A PERFECT STORM: DEMOGRAPHIC AGEING, SEVERE HEALTHCARE STAFF SHORTAGES, AND GLOBALISATION OF HEALTHCARE LABOUR MARKETS

Mojca Vah Jevšnik and Sanja Cukut Krilić
CC BY-NC-ND, https://doi.org/10.3986/9789610508021_03

INTRODUCTION

The World Health Organisation recently characterised Europe's health and care workforce shortages as a ticking time bomb (WHO 2022). High global demand for healthcare workers[1] has indeed been a formidable and well-documented global challenge for decades, with renowned experts and scholars across the globe calling for a stern policy response to ensure sufficient staffing levels and work towards limiting geographical imbalances in supply and demand of healthcare workers (see Buchan et al. 2014, 2022). The European Commission addressed the problem in 2008 by acknowledging that all Member States will face foreseeable challenges in the years to come due to a variety of reasons, including the demographic transition of an ageing general population that will increase the demand for healthcare, ageing health workforce and insufficient replacement, the lack of attractiveness of a wide variety of health care and public health-related jobs to new generations, fiscal pressure due to a reduction of the active workforce relative to the dependent population, the migration of health professionals in and out of the European Union, and the unequal mobility within the European Union, in particular the movement of health professionals from poorer to richer countries within the European Union, as well as from third countries from outside the European Union (European Commission 2008).

An additional strain emerged during and after the COVID-19 pandemic, when the demand for healthcare services increased significantly, and healthcare providers became confronted with what was already a chronic shortage of health

1 The chapter defines healthcare workers as all healthcare service providers, including physicians, dentists, nurses, midwives, pharmacists, and other providers who deliver personal and non-personal health services. The term does not include managerial and support staff, such as managers and planners, who are not engaged in the direct provision of health services.

workers (Yeates et al. 2022). Namely, severe burnout and mental health issues experienced by frontline workers, especially nurses, resulted in prolonged sick leaves, early retirements, resignations, and, consequently, high turnover rates and unfilled vacancies. Their withdrawal had a ripple effect on the remaining health staff, who were required to work longer hours, pick up more shifts and take on additional responsibilities.[2] In the EU, the shortage of healthcare workers during the pandemic was estimated to be one million (McGrath 2021), and many Member States resorted to ad hoc recruitment from other countries to fill the vacancies and ensure uninterrupted delivery of healthcare. However, other OECD countries were also facing severe shortages, prompting an even more intensive wave of competitive recruitment efforts in global health labour markets than observed before the pandemic. This raises strong ethical concerns and once again directs attention to the perplexing interplay between the right to mobility of healthcare workers and the right to healthcare of the population that stays behind, as well as to the competitive advantage of high-income versus low-income countries when mitigating the losses of healthcare workers by recruitment from abroad.

The chapter explores the interplay of three intertwining and mutually reinforcing determinants that have a significant impact on the delivery of public healthcare in the EU: i) demographic trends and increased demand for the healthcare of the ageing population, ii) severe healthcare staff shortages and the leading underlying causes of unfilled vacancies, and iii) globalisation of healthcare labour markets and ethical concerns in the light of the cost-containment measures and privatisation of public services. The discussion builds on a review of academic and grey literature on public health, migration, mobility, and strategic healthcare workforce planning, demographic projections, statistics, policy reports, and investigative media reporting.

DEMOGRAPHIC CHANGES, AGEING HEALTH WORKERS AND INCREASED DEMAND FOR HEALTHCARE OF THE AGEING POPULATION

In most European countries, USA and Canada, we are witnessing a decline in fertility levels and an increase in life expectancies at the national levels, particularly from the 1970s. Consequently, these countries are increasingly

2 Surveys of the UK nursing and midwifery workforce conducted during and after the pandemic found high levels of psychological distress, including post-traumatic stress disorder, stress, and anxiety (Couper et al., 2022), high levels of substance misuse, and even suicide (Greenberg et al., 2021; see also Buchan 2022).

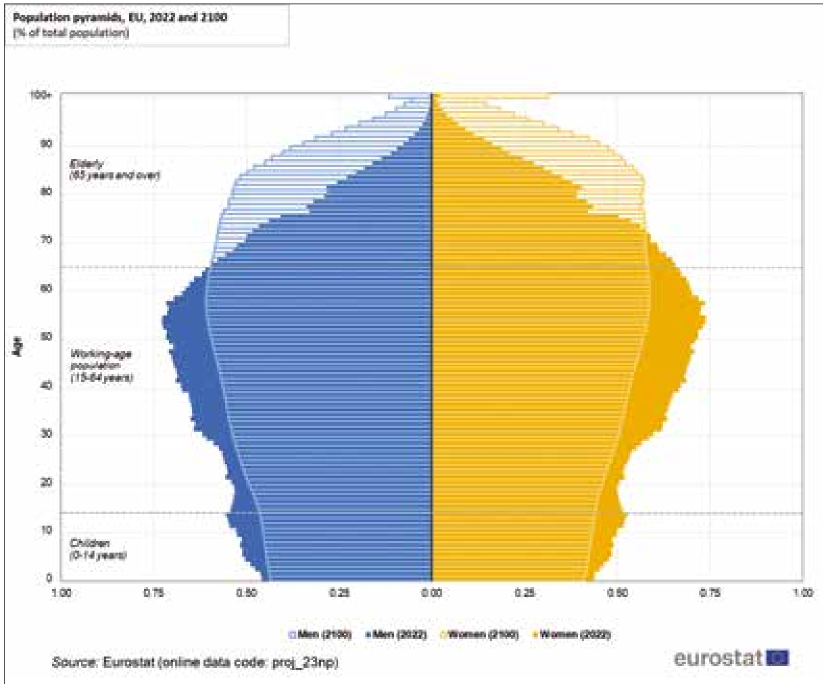
facing issues such as population ageing, the decrease in the number of the active labour force, consequent decreases in productivity and economic growth, and the increased burden of healthcare and pension insurance and systems (Linz & Stula 2010; England & Azzopardi-Muscat 2017; EUROSTAT 2020). Douglass et al. (2005: 4–6) further argue that, particularly from 2000, media headlines about a "population explosion" shifted to those about a "population implosion" as fertility levels started to fall in the so-called undeveloped world. Fears about the long-term dangers to the EU's position as a global economic and political force persistently arise in political and other public discourses (Fertility and family issues in an enlarged Europe 2004). The Green Paper on "confronting demographic change" produced by the European Commission in 2005 and the European Commission's communication on "the demographic future of Europe" are among the key early documents discussing how the EU could alter the changes in population age structure towards the predominance of the elderly. Furthermore, the European Commission has been reviewing the economic implications of ageing every three years since 2009 in its *Ageing reports* (EC in Goetz et al. 2022). Although the COVID-19 pandemic has impacted these demographic developments, according to Goetz et al. (2022), it has not changed them significantly since the reduction in life expectancies was only temporary. Furthermore, a halt in international migration was also temporary, so these trends remain among the key policy concerns in the EU even after the pandemic.

According to the latest population projections developed by EUROSTAT (2023) and released in March 2023 and as evident on the projected population pyramids for the year 2100 (Figure 1), a clear development towards a shrinking and ageing society is also expected in the future. From 2022 to 2100, the projections foresee decreases in the shares of children and young people below 20 as well as of individuals of working age, while on the other hand, there will be increases in the share of people aged 65 or more. For the year 2100, the pyramid does not start contracting after the age of 55 as in 2022 but remains relatively stable until around 85 years of age, which further points to the ageing of the population.

Furthermore, EUROSTAT (2023) used various other demographic indicators to analyse the shift in age distribution towards older ages. For instance, the median age of the EU population, meaning that half of the population will be older than this age, is projected to increase from 44.4 years in 2022 to 50.2 years in 2100 for both men and women. Secondly, the projections forecast that the share of the working-age population (15–64 years old) in the EU total population will decrease from 63.9% (285.5 million) at the beginning of 2022 to 54.4% (228.1 million) in 2100. The proportion of the elderly (65 years and over) in the EU total population is projected to increase from 21.1% (94.3 million)

at the beginning of 2022 to 32.5% (136.1 million) in 2100. With the overall EU population projected to decline by 2100, this is the only main demographic age group expected to grow, both in relative and absolute terms. Furthermore, the projections forecast that the number of very old people (defined as those aged 80 years and over) in the total EU population will more than double in absolute as well as relative terms from 27.1 million in 2022 (6.1%) to 64.0 million (15.3%) in 2100.

Figure 1: Population pyramids, EU, 2022 and 2100 (% of the total population).



Publicly most discussed issues in response to these expected trends refer to shrinking populations or negative population growth, national decline in terms of loss of power and privilege, population ageing (increased number/share of people over 65 years of age), the issue of immigration, and policy responses to these topics (Teitelbaum 1999; Douglass et al. 2005).

In the last few decades, two measures to counteract such a demographic situation are thus at the forefront of analysis of researchers as well as efforts

of stakeholders. The first proposed solution refers to pronatalist measures to increase birth rates and the natural increase in particular countries.[3] In turn, this would contribute to lessening the ageing of the population. The second set of measures refers to the so-called migration scenario, whereby the ratio between the economically active and the dependent population would change through international migration (ESA/P 2001; Knežević Hočevar 2011; Goetz et al. 2022). The United Nations Department of Economic and Social Affairs has even proposed using the term replacement migration as the solution to population decline and ageing of the population (ESA/P 2001). Nevertheless, states in the EU are becoming increasingly restrictive instead of more open towards international migration, particularly from non-EU countries. Hence, the migration scenario is unlikely to substantially contribute to reversing the mentioned demographic trends (Douglass et al. 2005). This is further evident in discourses about the proper composition of particular national populations. Talk about the demographic crisis, dying out of the nation, and legitimate and illegitimate migrants implicitly assumes who should and should not be reproducing and/or migrating to nation-states of the EU (King 2002; Kligman 2005). As Kligman (2005: 253) aptly puts it: "The historical or, to some, traditional understandings of 'the nation' are increasingly at odds with demographic verities that are transforming the more familiar faces of European nations."

The ageing of the population has also been an incentive for national governments to develop healthcare policies that aim to balance the economic difference between the younger and the older populations (Gu 2020). In that respect, the ageing of the population has caused an increased need for the provision of health care and other social services among the old age cohorts. Older adults may experience more age-related health issues, which can be physical (e.g., impaired sight, vision, arthritis, hypertension, osteoporosis, diabetes, asthma, cancer) and cognitive (e.g., memory and information processing issues) (WHO 2015; Gu 2020). In relation to population ageing, the WHO (2015) has noted a shift from communicable life-threatening diseases to chronic noncommunicable diseases that can cause temporary or permanent functional impairments and a decreased quality of life. These conditions are increasing not only the costs of health care but also long-term care (home health care, nursing homes, personal care, and day care). Given the increasing life expectancy, the EU's demand for healthcare and long-term care will likely increase further. According to estimates,

3 On the other hand, family planning policies have become the proposed solution for the "population bomb" of international overpopulation, although fertility is also now declining in some of the "developing" countries (Douglass et al. 2005).

the number of EU citizens requiring long-term care will grow from 19.5 million in 2016 to 23.6 million in 2030 and to 30.5 million in 2050. It is projected that between 2021 and 2031, there will be eight million job openings in the health and care sector and the supply of healthcare workers will certainly not be able to meet the demand (Brady and Kuiper 2023). The increase in demand for healthcare for the older population is also associated with smaller family sizes and family members dispersed at different locations, thereby reducing the incidence of home support. On the other hand, the economic crisis has also made older people more dependent on their families and home support, especially for populations in economically deprived rural and remote areas (EUROSTAT 2020; Gu 2020). Furthermore, a growing need for home healthcare for the elderly, as well as the development of community-based services for this group, are also among the most debated issues among policymakers and stakeholders (WHO 2015; Gu 2020). The COVID-19 pandemic has also impacted the health of older people, and particularly older people in residential care were more likely to face challenges associated with a lack of personal contact with family members and friends (EUROSTAT 2020).

With the ageing of the population, one of the publicly and statistically observed trends is also the ageing of the labour force in various sectors, including the health care sector, where the older workforce faces the already mentioned increased demand for health care (Rice et al. 2021).

To illustrate, the State of the World's Nursing (SOWN) report highlighted that one in six nurses worldwide are 55 or older. They estimate that 4.7 nurses must be trained in order to replace only those retiring in the next ten years, in addition to the already existing shortage of about 5.9 million nurses. The lack of nurses is particularly dire in low and lower-medium-income countries. According to the WHO (2022), all countries of the WHO European Region – encompassing 53 Member States across Europe and Central Asia – currently face severe challenges related to the health and care workforce. One of its findings is that 13 of the 44 countries that reported data on this issue have a workforce in which 40% of medical doctors are already aged 55 or older. The European Labour Authority's 2021 report on labour shortages (McGrath 2021) presented an estimate of the deficits of healthcare professionals in most European countries. Of the 30 surveyed countries, 18 reported shortages of nursing professionals, 13 shortages of general medical practitioners (GPs), and 11 shortages of healthcare assistants, specialist medical practitioners, and nursing associates.

Buchan et al. (2022) identified two challenges regarding this issue. The replacement challenge refers to the ageing of healthcare staff. Buchan et al. (2020) frame the second issue as a participation rate challenge, which refers to

ensuring that age-related discrimination, lack of incentives for part-time work, and a lack of policies aimed at encouraging and enabling older nurses to stay at work do not prevent older healthcare workers from fully participating in employment. The associated efforts towards retaining healthcare staff have been connected to the concepts of "ageing well" (Buchan et al. 2022, as well as "active ageing". The European Commission defines the latter as "helping people stay in charge of their own lives for as long as possible as they age and, where possible, to contribute to the economy and society" (Eurofound 2018). Nevertheless, the public operationalisation of the concept has been dominated by a neoliberal perspective that prioritises the extension of working life and restricts the social contribution of older adults to work-related activities, with increased pressure on older workers to keep working longer (Ishikawa 2022). A further incentive for keeping older healthcare staff at work has been the COVID-19 pandemic, during which underlying healthcare staff shortages became even more apparent. During the pandemic, many countries brought older healthcare staff (e.g., nurses) back to work, restricted them from leaving work using emergency powers, or initiated programmes to "fast track" the return of people with nursing qualifications who have left nursing (Buchan et al. 2022. However, such measures might also lead to the outflow of the workforce after the COVID-19 measures have ended, so we are witnessing a retention challenge in healthcare (Buchan et al. 2022). The challenge is exacerbated by the physically and psychologically demanding nature of work in the healthcare sector, which is among the factors contributing to the vulnerability of workers in this sector.

HEALTHCARE STAFF SHORTAGES AND THE IMPACT OF MOBILITY

In terms of being constantly understaffed and under strain, the vulnerability of the healthcare sector should be perceived not only as a consequence of healthcare worker mobility but also as a cause. Persistent challenges, such as low remuneration, poor working conditions, a lack of flexibility in working hours, limited career opportunities, and growing work pressures, may lead to the mobility of healthcare workers to other countries. Conversely, increased mobility may exacerbate shortages and put further strain on healthcare systems. The extent of the challenges faced by individual EU countries varies, but no Member State is void of these issues (Brady and Kuiper 2023).

Skill shortages across the EU are widespread in several occupations, although there are significant differences among EU/EEA countries. Norway, for example, has identified 250 shortage occupations and has reported a shortage in every single

occupation group, while Greece, on the other hand, identified only 11 shortage professions (McGrath 2021). Overall, however, every country faces some type of shortage in the healthcare sector and is reporting demand for healthcare skills as the vacancies are not filling (McGrath 2021; WHO 2022). The occupation of nursing professionals is in the highest demand and was ranked first among all reported EU workforce shortages in 2020 and second in 2021 (Ibid.).

Healthcare labour shortages are more prevalent in Southern and Eastern European countries. These countries tend to be impacted by high labour mobility of health professionals, which can be attributed to differences in salaries and working conditions[4] between countries in Northern and Western Europe and those in Eastern and Southern Europe (Brady & Kuiper 2023), as well as poor strategies for workforce planning and retention (Plotnikova 2018). The EU has played a significant role in facilitating intra-EU mobility of healthcare workers by introducing the directive on the recognition of professional qualifications (EC Directive 2005/36/EC), as six of the seven professions outlined in the directive are in the healthcare sector. This policy undoubtedly provided healthcare workers with great career opportunities, but it had different outcomes across countries, and some states have benefitted from the directive more than others. Data shows that in some cases, the loss of medical professionals due to mobility to higher-income Member States was "dramatic" and has led to critical shortages in countries such as Bulgaria and Romania (Mans et al. 2020). Moreover, one-directional mobility to wealthier countries speeds up ageing and population decline in other countries and further exacerbates the problem.

Nevertheless, several higher-income EU countries also continue to struggle to recruit and retain their own healthcare workforce. French hospitals have closed thousands of beds due to staff constraints (Desai 2022), and the extent of medical deserts, areas where inhabitants lack proper access to health care, has been growing significantly (Chevillard et al. 2018). More than 6 million people, including 600,000 with chronic illnesses, do not have a regular GP, and 30% of the population of France do not have adequate access to health services (Henley et al. 2022). The situation is also dire in Germany, where 35,000 care sector posts were vacant last year, 40% more than a decade ago. The Federal Ministry of Health anticipates that the future care needs will range between 110,000 and 200,000 additional nurses by 2025 (Mans et al. 2020). Facing unprecedented hospital overcrowding due to a severe shortage of nurses, Finland will need 200,000

4 A variety of factors may influence individuals' career choices and mobility planning. Motivations for mobility change with age and vary according to life stages. Unique life situations and desires also affect these motivations, which makes policymaking and healthcare workforce planning challenging (see Vah Jevšnik 2021).

new workers in the health and social care sector by 2030. In Spain, more than 700,000 people were waiting for surgery in 2022, and 5,000 frontline GPs and paediatricians in Madrid had been on strike for nearly a month in protest of years of underfunding and overwork (Henley et al. 2022). In Slovenia, healthcare staff shortages led to the occasional closure of several hospital wards nationwide. Mobilisation of retired nurses and overtime work were the main strategies put in place to cope with the workload, as vacancies continuously remained unfilled, leaving nurses burnt out and under immense psychological pressure. In the University Hospital Ljubljana, one-third of the intensive care unit was closed down in 2018 as nine nurses resigned, and the management could not replace them. The same hospital reported critical shortages of nurses and physicians in several departments, including children's intensive therapy, cardiology, cardiovascular surgery, pulmonology, otorhinolaryngology, orthopaedics, dialysis, transplant medicine, emergency medicine, and the intensive care unit (RTV SLO 2018). Community-level healthcare centres across the country have also been overburdened for years. Family medicine specialists (GPs), gynaecologists, and paediatricians are in short supply in most regions. In the first half of 2019, GPs in two larger healthcare centres collectively resigned due to caseload quotas, which they claimed had led to their burnout and, thus, put patients at risk (Jager 2019). It is estimated that one hundred GP specialisations would need to be filled yearly to stabilise primary healthcare. However, only 27 medical students applied for specialisation in 2023 (RTV SLO 2023).[5] In addition, historically established patterns of immigration of healthcare workers from the countries of the Western Balkans (former Yugoslav republics) became disrupted due to strong incentives introduced by higher-income countries. Individual healthcare providers in several Slovenian regions, therefore, reinforced their efforts to recruit from those countries by hiring recruitment agencies or travelling there themselves to offer positions (Šestan 2022). The mobility of healthcare workers from other EU countries to Slovenia continues to be minimal.

The challenges related to the shortages of healthcare workers are not new but were further exacerbated by the COVID-19 pandemic. Most Member States already entered the pandemic with insufficient numbers of healthcare workers and imbalanced geographical distributions. During the pandemic, healthcare providers used various strategies to upskill and re-deploy their existing health

5 Such a low application rate could be attributed to a variety of reasons, one of them being the requirement that candidates must commit to work for the same healthcare provider that offered them the position for at least four years after they obtain the specialisation. This commitment, therefore, restricts them from being able to immediately take a position abroad, commute to the neighbouring regions (especially Austria), or accept jobs in private healthcare.

workforce, such as expanding the work hours, hiring students, or recruiting retirees (Panteli & Maier 2021). The overcrowded and under-resourced hospitals have placed further pressure on an already overburdened healthcare workforce (Brady and Kuiper 2023). They were expected to cope with heavy workloads and increased job-related stress and faced burnout and severe mental health risks. Several workers reported experiencing violence and harassment at the workplace. Smith et al. (2022) note that:

> Globally, highly skilled nursing professionals, often with limited infectious disease experience, have encountered numerous stressors whilst providing vital nursing care to communities during this pandemic. These stressors include the risk of being infected with COVID-19 because of inadequate protective equipment, bearing the brunt of verbal and physical violence from anxious consumers of health services, having to work in understaffed clinical areas and fear of exposing loved ones to infection. As a result, elevated levels of stress, anxiety, frustration, depression, burnout, sleep disruption, feelings of being underappreciated, and, in some cases, suicide has been reported in nurses during the pandemic.

These circumstances have increased resignations and demotivated potential new recruits from applying for healthcare jobs. Nurses are among those healthcare workers who had been most overworked during the pandemic, and the inability to recruit them in essential services such as primary care, long-term care and rehabilitation continues to be a major challenge. Problems with recruitment and retention have been observed particularly in the public sector and underserved geographical areas – especially rural, remote, or poor urban zones (WHO 2022). In addition to high attrition rates, nurses, especially in the bordering regions, tend to resort to commuting to neighbouring countries that offer better pay and working conditions.

It is estimated that in the past thirty years, hundreds of thousands of European healthcare workers have left their countries of origin for more promising opportunities in the west and north. This has created significant tension between Member States, who are, to varying degrees, struggling to secure their citizens' right to healthcare, and, some argue, denotes failure of the promise of European solidarity and integration (Mans et al. 2020). Brady and Kuiper (2023) also note that the main challenge with mobility is balancing opportunity with efficiency to ensure that the demand and supply of healthcare workers are in equilibrium across the EU, which does not seem to be the case at present. However, it should be acknowledged that workforce planning in the public healthcare sectors that are in continuous demand of highly skilled professionals is a challenging task.

The so-called vulnerability of the healthcare labour market is exacerbated by the fact that motivations for the emigration of healthcare workers vary significantly, which makes healthcare workforce planning challenging. As Plotnikova notes, policies are "not always attuned to the individual creativity and imaginaries of health workers that ultimately affect their mobility" (Vindrola-Padros 2018: 7). Migration as a physical movement is always accompanied by internal phenomena, the so-called inner negotiations people engage as they consider and employ mobility as a resource in their search for care and caring (Pfister 2018), welfare and wellbeing. Specific incentives may, therefore, either be a success with some healthcare workers or a failure with others. Moreover, motivations to migrate change with age, vary according to life stages and are affected by unique life situations and desires. The thought processes and emotions that guide and affect the decision to migrate are always dynamic and perpetually evolving processes. At some stage in their lives, healthcare workers might be attracted by the prospect of low-cost housing, childcare, or other job-related benefits offered to them. In contrast, at some other period of life, they may be drawn by the need to provide care to disadvantaged people in poor regions or countries. Their narratives illustrate how unpredictable and intangible ground-level decisions to emigrate may be and their substantial effect on healthcare planning, provision and, subsequently, public health (Vah Jevšnik 2021).

GLOBALISATION OF HEALTHCARE LABOUR MARKETS AND THE QUESTION OF ETHICS

Health workforce migration flows are governed by labour market principles (Mans et al. 2020). Global shortages of healthcare workers have prompted migration not only from poor to affluent countries but also between affluent countries and (albeit to a smaller extent) between poor countries based on the economic principle of supply and demand. The result is a growing and highly competitive global labour market for healthcare professionals (Clark et al. 2006).

Countries have been competing to attract foreign workers by offering various incentives and adopting measures to reduce language requirements, waive fees for conversion exams, automatically extend visas and licences to practice for trained healthcare professionals, and granting temporary access to the health workforce to refugees or asylum seekers who are qualified health professionals (Yeates et al. 2022). Recruitment efforts are usually directed towards countries in geographical proximity or countries with historical or colonial ties. Diaspora initiatives have also been used to attract emigrated healthcare workers from

abroad.[6] Especially during the pandemic, several countries reached out to their diaspora and issued appeals for expatriate healthcare workers to return home (Yeates et al. 2022).

The globalisation of the healthcare labour market has had a profound effect on the ability of national health services to deliver vital services to their citizens, regardless of whether they opted to intensify international recruitment or shift to self-sufficiency. Those countries that decided to resort to recruitment from abroad are competing to attract workers from around the globe, and those that are pursuing the policy of self-sufficiency are struggling with the costs of education and training of the domestic workforce, as well as with the brain drain and retention of their healthcare graduates. Due to the fierce competition, the World Health Organisation has long ago called for fair and development-sensitive healthcare worker migration, which is mutually beneficial for both sending and receiving states and has developed the Global Code of Practice on the International Recruitment of Health Personnel (WHO 2010). The Global Code states that Member States should discourage active recruitment of health personnel from developing countries facing critical shortages of health. However, several contradictions and inconsistencies have been noted in these guidelines, including the apparent trade-off between restricting active recruitment from poor countries (Article 5.1.) and, at the same time, respecting the principle of free mobility (Article 4.3) (see Angenendt et al. 2014). It is also difficult to assess the degree of active recruitment in practice, which "paves the way for arbitrary interpretation" (Angenendt et al. 2014). In any case, as Yeates et al. (2022) note, such codes are valuable but largely aspirational and voluntary, and their robustness in effectively supporting ethical international recruitment of health workers remains in doubt.

To ensure ethical recruitment and migration, government-to-government agreements that are drafted in cooperation with all stakeholders in both receiving and sending countries have been praised as favourable policy tools. The primary concept underpinning the development of bilateral agreements is one of shared responsibility, which reflects the needs, admission policies and responsibilities of the destination countries and various concerns of the source countries and migrant workers themselves (Panizzon 2009). In that respect, it is a mechanism that should ensure regulated, transparent and fair exchanges, reduce the need to utilize commercial recruitment agencies and directly address and respond

6 Since 2010, the proportion of foreign-trained nurses and doctors has risen faster than the domestically trained ones, with "increased mobility driven by rising East-West and South-North intra-European migration, especially within the European Union" (Williams et al. 2020).

(possibly also in economic terms) to the negative effects of recruitment for the country of origin. Bilateral agreements have increasingly become a policy tool of choice for governments seeking to increase their health workforce capacity (Yeates et al. 2022).[7] However, having the bilateral agreements in place does not automatically guarantee workforce supply and may, therefore, not always be an optimal solution for countries with shortages – even the high-income ones within the EU.[8] Ultimately, active international recruitment of healthcare workers can never be a substitute for long-term and strategic health workforce planning (Mans et al. 2020). On the other hand, it would be overly simplistic to claim that merely an adoption of different strategies and policies on a national level could ensure self-sufficiency, given the steeply rising need for healthcare provision in ageing societies. Even if fully embracing the turn towards sustainability of the healthcare workforce, some member states will likely still need to recruit healthcare workers from outside the EU to meet the increasing demand (Brady & Kuiper 2023).

The mounting problem for public healthcare is also increasing commodification, commercialization, and privatization of public services that interfere with the principles of solidarity and shared responsibility in support of equitable, sustainable health workforces (Mans et al. 2020). Welfare states have been facing financial constraints, austerity measures and cost-containment measures that are having a significant impact on healthcare funding and affect their ability to recruit new students and retain the existing staff. However, whenever the policies change to attract or retain new workers, i.e., countries introduce liberalisation of visa regimes or shorten the bureaucratic procedures concerning employment, the private healthcare sectors benefit from these measures too. Moreover, the policies may even be designed in a manner that encourages further privatisation. Mans et al. (2020: 7), for example, point out the case of mutual recognition of qualifications in the EU:

7 Prior to COVID-19, a number of such agreements were already in place, such as, for example, between the Philippines and Bahrain, the UK and Germany, Bangladesh and Italy, Tunisia and Germany, Bosnia and Herzegovina and Germany, and Sudan, Saudi Arabia, and Ireland (Yeates et al. 2022).

8 For example, bilateral agreement between Romania and Austria was designed to allow Romanian temporary workers in the social and long-term care field to work in Austria. Given the existing acute shortages of health workers in Romania, this agreement seems to have failed to address the immediate service provision needs arising from the country's own health workforce crisis (European Parliament 2022: 62).

> Ironically, the mutual recognition of professional qualifications across Europe is arguably part of this problem. Such mutual recognition was deliberately designed to increase flexibility and mobility on the EU labour market, to further liberalize the provision of services in the European Union, and to remove barriers to private sector recruitment. This is very much in line with policies in many EU countries to further privatize and deregulate public functions, including health care services. Although it has contributed to the quality of health care, it has increased health inequities, too, and has substituted for a more comprehensive public-sector approach to health workforce development.

To understand the phenomenon and dynamics of the global healthcare labour market, we must look beyond the perspective of national (or EU-level) health workforce planning and analyse it beyond the framework of methodological nationalism. Moreover, the analysis also needs to include key *international* organisations, such as the United Nations (UN), World Bank (WB), Organisation for Economic Cooperation and Development (OECD), and International Labour Organisation (ILO), whose interactions have been shaped by several overlapping institutional regimes at the global scale – not only those that govern healthcare and migration but also the regimes that govern social protection, labour, development, human rights, and international trade and business (Yeates & Pillinger 2019). The concepts of global structural inequalities and histories of uneven development are important variables, too, and should also be used to guide the discussion on the migration dynamics and functioning of the global labour market for healthcare (Yeates & Pillinger 2019).

CONCLUSION

Following a revised outlook on the demographic situation and the state of public health in the EU, it once again becomes clear that it is necessary to immediately address the diminishing capacity of Europe's health workforce (Brady & Kuiper 2023). In the aftermath of the pandemic, the European Commission called for the establishment of the European Health Union, which aims to better protect the health of European citizens, equip the EU and its Member States to better prevent and address future pandemics, and improve the resilience of Europe's health systems (European Health Union). These aims are commendable but unattainable without ensuring a sufficient number of qualified and skilled workforce across the EU. However, the policies and strategies aiming to holistically address the immense future challenges faced by the EU Member States are yet to be developed.

One of the many challenges refers to the privilege of free mobility of workers within the EU that may lead to an increase in the numbers of healthcare staff in some Member States at the expense of others. Mans et al. (2020) rightfully argue:

> Older (and often richer) EU member states can mitigate their own losses of health professionals with immigration from the newer member countries. These newer member countries, in turn, do not have easy access to replacement of these health professionals themselves, at least not from within the European Union. The EU market as a single market supports this by removing technical, legal, and bureaucratic barriers in order to ensure free movement of goods, services, capital and persons. However, the European Union does not have any mitigation action for the consequences of free mobility. The European Union support for the poorest regions tends to be focused on general economic activity, not on specifics of the health care sector.

Demographic trends, especially the old-age dependency ratio, differ between Member States, too, with Southern EU countries facing the most unfavourable situation in the coming decades. Healthcare workforce projections and planning in individual Member States, therefore, need to take into consideration country-specific, regional, and global demographics, labour market, and mobility dynamics. Moreover, future planning needs to consider the growing frustration of healthcare workers that has increasingly been resulting in industrial action and that contributes to their mental exhaustion and high turnover rates. The result of the convergence of these variables is inevitably the worst-case scenario that has become a tremendously unenviable policy challenge.

ACKNOWLEDGEMENTS

Slovenian Research and Innovation Agency (ARIS) co-financed this work under the grant for the research programmes Studies on distress and being well (P5-0439) and National and Cultural Identity of Slovenian Emigration in the Context of Migration Studies (P5-0070), and under the grant for the research project Challenges of International Labour Mobility in a National Context: The Case of Slovenia (J5-50182). ARIS and Slovenian Academy of Sciences and Arts co-financed this work under the grant for the research project Mental Health Difficulties Among Migrants: Experiences of Recognition and Treatment (L5-3183).

REFERENCES

Angenendt, S., Clemens, M., Merda, M. (2014). *The WHO global code of practice: a useful guide for recruiting health care professionals? Lessons from Germany and beyond*. https://www.ssoar.info/ssoar/bitstream/handle/document/39182/ssoar-2014-angenendt_et_al-The_WHO_global_code_of.pdf?sequence=1&isAllowed=y&lnkname=ssoar-2014-angenendt_et_al-The_WHO_global_code_of.pdf (16. 8. 2023).

Brady, D., Kuiper, E. (2023). *Addressing the challenges of the healthcare workforce: Ensuring the future of health in Europe*. Policy brief. https://www.epc.eu/content/PDF/2023/CHES_PB.pdf (10. 1. 2023).

Buchan, J., Wismar, M., Glinos, I. A., Bremner, J., World Health Organization (2014). *Health professional mobility in a changing Europe: new dynamics, mobile individuals and diverse responses: volume II*. World Health Organization. Regional Office for Europe.

Buchan, J., Catton, H., Shaffer, F. (2022). Sustain and Retain in 2022 and Beyond. *International Centre on Nurse Migration*, 71, 1–71. https://www.intlnursemigration.org/wp-content/uploads/2022/01/Sustain-and-Retain-in-2022-and-Beyond-The--global-nursing-workforce-and-the-COVID-19-pandemic.pdf. (15. 1. 2023).

Chevillard, G., Lucas-Gabrielli, V., Mousques, J. (2018). 'Medical deserts' in France: Current state of research and future trends. *L'Espace géographique*, 47/4, 362–380.

Clark, P. F., Stewart, J. B., Clark, D. A. (2006). The globalization of the labour market for health-care professionals. *International Labour Review*, 145, 37–64.

Couper, K., Murrells, T., Sanders, J., Anderson, J.E., Blake, H., Kelly, D., Kent, B., Maben, J., Rafferty, A.M., Taylor, R.M., Harris, R. (2022). The impact of COVID-19 on the wellbeing of the UK nursing and midwifery workforce during the first pandemic wave: A longitudinal survey study. *International journal of nursing studies*, 127.

Desai, S. (2022). *More than 4,300 hospital beds closed in France due to staff shortage*. https://www.aa.com.tr/en/europe/more-than-4-300-hospital-beds-closed-in--france-due-to-staff-shortage/2697235 (16. 8. 2023).

Douglass, C. B., Nash, R., Erikson, S. L., Lim., A. (2005). Introduction. *Barren States: The Population "Implosion" in Europe* (ed. C. B. Douglass). Berg, 1–28.

European Parliament (2022). *Revaluation of working conditions and wages for essential workers. Policy Department for Economic, Scientific and Quality of Life Policies Directorate-General for Internal Policies*. Brussels, European Parliament. https://www.europarl.europa.eu/RegData/etudes/STUD/2021/695491/IPOL_STU(2021)695491_EN.pdf (9. 1. 2023).

England, K., Azzopardi-Muscat (2017). Demographic trends and public health in Europe. *European Journal of Public Health*, 27/4, 9–13. https://doi.org/10.1093/eurpub/ckx159.

ESA/P (Department of Economic and Social Affairs/Population Division) (2001). *Replacement Migration: Is It a Solution to Declining and Ageing Populations Populations?* New York: United Nations.

European Commission (2008). *Green Paper on the European Workforce for Health*. https://ec.europa.eu/health/ph_systems/docs/workforce_gp_en.pdf (10. 1. 2023).

Eurofound (2018). *Active ageing.* https://www.eurofound.europa.eu/observatories/eurwork/industrial-relations-dictionary/active-ageing. (15. 3. 2023).

EUROSTAT (2020). *Ageing Europe: looking at the lives of older people in the EU*. https://ec.europa.eu/eurostat/documents/3217494/11478057/KS-02-20-655-EN-N.pdf/9b09606c-d4e8-4c33-63d2-3b20d5c19c91?t=1604055531000. (10. 1. 2023).

EUROSTAT (2023). *Population Projections in the EU.* https://ec.europa.eu/eurostat/statistics-explained/index.php?oldid=497115#Ageing_society (9.1. 2023).

Fertility and family issues in an enlarged Europe (2004). *European Foundation for the Improvement of Living and Working Conditions*. Dublin**.**

Goetz, J., Höeft, S., Oláh, L., Petö, A. (2022). *Discourses on demography in the EU institutions* (e-paper). https://eu.boell.org/sites/default/files/2022-03/Demography_EU_institutions_FIN_web.pdf (15. 1. 2023).

Greenberg, N., Weston, D., Hall, C., Caulfield, T., Williamson, V., Fong, K. (2021). Mental health of staff working in intensive care during Covid-19. *Occupational Medicine*, 71/2, 62–67.

Gu, S. (2020). A Comparative Study of Increasing Demand for Health Care for Older People in China and the United Kingdom. *World Scientific Research Journal,* 6/4, 218–251.

Henley, J., Connolly, K., Jones, S., Giuffrida, A. (2022). »A ticking time bomb«: healthcare under threat across western Europe. *The Guardian.* https://www.theguardian.com/society/2022/dec/14/a-ticking-time-bomb-healthcare-under-threat-across--western-europe (14.12.2022).

Ishikawa, M. (2022). Media portrayals of transitions from work to retirement in two ageing societies: the case of ageing baby boomers in Japan and Finland. *Journal of Aging Studies*, 62. https://doi.org/10.1016/j.jaging.2022.101062.

Jager, V. (2019). Izsiliti privatizacijo [To force out privatisation]. Mladina 15. https://www.mladina.si/190542/cilj-domnevno-spontanega-upora-druzinskih-zdravnikov-je izsiliti privatizacijo/ (12.4.2019).

King, L. (2002). Demographic trends, pronatalism and nationalist ideologies in the late twentieth century. *Ethnic and Racial Studies*, 25/3, 367–389.

Kligman, G. (2005). A Reflection on Barren States: The Demographic Paradoxes of Consumer Capitalism. *Barren States: The Population "Implosion" in Europe* (ed. C. B. Douglass). Oxford and New York: Berg, 259–269.

Knežević, Hočevar, D. (2011). Obrazi migracij v govoru o rodnosti. *Dve domovini / Two Homelands*, 33, 7–22.

Linz, K., Stula, S. (2010). *Demographic change in Europe – An overview. Working paper no. 4 of the Observatory for Sociopolitical Developments in Europe*. Observatory for Sociopolitical developments in Europe. https://www.sociopolitical-observatory.eu/uploads/tx_aebgppublications/Working_Paper_no_4_Observatory_Demographic_change_in_Europe_Overview.pdf (10. 1. 2023).

Mans, L., Santric Milicevic, M., van de Pas, R., Güldemann, H. (2020). Working Together to Address Health Workforce Mobility in Europe. Recommendations for Action. *Open Society Foundations*. https://www.opensocietyfoundations.org/uploads/2cb79839-1599-41ff-9f65-6940c83e62f3/working-together-to-address--health-workforce-mobility-in-europe-20200914.pdf (17. 8. 2023).

McGrath. J. (2021). *Report on labour shortages and surpluses*. European Labour Authority. https://www.ela.europa.eu/sites/default/files/2021-12/2021%20Labour%20shortages%20%20surpluses%20report.pdf. (14. 1. 2023).

Panizzon, M. (2009). Bilateral Labour Agreements and the GATS: Sharing Responsibility for Managing of Migration and MFN Trade Reciprocity. *Journal of Migration and Refugee Issues, 5*/3, 70–133.

Panteli, D., Maier, C.B. (2021). Regulating the health workforce in Europe: implications of the COVID-19 pandemic. *Human Resources for Health*, 19, 1–6. https://doi.org/10.1186/s12960-021-00624-w.

Pfister, A. E. (2018). The effect of imagination on mobility as a resource in the search for care and caring. *Healthcare in motion. Immobilities in health service delivery and access* (Eds. C. Vindrola-Padros, G. A. Johnson, A. E. Pfister). Berghahn, 73–76.

Plotnikova, E. (2018). Governing Mobility of Health Workers across Borders: From Local to Global Policy Tools. *Healthcare in Motion. Immobilities in Health Service Delivery and Access* (Eds. C. Vindrola Padros, G. A. Johnson, A. E. Pfister). Berghahn, 116–138.

RTV SLO (2018). UKC Ljubljana zapustilo že 115 sester, a razmere so drugod po državi še slabše [115 nurses resigned from the University Medical Centre Ljubljana, but situation in other parts of the country is even worse]. https://www.rtvslo.si/zdravje/novice/ukc-ljubljana-zapustilo-ze-115-sester-a-razmere-so-drugod-po-drzavi--se-slabse/457723 (18. 8. 2023).

RTV SLO (2023). Za stabilizacijo primarnega zdravstva bi potrebovali 100 specializantov letno – letos le 27 prijav. https://www.rtvslo.si/zdravje/za-stabilizacijo-primarnega-zdravstva-bi-potrebovali-100-specializantov-letno-letos-le-27-prijav/666366. (27.4.2023).

Rice, B., Martin, N., Fieger, P. Hussain, T. (2021). Older healthcare workers' satisfaction: managing the interaction of age, job security expectations and autonomy. *Employee Relations*: *The International Journal*. ahead-of-print. 10.1108/ER-07-2020-0346.

Smith, G.D., Bradbury-Jones, C., Gelling, L., Neville, S., Pandian, V., Salamonson, Y., Hayter, M. (2022). Addressing the mental health of nurses during the COVID-19 pandemic: Time for support. *Journal of Clinical Nursing,* 31:e32-e33, 2665–2981.

Šestan, U. (2022). Direktor ZD Velenje na lastno iniciativo in stroške po zdravnike v BiH. https://www.24ur.com/novice/slovenija/direktor-zd-velenje-bo-na-lastno-iniciativo-in-stroske-zdravnike-iskal-v-bih.html (16. 08. 2023).

Teitelbaum, M.S. (1999). Sustained below-replacement fertility: Realities and responses. *Population Bulletin of the United Nations*, 40/41, 161–182.

Vah Jevšnik, M. (2021). Welfare considerations underpinning healthcare workers' decision about migration: the case of Slovenia. *Migration to and from welfare states: lived experiences of the welfare-migration nexus in a globalised world* (Eds. O. Ryndyk, B. Suter, G. Odden). Springer, 123–141.

Vindrola-Padros, C., Johnson, G. A., Pfister, A. E. (2018). Introduction: Healthcare in motion. *Healthcare in motion. Immobilities in health service delivery and access* (Eds. C. Vindrola-Padros, G. A. Johnson, A. E. Pfister). New York/Oxford: Berghahn, 1–13.

WHO (2010). *Global Code of Practice on the International Recruitment of Health Personnel*. World Health Assembly. Geneva. https://www.who.int/publications/m/item/migration-code (10. 1. 2023).

WHO (2015). *The growing need for home health care for the elderly.* https://applications.emro.who.int/dsaf/EMROPUB_2015_EN_1901.pdf?ua=1 (13. 1. 2023).

WHO (2022). *Ticking timebomb: Without immediate action, health and care workforce gaps in the European Region could spell disaster*. https://www.who.int/europe/news/item/14-09-2022-ticking-timebomb--without-immediate-action--health-and-care-workforce-gaps-in-the-european-region-could-spell-disaster (13. 1. 2023).

Williams, G. A., Jacob. G., Rakovac, I., Scotter, C., Wismar, M. (2020). Health professional mobility in the WHO European Region and the WHO Global Code of Practice: data from the joint OECD/EUROSTAT/WHO-Europe questionnaire. *European Journal of Public Health*, 30/4, iv5–iv11. https://doi.org/10.1093/eurpub/ckaa124.

Yeates, N., Pillinger, J. (2019). *International health worker migration and recruitment: global governance, politics and policy*. Routledge.

Yeates, N., Pillinger, J., Vaillancourt-Laflamme, C., Gencianos, G., Ismail, N., Montoro, C., Ismail, G. (2022). *Policy responses to address risks of harm to migrant health care workers in times of COVID-19*. Open University. http://pop-umbrella.s3.amazonaws.com/uploads/3da7f051-87a9-4ad3-86e0-7d4430251f49_Responses_FINAL_for_publication.pdf (11. 1. 2023).