approaching retirement age [5].

Although almost all EU Member States have increased the number of graduating medical doctors and nurses per inhabitants in the last decade [6], the crisis from both short and long-term perspectives remains. The WHO's *National Health Workforce Accounts* data also show progress in increasing the size of the health workforce globally: while the 2016 *Global Strategy on Human Resources for Health: Workforce 2030* predicted a global health workforce shortage of 18 million by 2030, this has been revised (in 2022) to 10 million health workers [7]. Nevertheless, the estimates remain alarming, and continue to endanger progress towards Sustainable Development Goal 3.8 on Universal Health Coverage (UHC).

Zooming in on EU Member States, there is a clear correlation between high health worker densities and high levels of Universal Health Coverage, while – not by coincidence - some of the countries with the highest densities of doctors, nurses and midwives (Ireland, Germany, Austria and Sweden) are also countries with high levels of foreign-born, foreign-trained health workers. Similarly, countries with the lowest UHC scores and lowest health worker densities include major health worker source countries, such as Hungary, Poland, Latvia and Bulgaria [8].

Momentum for action on the health and care workforce in the Europe

The health and care workforce has been and remains a main concern in WHO's European Region. But times may be changing. WHO's Regional Office for Europe issued a landmark report in 2022, *Health and care workforce in Europe: Time to Act*, co-organized a regional meeting in March 2023 in Bucharest where Member States adopted the Bucharest declaration, and has drafted a *Framework for action on the health and care workforce in the WHO European Region 2023–2030*, adopted during the Seventy-third Regional Committee for Europe held in October 2023. The framework for action is based on five pillars, with health workers at the center, focusing on the actions needed to recruit and retain them. The other pillars foresee optimized performance, ways to build a sustainable workforce, good governance for investment and planning, and a

whole-of-society approach. Each pillar includes actions to be undertaken by the WHO Member State and actions to be taken by WHO.

Key findings from our research on health workforce mobility in the European context

The [Pillars of Health](#) project brought together a coalition of non-State organizations from different European countries: France, Germany, the Netherlands, Romania and Serbia. Each country faces a shortage of health and care professionals attributable to various causes, including unattractive working conditions, in-country deficient strategic planning and retention policies, limited opportunities for continuing professional development, and, in some cases, excessive health worker outward mobility and migration, with some countries benefiting disproportionately from such mobility and migration. Our research therefore focused on understanding the root causes of the health workforce crises in the various countries and their interlinkages, and on highlighting the national responsibilities as well as the added value of current and future European action.

The findings are presented here in the following order:

- Quantitative cross-country analysis
- Qualitative findings on migrant health worker experiences
- Country case studies for [Germany](#), [France](#), [Romania](#), [Serbia](#), [the Netherlands](#).

1. Quantitative cross-country analysis

In short

- There is an increasingly unclear distinction between countries sending and countries receiving health workers across Europe.
- High-income EU Member States, as well as high-income neighbouring countries, increasingly rely on doctors and nurses trained abroad.
- Estonia, Denmark, Romania, Hungary and Slovakia (doctors) and Romania, Portugal and Denmark (nurses) observe an ongoing drain on their health workforce.

- There is a lack of mobility data from certain countries, years, and health professions, which makes it difficult to monitor developments.

Geography of mobility across the European Region

Our cross-country report presents a secondary analysis of health worker migration data retrieved from the Organization for Economic Co-operation and Development (OECD) database and the European Commission Regulated Professions Database (RPD), using data from 2010 to 2022. Our report illustrates the *reliance* on foreign(-trained) doctors and nurses, highlights the *trends* over time and explores key geographical patterns and the *magnitude* of intended mobility flows of medical doctors and nurses between subregions and countries within the European Region. Further, this secondary analysis revealed key gaps and limitations of data available on health worker mobility in the EU and neighbouring countries, similar to the data challenges reported in the recently issued WHO report on global health workforce mobility [9].

Findings from this secondary analysis emphasize the increasingly unclear distinction between countries sending and countries receiving health workers across Europe. The findings highlight that certain high resource EU Member States (e.g. Germany) and high resource neighbouring countries (e.g. the UK, Switzerland, Norway) continue to be popular receiving countries. OECD data show these countries to increasingly rely on doctors and nurses trained abroad. RPD data shows that these countries have been the top choices for medical doctors and nurses seeking recognition of their qualifications over the last ten years. Our analysis identified two main mobility patterns across European countries (see *Figure 1* and *2*):

1. intended movement from Eastern and Southern European regions to Western and Northern European countries, and
2. intended movement within Western and Northern European regions.

In particular, the countries from which most medical doctors plan to migrate abroad include Germany, Romania, Italy, Greece, and Poland. As for nurses, countries from which most plan to migrate abroad include Romania, Spain, France, Italy, and Portugal. On the receiving end, the countries receiving most requests for recognition of foreign qualifications include the UK, Switzerland, Norway and Germany. Followed by Sweden for doctors in particular, and Belgium for nurses.

The magnitude of intended mobility flows (i.e. the intended outflow as percentage of national doctor and nurse stock) appeared highest in Estonia, Denmark, Romania, Hungary and Slovakia

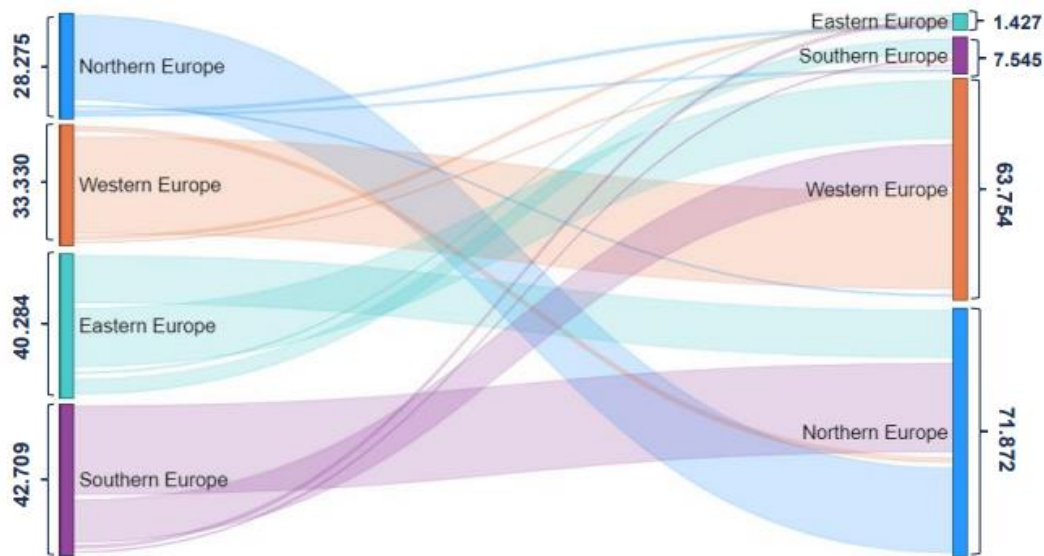
for medical doctors (>15% total from 2010 – 2022) and in Romania, Portugal and Denmark for nurses (>10% total from 2010 – 2022). The inflow of foreign-trained health workers did not appear to make up for this intended outflow and these countries may therefore observe an ongoing drain of their health workforce.

Figure 1. Intended mobility flow of medical doctors between European subregions¹



¹ The geographic subregions of Europe used here are as defined by the UN Statistics Division and used as such in all UN databases. See [here](#).

Figure 2. Intended mobility flow of nurses between European subregions



Data gaps and limitations

Understanding the mobility of healthcare workers within the European Region faces challenges due to significant gaps and limitations in the available data:

- The data is only available for certain countries, limited to those included in the OECD health statistics database and the Regulated Professions Database of the European Commission.
- Data is not consistently collected. There are missing data for certain years or specific indicators in some countries; the data might focus only on particular professions, such as only medical doctors and nurses; or there are differences in data collection methods and definition of indicators.
- The data available to quantify health worker mobility is restricted to records of "intention to leave". The data from the RPD does not show whether, after obtaining certificates recognizing qualifications, the healthcare professionals actually move to the receiving country as intended.
- Along similar lines, the available data does not provide insight into what happens during and after migration. It remains unclear whether healthcare workers find employment or become unemployed, if they end up in jobs that are below their skill level, if they transition to work in different sectors, or if they return to their home country or move to yet another country.
- Data are not disaggregated for gender, ethnicity, specialties within health professions or other social and economic dimensions.

These limitations challenge our ability to draw definitive country comparisons and track trends over time and hinder our ability to understand the diverse characteristics of migrant healthcare

workers. For example, it hampers insights into their socio-economic backgrounds, reasons for migrating, motivations, and career aspirations.

2. Qualitative findings on migrant health worker experiences

In short

- Our research among health workers found the following main reasons for wanting to migrate: job availability, career advancement prospects, inadequate working conditions and insufficient acknowledgement, respect and recognition in their countries of origin.
- As regards experiences, migrated health workers who generally feel welcome in destination countries attributed this to benefits, job rewards and satisfaction, permanent contracts, increased professional recognition and opportunities, in addition to different hierarchical structures.
- Key challenges reported by migrant health workers were language, scope of employment, stereotyping, differential treatment or exploitation in destination countries or a lack of trust in their skills.

Health worker accounts on reasons for migration within the European region

We explored key health worker accounts on migration reasons and experiences in a literature review encompassing studies concerning work and life experiences of individual migrant health workers in European destination countries spanning from 2000 to 2021. Additional survey and interview data were collected concerning similar themes, between April and July 2023. These endeavours revealed key reasons to migrate and health worker experiences in European destination countries. Quotes included in this section come from survey and interview data collected by the Pillars of Health coalition.

European health workers continue to migrate primarily because they encounter challenges related to job availability, career advancement prospects, inadequate working conditions and insufficient acknowledgement, respect and recognition in their countries of origin. Even in cases where health workers have a wish to move back to their country of origin, the working conditions in their country of origin may result in them staying in destination countries for prolonged periods.



"My kind of research opportunities in Spain were very limited in terms of funding. In terms of infrastructure as well... After seeing all the kind of opportunities in the UK then I thought well, I think I'll have better options and better training and better learning and progression opportunities if I move."
(Spanish doctor (female) in the UK)

"[The reason I migrated is because the] too high workload during a long period without expectation that it will become better."
(German nurse (female) in the Netherlands)

"Would maybe consider moving back, because of my family and homesickness in some periods. [An incentive would be] better salary, lower working pressure. Nothing has changed since I left."
(German nurse (female) in the Netherlands)

"Those who still leave do it especially because they want to work at a high-level performance hospital, they want to learn and do more than is possible in Romania, because not all Romanian hospitals provide the same conditions."
(Head of ward, Romanian doctor (female) in Romania)

Better workplace circumstances, work-life balance as well as opportunities for advancing knowledge and experience in destination countries played a role in decisions to migrate and in turn, were also reported as incentives for return migration. Further, personal reasons such as relationships and family circumstances impacted one's decision-making to either stay in the destination country or migrate elsewhere.

"That's why I think as long as it benefits me here with small children I'm here, but if I want more challenge, more growth, then I may have to go to Netherlands. Surely there is more development there, it's a bit more exciting there. It's really a very different environment."
(Dutch doctor (female) in Norway)

"[I] moved back due to getting a permanent contract."
(Spanish nurse returned from UK to Spain)

"I moved over with my partner. Our 2 children were born here. [I am] settled and retrained here. I am happy with my standard of living."
(UK nurse (female) in the Netherlands)

Health worker accounts of migration experiences within the European Region

The literature review revealed key benefits and challenges of migration experienced by individual health workers in European destination countries. These are supported by qualitative accounts of health workers. Quotes included in this section come from survey and interview data collected by the Pillars of Health coalition.

Migrant health workers generally feel welcome in destination countries, which is attributed to benefits, job rewards and satisfaction, permanent contracts, increased professional recognition and opportunities, in addition to different hierarchical structures. Looking native (e.g. being white) and mastering the local language were reported to be key facilitators of workplace integration.

"Because I look Dutch, blond, blue eyes and pretty quickly mastered the language I have always been approached with interest towards my origins."
(Danish nurse (female) in the Netherlands)

Language was identified as a key barrier to proper workplace and social interactions with colleagues and patients as well as workplace inclusion, leading to increased insecurities and feelings of inferiority at work, lack of trust regarding clinical expertise, higher levels of stress and anxiety and increased difficulty in transferring medical knowledge in a new language. Having a social network such as friends and family in the destination country supported health workers in their transition to a new culture and environment but also increased reliance on such networks.

"One of the key challenges was the language, at the beginning it was very difficult to communicate properly. I felt the lack of trust in general in foreign workers, at least at the beginning."
(Spanish nurse (female) in the UK)

Language barriers as well as key differences in scope of employment (e.g. deskilling or being assigned 'easier' tasks) in destination countries led health workers to be challenged in their professional identity and experience a loss of professional competence. Some health workers report experiences of stereotyping, differential treatment or exploitation in destination countries or report a lack of trust in migrant health workers.

Navigating systems and structures, and specifically obtaining a license and getting registered in the destination country continue to be demanding and complex tasks for migrant health workers.

This leaves health workers in particularly vulnerable positions after migration. For instance, it may impact one's ability to apply for maternity leave.

"While doing the first six months of the induction programme participants don't pay taxes and don't have the same rights as those officially working. If they want to apply for maternity leave, they need to officially work and pay taxes for another year after the completion of the programme. So it is not possible for migrated health workers to apply for maternity leave in the first year and a half of working."

(Spanish doctor in the UK)

"How I happened to figure it out [registering as a health worker] is a kind of miracle work, this is very hard to find. If you haven't mastered the language well, most people cannot find it. I was lucky that I happened to meet someone who says 'this is how it works.'"

(South African nurse (female) via the UK now in the Netherlands)

3. Country case studies for France, Germany, Romania, Serbia and the Netherlands

France

In short

- France is highly reliant on foreign-born, foreign-trained health and care workers.
- French recovery and resilience plans include reforms to the health and education sectors to tackle workforce shortages, but the country mostly allocates significant investments in the 'hardware' of its health system, such as modernization and restructuring of hospitals and health care supply.
- The unequal geographical availability of health and care workers (including so-called medical deserts) remains a pressing challenge.

WHO's report on global health worker mobility [9] shows that in the past two decades, France has consistently been among the key global destination countries for mobile medical professionals, alongside Australia, Canada, Qatar, Saudi Arabia, the United Kingdom, and the United States. Data from 93 countries indicate that France is of one of six top destination countries for mobile doctors.

France can count on 43% of personal care workers in health services originating from other countries. Nurses trained in Belgium, Morocco and Tunisia constitute 63% of the foreign-trained nurses in France. At the same time, there is dynamic migration and mobility in Europe: with French as the common language, 87% of mobile nurses trained in Belgium are in France and 94% of mobile nurses trained in France are in Switzerland.

Our own (Pillars of Health) research – i.e. our [country report on health worker migration and mobility in France](#) - concludes that, as the country emerges from the Covid-19 pandemic, it is clear that France's health system and workforce are experiencing major challenges: an ageing population and its specific care demands, an ageing population of doctors, medical deserts, the distraction of time spent formfilling by practitioners to the detriment of care, and exhaustion from unremitting work demands. While some of these challenges had already been apparent, the pandemic served to bring them into sharper focus.

Some of these pressures could be partially alleviated, particularly in France's public hospitals and its nursing and care homes, with the recent reforms to the health and education sectors aimed at tackling the health worker shortages and the significant investments announced in France's Recovery and Resilience Plans (see further down). However, there is considerable room for France to make further progress towards self-reliance in training and retaining health professionals.

For example, while many health workers in France have trained in other EU Member States, it is evident that French-trained health professionals also migrate to other EU countries and to Switzerland. The traffic is therefore two-way, although when French health professionals migrate, they tend to move to other French-speaking countries, such as Belgium, Luxembourg, and Switzerland.

In addition, accounting for two-thirds of the health work force, nurses play a pivotal role in France's health system. The proportion of foreign-trained nurses in France rose from 1.71% in 2000, to 2.44% in 2010, and to 2.86% in 2019. However, some of these are French nationals who have been trained elsewhere in the EU.

As regards the French National Recovery and Resilience Plan, the European Commission classified health and the resilience of the healthcare system as one of France's challenges: "France should [also] improve the resilience of its health system by ensuring availability of critical medical products, promoting a balanced geographical distribution of health workers and fostering

the digital transformation of the sector.” The national strategy for the transformation of the health system indeed allocates significant investments in the modernization and restructuring of hospitals and health care supply (including construction, technical installations, energy renovation, equipment and modernization work), in technical standards for digital health and in renovation of medico-social establishments (such as investments in 3 000 nursing homes to improve residents’ living conditions). While undoubtedly helpful to improve the ‘hardware’ of health and social service delivery, and thus potentially creating better working conditions for the health and care workforce, the plans do not explicitly address the health workforce challenges as outlined above.

Germany

In short

- Our research shows that Germany is both a source and destination country for health workers, in almost equal measure. Outflow as well as massive resignation are symptoms of a wider German healthcare crisis, and have triggered increasing recruitment from abroad. E.g. its reliance on foreign nurses has increased from 5,8% in 2013 to 11% in 2022.
- Our analysis is also critical about Germany’s compliance with the WHO Code of Practice on the International Recruitment of Health Personnel.

According to the 2023 WHO Report on Health Workers Mobility, Germany is also among one of the six top destination countries for medical doctors. At the same time, Germany is not only an important destination country, it is also a source country for many migrating health workers, with destinations in Switzerland, Austria, the UK, Norway. The country is one of the seven countries of training that together educate 30% of the mobile medical doctors globally [9].

The 2022 Pillars of Health research – [our country report on health worker migration and mobility in Germany](#) - gives an overview of the challenges in the German health labour market situation and gives recommendations to the German government, German civil society and the European Union.

The report also specifically raises the issue of the significant and problematic influence of German international health worker recruitment, and the impact this phenomenon has on the unequal availability of health workers in the European region. It is specifically critical about the fact that

Germany doesn't act according to the WHO Code of Practice principle that "*all Member States should strive to meet their health personnel needs with their own human resources for health*". Quite the opposite, Germany shows a growing shortage of nurses and a growing dependence on international recruitment of health workers. The share of foreign nurses increased from 5,8% in 2013 to 11% in 2022. 43% of these nurses come from other EU Member States and 17.5% from the Western Balkan countries. In absolute numbers, this means that 29.3% of the registered nurses in all Western Balkans countries work in the German health sector. While being an important destination country for health workers from Eastern-Europe for many years, the German government also started to invest in the active recruitment of health workers from non-European countries around 2013.

Our report also takes a closer look at the root causes of the German care crisis, describing the growing dissatisfaction of nurses with their jobs, leading to considerable resignation, especially since the introduction of the Diagnosis-Related Groups (DRG) based hospital financing system in 2003. The declining nurse-to-bed ratio, which is one of the lowest in the EU, results in a very high workload, and motivates many nurses to search for jobs in other sectors. The situation triggered a reactivation of industrial action, resulting in targets for health workers-to-patient ratios being incorporated in the collective bargaining agreements of many German hospitals.

Not all remedial actions are deemed effective, though. A major hospital reform was announced with the promise of a radical step towards de-commercialization of German health care, however, many civil society organizations criticized it for not breaking with the existing DRG logic and failing to present real solutions to the growing crisis of the German health system¹. And a 2023 draft for a new skilled labour migration Act [10] promises new chances for migrating people, but also creates new dangers of their exploitation as cheap workforce.

On the occasion of a hearing of the parliamentary subcommittee for Global health in May 2023, to discuss the issue of international health worker recruitment, the German platform for Global health published and distributed a position paper, initiated by Pillars of Health project partner *vdää** [11]. It demands more sustainable solutions to the German health workers shortages and the actions to ensure that health workers recruitment is performed in the fairest way possible, both for countries of origin and individual migrants.

Romania

In short

- Romania is an important supplier of well-trained doctors and nurses for the European and US health labour market, despite a significant income increase of health personnel in the public healthcare system.
- Our research into motivations for migration revealed the following predominant features: for doctors, opportunities for professional growth and career development are the main factors influencing their decision to migrate. For nurses, a better-paid job and an appropriate workload still fuel the decision to practice abroad.

Romania is widely recognized as a source country of well-trained medical doctors and nurses. The *2023 WHO Report on Global Health Worker Mobility* added Romania to the international cluster of source countries in the last two decades. Romania and six other countries (Egypt, Germany, India, Pakistan, Russian Federation and the United Kingdom) account for the education of 30% of all doctors working abroad. The top three destination countries for the medical doctors educated in Romania (more than 50% of the migrating physicians) are France (18.6%), Germany (8.4%) and the USA. Italy, the UK (6.8%) and the USA represent the top three destination countries for (Romanian?) nurses [9].

Therefore, within the Pillars of Health project, we investigated the reasons for the Romanian health workforce mobility and migration through qualitative and desk research. In-depth interviews collected information about mobility root causes, perception of the push and pull factors, and their attitudes towards mobility and migration. The study also collected views on policies and measures to increase health workforce retention.

The analysis in [our country report on health worker migration and mobility in Romania](#) revealed two predominant features that still foster the mobility and migration of Romanian health professionals, despite the significant income increase of health personnel from the public healthcare system:

- for doctors, opportunities for professional growth and career development are the main factors influencing their decision to migrate.
- for nurses, a better-paid job and an appropriate workload still fuel the decision to practice abroad.

The reasons for health professionals' mobility and migration were grouped into four main categories: economic, psychological, social and political/systemic.

1. Economic drivers of mobility and migration

The economic causes cover better living and working conditions abroad. The living conditions include the cost of living, access to improved education for their children, the safety of their family, access to public services and social protection, and dissatisfaction with the present income level. The findings are consistent with previous research suggesting that retention measures for doctors include investments in modern medical technologies. For nurses and midwives, retention measures would be better monthly net income/salary. However, a recent narrative suggests that the monthly income for doctors no longer represents a reason to migrate after a significant increase in health workers' salaries from the public healthcare system in 2018.

“Those who still leave do it especially because they want to work at a high-level performance, they want to learn and do more than it is possible in Romania, because not all Romanian hospitals provide the same conditions.”

(Head of ward, doctor in Romania (female))

2. Psychological drivers of mobility and migration

The psychological causes of mobility and migration include burnout and anxiety. Many doctors and nurses work under pressure, with heavy workloads or fear of medical malpractice lawsuits. Anxiety is amplified by a perceived lack of protection and support from the hospital administration, College of Physicians or colleagues. Health professionals also fear receiving penalties from mandatory health insurance for any minor administrative fault. They also reported a lack of flexibility at work, sometimes opposition from the management to their professional development (restrictions to leave work or to travel for professional purposes). The health workers ask for revised malpractice legislation, a supportive working environment with room for their professional decisions and professional development, simplified rules of practice, flexible working hours allowing rest, and appointment of additional staff where available but subject to budgetary constraints.

“The most important negative aspect is the fatigue that kicks in at some point, after so many sleepless nights. No matter how much we like to tell ourselves and others that we are not tired, we are. Burnout is a silent challenge. The majority felt it, especially during the pandemic. I think that many of us have this problem even now. But it is neither documented nor evaluated... We try to overcome it on our own.”

(Doctor in Romania (female))

3. Social drivers of mobility and migration

The social causes of migrations include the lack of respect from patients, an unfriendly environment at work, and the neglect of proper communication and cooperation between colleagues, instead increasing their competition. The health professionals would not migrate or would return to Romania firstly due to social factors (family commitments, children's education, or longing for the native place).

"I would ask for more respect, to be more respected as a profession. It's important to be valued more for the role we play. Clearer delineations of responsibilities and roles would also be beneficial. However, I think the most important thing is the mentality, because after all we are a team. In our case, the doctor and the nurse are simply collaborators, colleagues."

(Doctor in Romania (female))

"You feel helpless, you feel that you cannot do your work, that you are not valued in any way and valued, you do not have any kind of satisfaction."

(Head-nurse in Romania (female))

4. Political/systemic causes of mobility and migration

More systemic drivers of mobility and migration include political influence and corruption, bureaucracy excess or a rigid undergraduate and postgraduate medical education system. Gathered examples include access to working places in big hospitals or managerial positions, as subject to bribery or influence, excessive bureaucracy, outdated undergraduate education information, and a deficit of sites in the postgraduate education for specialties the young graduates would like to apply for. The postgraduate medical education system is perceived as limiting professional development options, like the possibility to modify a chosen specialty, low support in the learning years, and no good job opportunities after 10-13 years of education. Doctors decide early to migrate to enhance their educational opportunities and career advancement. Medical doctors call for the health system's depoliticization, transparency and fairness across all system levels. There is a need for a holistic intervention to attract and retain medical personnel.

"It is very important who leads an institution. I have 34 years of experience and I have seen that this matters a lot, everything starts from the leaders and if people collectively want to do more, then things will happen."

(Head-nurse in Romania (female))

Serbia

In short

- Serbia has no up-to-date health workforce plan or strategy. Health workforce data are incomplete and out-of-date, and unemployment is high.
- In combination with high intentions among the health workforce to leave the health sector and/or the country, the situation of this candidate-country to the European Union calls for immediate action, in order to avoid high outmigration of health workers after accession.

Health workforce governance in Serbia is complex, regulated with many legislations, regulations, strategies, and programmes, belonging to health and other sectors. Such fragmentation complicates clear governance in terms of common goals and objectives for the health workforce, including health workforce capacity and quality for the near future or in the long term.

Serbia also does not have an official health workforce strategy or Master Plan. One of the reasons is the lack of data, for example about the total number of full-time equivalent staff or full data on the size of the workforce (licensed, practicing, active, unemployed) and their distribution (age, sex, urban/rural level, public or private sector). The last available comprehensive and overall health workforce forecasts were done by 2017, indicating a significant mismatch between the forecasted supply of physicians and available posts. Valid and complete information on the trends in workforce migration is not available either.

National Health Workforce Accounts database reflects this situation: health workforce data for the Republic of Serbia are incomplete and not updated (they cover the period 2013 to 2016). According to 2020 national statistics, the total number of registered employees in human health and social work activities amounts to 155,240 (approx. 7% of the total workforce), most of them active in the public sector. Data on private practitioners in Serbia is insufficient to meaningfully contribute to a comprehensive analysis of the health labour market and the comprehensive and strategic planning of health workforce requirements at the national and community level.

At the same time, according to the data from the National Employment Service, in October 2019, 15,000 health workers were waiting for a job, of which 55% were women, and 21.2% younger than 30. 58.4% of unemployed persons had been unemployed for the last 2-3 years. High unemployment indicates a problem with strategic planning of the health personnel.

As regards job satisfaction, a 2019 survey in state health institutions revealed that 27.1% of all surveyed employees reported an intention to leave the job in the next five years: 7.5% would look for jobs outside the health care system, 4.6% would go to work in the private health sector, and 15% said they intended to go abroad. The country has indeed faced the departure of a large number of health workers in recent years, including in the context of government-to-government arrangements, for example with Germany. This raises concerns about the quality of health services in Serbia and about the prospects of transfer of knowledge and experience to younger generations.

As in other countries, the Covid-19 pandemic has increased the dissatisfaction among healthcare workers regarding their working conditions and pay; the latter in spite of public sector pay raises of up to 12% (depending on qualifications). Many healthcare workers have quit their job in public health institutions to continue working full time in private health institutions. This has left a gap in skilled healthcare workers in public health institutions, and increased the workload on the remaining healthcare workers, potentially driving further health worker migration.

In the meantime, there are no reliable data on actual annual net in-migration and out-migration of health professionals. The *2023 WHO Report on Health Workers Mobility* mentions Serbia only in relation to the main destination countries for its doctors, namely Germany, USA and Slovenia, but no absolute figures are given [9]. The country has not implemented the WHO Global Code of Practice on the International Recruitment of Health Personnel that requires the establishment of a national authority for organizing and recording the mobility of healthcare workers. Other sources of information such as research studies, or health professional records and employment office, have not succeeded in providing comprehensive or reliable information. However, in one study, the intention to work abroad among students was as high as 81% among medical students, 70% among college nurses and 66% among specialist nurses.

Towards the EU and beyond

Serbia being a candidate EU Member State, the high intention of new generations of health workers to work abroad, in combination with experiences of other countries that suffered serious outflows in the post EU accession period, is calling for the attention of the Serbian government. Immediate action is needed in order to prevent similar scenarios, e.g. by adequate planning and forecasting, monitoring the professional expectations and intentions of health workers, implementing and monitoring retention policies, and setting up a solid information system to track of in- and out-migration of health professionals.

The Netherlands

In short

- The Netherlands has low levels of foreign-born, foreign-trained health workers. However, the Covid-19 pandemic has had a dramatic effect on the health workforce, which was struggling with growing shortages already before 2020. The appetite to recruit health and care workers from abroad, especially for long-term care, is growing.
- Measures to increase domestic training, recruitment and retention do not seem to have noticeable effects.
- Measures proposed in the National Recovery and Resilience plan address health workforce challenges in crisis times, but have little relevance to alleviate workload or improve working conditions and job satisfaction in non-crisis times.

The Netherlands is a minor player in the international health labour market, because of its small size in comparison to economic giants like the USA, UK, Australia and, in the European context, Germany and France. The percentages of foreign-born, foreign-trained pharmacists, physicians, physiotherapists, midwives, nurses in the so-called BIG-register (the register of 'professionals for individual healthcare' registered in the Netherlands) varies from 0,1-0,3% of the total stock. For dentists, this percentage is slightly higher at 1,7%. Therefore, the Netherlands cannot be labelled as a driver of global or European health worker brain drain, as we also describe in our Pillars of Health [position paper 'Handle with care'](#) on the international recruitment of health and care workers for the Netherlands [12].

However, the Covid-19 pandemic has had a dramatic effect on the Dutch health workforce, which even before 2020 struggled with increasing shortages. In 2017, the Dutch Ministry of Health, Welfare and Sport (MOH) developed the 'Labour Market Agenda 2023', followed in 2018 by the Action Programme 'Working in the care sector', containing measures to meet the (then) forecast shortage for 2022 of 100,000 to 125,000 employees in health and social care [13, 14]. These efforts have been partially successful, but the Covid-19 pandemic has confused existing plans and ambitions. Updated estimates of health and care personnel shortages reveal the staggering number of up to 155,000 staff shortages by 2032; 137,000 if government measures prove effective.

In the wake of the pandemic, several recent developments indicate an increased interest in international recruitment to increase staffing levels. For example, the possibility of recruiting from

abroad has been mentioned by influential stakeholders and thinktanks, such as in an important report by the Netherlands Scientific Council for Government Policy (WRR) in September 2021 on the long-term sustainability of the Dutch health care sector. The report stresses that an explicit government policy in this area has ‘far-reaching implications, not just for healthcare but also for society, the economy, and government policy. This is why a broad-based political consideration is needed’ [15].

In September 2022, the Dutch Advisory Council on Migration Affairs published a report exploring the opportunities and conditions for ethical labour migration policy for health workers. The report shows an in-depth understanding of the practical and ethical pros and cons of international recruitment of health workers and translates these into concrete policy recommendations. It can therefore be considered a landmark publication that could trigger a change in official government policy, including measures to overcome current legislative obstacles for the deployment of foreign nationals [16].

Last but not least, a key recommendation in this report is that the Dutch government – if/when explicitly choosing for the option of international recruitment – should take the lead in the legal, administrative, labour law and other changes required and guarantee true triple win arrangements, and develop ethically responsible partnerships, benefitting the individual migrant, Dutch health care and the country of origin. Meanwhile, the official position of the Dutch government is still that international recruitment of health and care workers remains a last resort. At the same time, news items are reporting regularly on health facilities recruiting international students. These students follow classes for a couple of days per week, while doing their internship in a health facility (e.g. elderly homes) for the remaining days, employing mainly students from Indonesia and the Philippines. This has not gone unnoticed: several key stakeholders in the health sector are calling on the government to ‘roll out the red carpet for health workers from abroad’ [17].

The European Semester Country Specific Recommendations (CSR) for the Netherlands have addressed health labour market challenges in several ways. In 2020, the recommendations focused on enhancing the health system’s resilience by addressing worker shortages and promoting e-Health tools. The 2022 CSR call for addressing labour and skills shortages in healthcare, suggesting the utilization of underutilized labour potential from part-time employment and migrants. And the 2023 CSR propose policies such as increasing wages in sectors with shortages, improving work-life balance, enhancing career guidance, and ensuring accessible

childcare. Additionally, targeted upskilling and reskilling measures are recommended to alleviate shortages and improve social outcomes for marginalized and inactive workers.

One of the six priorities in the Dutch Recovery and Resilience Plan is to strengthen the public health sector and pandemic preparedness. The measures and investments foreseen are aimed at:

- (temporarily) limiting health worker shortages in times of crisis through the creation of a National Care Reserve of approx. 2500 health professionals, and through the recruitment of support staff to take over non-medical workload.
- expanding the currently limited Intensive Care capacity and strengthening pandemic preparedness. This includes structural adjustments to hospitals as well as the training of additional IC nurses.
- Promoting e-health applications that provide remote support or care. Examples are screen care, asking for an indication via an app and the provision of medication via medication dispensers. There is a subsidy for this provided to care providers in, among others, general practitioner care and district nursing.
- the development of an integrated, national health data and research infrastructure.

While undoubtedly helpful to address challenges in times of crisis, these measures do not seem to be directed at solving equally urgent health workforce challenges in non-crisis times, including those relating to work load, working conditions, and other elements in work satisfaction as suggested in the CSR 2023.

Conclusions

The Pillars of Health partners have conducted research in select countries in Europe that add to the existing body of knowledge about health workforce challenges, their root causes, and the contribution of health worker mobility and migration to either the workforce problems or their solutions. We have conducted in-depth situational analysis in the project countries and enriched current knowledge with extensive qualitative research.

In summary, the Pillars of Health research findings illustrate:

- the diversity and similarity of the challenges in the health workforces in EU Member States.
- the considerable dimension of health worker migration in Europe and its neighbouring countries. Although it is a complex pattern, with no country being just country of origin or destination country, the patterns show how especially countries from the South and East lose,

while countries in West and North win health workers. These patterns follow economic gradients.

- that health worker migration is not a problem in itself, but rather the symptom of a larger crisis: EU national governments' underinvestment in their health systems have resulted in underfunded health sectors, making them an unattractive employment sector for health workers. This creates a vicious cycle: health workers become overburdened, leave the sector in their country of origin, and/or migrate elsewhere for e.g. better career opportunities, salaries and professional development. In turn, the colleagues they leave behind risk becoming even more overburdened due to an increased workload and patient-health worker ratio, and increasing the risk of them leaving the sector and country too. Ultimately, neither health workers nor patients/populations benefit from such situations.
- that health workers quitting their jobs and health workers migrating are two sides of the same coin: due to job dissatisfaction, they either leave the healthcare sector and switch to another sector, or leave their country of origin altogether, seeking better professional prospects in a destination country's healthcare sector.
- the difficulty in retrieving quality data on the healthcare workforce in general, and on health worker mobility in particular.
- that, although unprecedented funding is available from the European Commission, for example for the National Recovery and Resilience Plans, not all EU Member States dedicate proportionate investments to strengthening their health workforce.

Recommendations and points for action

Changing the narrative: health access and workforce challenges are a joint responsibility

Health is the foundation of people's well-being and a basic human right. Health and well-being closely linked with robust, sustainable and resilient health systems. And one of the most indispensable pillars under any health system is its workforce.

We believe that the imbalance of health workforce numbers in the European Member States is undermining the European ambition of shared prosperity, in solidarity. While some Member

States invest in the education and training of health and care workers, only to see them leave, other Member States benefit from such mobility and migration, as a quick fix to their own workforce shortages. Still, the complexity of this phenomenon is poorly analyzed.

And while the European competences in health are limited, we feel the need to change the current narrative. **We need to move *from an international competition for skilled health workforce in crisis-ridden health systems, towards* united action from all EU Member States to create working conditions for our health and care workers, that enable them to deliver high-quality health care in Europe to all who need it and commensurate to their health needs.** Shortages in the health workforces, and inequalities in their availability, should be perceived as a shared concern, and a joint responsibility. The EU can and should do more, even within its current mandate. Without EU intervention, the EPSR aspirations will remain a distant dream.

For this united action by EU Member States, we recommend the following:

- EU Member States must invest in robust, attractive health systems by increasing the education and training of health workers, increasing health worker retention and recruitment efforts, optimizing health workers' performance and enhancing planning and forecasting capabilities.
- The European Commission should disseminate existing examples of how different EU funding sources (Recovery and Resilience Funds, Cohesion Funds, European Structural and Investment Funds, and others), can be used by Member States to boost health systems performance and provide more attractive working conditions for the scarce health and care workers.
- The incoming Members of European Parliament should use the upcoming 2025 revision of the European Pillars of Social Rights Action Plan to develop and start monitoring health workforce targets indicators and equitable access to health services. This could be achieved through dedicated actions and funding in a (new) EU Action Plan for EU Health Workforce. We thereby also propose a workstream on strengthening the nursing workforce and primary healthcare, given the evidence that investing in the development of the nursing workforce is a solution to increase access to health services. And it is known that strengthening primary health care contributes to improving population health.
- The European Semester process should make it mandatory for Member States to report on health workforce shortages, in combination with data on the recruitment of doctors and nurses

from abroad and their reliance on foreign-born, foreign-trained doctors and nurses. These reports should become publicly available.

- Policy makers involved in the European Health Data Space (EHDS) should make an effort to expand the EHDS's remit, to include a standardization of indicators for health worker mobility, and to ensure regular reporting and integration of data from various sources and data collection bodies. Both more qualitative *and* quantitative data are needed; they complement each other and can provide deeper insights into health worker mobility and migration.
- EU duty bearers, institutions and dialogues should ensure that more non-state actors are invited in debates about Europe's health workforce crisis – and most importantly, about the solutions to this problem. Space for civic involvement has been decreasing at EU and national levels. By giving non-State actors a voice – in research, knowledge generation and advocacy in their countries – they can provide a valuable contribution to the discussion, as the last decades (pre-Covid pandemic) have also shown that Member States have had fluctuating interest in the topic.

About Pillars of Health

The Pillars of Health coalition is an alliance of EU-based organizations that wants to contribute to an equitable geographic distribution of health workers across the European Union (EU), to ensure that all European citizens have equal access to health workers. We consist of lead partner organization Wemos (the Netherlands), Center for Health Policies and Services (Romania), Media Education Centre (Serbia – until 2023), and VU Athena (the Netherlands). Together, we aim to influence policy-makers so they actively implement policies that mitigate the negative effects of health worker migration and mobility, and instead contribute to a strong and sustainable health workforce across the EU.

Visit <https://www.pillars-of-health.eu> for more information.

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