PILLARS OF HEALTH

Country report on health worker migration and mobility

Romania

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Table of contents

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About Pillars of Health

Pillars of Health is an alliance of EU-based organisations 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. In 2021, as part of the Pillars of Health project, lead partner organisation Wemos (the Netherlands) joined forces with the Center for Health Policies and Services (Romania), Media Education Centre (Serbia), and VU Athena (the Netherlands) to identify ways to address the negative effects of excessive health worker migration and recruitment. In 2022, we also started collaborating with the Association of Democratic Physicians (Verein demokratischer Ärzt*innen (vdää*)) (Germany). Moving forward, we aim to do joint advocacy within a wider coalition. 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. Read more about Pillars of Health, and join us.

This country report is part of a series on health workforce migration and mobility in the focus areas of Pillars of Health: Germany, France, Romania, Serbia and EU level.

This report was written by the Pillars of Health partner organisation in Romania: Centre for Health and Policy and Services (CHPS).

In Romania, CHPS' two outcomes for our project are:

Outcome 1: A coalition of non-state organisations (local, national and diaspora) representing health worker interests is involved in **generating evidence on health worker mobility and migration and becomes active both at national and at EU level**.

Outcome 2: Policymakers **are aware of the main reasons** why doctors and nurses leave the country to work abroad **and put forward relevant policies and measures** to improve retention, to identify and promote measures and innovative mechanisms to better regulate health worker retainment and their return, and to support and stimulate the health workers from the diaspora to provide services to vulnerable Romanian patients (telemedicine services, training, peer-consultations, etc.). Supporting country specific outcomes, the first year of the Pillars of Health

project concentrated on generating evidence **about health worker mobility and migration** through **a comprehensive desk research** and **a series of in-depth interviews**.

Executive Summary

The development of the EU single internal market has facilitated an excessive outflow of health workers, accentuating the global crisis of workforce. This phenomenon is widespread in Romania as well, as health workers migrate to economically prosperous countries in search for better working conditions and career opportunities, whilst destabilising the already vulnerable health system of Romania, the source country.

To identify solutions for the retainment and return of migrant health workers, and to strengthen the health system, there is a need for a comprehensive understanding of the main reasons and factors that influence Romanian doctors and nurses' mobility and migration.
Through a series of in-depth interviews conducted with Romanian health professionals both within the country and abroad, this study aims to identify the (push and pull) factors that influence the migration of Romanian health workers, to analyze their personal working experience as well as to showcase the proposed solutions to retainment and returning. This provides a much more detailed depiction of the reasons behind health worker migration in Romania.

The main part of the report is divided into two major sections, one which presents the perspective on migration from healthcare workers that remained in Romania and one section presents the experience of migrant Romanian medical personnel working abroad. Each section presents the analysis of the motivation and attitudes, experience as well as potential interventions and solutions for improving healthcare worker retention, as proposed by the interviewees.

This report also includes a section that aims to explore the influence of gender and whether it is a factor accounted in the decision to migrate.

Finally, we provide conclusions and recommendations, synthesizing the push and pull factors that influence the medical personnel to migrate and accounting for the solutions identified through research (see below).

Recommendations to improve the retention of health workers in Romania

Our interviews with health care professionals resulted in the following suggested solutions for the retention of health workers in Romania. The success of these recommendations depend on the actions of central authorities, such as the Romanian government's Ministry of Health, and the general political will to implement these reforms.

Recommendations for the Romanian government, specifically the Ministry of Health

- Increase financial resources in the health system to make due investments in updating the infrastructure and medical equipment.
- Make more jobs available to lead to fewer patients per professional, which would, in turn, contribute to an increase in the quality of services provided to the patient and an increase in health professionals' work satisfaction.
- Implement changes in the education system to provide more practical training and interactions with the patients. Adjusting the number of graduates from medical universities and correlating places available in different specialisations with the needs of the population would also be needed.
- Focus more on prevention, including a reform of public health institutions, to make them more effective, and general practitioners' status/position/importance within the healthcare system.
- Addressing the centre-periphery discrepancies – i.e. the uneven distribution of resources between urban and rural areas in the country - would enable more young professionals to work in Romania, rather than abroad.

1. Introduction

With more than 80 million inhabitants, Germany is a European giant and an economic powerhouse. Hence, its health workforce policy and cross-border recruitment have a significant influence on the surrounding countries. Therefore, Germany has extra good reason to adhere to ethical recruitment practices and to implement the principles stipulated in the World Health Organization (WHO) Code of Practice, particularly that *all Member States should strive to meet their health personnel needs with their own human resources for health* [1, § 5.4].

But what we see in practice is just the opposite: a ruined nursing profession with deplorable working conditions (see section **Error! Reference source not found.**) and as a result an ever-growing German demand for the import of health workforce - particularly nurses - from abroad.

Up to 2012, Germany concentrated its recruitment efforts on the old and new EU Member States, but then it opened up its labour market for international nurses from third countries. While in 2013 the share of foreign nurses in the German nursing workforces was at 5.8% [2], this number doubled up to 11%, and an absolute number of 200,000 non-German nurses are working in the formal German health care system[1] [3]. 43% of these are coming from other EU Member States and 17.5% from the Western Balkan countries [3]. The rest is coming from East European non-EU countries, the Middle East, and from countries where the German government engages in active recruitment efforts, e.g. Tunisia, the Philippines, Vietnam, India, Indonesia or Mexico.

The most significant increase of the last five years was observed in nurses from the Western Balkans, where Germany intensified its recruitment efforts in 2016. Germany did so, despite the fact that the overall amount of nurses in this region is rather modest: according to the WHO National Health Workforce Accounts data base, Albania has 15,692 nurses (2020), Montenegro 3,118 (2020), Bosnia and Herzegovina 19,057 (2018), Serbia 53,881 (2016) and Northern Macedonia 7,884 (2015) [4]. Kosovo has 16,398 registered nurses (2019) [5]. Since Germany lowered the immigration thresholds for nurses, the numbers of immigrants tripled and nowadays

[1] Most likely this number can be doubled, when also taking into account the often informal home-based care sector and the foreign nurses employed by private households. Current estimations range from 300,000 – 700,000 foreign caretakers, the major part being women from East Europe, often equipped with a nursing diploma. But reliable numbers on the size and composition of the workforce in this sector are not available. For more details see chapter 2.3.3.

34,000 West Balkan nurses are working in Germany [3]. This corresponds to a staggering 29.3% of the absolute number of 116,000 registered nurses in the Western Balkans.
The systematic brain drain of health workforce towards Germany is a European and a global health scandal: Germany's foreign health workforce recruitment activities hold a significant risk for source countries, as the source countries' populations are left behind with insufficient health workers needed to meet their health care needs due to the significant influx of health workers to Germany.

2. Romania: country situation

In this section we describe the Romanian country context, including a short analysis of the health care system, health labour market and health worker mobility.

2.1 General country profile

The population of Romania has experienced a constant decrease in the last decades. On January 1st, 2021, the Romanian population counted for 19,186,201 inhabitants, compared to 19,414,458 in 2019 (Eurostat, 2021). The continuous downward trend can be associated with the intense out migration., Between 1990 and 2017, Romania registered the highest increase in the out-migration stock, at 287%. The high increase in migration can also be exhibited in recent years, as 2020 recorded a net out/emigration of 21,031 inhabitants.

In terms of the economic context, Romania has achieved a noticeable record of high economic growth, with the World Bank classifying Romania as a high-income country for the first time based on the 2019 data regarding per capita income of 12,610 US dollars. The expansion of the economy can also be demonstrated by the annual growth rate of 4.67% in 2019. While the pandemic impacted the economy and caused slight decreases, the economy is in the midst of a rebound, with GDP returning to pre-pandemic values and growth recovering sharply to 6.5% in the first half of 2021 (World Bank, 2020). Yet, in March 2022, European Bank for Reconstruction and Development (EBRD) has revised downwards the advance of the Romanian economy for 2022, from +4.4% anticipated last November to +2.8%, because of the impact of the war in Ukraine.

The social context of Romania is characterized by striking inequalities, which affect mainly the population in rural areas, Roma and people with disabilities, inequalities which can also be demonstrated by the high GINI coefficient of 0.34 (Statista, 2018). Romania also records one of the highest poverty rates in the European Union, despite the decrease in the share of Romanian population living on less than $5.5 a day in 2011 (revised PPP prices) having declined from 11.6% in 2020 to 11% in 2021 (OECD, 2021).

In terms of the gender perspective, the gender wage gap (employees) is low, at 3.5% in 2018 (last available) compared to the EU27 level (11.2 in 2019). The share of women in management positions in Romania is above the EU average (approximately 40%), yet there is a low share of women involved in entrepreneurship (10.2%) and holding positions in Parliament and Government (20%) (Eurostat, 2020).

As far as the political framework is concerned, Romania is a semi-presidential representative democratic republic.

2.2 Health system

Romania has a mandatory health insurance system. The Health Law (Law 95/2006) stipulates the way the health system functions in terms of organisation, financing, service delivery and benefits provided, and public health. The Ministry of Health is responsible for the overall governance of the social health insurance (SHI) system, while the National Health Insurance House administers and regulates the National Health Insurance Fund (NHIF). NHIF represents the main financial source for the healthcare system, is a central administration body with its president appointed by the Prime minister. The Ministry and the National Health Insurance House are locally represented through district public health authorities and district health insurance funds. Health care services are provided by 41 districts and the capital, in line with centrally determined rules (OECD, 2019).

The healthcare system remains underfunded, despite the constant increase in the public health expenditure. From 2000 to 2020, the National Health Insurance Fund budget has increased fifteen times, with the 2019 budget counting for EUR 8.89 billion (National Health Insurance Fund, 2021). Still, the total health expenditure is the second lowest in the EU, at 5.56% of the GDP in 2018, with EUR 1,212 per inhabitant (EU average is of EUR 3,078) (Eurostat, 2021).

When it comes to type of financing mechanism, 64% is represented by compulsory health insurance, 16% comes from the state budget through the national programmes, 20% is out-of-the-pocket and 1% voluntary health insurance. Health insurance is statutory, yet in practice, only around 89% of the Romanian population was covered by SHI in 2017. The coverage gap is mainly due to the general characteristics of rural communities, where a large share of the working-age population is self-employed in agriculture and does not contribute to the health insurance fund (OECD, 2021).

The overall health system performance is low, being characterised by an impeded capacity of the system to respond to the beneficiary's needs, significant access inequities from all perspectives (rural/urban, regions & counties, age groups, vulnerable groups), low financial protection and services coverage as well as weak managerial capacity at all decision-making levels, together with a generalised lack of reliable data.

2.3 Health labour market, migration and mobility

According to WHO data, the total number of medical doctors in Romania is 44,670 in 2016, with 70% being female. Similarly, WHO reports 141,821 nurses and 3,405 midwives as of 2016, out of which 91% are women. According to the National Institute of Statistics, in 2016, the number of dentists was 16,442 people (5.7% more than for the previous year), and that of pharmacists was 17,180 people (0.3% more than in 2015). The share of female health personnel from the total number of dentists was 67.5%, and from that of the pharmacists was 89.6% (INSSE, 2016).

The numbers of physicians and nurses are relatively low compared to EU averages: 2.8 doctors per 1,000 population compared to 3.5 in the EU, and 6.4 nurses per 1,000 population vs. 8.4 in the EU, in 2015. According to World Bank, in Romania there is an average of 2.9 doctors per thousand inhabitants while the average at the European level is 4,9 per thousand inhabitants (World Bank, 2017). Furthermore, in 2019, Romania was among the EU states with the lowest number of doctors per inhabitants, along with Belgium and France, with roughly 310 doctors per 100,000 inhabitants (OECD, 2017).

This deficit can be mainly explained through the emigration of health workers, which has been facilitated by the freedom of movement with the EU, underlined by the mutual recognition of professional qualifications (EC Directive 2005/36/EC). This allowed for medical doctors to migrate from a member state to another, the process affecting mainly the developing, source countries. While it is difficult to provide an exact number, the estimated number of doctors leaving Romania

since 1990 was 21.000 in 2014 (Séchet & Vasilcu, 2015). The corresponding estimate for nurses is at least 21,500, according to OECD data (2015).

With regards to prospective health worker migration, in 2018, the students in health studies displayed an overall intention to migrate of 40% (Boncea & Voicu, 2019). However, out of these students that consider immigration as an option, only a quarter had clear plans. Also, the study shows that there is a decreased intention to migrate for students in higher years of study. Nonetheless, Saghin et al (2017) shares a different result, indicating that 85% of undergraduate students in medical schools intend to emigrate.

2.4 Relevant human resources for health initiatives

In 2016, as a response to several initiatives in the health workforce sector, the Ministry of Health developed the Multiannual Plan for the Strategic Development of Human Resources in Health 2017-2020, which aimed at adopting a strategic approach to managing the migration of medical staff in Romania. The plan intended to improve human resources for health governance, by adjusting the training of medical staff to make it skills-based, by implementing a modern human resources management system in health facilities, in addition to creating state policies to motivate medical staff to stay and practice in Romania. Yet, the plan is still not fully operational due to the lack of clear policy documents.
The absence of clear policies that encourage medical professionals to work in areas where there is a deficit of health workers as well as the lack of adequate management capacity at the level of health authorities has led to marked inequities in access to health services in various areas.

Another tactical intervention aimed at encouraging health care professionals to remain in the country was the increase in wages in the medical field. Since 2018, the salaries of doctors and nurses have increased by percentages ranging from 70% to 172%, according to the framework law 153/2017 regarding the remuneration of medical staff from public funds (Ministry of Health, 2018). While the intervention was considered successful and the increase in wages had brought Romania to the same level as other EU member states that represent the destination countries of choice, it also revealed that **the fixing of this concern allowed for the reveal of other problems that reinforce the wish to migrate, such as the lack of satisfaction with the current working conditions.**

Since the outbreak of COVID-19, a number of additional interventions were put into place. Hence, the Emergency Ordinance no. 196 of 18 November 2020 forwards the use of telemedicine in

order to boost the accessibility of medical services to the rural population, less accessible geographical regions or areas with a deficit in the provision of specialist care as well as of pathological and radiological medical investigations. Telemedicine thus constitutes the secure transmission of medical data and information in the form of text, sound, images or other formats necessary for the prevention of disease, diagnosis, treatment and monitoring of patients (Romanian Government, 2020).

A similar intervention which aims to enhance the accessibility to medical services is the recently adopted law regarding mobile medicine, which aims to provide medical services in mobile regime for prevention and prophylaxis, screening for prevalent medical conditions, regular, general and specialist medical check-ups, and home delivery of medicines from national health programs for the chronically ill as well as for the patients with acute pathologies. This intervention represents the result of the pressures made by non-profit organisations and volunteer medics which successfully implemented such mobile initiatives and observed positive outcomes in access to medical care (Law 65, 2022).

Recently, the Ministry of Health has developed and launched for public consultations (in April 2022) the National Health Strategy 2022-2030 as an output of the project “Creating the strategic and operational framework for planning and organizing national and regional health services”.

3. Desk research

In order to gain an in-depth understanding on the phenomenon of emigration of health care workers, the desk research includes 3 sections: a report analysis, a media analysis and a brief analysis of the existing health worker diaspora organisations.

The report analysis used a variety of secondary sources, including annual reports, journal articles and authorities’ declarations.

The research process began with searching keywords on academic platforms such as Goggle Scholar and then collecting the secondary sources related to the phenomenon of health worker migration. For a comprehensive review, the reports selected date back to 2011 and are as recent as 2022.

12 reports have been gathered in order to carry out the report analysis. For the media analysis, we conducted a thorough online search for any press articles that has addressed the issue of medical migration, causes for health worker migration as well as potential solutions to retain or recover medical personnel. In order to gain a proper representation of the current context on medical migration, the media analysis used recent press sources, written between 2020 and 2022. Overall, a number of **15 articles** were selected to conduct the analysis.

Annex 1 comprises the full list of reports and media sources included in the desk research.

Finally, the desk research analyses the existing health workforce diaspora organisations present in the main countries of destination for Romanian health workers. We conducted an online search for diaspora organisations, with particular importance given to organisations in Germany and France which, according to the College of Medical Doctors (Apostu, 2022) are the most popular destinations for health workers. A total number of **7 associations** have been identified. The organisations have been contacted via email, social media channels (Facebook) and telephone, yet the response rate has been low due to the on-going pandemic that has slowed down their activity.

Reports analysis

The existing literature emphasizes that, in the last two decades, the phenomenon of international migration of healthcare personnel had rocketed, pointing out that there in an-going global crisis of health workforce. Of particular concern are developing countries, such as Romania, that act as source countries and thus are experiencing critical shortages of skilled health professionals.
In order to adequately organise the wide range of reasons for health worker migration, this analysis will utilise four main categories of causes: **economic**, **psychological**, **social** and **political**.

While analysing **the economic causes** for Romanian health worker migration, it is observed that **the living and working conditions in the country** is the predominant reason that incentivises people to practice their profession abroad. Among the living conditions identified by the majority of reports as most important in their decision to migrate were the **cost of living, access to improved education for their children, the safety of their family as well as social protection** (Rotila, et al., 2018). Similarly, the dissatisfaction in the current wage level was also considered among the causes. In fact, a 2018 report suggests that **for doctors**, **the working conditions in the hospitals and the investments in modern medical equipment represent the most**

important factor that would pull them to remain in the country, while **for nurses and midwives**, it is **an increase in their monthly salaries that would incentivise them to remain** (Rotila, et al., 2018). Nonetheless, since 2018, the salaries of doctors and nurses have increased by percentages ranging from 70% to 172%, according to the framework law 153/2017 regarding the remuneration of medical staff from public funds, while other studies suggest that now **the wage levels are satisfactory and no longer represent a reason to migrate** (Ministry of Health, 2018).

A significant factor in the decision to exit the Romanian healthcare system is at the **psychological level**, which is mainly observed through the **high stress levels reported** by the health workers. Thus, the **very large workload under extreme pressure, combined with the shortage of staff, can lead in some situations, to work burnout and exhaustion**. Similarly, the reports revealed that **health workers perform under the constant fear of being criminally liable and fined** by the National Health Insurance House for any small fault due to the **lack of support and protection** from any entity involved such as the administration of the hospital, the College of Physicians or fellow colleagues. The internal battle fought by the health workers is also accentuated by the constrains established by the healthcare system:, **health workers criticise the lack of flexibility in the system exemplified by the impossibility to change their specialisation**, not having any understanding from the management as well as they feel restricted from fundamental rights and freedom of expression. These fears and limitations lead to a **decrease in the overall confidence, and in the abilities of the professionals, as well as putting additional pressure on the decision making ability of the health workers**. Among the recommendations presented by the analysed reports, the healthcare system ***should supplement the health worker deficit and establish a more flexible programme which will allow the medical staff to rest***. Similarly, one report discusses the importance of having ***access to courses and trainings at least once per month***, which can have a positive impact on the confidence of health workers and on increasing the enthusiasm to practice their profession.

As far as the **social causes** of migrations are concerned, the reports discuss the **lack of respect from the patients** towards professionals, **the cold, unfriendly environment at the workplace** and the **substitution of proper communication between colleagues with an ineffective competition** as the social causes of migration (Rotila, et al., 2018). The social aspects also represent the main reason for which health workers decide to remain or return to the Romanian healthcare system. ***Personal reasons such as family commitments, raising their children and longing for their native place is the main reason why health workers have returned or***

remained in Romania. This suggests that the incentives to remain are only partially associated with improvements in the Romanian healthcare system, social aspects such as a better environment at the workplace, and proper communication between colleagues remains equally important.

A final group of causes for the migration of medical personnel is linked to the **political aspects**, emphasizing on the **high levels of corruption in the state health system**. One report indicates that the **reduction of bonuses and the taxation of food allowance in the form of wage rights** (assimilated to theft) are most often invoked as expressing disrespect on the part of the authorities (Rotila, et al., 2018). Another report reveals that **most hiring in the system is done through political affiliation and that the promotion system in hospitals is not related to one's level of competence and merit** (Rotila, 2011). The reports analysed suggest the need for a ***depoliticization of the institutions, of the functions at the hospital management level as well as among the health workers***.

In addition, a significant cause for health worker migration is the **rigid educational and residency system**. In particular, there is a substantial **deficit of places in the residency program for the chosen specialisation** which forces young professionals to migrate in order to perform in their area of expertise (Paunica, et al., 2017). While in 2021, the number of residency places was supplemented with 418 places, it seems that the concern still stands (Ministry of Health , 2021). Furthermore, the residency system constraints the trainee doctors and limits their professional development, as they experience **difficulty in changing specialisations during their residency**, **not receiving enough support in their learning years and not being able to practice what they have learned during their studies**. Thus, health workers decide to migrate from early on in order to enhance their educational opportunities and career advancement.

What the reports analysis points out is that social, political, economic and psychological factors contribute to the decision to migrate and therefore ***there is a need for a holistic intervention in order to attract and retain the medical personnel***.

Media analysis

According to media reports, Romania is one of the countries that deals with the largest medical staff deficit in the EU due to massive migration of health workers. After adhering to the European Union (2007), Romania experienced a steep wave of health worker migration, with 14,000 doctors and 28,000 nurses leaving towards Western countries upon graduation of medical studies (Ziarul

de Vrancea, 2017). While the number has slowly decreased in recent years, in 2020 it was reported that more than 800 doctors requested the issuance of the current professional certificate, used to practice in other States.

The media analysis illustrates a similar picture in terms of the causes of migration of Romanian health workers. A prevalent deciding factor to migrate is the **lack of hospital infrastructure and poor working conditions in the medical institutions**. This reason is mentioned in half of the articles used in the analysis. Of interest is the fact that 3 articles express that an **increase in wages is no longer a relevant incentive for doctors to remain in the Romanian healthcare system**. Doctor Daniel Coriu (president of College of Physicians) argues that, while granting financial remuneration used to be essential for medics to practice, it is now imperative to practice the medical act with dignity, with good conditions and in an appropriate working environment (Mediafax, 2021). Consequently, it is predominantly the **lack of access to advanced medical equipment, physical deterioration of buildings, the scarcity of investments in maintenance and modernization** that lead to the health worker migration. As a solution, it is recommended that the Romanian authorities establish a **long-term development plan that aims to build a modern sanitary system and improve the conditions needed for the provision of medical services** (Mediafax, 2021).

One theme that has been mentioned in some articles is the lower wages that health workers receive compared to other European countries (Alpha News, 2021). However, the salaries of medical staff in Romania have increased significantly in recent years, as one article shows that the monthly earning of a general practitioner can be as high as 10.000 euro (Mediahub, 2021). Hence, the remuneration concern can no longer be considered as a valid cause of migration.

Another prevalent reason to migrate is the **attitude of the wider population towards health workers**, a factor which has been mentioned in 5 of the 14 articles. Thus, the lack of respect that health workers receive from patients and the hostility shown towards them becomes an essential part of their decision to exit the Romanian healthcare system (DW, 2021). One article acknowledges the appreciation that Romanian health workers receive in Italy, due to the ambition and valuable capabilities that the professionals demonstrate (Libertatea, 2021). Within a culture of respect, the health workers perform better, display greater resilience and are more motivated to conduct their work at the highest levels.

Unfortunately, **the health workers are motivated to leave the country from very early on in their careers, due to the obstacles and constraints that they experience**. First of all, the system has a **deficit of positions available upon graduation**. Even more, it appears that **most of the vacancies that are open are allocated to people with connections with the employer, which also uncovers the corruption of the healthcare system** (Libertatea, 2021). Second of all, there is a **lack of appropriate conditions to practice** which impedes the young resident to learn how to properly conduct their profession and does not allow them to apply the theory learned in university (Ziarul Financiar , 2020). In an attempt to solve the issue, neurosurgeon Dorin Bica recommends using the case of Germany as an example, where the training of some residents is not done strictly in university clinics (Puterea, 2021). In these institutions, residents can receive more attention from experienced specialists and have the opportunity to perform more surgeries by the time they finish their residency, leading to better trained, prepared specialists. He continues to forward the need for a ***reform of the residency system and of the schooling system in Romania*** in order to minimise the migration of doctors (Puterea, 2021).

Fortunately, the media analysis demonstrates that there is openness to the idea of returning to the country, mainly due to the social aspects. Thus, ***many health workers wish to return for their families but also due to missing the country's culture and the Romanian nation and the way of living***. Even while working abroad, the ***diaspora continues to remain closely connected to the country and wish to aid the advancement of the healthcare system so as to one day be able to return and practice their profession***. One article shares the story of a doctor who practiced in Italy and kept contact with the Romanian doctors during the early stages of the pandemic, in order to share his knowledge and the methods used by the Italian healthcare system to deal with the complications of the virus (Libertatea, 2021). Furthermore, ***many of the health workers interviewed express their satisfaction to serve the Romanian patients and the wish to return and help them*** (Monitorul de Fagaras, 2019). Therefore, ***the migration of the health workers should not be seen as a negative aspect, but rather as an opportunity***. Dr. Bica believes that the ***young professionals can be attracted back into the Romanian health system and can bring a new vision, a different mentality and offer a particular know-how which is vitally needed for the Romanian healthcare system*** (Puterea, 2021).

The research carried out on the basis of a media analysis revealed the **dissatisfaction of the doctors currently practicing in Romania, which translates into many arguments for the decision to emigrate** but also some ***elements on which to build the retainment or returning strategies***.

Health worker diaspora associations

In order to offer support and assistance to the health workers that migrated, a large number of organisations have been established all throughout Europe. This section will present the main associations identified, their mission and main activities within the Romanian health worker community. Initially, the intention of the field evaluation was to contact the diaspora organisations in order to comprehensively research the drivers of skilled health professional migration. However, there has been a low response rate from the associations, with most of them having interrupted their activity now due to the on-going pandemic. Nonetheless, it is worth mentioning the organisations' mission and focus areas, as they still represent an important point of action for future initiatives and interventions once they resume their activity.

The **Annex 2** of this report (Contact Information for Diaspora Organisations) offers the contact details for all the organisations listed.

Association "Doctors for Romania"

The association has an essential role in building a communication bridge between Romanian doctors both in the country and abroad. Its mission is to bring medics together to find solutions so as to develop European standards and good working conditions in Romania. The organisation also supports doctors who want to return to Romania, with the process of (re-)integration into the Romanian medical system.

The Association of Doctors of Romanian Origin on the Cote d'Azur

The association aims to foster links with all the healthcare players in the region, both in the public and private sectors, including other associations of healthcare professionals as well as patients. Similarly, they organize meetings in which members can share their experiences, as well as identify legal, technical, leisure and administrative advice, to support the health workers with settlement in the country of destination.

The Association of Romanian Medics in Germany

The main goal of the association is to facilitate direct communication within the Romanian medical community in Germany. Within the association, members can exchange views, receive and offer advice with any problems encountered in Germany. Moreover, members can participate in events where they have the opportunity to discuss and promote the latest innovations in the medical field.

The Solidarity Network

The association connects Romanian experts in the medical, social and legal fields. Of particular interest in the activity of the organisation is the fact that it facilitates a channel of communication between the diaspora doctors with the doctors in the country. Therefore, in times of crisis, the association facilitates the transfer and exchange of information between Romanian doctors in the diaspora and doctors in Romania.

Romanian Doctors Association in Italy

The association aims to provide a first point of contact for Romanian doctors who practice their profession in Italy. In addition, the organisation also elaborates health programmes dedicated to the Romanian community raise awareness on the subjects of health and lifestyle choice as well as to prevent cardiovascular diseases.

Association of Romanian Nurses in Germany

The association represents the professional interests of Romanian nurses in Germany in relations with governmental and non-governmental authorities and institutions, domestic and international.

Centro Medico Maria

The medical centre is the first Romanian private clinic abroad through which Romanian citizens in Spain can benefit from medical services and consultations in Romanian language.

4. Qualitative research (in-depth interviews)

The in-depth interviews aim to help identify what are the factors that still influence Romanian doctors and nurses' mobility and migration, (despite the salaries increases) as well as what is respondents' personal working experience (in Romania or abroad), what is their perception of health worker mobility or migration and what are the most efficient retainment, returning and collaboration solutions in their opinion to help build the foundations of the second year of the Pillars of Health project activities.

The in-depth interview method was chosen because we needed to collect information about the mobility behaviour, the perceptions of the respondents related to it and the push and the pull factors as well as their attitude towards the migration phenomenon and the potential solutions

they see without any limitation that would have been generated by more controlled research methods (such as a written survey). It allowed the project team gain insight into the experiences, feelings, and perspectives of the interviewees and to generate more in-depth responses regarding sensitive topics related to push or pull factors. Moreover, the format allowed the researcher monitor changes in tone and word choice of participants to gain a better understanding of opinions and to explore new ideas and contexts that offered a complete picture of the driving factors of the mobility and migration phenomena.

The interview guide structure was similar for all respondents. Yet, some specific questions have been introduced (or re-phrased) for health workers with mobility experience, for the health care managers and for professionals representing professional organisations and health worker diaspora organisations. The full guide is included in **Annex 3**.

The final list of respondents comprised 19 health professionals or students and includes:

- health care professionals that graduated in Romania and remained to work in the country (at the time of the interviews) – 3 doctors and 3 nurses;
- health care professionals (doctors) that graduated in Romania and who now work abroad - 3 doctors (2 from France and 1 from Germany);
- managers from different health care facilities in Romania – 2 doctors who are heads of wards and 2 nurses who are team leaders;
- representatives of professional organisations – 2 representing the College of Physicians and 1 representing the Nurses Order;
- representatives of students' associations – 2 students;
- representative of a health worker diaspora organisation - 1 doctor from France.

Category of respondents	Gender		Age interval	Migration experience
	M	W		
Doctors in Romania	1	2	35-55	No
Nurses in Romania	1	2	35-55	No

Doctors abroad	2	2	35-55	Yes (ongoing)
Managers – doctors (heads of wards)	0	2	35-55	No
Managers – nurses (team leaders)	0	2	35-55	No
Representatives of professional organisations in Ro	0	2	35-57	No
Representatives of students' associations	2	0	23-25	No
Representatives of health worker diaspora org.	1	0	35-55	Yes (ongoing)

After defining the characteristics to be used in selecting respondents, we built our sample by combining the use of professional and personal networks and attempts to reach professionals and organisations - students' associations, diaspora organisations, recruitment companies.

We did not encounter significant problems with doctors, nurses, managers, professional and students' associations and managed to conduct the interviews required, but the experience with diaspora organisations and recruitment companies was different. The contact information for these associations was gathered, and they were first contacted via email. As no response was received, the next step was to contact them by telephone and/or Facebook. For diaspora organisations, there were cases in which the phone number was not available, or it had been disconnected at some point. From the interviews with Romanian doctors working abroad, our understanding is that these organisations, as resources for integration, might have been partially replaced by looser forms of interacting, such as Facebook groups, especially given the rise in mobility for Romanians after entering the EU. We thus chose to adapt and tried to reach

Romanian doctors working abroad, to begin building an understanding of the experiences of healthcare professionals abroad.

In the case of recruitment companies, there seems to have been a lack of interest, because no fruitful contact was established.

The interviews were conducted via Zoom or telephone, including WhatsApp, depending on the availability and resources most used by the respondents. The interviews were always a tight fit in the schedule of the respondents, and thus a lot of flexibility was required, in terms of schedule and platforms on which to conduct the interviews. Sometimes, at the beginning of the discussions, respondents would mention that they only have a limited amount of time and that we should try to keep to the timeline. As a general rule, we made all the efforts to have a video connection accompanying the audio one. The collected data was analysed with NVivo 11, and the list of codes is available as Annex 4.

4.1 Migration (health workers from Romania)

4.1.1 Motivation and attitudes

The good, the bad and the necessities of the profession

Working in the Romanian healthcare system sometimes seems to be a challenge, as accounted for by the professionals we interviewed. However, they do not fail to recognize the positive aspects of their jobs, the things that keep them going. The **good parts of their jobs are rooted in the effects of their activities on the health of the patients, thus being more individual in nature**, whereas the **negative aspects are linked to the state of the system or other more general factors, derived from how the system is like**. At the same time, perceptions are impacted by the motivations individuals had for pursuing healthcare careers, even though things settled and gained clarity along the way, by choosing a certain specialisation and becoming experienced in a certain type of care.

The **good parts**, the ones that provide satisfaction are variations of the idea that **they, as healthcare workers, improve the lives of their patients and make a significant difference for the better**. A successful resuscitation, solving a trauma case or helping patients in their recovery are examples of what brings professional joy:

"When you see that the patient leaves on his own after being hospitalised repeatedly, when he comes in on a stretcher, with Pampers and leaves in a much better condition. This is when you feel that your work is useful." (nurse, woman)

"The satisfaction is great, the fact that you manage to have such a detailed understanding of your patients over a long period of time, this is what brings satisfaction. Also, the fact that your patients recommend you to other potential patients, this is ideal and very important, as well as the fact that patients trust you and ask for your advice." (representative of a professional organisation, doctor, woman)

The **negative aspects** of the healthcare professions **are not related to their activity as such, but to the work conditions, the equipment or resources and the way that they are perceived or treated by decision makers or superiors.**

The **lack of recognition by the outside entities within the system is a source of discontent**. Data seems to suggest that it can be perceived as a particularity of some specialisations, such as that of general practitioner, having a lower (attributed) status:

"When you put it all together, when you work and put in all the effort and those who should appreciate your work minimize it instead, things can't go on". (representative of a professional organisation, doctor, woman)

Data suggests that general practitioners constitute a special case when it comes to their medical profession. What is seen as a negative aspect and, consequently, what turns into a major driver for migration, is the lack of professional independence. The fact that their actions are limited and, most often, they are forced to direct patients towards specialised doctors even for basic procedures such as CTs, is an example here, and it is also presented as something that burdens the system. This is related to what they perceive as being a downgrade of their work and their placement at the periphery of the healthcare system.

The fact that **evolved technological equipment is sometimes lacking** seems to be known and taken as a given by the respondents. But the **lack of rather basic stuff such as protection equipment**, was also pointed out:

"Let me tell you about shortcomings. First of all, I'll start with a basic thing, such as the lack of protective equipment, that I am forced to buy on my own. Protective footwear and the like are expensive. So, from 2006 onwards, in 14-15 years I don't know if we received protective equipment three or four times. Out of which two were the result of sponsorships brought in by me."(nurse, man)

Another recurring presence in the interviews is the **lack of human resources**, **which contributes to the exhaustion of the existing professionals**. It can refer to medical institutions being understaffed in general, or it can be more specific, pointing at certain positions/professions that should be brought on board to support doctors do their jobs and reduce the emotional burnout:

"More should be done in what concerns communication with patients' relatives. It's not that there is no communication, but we should be more patient. And it is very hard when you have a lot of work to do and you are only one doctor, in resuscitation, for example." (doctor, woman)

In this broad context, the situation of the last years, dominated by the COVID-19 pandemic that triggered a worldwide crisis in national healthcare systems, **this lack of personnel was felt even more.** What is also noticed is the lack of information on this exhaustion, on the professional burnout that has already happened or is about to happen. In the absence of specific research on this topic and of interest manifested from above, professionals are left to manage being chronically tired and depleted of resources on their own:

"The most important negative aspect is the fatigue that comes in at some point, after so many wasted nights. No matter how much we like to tell ourselves and others that we are not tired, we are. Nobody admits burnout, but it comes in and especially during the pandemic I think that many of us had or have this problem, but it is neither documented nor evaluated… we try to overcome it on our own". (doctor, woman)

Sometimes, keeping your enthusiasm about your job is a matter of will. In these situations, finding joy in what you do happens in spite of how things are, such as the dynamic at the workplace:

"So, no matter how conflictual the situation is in our ER and my own situation as well, I can't say that I don't enjoy going to work, because when I go there and begin resuscitation, I feel like home,

so it [the conflict] did not manage to ruin my pleasure to work. It disgusted me in other aspects, but this is something else…" (nurse, woman)

Somewhat mirroring what is perceived as missing, the things that are mentioned as being most **needed by healthcare workers for doing their jobs cover a vast array, from rather abstract aspects such as professional independence, to more concrete factors such as proper protection equipment**.

Individual discourses seem to have a high degree of coherence, in the sense that what is described as a negative aspect of the job is later on recommended as immediate necessity.
For example, a respondent for whom the dynamic at the workplace and the interactions between doctors and nurses is central will point to the importance of ***being appreciated at your true value*** (nurse, woman), while for someone who faced the lack of protection equipment it is important to ***have this need fully covered***.

Thus, perceptions on what is most needed by the healthcare workers for doing their jobs properly vary, and they consist of ***both additional colleagues to lower the number of patients per specialist*** and ***better working conditions***. Furthermore, working conditions refer to both ***better workplace dynamics - relations between doctors and nurses***, an issue that appears as very important in the interviews with nurses, as is the ***material infrastructure in hospitals***.

Perceptions on migration: motivation, destination
When it comes to the migration of healthcare workers, perceptions tend to be quite coherent: **migration is an option for those who are in search of better work conditions and a better recognition of their work**.

This being said, there are a few details to be mentioned: although the situations are similar in many respects, they also differ for nurses and for doctors.

What is **similar** is the fact that **those who leave are most likely those who did not manage to find jobs in the Romanian healthcare system.**

What is **different** is that **financial reasons are no longer present in the case of doctors, whereas they might still be an issue for nurses, given the fact that their wages increase in the last years was not as substantial as compared to the doctors**.

The changes in mobility regimes for Romanian citizens, as well as those in wage policies in Romania lead to the existence of **various stages in healthcare workers' migration**:

"The first stage would be sometime between 2001-2007, approximately. After that, it is the stage with financial motivations, from 2007 until closer to us. And in the last two-three years they did not leave [as much], because they couldn't, due to the pandemic. But two years prior to the pandemic this was the trend, pretty much: to start a new life elsewhere. Many of them followed their husbands and had children abroad. Other were young and didn't have anything here and it was easier for them to develop and grow elsewhere." (representative of a professional organisation, nurse, woman)

The stages defined by the respondent probably stand true for doctors and nurses alike, defined by **events such as** Romanians being allowed to enter the Schengen space without Visas, in 2001; Romania entering the EU in 2007; financially motivated migration, followed by migration as quest for a new life; lower migration fluxes as an effect of the pandemic. However, motivations such as following one's spouse are more likely to be encountered in the cases of nurses than in the case of doctors.

The **favourite destinations** for Romanian healthcare workers seem to be countries such as the UK, France or Germany. Italy has also been enumerated, especially in the case of nurses. The UK is associated with better wages, but the effects of Brexit are yet to be disentangled, as the respondents put it. France's appeal is attributed to cultural similarities, while Germany, and, more recently, Switzerland, are among the most attractive destinations due to the quality of life and the standard of living, but are reserved for those who have the proper language skills or who are willing to invest in acquiring the proper skills.

For **doctors**, professional motivations such as **increasing one's skills, being able to practice what you learned in school**, are offered by the respondents. But they are embedded in **financial aspects and in issues such as not being able to find a job in the Romanian healthcare system**:

"There were seven of us in my group [at the university]. When I left, there were only two of us in Romania. With all sorts of motivations. Professional motivations, financial ones. Professional ones, in the first place, I think." (doctor in France, man)

Migration is **an option especially for the young doctors**, who face more constraints than experienced professionals and, at the same time, are more willing to take chances:

"I think young doctors leave because they can't find a job, the ones who leave are those who were not satisfied with their medical training, who feel that they don't have a place of their own in the medical system. They have the courage and the willingness to adapt to new life conditions. "(Head of wards, woman)

But in all cases **the search for better work conditions** is among the motives for migration, especially given the uneven distribution of resources in Romanian hospitals:

"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 wards, woman)

The case of **general practitioners** is special, due to the **administrative aspects and organisation of their profession**. As respondents put it, they were forced to become entrepreneurs and they receive funding depending on the number of patients. But their activity is described as being a complicated one, from a bureaucratic perspective, while the financial gains are not always as expected, because the costs of their activities are quite high and unrecognised as such by the authorities:

"First, the lack of professional satisfaction followed by the lack of proper financial gains. "(Representative of a professional organisation, doctor, woman)

As mentioned at the beginning of this section, financial aspects are more prominent for nurses, but, just as in the case of doctors, they cannot be disentangled from structural aspects, such as the overall working conditions. In other words, **nurses' motivations for leaving** stand in **better wages, better conditions, more personnel. These are the necessary stimulants.**

As in the case of doctors, the nurses who are more prone to migrating are those who cannot find employment in the (public) healthcare system. After obtaining a job here, the temptation to go abroad for work is diminished: **Those who have jobs in the medical system don't leave anymore. Those who leave are the ones who cannot find employment. There are many of them**.

4.1.2 Experience (personal, and that of the migrating personnel they know)

Being a healthcare professional in Romania

Being a healthcare worker in Romania poses a **series of challenges, for doctors and nurses alike**. The accounts of the respondents describe **a system in which the nurses are overburdened with patients and, as a consequence, it is very hard for them to offer the proper care in due time**. **Doctors are forced to invest, in terms of money and time, in their professional advancements on their own.**

The **system is perceived** as **suffering from a lack of transparency, and being sometimes governed by personal relations, especially when new jobs become available, and hospitals look to hire new personnel**. If in the case of **doctors**, the residency period somewhat cushions this effect, in the case of **nurses**' things are felt acutely:

"Of course, hiring was done based on personal relations, just as now, with a few exceptions. "(Nurse, woman)

The **system itself often fails to be intelligible, and patients are lost in the unknown**. This catalyses the importance of "knowing" someone within, someone who might guide you and assist you in solving your problems:

"Entering/needing the system is a drama. Even for me, as part of the system, at the top level. I couldn't do it if I weren't here [in this position]. I help people in hospitals almost every day: I need to go there [to a consultation], do you know anybody? Can you recommend a nurse for homecare? Can you recommend a nurse for my practice?" (Representative of a professional organisation, nurse, woman)

Thus, it seems that **entering the system is difficult for patients and practitioners alike**. The logic of the system seems to not be comprehensible, and navigating it is a matter of daily struggle. The system is sometimes depicted as an entity to be fought by doctors for the sake of their patients, instead of providing resources that enable doctors to care for their patients. It starts to resemble an entity in itself and for itself, instead of being centred on patients, professionals and their encounters.

When it comes to professional standards, the system can be 'worked' and the official requirements can be met without much effort. Self-sufficiency sometimes sets in, and keeping up to date with the latest scientific developments becomes a matter of personal choice, rather than a necessity for evolving professionally:

"If you want to accumulate credits, it is very easy to pay for a conference [the conference fee], obtain a diploma and get the credits without attending the event. So, we trick the system a little bit, we have the credits, we move on but without actually moving forward." (Doctor, woman)

The situation is complicated by the fact that **the system does not provide an even access for patients, and there are substantial differences in allocated resources, equipment and specialists between the centre** (cities with higher education institutions and teaching hospitals) **and the periphery**. Positions might be available, as there is a constant need of healthcare professionals in smaller size localities or at county level, but nobody is willing to work there due to the multiple shortcomings:

"This situation in which they complete a specialisation, they enter the exam, and they start a new residency programme is more and more common and I think that this is a problem for the Romanian medical system. Because in large cities, in University centres, in county seats, county emergency hospitals, municipal hospitals, everybody wants to work there, and in smaller hospitals there is an acute lack of personnel." (Representative of a professional organisation, doctor, woman)

There are also **differences between specialisations, as each has its own requirement in terms of both personnel and equipment**. In addition to that, the workflow differs greatly from the ER to 'regular wards':

"In ERs is the worst because, starting from the space in which the activity is performed and ending with interdisciplinary consults and features, shortcomings are everywhere. So, conditions differ from one specialisation to another." (Head of wards, doctor, woman)

Another significant aspect is that **sometimes the relations in the workplace might lack in positivity and involve various stages of abuse**, instead. **Nurses** share such experiences/instances and characterise the healthcare **system as being rather paternalistic, resting on the undisputed authority of doctors**. On the other hand, **doctors** sometimes **feel**

that nurses fail to adapt to what is new in terms of treatment and procedures and fail to respect their authority. These instances, however, **are not usually addressed formally, and they remain but day-to-day occurrences**:

"Management doesn't do anything, because it is often the case that it doesn't even know that there are doctors who call nurses stupid, who throw things after nurses, who call them names. Many times, management is not made aware, because nurses are afraid to tell on those doctors."
(Nurse, woman)

Experiences of Romanian professionals abroad

Healthcare workers in Romania get information about life, systems and organisations at the destination country from friends, acquaintances and former colleagues who chose to migrate. For doctors and nurses alike, even though the initial period might be somewhat difficult, integrating at the origin takes place. Discourses on **experiences at the destination are based on comparisons between the situation of the healthcare system in Romania, with its various shortcomings, and the situations abroad**.

Migration for work seems to open the door towards more harmonious workplaces and to allow individuals to pursue their professional, as well as their personal goals. Within this general observation, the **case of nurses** can bear some specificities: respondents mentioned that sometimes migration for work can lead to downgrading of the professional level, as nurses who go abroad, especially in Italy but also in the other destinations, enter the labour market as employees at centres for the elderly, and do not have the opportunity to exercise their medical/professional skills obtained during their training and working in Romania. Becoming a nurse can be the result of following university-level courses or college-level courses. Given that, for enrolling in college level courses, holding a baccalaureate degree is not a requirement, the experiences of nurses, both at home and abroad, might be more heterogeneous than in the case of doctors.

For most, **migration brings positive experiences and provides the opportunity of living and working in what are considered to be 'normal' conditions**. Sometimes, understanding this normality requires some attention and effort, but what is important is that things are intelligible:

"The vast majority has positive experiences, even though it was difficult at the beginning. It was difficult for them to understand how the system works, to adapt to some normalities." (Doctor, man)

Even though there is a lot of work, **the rewards match their efforts, in terms of patient satisfaction and financial gains, among others. The systems at the destinations are flexible in terms of specialisations (one can choose and change, as to fit one's skills and preferences) and working hours, and healthcare professionals are unburdened and can focus exclusively on their patients**:

"They say that they work harder and longer hours than here. But there is a sort of professional satisfaction, because cases are difficult, and they solve complicated cases and they are part of medical teams that do everything in their power for the patients. They are satisfied, however. But, again, they work hard for satisfying wages." (Head of wards, doctor, woman)

Increases in status are also reported, and being respected for what you do, becomes a driver for departures. In the **case of doctors and nurses alike**, respondents mention that **Romanians are well seen as professionals at the destinations, and this fosters their capacity to integrate and make the most out of their migration experience**:

"Their experience is very good and, as I told you, they are much more respected at the workplace, they are much better seen. Salaries are different [than in Romania], so they all did very well." (Nurse, man)

4.1.3 Experience (general, effects of migration)

The **perceived effects of migration on the Romanian healthcare system are considered to be negative.** However, this statement needs to be analysed further. Synthetically put, **migrant healthcare workers are either those who did not manage to become employed in the (public) healthcare system, or individuals in search of professional accomplishments that are impossible to obtain in Romania.**

The **migration of those who did not find jobs** here is **seen as natural and a direct consequence of how the system is built and the divergence between the education system,**

in which a high number of specialists are trained, and the healthcare system, in which suitable jobs are not available. Thus, the impact on the healthcare system is considered to be negligible, if any: (…)

"The effects are not necessarily devastating, because the ones who leave are those who, unfortunately, don't find their place here or consider that the system is not how they would want it to be." (Representative of students' association)

Respondents distinguish between **suitable and undesirable jobs**: **young professionals look for jobs that allow them to be at the centre of the action, in better equipped hospitals, where the renowned professionals are located,** whereas **jobs that are available far from these centres are not considered interesting and, thus, remain unoccupied.** Therefore, migration might contribute to perpetuating the deficit of doctors in remote or rural areas but, on the other hand, the system would have to change as to encourage young professionals to work there, at least for a clearly limited amount of time, at the beginning of their career. Otherwise, it is presented as understandable and natural for individuals to pursue better opportunities:

"There is a deficit of doctors at national level and it is obvious that smaller size hospitals, general practitioners' offices maybe, rural areas, areas far from large university centres are affected by this deficit and would benefit from these young doctors." (Head of wards, doctor, woman)

An underlying issue is the **political/decisional will of making use of the available human resource**. Specialists are trained each year, in numbers that would allow for the system to become less burdening for those currently populating it. But for this, certain actions need to be taken, such as **creating more jobs**:

"I think that we have enough work force and that we have nurses and doctors who come back every year and could occupy jobs. It is all about making those jobs available and wanting a better [health] system, in which people come to work unburdened by worries." (Nurse team leader, woman**)**

4.1.4 Potential interventions and solutions for improving health worker retention

The array of solutions offered by the respondents for improving the Romanian healthcare system, to make it more appealing for healthcare professionals and to foster retention and return, match the identified problems and reasons for migration. Respondents point to both systemic changes, which are related to mentalities and structural organisations, and punctual measures to be implemented.

The **changes that would benefit the Romanian healthcare system and that should be implemented in Romania** seem to be closer to home and easier to define than those to be implemented at the European level. Respondents' engagement with this item was rather low, due to lack of specific knowledge or simply due to deeming the question as somewhat unreasonable: why would any European institution be interested in implementing measures that would improve retention or encourage return, when Romanian specialists are well seen in Europe? Why would return be sought after, when Romanian specialists populate healthcare systems at the destinations, thus solving their deficit problem?

Changes to be implemented in Romania

Among the general principles that need to be put in place, are those related to **prevention activities and policies**. **Prevention rests on public health institutions and general practitioners** and, **if implemented correspondingly, would significantly unburden specialists and would lead to significant improvements of population's health**. But for this, an **institutional reform must be implemented:**

"Reform, implemented first of all at the base level, that of public health and general practitioners. Because, all in all, I think that these two entities, public health and general practice, are the backbone of the health system." (Representative of students' association)

Also related to prevention is the **activity of nurses**, who are a good resource for the healthcare system **if well trained**:

"First of all, I would be interested in this profession, that of nurses, because it is a very good resource for the system." (Representative of a professional association, nurse, woman)

The **educational component needs restructuring in the case of doctors as well: it is described as necessary for residents to be offered more practical activities and to be more closely involved in treating patients**. A corollary is that teaching activities within the hospitals should receive more attention and formal consideration, including proper remuneration.

The interviews also suggested the lack of attention that residents receive: *Practical training is quite hard to do, it is done among other chores* (Head of wards, doctor, woman). In comparison, the example of other destination countries, where there are medical specialists whose sole responsibility is training the residents, is given. There is also the concern of the rigid residency system with special regards to the selection of the specialisation, which often constraints young professionals and puts pressure on their choice from very early on in their career. Thus, improving the residency system in terms of its flexibility is considered an appropriate intervention which can retain the medical professionals.

Linking the education and the health system needs to be accompanied by increasing the financial resources allocated to the latter, before even considering specific improvements or investments:

"We work in an underfinanced system, more material resources are needed in every hospital." (Head of wards, doctor, woman)

More resources need to be directed towards hospitals but, at the same time, **more hospitals need to truly respect quality standards**. As one respondent exemplifies, material reality must match what is defined as reality on papers:

"First of all, we need hospitals. Because those in which we work now are hospitals only on paper, although we try to comply with the accreditation standards. They are old and they do not correspond to the current state of medicine in any way. We make it work on paper, but the reality is different." (Head of wards, doctor, woman)

And once the required material resources are directed towards healthcare, **investments in infrastructure must be made, especially for increasing the quality of care in remote/rural areas**, for the sake of the patients and for making it desirable for young doctors to work there, without them feeling alienated from professional knowledge and standards:

"I truly believe that investments in infrastructure are needed, I believe that we do not have everything we need in order to do things properly. From my point of view, this is the most important aspect." (Head of wards, doctor, woman)

All the defined changes are **within the power of central authorities**, as most of them, such as funding or changing the education and healthcare system, would require laws to attribute their implementation.

Changes and improvements in the European framework

When it comes to the European-level changes that might foster retention and the collaboration between specialists, respondents who were triggered by this item were mostly those with management or professional institutions experience.

What is generally thought of as helpful is included in the category of **periods of practice abroad**. Professionals would gain experience by collaborating with their peers from other countries. But enrolment in these programmes must come with the obligation of returning to Romania and working here:

"Courses or programmes such as the residency, but shorter, of course, which you can complete abroad while being obligated to return." (Head of wards, doctor, woman)

Another measure that is defined as beneficial is the **existence of standards for treatment, and elaborated guides for approaching different health issues**. These protocols would enable Romanian professionals to be up to date with the latest improvements and would make them able to provide better care for their patients:

"Introducing some European and international protocols in certain domains, in Romania. Do you know that in Romania there are some specialisations in which there aren't protocols for every condition? There are national protocols and guides, but not always for every condition." (Head of wards, doctor, woman)

4.2 Migration (diaspora organisations, health workers working abroad)

4.2.1 Motivation

The decision to go abroad

Healthcare workers who decided to migrate frame their motivation as a quest for **better opportunities and work conditions, and the possibility to evolve professionally**. We identified **three types of discourses** on the motivations for migration: one **centred on their profession**; one in which **going abroad was a result of curiosity** and one in which the **quest was not only for other conditions for doing their jobs and evolving in their career, but for another social environment as a whole**.

Professional growth as a catalyst for migration is associated with a good knowledge of the Romanian healthcare system, and with **seizing the opportunities that become available**:

"I left while I was still a resident, so I interrupted my residency and I enrolled for becoming a specialist, which was the new opportunity for France, which seemed very interesting to me, and I had the opportunity of keeping my residency years in Romania and of completing it upon return." (doctor in France, woman)

Going abroad is sometimes a decision that involves **personal costs, such as the need to adapt to a new society**, for the sake of one's professional trajectory:

"The decision was the same as for other colleagues, the desire to have a better specialisation. Adaptation was not easy, but it is a necessary step and eventually it was a success, I can't complain." (representative of a diaspora organisation, France)

Curiosity and serendipity

The fact that mobility became rather free of previous constraints (such as those in place prior to entering the EU, for example) made it an easy option and reduced the selectivity of migration. Thus, the decision to go abroad can also be a result of a spur of the moment, rather than a highly prepared and intended personal trajectory:

"I recall that it was July most likely, I was sitting at home one evening with nothing to do, and I was surfing the internet and I found a recruitment firm: "we pay for your language course, for the accommodation, we find you a job"." (doctor in Germany, man)

Experiencing other social environments

Apart from being a result of game of chance or following career/profession goals, migration can also be an **option motivated by negative evaluations of the social system at the origin country**. It thus becomes a lifestyle choice, rather than being primarily an outcome of professional self-requirements:

"I came here because I wanted to see/experience something else as well. I started a specialisation which I completed here." (doctor in France, man).

In this case, the negative evaluations of the Romanian healthcare system are embedded in dissatisfaction with the Romanian society as a whole. Experiencing something else becomes a solution for obtaining satisfaction or exiting the shattered expectations:

"(…) medicine, the way it was done in Romania back then was pretty far from what I would have wanted and what I had imagined. Although I come from a family of doctors, my mother is a doctor, I should have known what to expect, but I lived a period of discouragement. In my residency, it was very hard for me, I almost quit and started something else." (doctor in France, man)

Going further

The interviews conducted with doctors who decided to migrate seem to suggest that there is a tendency to settle at the destination, once migrants experience life in a new society and get to develop their career.

Maria, for example, arrived in France in 1997, while still in her years as a resident in Romania. She had the opportunity of officially interrupting her residency in Romania, going to France to gain experience, and continuing her studies back home, upon return. Her departure had a high degree of organisation/formalisation, as it relied on official programmes and institutional relations between the two countries. As such, she recalls that her arrival and her first period spent in France were dominated by obtaining knowledge on how the system works there, and that she received help from colleagues and employers there, so it was all very clear and ran smoothly, even though it required a lot of work on her behalf. She mentioned that there were only five Romanian doctors in France who left within the same framework as her, but, over the years, things changed and now she has many colleagues from Romania, who have had a different migration/arrival experience compared to hers. She points to the many unknown/uncertain aspects that sometimes new migrants have to face, as there are less formalisation of the departure and people can

circulate freely. Her initial plans were to spend a limited amount of time in France, and then to return to Romania. But things changed, she started a family there and, 25 years later, she is still a doctor there.

Another type of migration experience is that of **Mihai**. His departure was based mostly on curiosity: he vividly recalls finding a flyer of some recruitment company, advertising work migration to Germany. And he took that opportunity, and left for Germany in 2012, while still a resident in Romania. He started a new residency programme there, and intends to finish it in Romania, because he is now focused on earning money, rather than completing his residency programme. He has a work agreement in which he is paid by the hour, and he mentions that it is very flexible and he can work as much as he wants, while for completing his residency, he would have to change this and work as a resident in the hospital, under the guidance of a senior doctor. He plans on returning to Romania and, eventually, settling in his hometown. Family ties seem to be important in his case, and he tends to associate being abroad with professional gains (in terms of both money and experience) and personal losses. While in Germany, he met a woman with whom he had a child, but they are now separated. So, coming back home can be understood as him re-focusing his attention from the financial aspects to rather personal ones: starting a (new) family, being close to the extended family at home.

The previous two examples are of young professionals who migrated while being single, without a family of their own. From there, their trajectories developed in different directions, as described above. But migrating while having a family of your own seems to be an open ended project as well, in which what starts as an exploration becomes a rather permanent option. The experiences in the new country and the relocation of the whole family are the bases for a life trajectory associated with the destination, rather than the origin:

"Things are like this: I now have tenure in France, my wife works in France, I have four children, out of whom three are born here. When it comes to reuniting the family, the ones at home come here, rather than us going there. So, this is how it is home now, rather here than there, unfortunately. I don't see myself returning. When I left, I thought that it was crazy, that I might regret it, but so far, I didn't have reasons to regret the decision to leave. Not professionally, not personally. I don't know what my life would have been like, had I decided to stay in Romania. But I clearly didn't like the way it was when I left." (doctor in France, man)

4.2.2 Experience (personal/general)

The migration process: new country, new life

Given the fact that France and Germany appeared to be among the favourite destinations for Romanian healthcare workers, we made efforts to reach migrants from these countries. When it comes to arrival at the destination and the resources available for integration, our choice of respondents had an unintended consequence: given the fact that they migrated to countries in which there are many Romanians, especially healthcare workers, their adaptation was made easier, because they had an ethnic network at their disposal:

"In the hospital where I work, Romanian doctors make up for about 30-40% of all doctors, and they are much younger than I." (doctor in France, woman).

In this context, profession and ethnicity intersect in networks that ease migration, for example by intermediating between employers and potential migrants. Formal networks are gradually being replaced by the informal ones mentioned above, and recruitment companies are described as a last resort for finding people to place in difficult jobs and work environments:

"Do you know what the problem is with recruitment firms? In fact, there is a hierarchy when a hospital looks to hire a doctor. They [recruitment firms] are the last resort, only if no doctors are to be found, or the place is very isolated or the people working there are difficult to get along with." (doctor in France, man)

The same tendency to decrease the level of formalisation can be found when it comes to associative forms within the Romanian diaspora. Well established organisations are now doubled by the existence of Facebook groups that enable information to circulate rapidly, putting together doctors who are settled at the destination and doctors who are looking for jobs or other types of information.

Respondents mention that they do not feel the need to belong in any professional groups, and that the choice for interactions with fellow Romanians is rather characteristic in the personal, rather than professional sphere:

"All the Romanian doctors who I know here are well seen and integrated and they don't need to form professional associations." (doctor in Germany, man)

The experiences at the destination allow for broad comparisons between it and the origin, comparisons that make up for a significant part of respondents' accounts, especially when migration was prompted by negative evaluations of Romania as a whole. The destination becomes a place that enables individuals to pursue their goals and, even though you start with no 'social credit' whatsoever, everything you do speaks to what you are like as a person and you are rewarded as such:

"(…) relations in the society are different, in general. When you arrive here nobody trusts you, but you get to earn that trust. In Romania, there is a high level of mistrust that you would have to face all the time." (doctor in France, man)

Whether professional aspects motivate one's choice to migrate or not, relocation has positive effects on one's profession and provides an opportunity for acquiring new knowledge:

"Professionally, even though I am not a specialist, I feel accomplished, I feel happy. That I accumulated experience, that I know a lot of things, I am able to do a lot of things." (doctor in Germany, man)

Origin and destination: collaboration and comparisons

Respondents' willingness to participate in the Romanian healthcare system was apparent. Even though they do not do it yet, the idea of splitting their (professional) time between Romania and their current destination is something they would like to do. Apart from this individual choice, the existence of collaborative institutional endeavours was mentioned:

"At the hospital where I work, we have four residents this year: two are French and two are Romanian. We have a resident from Cluj and a resident from Oradea." (doctor in France, man)

The choice to go abroad, as a result of individual-level motives, is sometimes framed as contributing to the degradation of the Romanian healthcare system. In this vein, migrants can be seen as guilty for leaving, and having put individual gains above the greater, societal outcome. But what was, originally, individual in nature, is constantly reframed, including as an investment in children's future, by allowing them to live in a society that respects and makes the most out of individuals' potential:

"I mean, in a sense, we are guilty for leaving. On the other hand, I am absolutely convinced that if I didn't leave, I wouldn't have reached my current professional level. I'm thinking, my wife and I are French citizens, we have four children raised here, and they have the opportunity of living in a society which would help them, which will enable them to make the most of their potential. If a child is talented, s/he will receive support." (doctor in France, man)

Narratives about the destination, based on implicit or explicit comparisons with the origin, are centred on structural differences that enable individuals to enjoy the fruits of their labour. The social system is predictable, and success or having a good, accomplished life are aspects that will surely come if you put in the work. Something that is seen as sometimes missing in Romania:

"In France, if you work and you mind your own business, you grow and you reach your goals. In Romania, if you work and you mind your own business, it is not very certain that you will grow. This is my feeling; I might be wrong. Here, if you work hard, you cannot fail, I don't know of anyone who screwed up by working. In Romania, I know many such cases." (doctor in France, man)

4.2.3 Potential interventions and solutions

The Romanian healthcare system: perception on its state

The Romanian healthcare system is perceived as being in crisis, battling underlying issues such as insufficient resources or hierarchies built on social, rather than human capital.

Through the years, the healthcare system was subject to various reforms, not all of them coherent with the others. These constant changes were felt as generators of a lack of stability, which made the system unintelligible for the professionals:

"The system was in a constant crisis. Things and rules would change constantly, every two weeks, every month." (doctor in France, man)

Sometimes, experiences in the healthcare system, not as professionals but as patients or relatives of patients, become deterrents for return, even though the initial migration plans were made for a short period of time. The excerpt below exemplifies how return home is constantly in the background, but contingent upon improvements of the Romanian healthcare system, that is not perceived as providing satisfying/adequate work conditions:

"So, the idea was always of keeping Romania as a first option. I bought an apartment in Bucharest, and I have never spent even one night in it. This was the purpose, to return when things get calmer and more enjoyable. But when someone in my family would have a health issue, the contact with hospitals was not necessarily enjoyable. The colleagues [doctors] were always very attentive, even those whom I did not know personally. But the conditions in hospitals, the way in which medical personnel interacts with patients, even with us…" (doctor in France, woman)

The fact that many (young) doctors chose to go abroad is presented as the result of the fact that the system is still tributary to personal connections or political involvement, rather than competencies. Finding a job abroad is a natural consequence of not being able to find a job in Romania:

"But in our Romania nobody hires you based on your competency, and this is a general rule, you get hired if you are politically connected and so on. And many competent people preferred to leave. (…)" (doctor in Germany, man)

The Romanian healthcare system: changes to be implemented

The changes that need to be implemented in the system in order to increase retention and/or return correspond to the problematic aspects pointed out by the respondents:

- Replacing personal connections with competencies and abilities as grounds for being hired in the healthcare system - "*To eliminate nepotism. Now, if you don't go to the political party, you don't have a job! Not all of them, but the majority of specialist positions are dedicated to certain candidates."* (doctor in Germany, man)

- Adding predictability to the system – following treatment standards for the benefit of the patients. "*It is very important to have protocols. Consultative protocols, not mandatory, but to be possible for a doctor to consult the protocols when in doubt. This does not exist in Romania and it is tragic."* (doctor in France, man)

- Improving the infrastructure and the equipment, as a natural second step after improving doctors' salaries - "*Now, I hope that the second step will follow, the one centred on infrastructure and equipment. Everything related to supporting medical acts: investments in hospitals, new hospitals are needed, new equipment and access to it."* (representative of a diaspora organisation in France, man)

Roads towards collaborations

The factor that would foster collaboration seems to be, in the perception of the respondents, the **existence of a dedicated institutional infrastructure**. Exchanges are seen as an important resource, as knowledge and experience sharing will most likely contribute to improving the Romanian healthcare system. Thus, the **legal framework should be defined in order to make it possible for doctors to engage in such exchanges not only when they are residents, but in all stages of their career**.

Exchanges could mean working part of the time at the destination and part of the time in Romania:

"Another way in which we can collaborate is through exchanging experiences among us. But I don't know how this can be implemented. It is up to the ones in charge [political actors in government]. This is easier for residents, but for older doctors [more advanced in their careers] it is more complicated. I would be tempted, you know, to work six months in Romania, why not?" (doctor in France, man)

Romanian doctors who have the experience of working abroad are considered by the respondents to be a resource for the improvement of the Romanian system. At the same time, making use of their experience would mean recognizing their knowledge which, in turn, might come into conflict with the way the system is built, often based on personal connections rather than competencies. This might mean a profound change, related not only to the healthcare system, but to broader layers of mentality:

"We are stupid, you lived in other countries, you saw how things were over there, help us organize a little bit!" But, if he comes and starts organizing, he won't be able to do anything, because he will have to face X and Y, different nepotisms… first of all, we have to change mentalities, and this starts in primary school." (doctor in Germany, man)

This excerpt above provides an example of how the healthcare system is actually an exponent of the Romanian social system in general, and of how various parts of the social organisation, such as healthcare and education, are interconnected.

At the European level, having a platform that would allow associations of medical professionals from different European destinations to communicate is presented as desirable:

"It would be ideal if these associations would meet and communicate, including the decision factors/actors in Romania. But this is no easy task to accomplish. But I would like for it to exist a federation, an assembly of many associations, a federation of Romanian doctors in Europe." (representative of a diaspora organisation in France, man)

4.3 Gender aspects

Approaching the gender dimension in the interviews revealed that, most often, this issue is not a prominent one, and that things are usually taken for granted or treated as given. This was, usually, the first type of engagement with the questions on behalf of the respondents, followed, in some cases, by recollections, evaluations and descriptions that constitute, in fact, instances of gendered practices, conflicts or distributions of personnel within the profession.

Gendered differences in healthcare professions

In all the interviews that were conducted, the main discourse is centred on how you can do whatever you set your mind on, and it is a matter of will and hard work. Respondents provide their personal example as proof for this: in the case of doctors, biographies tend to be more linear, with decisions regarding their career taken earlier on, while in the case of nurses sometimes career changes take place in one's life course.

A finding that is in line with known stereotypes about doctors and nurses is that these professions are gendered, especially in the case of nurses, with the majority of them being women. Men who choose to become nurses are rather exceptions, and usually work in specialisations considered to be tougher and to require physical strength.

"They [men] are usually in tougher places [within the profession]. I have never seen a man being the nurse of a general practitioner. A lot of them are in the ERs, Neurology, Neuropsychiatry, maybe in places where a male presence is important, not only from a physical standpoint, but simply as an appearance. And those who dedicate their lives for this profession are those working in ERs or on ambulances and they are extremely well prepared, willing and suited. But yes, in general there are more women nurses." (Nurse team leader, woman)

On the other hand, while respondents tend to estimate that there are more men than women who become doctors, things are not as clear as for nurses. Being a doctor is considered to be more

time consuming and, thus, sometimes to stand in the way of having a family or dedicating yourself to your family. This is provided as explanation for the fact that more men than women are doctors, based on the traditional association between performing household/family activities and women.

"I don't have any statistics, but there are more doctors who are men. It is a tough profession, in which you have to spend a big part of your life at the workplace. And this is sometimes easier for men than for women.: (Nurse team leader, woman)

The fact that the two medical professions tend to be gendered is known by the patients, who adapt their behaviour in order to address this/to navigate the interactions/relations with their healthcare providers. This involuntary discrimination by the patients, who tend to associate men with higher status jobs and women with lower status occupations, is a variant of what respondents mentioned in terms of gender distributions between healthcare professions:

"There are few of them [men], the majority of them in Orthopaedics, a specialisation dominated by men. We have about three men. They are only a few, in general. They are better seen by the patients, who call them doctors. And the women nurses get called nursemaids.
" (Nurse team leader, woman)

But there are underlying aspects that seem to go beyond physical strength or traditional gender roles. The complicated specialisations are sometimes described as the realm of men, and this is presented as an unwritten law, a piece of common knowledge:

"I think that, as an unwritten rule, there are specialisations that are not for women, of course, such as Neurosurgery, Cardiovascular surgery, the complicated/hard things and Orthopaedics. But no, I couldn't say, I don't think that there is any obstacle, you can follow any specialisation you like." (Head of wards, doctor, woman)

Respondents describe the workplace dynamics as sometimes including gender issues that do not pertain to the scientific or professional realm, but rather to the broad gendered interactions, such as how "*sometimes women can have some advantages with the chief doctor, but not on professional grounds"* (doctor, man), or "*attitudes manifested by some women doctors who prefer to work with young men nurses".* (Nurse, woman).

Sometimes, conflicts may arise, due to the high pressure in the work environment. These conflicts seem to develop following the organisational hierarchies, in which nurses occupy a lower position than doctors. This distribution of power is superposed on the gendered distribution of persons within the profession, and thus the conflicts and occasional tensions between doctors and nurses tend to be, at the same time, tensions between women (on which authority is manifested) and men (who manifest authority).

"Never will a woman be right. There are things you cannot prove, and, in general, at my hospital as well, you accumulate a lot of tension when there are tough cases, and the majority blow the steam with jokes, throwing things around. There are some moments like this, not on a daily basis, but some of them leave a mark." (Nurse team leader, woman)

Gendered attitudes towards migration

When it comes to the intentions of migrating and attitudes towards migration, respondents' perceptions mention the existence of gendered differences. While there is no consensus regarding the hardships entailed by migration (whether it is harder/easier for women or men to adapt at the destination), what seems to be undisputed is the fact that migration is more complex to integrate in women's traditional life path.

Women are depicted as being more tied to the idea of home and keeping family relations close. Even though the desire to go abroad for longer periods of time might occur, it seems to come after the needs of extended families, and after having children:

"Yes, I was an intern for two months at a hospital in London and it was very, very good. I liked it very, very much but I returned home. Children came along the way and, as I was saying, a woman is more tied to home, land, and parents." (Representative of a professional organisation, doctor, woman)

"Thus, leaving and working abroad seems to be harder for women, in the sense that this decision is contingent upon their children becoming adults: It's just that it is harder for women to leave. Those who have children, small children. They wait for their children to grow or wait until they have a child and [they leave] after." (Nurse, woman)

In the interviews, there were also accounts of how it is easier for women to migrate, but how men feel more pressure to leave in order to pursue better financial gains that would allow them to provide for their families:

"Leaving abroad is easier for women, not only in healthcare, I think that in other sectors it is easier. And men, they have to provide for their families and temptations [to migrate] are stronger. I think men are tempted to leave because they earn more there, and they can provide for their families easier than in Romania". (Nurse team leader, woman)

The interviews, thus, revealed **the existence of gendered biographies. From specialisations that are not considered to be for women, to the propensity to migrate, gender, as a master status, permeates all aspects of individuals' lives**. Be they healthcare workers or having other professions, men seem to be seen as providers, while women are more tied to their families and the role of mothers is prominent. These beliefs/attributions are deeply rooted in ways of seeing life and become a repertoire of orientations that fall beyond explanation, in the taken-for-granted.

For the respondents, **at a first glance, gender does not constitute an issue and there is no discrimination at the workplace.** The excerpts presented above were the result of multiple invitations addressed to the respondents, or invocations of gender on behalf of the researcher.

5. Conclusions

The interviews conducted with healthcare professionals suggest the existence of individual discourses with **a high degree of internal coherence, indicated by the correspondence that exists between what is indicated as problematic in the Romanian healthcare system, perceptions of the motivations for migration and changes to be implemented. Moreover, descriptions of healthcare systems at the destination complete this picture by becoming proof that things can be different.**

Another **layer of consistency is that between discourses of different individuals, sometimes having totally distinct experiences and trajectories in the healthcare system - for example, students and doctors (heads of wards). Although accounts of problems and changes that are needed are not the same from one respondent to another, the differences are very**

nuanced and underlying factors can be noticed such as mentality issues or the system being underfinanced.

These characteristics of the discourses point to the idea that **respondents have thought about these or similar issues, in other words that they displayed some level of professional and personal reflexivity in their life course.**

The choice to **remain seems to be a voluntary one**. Throughout the interviews, people's **attachment to Romania was visible, as home in a broad sense, a place associated with one's (extended) family. Family related aspects constitute, in fact, an important deterrent for migration, especially in the case of women, in relation to traditional gender roles and family dynamics.**

In this context, in which (still) working in Romania **is a constant, active choice, changes that would solve the existing problems within the system become extremely important**. Healthcare professionals wait for changes that would turn things towards normality, or versions/degrees of normalities in which hospitals are equipped, not understaffed and, overall, in which professionals and patients become the centre of the system. Working in healthcare in Romania is sometimes framed in terms of individual professional costs, seen as temporary, most likely at the beginning of one's career. It is portrayed as a challenge, mainly the challenge of doing your job properly in the absence of the necessary infrastructure. In general terms, migration is seen as an easy, but perfectly understandable way out, towards more intelligible, more effective and more rewarding societal and professional structures.

This being said, two cases appear to be special. One is that of nurses, for whom workplace relations can be problematic sometimes, based on the traditional authority of doctors. This leads to professional anxieties rooted in not feeling appreciated or considered a professional. The other is that of general practitioners, whose activity is grounded in running a private business. Unlike in the case of doctors from other specialties, monetary issues are relevant for them, as well as the lack of professional independence, that clashes with what they perceive to be their role within the system, as **gatekeepers**, as one respondent put it.

Framing health worker mobility

The qualitative data leads us towards an understanding of their mobility as being rooted in a broader quest for better living and working conditions. If, at the beginning, working abroad provided a solution for the lack of financial resources at home, the changes in wage regimes practically eliminated this issue, at least in the case of doctors. Now, it is mostly a matter of seeking better career opportunities and social conditions. Starting from these points, better payment, in the sense of just wages and work/payment ratio also come up, but they are rather in the background.

Between origin and destinations: push and pull factors

An attempt to simplify the issue of healthcare workers' migration can rely on listing what pushes individuals away from the Romanian system and, on the other hand, what makes certain destinations appealing for them. For these professionals, what drives them away from home and, consequently, what leads them towards other countries rests in the situations and specifics of the healthcare systems.

The repertoire of motives for migration (**pull factors**) includes the following aspects related to specific destinations:

- Higher status at the destination: feeling respected;
- Having the necessary infrastructure that allows them to use their knowledge;
- Working in a flexible system in terms of schedule;
- Working in societies and in healthcare systems where hard work is recognized.

What **pushes professionals away** from the Romanian system has the lack of proper allocation of resources as the underlying cause, but also touches broad aspects such as certain mentalities and attributing/recognizing value within society. To synthesise, the factors at the origin contributing to the decision to migrate are:

- Lack of financial resources within the system, that triggers the persistence of faulty infrastructure and the absence of proper equipment;
- The system as severely understaffed, which leads to chronic fatigue and burnout;
- The system as having a life of its own and failing to put the patient and the professionals at its core;
- The discrepancies between the education system, that trains thousands of young doctors and nurses, and the jobs available that are desirable, at the same time;

- The uneven distribution of resources between the centre and the periphery – having some focal cities, with teaching hospitals, that are overcrowded with work offers, and rural/remote areas in which nobody wants to work.

Solutions for the retention of health workers

The solutions provided by the respondents address the now problematic aspects of the healthcare system.

- What seems to be crucial is directing more financial resources towards the system, in order to be able to make the due investments in updating the infrastructure and the equipment.

- Making more jobs available would lead to fewer patients per professional, which would, in turn, contribute to an increase in the quality of services provided to the patient and an increase in professionals' work satisfaction.

- Implementing changes in the education system would be beneficial, in order to provide more practical training and interactions with the patients. Adjusting the number of graduates from medical universities and correlating places available in different specialisations with the needs of the population would also be needed.

- A focus on prevention is needed, including a reform of public health institutions, to make them more effective, and general practitioners' status/position/importance within the healthcare system.

- Addressing the centre-periphery discrepancies would enable more young professionals to work in Romania, rather than abroad.

All the designated solutions are dependent on the actions of central governmental authorities in Romania, such as the Ministry of Health, and the political will to implement these reforms.

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Annex 2 - Contact information for diaspora organisations

Association “Doctors for Romania”

Website: https://medicipentruromania.ro/contact/

Email address: contact@medicipentruromania.ro

Phone: +40729 155 144

The Association of Doctors of Romanian Origin on the Cote d'Azur

Website: http://www.amoro.fr

Email address: amoro.cotedazur@gmail.com

The Association of Romanian Medics in Germany

Website: http://www.amrg.de/?page_id=5678

Email address: contact@amrg.de

Phone: +496998956896

The Solidarity Network

Website: https://reteauadesolidaritate.com

Email address: contact@reteauadesolidaritate.com

Association of Romanian Nurses in Germany

Website: https://www.facebook.com/oamgmamrg/

Centro Medico Maria

Website: https://centromedicomaria.es

Email address: info.centromedicomaria@gmail.com

Phone: +34 641 36 18 33

Annex 3 - Interview guides

Interviews with young doctors (3 in total)

1. What motivated you to become a health professional in Romania in the first place?

2. How would you describe the journey which led you to your current position?

3. Describe what it was like working as a health professional in Romania?
(E.g. if need prompt to factors such as: work load (now and before the pandemic), over hours, education, salary, hierarchy in the workplace, access to equipment, access to protection material, teamwork, getting promoted, patient satisfaction, gender aspects etc.).

4. Do you think that your experience would have been different if you were a woman/man (opposite gender). In what way?

5. What do you like most about your work? (E.g. if needed, prompt to factors such as the ones mentioned with Q2)

6. What are possible negative aspects?

7. How has Covid-19 impacted your work?

8. What do you and your colleagues need most at this moment, to ensure you can properly carry out your profession?

9. It is a fact that health workers move abroad to high-income countries – from Europe or beyond – to pursue their career there. Thinking of the health professionals whom you know have migrated to other European countries, what would you say was their motivation?

10. What do you know about their experience in the new country?

11. Are you aware of any 'public image' or idea of these countries as better employers for health workers than Romania?

12. Have you ever considered to migrate yourself?

13. As far as you know, in the healthcare sector/amongst your friends and colleagues, are men or women more prone to migrate?

14. If you could call on actors who have a role in health in Romania – like politicians - what would you ask them to do or change (to improve retainment/ return/collaboration)?

15. If you could call on actors who have a role in health in Europe – like politicians - what would you ask them to do or change (to improve retainment/ return/collaboration)?

16. Are there any policies in Romania, in the healthcare system, that take into account gender as a relevant variable? (For example, policies to address potential differences in employment or work conditions)

17. If there was one thing that needed to be changed in Romania for young professional to work here (or to return), what would it be?

Interviews with nurses (3 in total)

1. What motivated you to become a health professional in Romania in the first place?

2. How would you describe the journey which led you to your current position?

3. Describe what it was like working as a health professional in Romania?
(E.g. if need prompt to factors such as: work load (now and before the pandemic), over hours, education, salary, hierarchy in the workplace, access to equipment, access to protection material, teamwork, getting promoted, patient satisfaction, gender aspects etc.).

4. Do you think that your experience would have been different if you were a woman/man (opposite gender). In what way?

5. What do you like most about your work? (E.g. if needed, prompt to factors such as the ones mentioned with Q2)

6. What are possible negative aspects?

7. How has Covid-19 impacted your work?

8. What do you and your colleagues need most at this moment, to ensure you can properly carry out your profession?

9. It is a fact that health workers move abroad to high-income countries – from Europe or beyond – to pursue their career there. Thinking of the health professionals whom you know have migrated to other European countries, what would you say was their motivation?

10. What do you know about their experience in the new country?

11. Are you aware of any 'public image' or idea of these countries as better employers for health workers than Romania?

12. Have you ever considered to migrate yourself?

13. As far as you know, in the healthcare sector/amongst your friends and colleagues, are men or women more prone to migrate?

14. If you could call on actors who have a role in health in Romania – like politicians - what would you ask them to do or change (to improve retainment/ return/collaboration)?

15. If you could call on actors who have a role in health in Europe – like politicians - what would you ask them to do or change (to improve retainment/ return/collaboration)?

16. Are there any policies in Romania, in the healthcare system, that take into account gender as a relevant variable? (For example, policies to address potential differences in employment or work conditions)

17. If there was one thing that needed to be changed in Romania for nurse to work and have a fulfilling professional life there (or to return if the case), what would it be?

Interviews with healthcare managers (4 in total) – 2 with doctors, heads of wards, and 2 with nurses team leaders

1. It is a fact that health workers (doctors and nurses) move abroad to high-income countries – from Europe or beyond – to pursue their career there. Thinking of the doctors / nurses whom you know have migrated to other European countries, what would you say was their motivation?

2. As far as you know/in your experience, are women or men more prone to migrate? (both cases to be explored, doctors and nurses)

3. What about their experience in the new country?

4. Are you aware of any 'public image' or idea of these countries as better employers for doctors / nurses than Romania?

5. How do you think the migration of doctors / nurses from Romania to other countries affects the Romanian health system?

6. If you could call on actors who have a role in health in Romania – like politicians - what would you ask them to do or change (to improve retainment of doctors / nurses / return/collaboration)?

7. If you could call on actors who have a role in health in Europe – like politicians - what would you ask them to do or change (to improve retainment of doctors / nurses / return/collaboration)?

8. Are there any policies in Romania, in the healthcare system, that take into account gender as a relevant variable? (For example, policies to address potential differences in employment or work conditions)

9. If there was one thing that needed to be changed in Romania for young doctors to work here (or to return / collaborate in projects here), what would it be?

10. If there was one thing that needed to be changed in Romania for a nurse to work and have a fulfilling professional life here (or to return, if the case), what would it be?

11. In your hospital, what is the gender distribution of doctors? What about nurses? What about management/leading positions? Do you think that there are any differences between women and men when it comes to healthcare professionals?

Interviews with professional organisations (2 for doctors and 1 for nurses), medical students' associations (2)

1. It is a fact that health workers (doctors and nurses) move abroad to high-income countries – from Europe or beyond – to pursue their career there. Thinking of the health professionals whom you know have migrated to other European countries, what would you say was their motivation?

2. As far as you know/in your experience, are women or men more prone to migrate? (both cases to be explored, doctors and nurses)

3. What about their experience in the new country?

4. Are you aware of any 'public image' or idea of these countries as better employers for health workers than Romania?

5. How has Covid-19 impacted health professionals in their intention to move abroad?

6. What health professionals need most at this moment, to ensure can properly carry out their profession?

7. How do you think the migration of health workers from Romania to other countries affects the Romanian health system?

8. If you could call on actors who have a role in health in Romania – like politicians - what would you ask them to do or change (to improve retainment/ return/collaboration)?

9. If you could call on actors who have a role in health in Europe – like politicians - what would you ask them to do or change (to improve retainment/ return/collaboration)?

10. Are there any policies in Romania, in the healthcare system, that take into account gender as a relevant variable? (For example, policies to address potential differences in employment or work conditions)

11. If there was one thing that needed to be changed in Romania for young doctors to work here (or to return / collaborate in projects), what would it be?

12. If there was one thing that needed to be changed in Romania for a nurse to work and have a fulfilling professional life there (or to return, if the case), what would it be?

13. Do you think that there are any differences between women and men when it comes to healthcare professionals?

Interviews with diaspora representatives (1)

1. What is the goal of your organisation?

2. What motivated your members leave their home country and start a career here? (What did they hope to find here, that you couldn't in Romania?)

3. Are there more men or more women among the members of your organisation? As far as you know, are there any differences between them when it comes to their motivations?

4. How did the process go for the majority of them (e.g. with the authorities, administration, validation of diplomas, etc.)? Was there a specific challenge they encountered?

5. Would any of them consider moving back to Romania to work in the same profession? And why (not) (what would need to change for them to take that step?)

6. In your experience as a health worker, what are the similarities and differences between the Romanian and new country health systems?

7. How do you think the migration of health workers from Romania to other countries affects the Romanian health system?

8. If you could call on actors who have a role in health in Europe – like politicians - what would you ask them to do or change?

9. Are there any policies in Romania, in the healthcare system, that take into account gender as a relevant variable? (For example, policies to address potential differences in employment or work conditions)

10. If there was one thing that need to be changed in Romania for you to come back to work there, what would it be?

11. Have you ever heard of colleagues that are now working abroad who had educational activities/ short term practice or projects in Romania?

12. (personal example) If there was one thing that need to be changed in Romania for you to collaborate in various projects there, what would it be?

13. Do you think that there are any differences between women and men when it comes to healthcare professionals?

Annex 4 - The list of codes

The mobility of Romanian health workers Codebook

Code name	Additional details (when needed)
Diaspora (codes for interviews with Romanian HC workers abroad)	
Changes to be implemented Romania	Changes for improving the HC system in Romania
Collaborations at the origin	Actions the respondents are currently involved in
Diaspora associations	The use of such associations and perceptions on them
Differences between HC systems	Origin/destination comparison
Experiences at the destination	Integration, society/structural elements
Experiences in the Romanian HC system	Working in the HC system in Romania, prior to migrating
Gendered conflicts	How and when gender appeared as relevant
Migration process	Decision, resources, actions taken towards migration
Most important change for retention or return	To be implemented in the Romanian HC system
Motivations for migration	What drove them to go abroad
Plans for the future	Between origin and destination
Resources at the destination	What facilitated their integration

Things needed for doing their job	Both material and immaterial - equipment, attitudes, etc.
What would enable collaborations	What is needed for fostering the collaboration between Romanian health worker abroad and those in Romania
Interviews with health worker in Romania	
Experience general	
Perceptions on migration effects on Romania	Does professionals' migration impact the situation at the origin?
Experience personal	Respondents' accounts of their own experiences
Being a health worker in Romania	About the system and experiences within the system
Experiences at the destination friends acquaintances	What they learn from others who migrated
Personal trajectory	Professional, personal
Fighting the system	Accounts of how doctors need to 'work the system' for the sake of their patients
Gender aspects	How and when gender appears to be relevant
Gender distribution at the workplace	
Gender distribution in the profession	
Gender policies in the HC system	
Gendered conflicts	
Gendered differences in HC professions	
If they had the opposite gender	What their experience would be like if they had the opposite gender

Who is more prone to migrate	Men or women
Motivations and attitudes	General perceptions and accounts
Destinations countries	Favorite destination countries for HC workers from Romania
Destinations HC systems	HC systems at the destination
Destinations stages in health worker migration	
Motivations for becoming a health worker	What drove respondents towards careers as HC workers
Pandemic effects on intentions to migrate	
Perceptions on motivations for migration	Perceptions on what drove others to migrate
Profession Favourite aspects	
Profession Negative aspects	
Things needed for doing their job	Both material and immaterial - equipment, attitudes, etc.
Potential interventions	Perceptions on what needs to be done to foster retention/collaboration/return
Changes to be implemented Europe	
Changes to be implemented Romania	
Most important change for return or retention	