Chapter 8

Welfare Considerations Underpinning Healthcare Workers' Decision About Migration: The Case of Slovenia

Mojca Vah Jevšnik

8.1 Introduction

Slovenian public healthcare has historically relied on the immigration of healthcare workers¹ from former Yugoslavian republics such as Croatia, Bosnia Herzegovina and Serbia (Albreht 2011). After the country's independence in 1991 and the introduction of a restrictive migration policy for foreign nationals, shortages began to rise persistently. Slovenia counted on the supply of healthcare workers from the other European Union (EU) member states after joining the EU in 2004 but the realisation that they preferred to choose other countries with significant competitive advantages over Slovenia prompted a policy turn aimed at achieving self-sufficiency. The result was not entirely satisfactory for a variety of reasons that will be discussed further on; certain positions continued to remain unfilled, geographical imbalances in supply and demand persisted and discontent among an overburdened healthcare workforce began growing. Glances back towards the Western Balkan countries revealed that healthcare workers were now being heavily targeted by high-income European countries, some of which have adopted specific policy measures that make recruitment from third countries easier for employers (Lazarevik et al. 2016; Živković 2018). Many of the third-country nationals who did find employment in Slovenia used the country merely as a stepping stone, as the efforts to retain them failed in light of the better working conditions and remuneration offered to them in other countries. Different motivations prompted Slovenian healthcare workers to

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

M. Vah Jevšnik (✉)

Research Centre of the Slovenian Academy of Sciences and Arts, Ljubljana, Slovenia
e-mail: mojca.vah@zrc-sazu.si

start looking for jobs abroad themselves, be they in neighbouring Austria, other EU countries or overseas. It became evident that, in the global labour market for healthcare, Slovenia was going to draw the short straw.²

This chapter explores a complex interplay of motivations prompting healthcare workers to emigrate from one welfare state to help to sustain another, focusing in particular on motivations related to social-welfare protection. It draws on different notions and conceptualisations of welfare. First, it understands welfare as subjective wellbeing, happiness, health and prosperity (Greve 2008) and the fulfilment of the essential needs of individuals and families in terms of having, loving and being (Allardt 1975, cited in Greve 2008, 55). Second, it understands welfare in terms of service provision and institutional arrangements by the state with the purpose of ensuring the social and economic wellbeing of its residents. The use of the concept of welfare in this chapter therefore encompasses a person's everyday life perspective and a societal macro-level perspective (Greve 2008). Given the fact that healthcare workers are themselves providers of welfare to those in need of medical treatment and care, the chapter also discusses the workers' ethical considerations about leaving patients behind on the one hand and the pursuance of the provision of healthcare in other countries on the other – in other words, it explores how the provision of welfare to others builds into workers' own imaginaries and feeds the rationale behind their decision to migrate.

The findings are based on an extensive literature review and in-depth semi-structured interviews conducted with 27 healthcare workers, including ten nurses, ten physicians and seven midwives, who all emigrated from Slovenia to take up jobs in healthcare abroad. Ten interviewees were men – aged 28–45 – and 17 were women, aged 23–52. Seven out of the ten interviewed men were physicians, whereas three were nurses. All interviewees had obtained a university degree in midwifery, nursing or medicine. Prior to emigrating from Slovenia, they all worked in Slovenian public healthcare institutions for at least 2 years. The interviews were conducted in Slovenia, the United Kingdom, Norway and Australia – and via Skype – in the period from 2015 to 2018 and lasted between 1.5 and 2.5 h. Data collection was primarily guided by curiosity about the extent of the welfare considerations of these highly skilled professionals when deciding to move abroad as well as by the underlying concern shared with Buchan et al. (2014) that healthcare-worker mobility and migration will continue to be a significant element in European healthcare labour markets and will have a strong impact on healthcare delivery across EU member states. Hence, data outlining the rationale behind individuals' choices to emigrate from Slovenia were also collected with the aim of contributing to the evidence base that feeds policy and informs strategic responses to healthcare workforce planning. The research was therefore concerned both with identifying the deeply embedded rationale and trigger factors that prompt the decision by healthcare workers to move

² Given the urgency of the topic, especially when taking into consideration that Slovenia has statistically one of the fastest-ageing populations of all EU member states, has one of the lowest physician densities in the EU (OECD 2017) and is not particularly successful in retaining its healthcare workforce and achieving sustainability, it is surprising that the issue has not received more attention in Slovenian migration and healthcare policy studies.

abroad and with exploring the remarkable impact on and consequences of ground-level subjective decisions on systemic and normative frameworks. In line with Vindrola-Padros et al. (2018), an important point of departure was the realisation that migration and healthcare are not only influenced by global and national policies and structures but are also shaped daily by the aspirations of and choices made by individuals.

The chapter first sets the context and then moves on to identifying some of the particularities underpinning the growing vulnerabilities of the labour market for healthcare in Slovenia stemming from the healthcare workers' choice to emigrate. It does so by focusing primarily on the struggle to achieve the sustainability of the healthcare workforce and maintain the high quality of public healthcare services in an increasingly vulnerable welfare state. It then moves on to exploring a wide variety of motivations prompting healthcare workers' emigration from Slovenia,³ focusing in particular on the aspects related to the pursuance of subjectively defined welfare and wellbeing, welfare-state-provided social security and services and the welfare of new patients versus those left behind.

8.2 The Migration of Healthcare Workers

Healthcare provision is an integral part of a welfare state and its complex web of policies by which it intervenes in the operation of the market economy to reduce social inequalities (Bryant and Raphael 2018). The obligation of public healthcare systems operating within welfare states is to reduce differences in health outcomes between socio-economic groups and across geographic regions. To do so they need to work towards securing a steady supply and sustainability of qualified healthcare workers, since there can be no health without a workforce (Campbell et al. 2013). In other words, the provision of public healthcare depends heavily on the dynamics and functioning of the labour market for healthcare workers. Unfortunately, this latter is a particularly vulnerable structure and does not have the capability of adjusting to the dynamics of supply and demand with ease and rapidity. One of the main reasons for that is the fact that the reproduction of healthcare workers is a time-consuming and costly process (Plotnikova 2018). It takes several years to train a nurse and a decade or more to train a doctor. Investments in healthcare workforce education are therefore observed with a significant delay and in addition do not always result as planned. The stability of the workforce depends on many factors, including the levels of turn-over rates – which are often high due to heavy workloads, professional exhaustion, psychological pressures and low remuneration – and the ability to attract young graduates to take positions within specific specialties or take up work in rural and remote geographic areas.

³In some cases, the interviewees who emigrated from Slovenia did not stop at the initial country of destination chosen but continued migrating further. The analysis includes their narratives related to chain migration insofar as they are welfare-related and thus contribute to building the argument.

Shortages of healthcare workers are observed at the global level and are a persistent worry in both developing⁴ and developed countries (Buchan et al. 2014; Plotnikova 2018; WHO 2016). It is estimated that European Union (EU) countries will face a shortage of one million healthcare workers by 2020 (European Commission 2012), while challenges in ensuring an adequate supply are set to persist in light of an aging population that requires more healthcare, a high percentage of the aging healthcare workforce who are approaching retirement and insufficient replacement rates (Matrix Insight 2012). The problem for individual countries within the EU is significantly exacerbated by the rise of cross-border mobility or commuting, as well as continuous emigration to popular destinations outside the EU, such as the United States of America, Canada, Australia and New Zealand. As these countries are themselves experiencing deficits, they are actively recruiting healthcare workers from abroad in an effort to fill the vacancies, prompting other countries to follow such a *modus operandi*. The emergence and development of global care markets in the context of globalising care economies (Yeates 2009) has thus created a cycle where countries with more competitive comparable advantages recruit from countries with fewer – and the latter recruit from countries further down the hierarchy. For example, when doctors from the United Kingdom move to the United States of America, they are replaced by doctors from Britain's former colonies or other European countries such as Germany which, in turn, recruits from Central and Eastern-European or Western Balkan countries.⁵ Competitive advantage is, of course, a relative term as its definition depends on the aspirations of each individual healthcare worker but, mostly, it refers to high remuneration, good working conditions, opportunities for professional advancement and a better quality of life in general. Therefore, compared to lower-income, resource-strained countries, wealthier countries have more policy capacity to act and more means to invest – and are as such more successful in attracting healthcare workers (Glinos et al. 2014).

8.3 The Slovenian Case

Slovenia is among the countries that have historically relied on and benefited from the immigration of healthcare workers from abroad. Before its declaration of independence from the Socialist Federative Republic of Yugoslavia in 1991, Slovenia

⁴The World Health Organisation (WHO) estimates that a global deficit reached 17.6 million in 2013. The largest needs-based shortages are in South-East Asia at 6.9 million and Africa at 4.2 million. In relative terms, the most severe challenges are in the African region. Although the global demand in 2030 is estimated to decline overall by 17%, the African needs-based shortages are forecast to worsen (WHO 2016).

⁵It is estimated that, between 2012 and 2014, around 1700 physicians from Serbia, Macedonia, Albania and Kosovo left to work abroad (Lazarevik et al. 2016). The Bosnian Chamber of Medicine announced that, in 2016, about 300 highly qualified doctors left the country. This number does not include junior doctors who left immediately after completion of their medical degree. Germany is among the most popular destinations for the countries of the Western Balkans (Živković 2018).

was an attractive destination for healthcare workers from other Yugoslavian republics. Tit Albreht (2011) writes that physicians and dentists from Bosnia and Herzegovina, Serbia and Croatia were drawn to Slovenia because of three main factors: the chronic shortage of health professionals, the numerous opportunities for medical and dental graduates that resulted from those shortages and an expanding healthcare sector at a time of significant limitations in several other republics. In other words, while Slovenia was experiencing shortages, many other republics were experiencing an over-supply and new graduates encountered difficulties in finding employment. The three republics became the source of 80% of immigrant physicians and dentists in Slovenia. After independence, immigration came to a near stop due to the war erupting in the Balkans but the pace picked up again in 1995 (Albreht 2011). Although the trend was discontinued when Slovenia joined the EU and restrictive regulations relating to recruitment from third countries came into force, physicians from the republics of the former Yugoslavia still represent the highest share of foreign physicians today. According to the Medical Board of Slovenia, 524 registered physicians with foreign citizenship currently work in the country, of whom 187 come from Serbia, 96 from Croatia, 82 from Macedonia, 47 from Montenegro and 42 from Bosnia and Herzegovina (STA 2019).⁶

Because it was relatively easy for Slovenia to recruit from the former Yugoslavian republics, no active policies to attract healthcare professionals were introduced immediately after independence. As the opinion was that any shortages were only temporary and the evaluation of needs was based mostly on a retrospective impression, the intake of students remained limited and no new medical or nursing schools were established. However, shortages continued to persist in the period between 2000 and 2004. The Ministry of Health reacted by announcing its intention to recruit more healthcare workers from abroad but Albreht (2011) notes that this intention never materialised because of two main factors: diverging views on the topic among the key stakeholders in the newly established state – i.e., the Ministry of Health, the Health Insurance Institute of Slovenia and professional Chambers – and the limited interest of foreign healthcare workers in taking up jobs in Slovenia. Slovenia was not an attractive destination for healthcare workers from EU countries, who preferred to seek employment in the old, high-income EU member states. In the absence of favourable recruitment policies and incentives and due to restrictive policies relating to the immigration of third-country nationals, workers from the Western Balkans increasingly turned to those countries as well. Restrictiveness can be partly linked to the politics of the nation-building process that sought to establish and reaffirm Slovenian identity based on ethnic origin and as such viewed immigration, especially from third countries, as detrimental. Another reason can be found in the organisation of the Slovenian health professional regulatory system, which is decentralised and gives substantial power to the independent professional organisations

⁶At the end of 2017, the overall number of physicians employed in Slovenian healthcare facilities was 6408 (NIJZ 2018).

called Chambers, which have their own specific interests when it comes to health-care workforce planning (Albreht 2011).

The realisation that foreign healthcare workers will not be able to fill the shortages came after two important studies had laid out the projections for the supply and demand of physicians and nursing staff in the near future (Albreht 2002, 2005; see also Albreht and Klazinga 2002). In response, Slovenia attempted to move towards self-sufficiency by opening an additional medical faculty and five additional nursing schools, as well as by significantly increasing student intake in the two medical faculties. This resulted in an increased supply although self-sufficiency has not been achieved and shortages persist. Hospitals and primary care centres, primarily those in remote and rural areas, continuously warned that the system was at a breaking point as vacancies were not being filled. In 2011, an intervention law was passed for the recruitment of healthcare workers from third countries, which was successful in attracting a foreign workforce but did not stop the downward spiralling – and frustrations grew stronger. Although many recruited healthcare workers did settle in Slovenia, a substantial number used the country as a stepping stone to employment in other EU countries (Zupanič 2011). In addition, Slovenia-trained healthcare workers also increasingly started looking for jobs across the border, with some opting for settlement in other countries and others commuting to neighbouring Austria, where salaries are higher, working conditions are better and the workload is manageable (Fajnik Milaković 2018).

According to the Nurses and Midwives Association of Slovenia, most Slovenian hospitals were experiencing shortages of nurses and midwives in 2018. In the University Clinical Centre Ljubljana (UKC), the biggest Slovenian hospital, the shortages totalled 10% or 340 nurses while, in peripheral areas, the percentage was significantly higher. In Sežana, for example, 43% of vacancies remained unfilled while, in Šempeter, the figure was as high as 54% (RTV SLO 2018). In all Slovenian hospitals the shortage of nursing amongst midwifery staff is estimated to be over 2000 (Jager 2018). The mobilisation of retired nurses and paid overtime were the main strategies put in place to cope with the workload as vacancies continuously remained unfilled, leaving nurses burned out and under immense psychological pressure. In UKC Ljubljana, one third of the intensive care unit was closed down in 2018 as nine nurses resigned and the management could not replace them. In the same hospital, critical shortages of nurses and physicians were reported in several departments, including children's intensive therapy, cardiology, cardiovascular surgery, pulmonology, otorhinolaryngology, orthopaedics, dialysis, transplant medicine, emergency medicine and the intensive care unit (RTV SLO 2018). In the second-largest university hospital in Maribor, over 80 vacancies for medical specialists remained unfilled in 2016. Only one radiologist was employed in the oncology department and when she started her maternity leave, radiation treatment for new patients had to be suspended. The gynaecology department could not fill 16 vacancies, anaesthesiology 13 vacancies and the urology department was so severely understaffed that four burnout specialists resigned in protest. In the past couple of years, 70 physicians left the hospital to work either in other medical facilities in Slovenia or abroad or because they were due to retire (Seršen Dobaj 2017), leaving

behind a depleted system. Community-level healthcare centres across the country have also been overburdened for years. Family medicine specialists, gynaecologists and paediatricians are in short supply in most regions. The breaking point was reached in the first half of 2019 when, in the cities of Nazarje and Kranj, family physicians collectively resigned due to caseload quotas, which they claimed left them burned out and patients at risk (Jager 2019; Kos 2019). In Kranj, the number of physicians who resigned was 23 out of 34, which had an immediate impact on the 40,000 patients and family doctors across the country have declared that they will follow their colleagues' lead if conditions do not improve.⁷ Public healthcare seemed to have ended in intensive care and the discussion among healthcare workers about the possibilities of commuting or emigrating abroad intensified.

How many healthcare workers actually leave Slovenia to find employment abroad is not entirely clear. The Statistical Office of Slovenia does not systematically follow the number of Slovenian citizens abroad and bases its estimations on the data derived from the Central Population Register kept by the Ministry of the Interior.⁸ It also does not have comprehensive statistics on the number of emigrated or commuting healthcare workers (e-mail correspondence with Statistical Office of Slovenia, 12 March 2019). Estimates can be made based on the issued certificates of good standing which healthcare workers need to obtain from their professional chambers in order to apply for jobs abroad. The Medical Board of Slovenia has been issuing between 200 and 300 certificates on a yearly basis from 2013 to 2018 (Benedičič 2019) while, in the past couple of years, 420 nurses requested the certificate (Fajnik Milakovič 2018). However, these data do not indicate whether or not the person emigrated. Excluded from this proxy are also graduates who leave immediately after graduation or those whose employer did not request the certificate. The frequency of commuting to neighbouring countries has also not been statistically recorded although, based on the data collected through empirical research, the number of daily commuters is substantial. The geographical proximity of the Štajerska and Koroška regions to neighbouring Austria, which is experiencing major deficits in its own healthcare workforce,⁹ makes Austria one of the most convenient destinations

⁷There have been insinuations, based on the content of trade unions' internal correspondence with their members, that mass resignations are a collective mutiny of Slovenian primary-care physicians who, in this way, aim to set in motion the privatisation of primary healthcare (Jager 2019). Since this issue is not the immediate focus of this chapter, it will not be elaborated upon.

⁸The Central Population Register contains information on the citizens of Slovenia who are absent from the country for more than 3 months, either permanently or temporarily (Stropnik et al. 2014). Information on emigration flows and stock are derived from data on permanent residence deregistration and combined with data on the resident population. According to the Statistical Office of the Republic of Slovenia, 9900 Slovenian citizens emigrated from Slovenia in 2017.¹³ Most of them left for Austria (25%), Germany (19%), Switzerland and the United Kingdom. The negative net migration of citizens of Slovenia was recorded for the eighteenth consecutive year (Razpotnik 2018).

⁹According to the Austrian Medical Board, Austria has been losing an astounding 600 graduate physicians per year to other countries. Due to the high retirement rate, emigration and an increased demand for healthcare services, the Board estimates that they will need to fill 938 vacancies on a yearly basis in the near future. In 2017, 1665 senior students were set to graduate but, since an

for commuters as well as settlers. Data on intermediary or final destination of health-care workers have also not been systematically collected, which additionally reveals a significant niche in research on the migration of healthcare workers from Slovenia. Data on yearly outflows, however, are scarce or non-existent in most European countries. The information base on healthcare workers in Europe has, in general, been described as ‘patchy, of limited quality and outdated’ (Maier et al. 2014, 95).

8.4 Spectrum of Motivations for Migrating

Several factors impact on healthcare workers’ decision on the location of their employment. According to the OECD Health Working Paper No. 69 on geographical imbalances in doctor supply and policy responses (Ono et al. 2014, 15) these include: (i) the general attractiveness of the locational environment, including educational opportunities for children, career opportunities for spouses, housing etc.; (ii) the mode of employment; (iii) the income potential, i.e. payment schemes; (iv) the working conditions, including working hours, access to appropriate medical equipment and support services, challenging patient populations and professional development opportunities; (v) issues of prestige and recognition; (vi) the expectations of work and life in remote regions and the capacity to adjust to the environment. Glinos and Buchan (2014) propose an alternative typology, one that adjusted to the rationale for emigration in the context of European countries. They put forth a typology that identifies six types of mobile health professional based on their motivations for and purpose of migrating, conditions in the home and destination countries, personal profile and the likely direction of the move and length of stay abroad. They distinguish between the livelihood migrant, the career-oriented migrant, the backpacker, the commuter, the undocumented and the returner. In sum, the livelihood migrant moves to earn a (better) living, the career-oriented migrant travels to develop his or her career, the backpacker works to travel, the commuting migrant commutes across borders to work, the undocumented migrant is migrating for work unofficially and works in the informal sector and the returner migrates in reverse. The authors acknowledge that the categories sometimes overlap and that the mobile health professional can evolve from one type into another but, nevertheless, promote the categorisation by arguing that ‘each (arche) type translates into specific advantages and difficulties for data collectors and policy-makers’ (Glinos and Buchan 2014, 136). A noticeable absence of welfare concerns as a reason for emigration permeates this typology – be it concerns for their own welfare or concerns for the welfare of those to whom they will provide services.¹⁰

estimated 40% of graduates leave Austria to work abroad on a yearly basis, the deficit is likely to persist (Kordaš 2019).

¹⁰The category of the livelihood migrant does mention the better living standards of the migrant and his/her family as an encouragement to leave but this refers to the economically related advantages and job security.

The empirical research on the motivations of healthcare workers for emigrating or commuting from Slovenia to other countries revealed a somewhat similar rationale to that laid out by Glinos and Buchan (2014) but has, in addition, exposed a number of more-deeply embedded reasons, motivations and aspirations for migrating. In line with a number of other similar studies (Young et al. 2014) this one, too, confirmed that very few respondents explain their decision to migrate in terms of one single reason. A unique combination of push and pull factors was described by each respondent, in most cases spanning macro, meso and micro levels.¹¹ The analysis, however, focused in particular on motivations related to their subjective welfare and wellbeing, welfare-state-related provisions and the welfare of their patients.

8.4.1 *Subjective Wellbeing*

Subjective wellbeing is a social indicator and a welfare measure (Fischer 2009). It is the most often defined as a person's cognitive and affective evaluations of his or her life, which include emotional reactions to events and cognitive judgements of satisfaction (Diener et al. 2002). The concept includes experiencing pleasant emotions, low levels of negative moods and high life satisfaction (Diener et al. 2002). An important component of the concept of life satisfaction is job satisfaction, which is defined as the positive feelings of individuals towards their job (Gaszynska et al. 2014). The factors influencing the level of job satisfaction include salary, working conditions, recognition and responsibility (Gaszynska et al. 2014). In light of the current condition of the Slovenian healthcare system, most interviewees stated that their motivation to look for jobs abroad stemmed largely from their poor working conditions which led to stress, fatigue, anxiety and burnout but also from an indecisive and ambiguous workforce management and poor remuneration. These factors have contributed, in their opinion, to lower work and life satisfaction, quality of life and overall wellbeing, as Physician 3, who migrated to Germany, recounts:

I was longing for better management, more opportunities for professional growth, more constructive interaction and cooperation with other specialists. The promise of a better salary was definitely a welcome bonus. I was getting little satisfaction from my work and that was very disappointing for me. I was feeling tired. Bad-tired, not good-tired.

Eight out of ten nurses interviewed stated that they feared they would make a mistake leading to fatal consequences because their unit was continuously understaffed and they felt fatigued, emotionally drained and disorganised. They all believed that they deserved better pay as well as more respect from the physicians and human-resource-management department. Two nurses who migrated to

¹¹ The macro level includes (national) economic and socio-political factors, the meso level includes profession-specific factors (for example, education, training, work conditions and career development) and the micro level includes 'individual circumstances and attitudes through which macro- and meso-level drivers are viewed but which also influence migration decision-making in their own right' (Young 2011, 314).

Slovenia from Macedonia and Bosnia and Herzegovina strongly felt that they were not respected within the medical team due to their foreign diploma, ethnic origin and accent, which was thus an important motivation to look for jobs outside Slovenia. Two midwives who emigrated from Slovenia to the UK and then onwards to Australia also expressed their dissatisfaction with the way other medical staff treated them in the UK. It was the little things with a strong symbolic message, such as continuously mispronouncing their names or making jokes about their accent, as Midwife 1 said:

I constantly had to remind them that my name (Jelena) is pronounced Y-elena and not J-elena, that I'm from Slovenia not Slovakia and that I don't speak Russian but Slovenian. It didn't bother me that much in the beginning, but after a few years the frustrations grew and I felt disrespected. I left because of things like this. Not feeling accepted, not being respected.

The last straw for many interviewees was a gesture or occurrence that they subjectively perceived to be disrespectful. One doctor claimed that it was yet another request by the Medical Insurance Institute to check his patients' records in search of fraud committed by him or his staff. For one junior nurse, Nurse 1, who migrated to Austria, it was a refusal by the management to provide her with a parking space or cover her parking costs, which were significant due to her frequent overtime and double shifts.

I spent a tremendous amount of money on parking and I was on a minimum wage. The car park next to the hospital was too expensive for me to use, so I tried to park on the street somewhere close to my ward. I had to leave home early to find a spot and I was always struggling with this because the hospital is in the very centre of the city. The problem was also that I needed to renew the parking ticket for street parking every few hours. Since I couldn't manage to do that every day I got a bunch of fines. I work at a retirement home in Austria now and I have my own parking lot right next to the entrance.

For another young nurse it was the constant lack of eye contact with the doctors on her ward, making her feel disrespected and unappreciated. The lack of teamwork was the last straw for a young female physician as well, who said she found a position in Switzerland days after applying and left as soon as all the arrangements were made. When asked if her overall wellbeing has improved as a result of this emigration she responded that it has – not only because of her better relations at work but also because of the better work–life balance and higher socio-economic status. For all respondents, the promise of increased personal wellbeing was of paramount importance when contemplating migration.

Apart from work-related subjective welfare, the decisive factor for many interviewees was the possibility of embracing a desirable lifestyle, be it linked to a preferable climate, cuisine or cultural scene, to opportunities to pursue hobbies, to an affinity to live in a culturally diverse society or simply to a desire to embrace a mobile lifestyle. As Midwife 4, who migrated to Austria, the UK and Canada reveals, experiencing 'the romance of crossing borders' Doerr and Davis Taïeb (2017) for them went hand-in-hand with the pursuit of subjective welfare and wellbeing.

I always wanted to travel and I chose this profession because I knew it would enable me to go places. I've been working in Austria, the UK and Canada and had short placements in South Africa and Australia. I took every job opportunity that presented itself, even if it was not paid well. I wanted to lead a cosmopolitan life, I wanted to make friends with people around the world. I was never concerned about the safety net. I knew I would always be able to earn a living.

Nurse 5, who migrated to Australia, also states:

I left Slovenia because I was stigmatised for being gay. I felt I could not pursue my desired lifestyle there. I realised that I was leaving behind my safety net – family, social security, good public services. That made me a bit nervous. However, in the end it was my happiness that mattered the most and I gave it priority over guaranteed social security.

These narratives are in line with the findings of an extensive research project conducted by Papademetriou (2013), which determined the most important variables influencing high-skilled migrants' choices of destination. These include, among others, attractive lifestyle options, a healthy environment and a tolerant and safe society. All those factors were emphasised as important by a majority of my respondents in terms of contributing to their wellbeing.

8.4.2 *Social Welfare Benefits and Services*

The aspect of emigrating in order to benefit from better or more-generous social-welfare protection was not brought up as a decisive factor. All the respondents were confident that they would always be able to secure employment with their level of skills and that they would not have to rely on social benefits provided by the state. In other words, contrary to Borjas' (1999) welfare magnet hypothesis, according to which individuals' migration decisions are influenced by the generosity of the welfare system in the country of destination, respondents such as Physician 5, who migrated to the US, ruled out the robustness of the welfare state as a decisive factor for migration:

The Slovenian welfare state is not bad. Maternity leave is long and well-paid, the primary, secondary and university-level education system is free of charge and public healthcare is free at the point of entry. It's true that social transfers seem to be in decline and the healthcare system is facing tremendous challenges but the country is still providing a very decent safety net. When I decided to move to San Diego I realised that the situation was going to be very different. However, it never occurred to me that I would not take a job here because the welfare provision is poor, just as it would not occur to me to take a job in Norway just because they have a generous welfare system.

More than state-provided support, healthcare workers contemplated the social benefits which are part of the employment-quality dimension. In line with Wiskow et al. (2010) and Muñoz de Bustillo et al. (2009), who argue that contractual relations that allow for pension schemes, flexible retirement policies and childhood provisions are important factors influencing job quality, my respondents considered in-job benefits as a significant motivational factor. Many have been impressed by

the policy of providing free childcare and housing at least during a transitional period following immigration, which has certainly facilitated their decision to emigrate and settle down. Quality professional development programmes – i.e. the programmes that healthcare institutions provide for their employees in order for them to evolve professionally and personally – were also brought up by a number of respondents as an important incentive. These programmes vary significantly but often provide free-of-charge psychosocial support and counselling as well as training in how to cope with stress and anxiety.

Welfare-state-provided services such as healthcare, social care and education were nevertheless considered by some respondents as an important incentive, especially by those who had dependent members in their family and considered access to quality education and public services to be an important factor when choosing the destination. This is in line with Buchan et al.'s (2006) research on international nurses in the United Kingdom, which revealed that education opportunities for children are one of the main motivators for moving, as Nurse 2, who migrated to the UK, explains:

It's good to have a safety net, especially if you're in precarious employment. However, that's not the case with healthcare workers. We are in demand everywhere. I don't care about the generosity of social transfers in destination countries. However, when I was looking for a job abroad, I was googling public schools for special-needs students and social-care systems because my child has a developmental disorder. It was important for me to move somewhere where quality schools and public services would be provided.

8.4.3 *Patients' Welfare*

Healthcare workers who migrated to untypical destinations, such as India and remote Australian territories, spoke about a different rationale behind the decision to emigrate. For them it was mostly the urge to put their skills to good use in socio-economically disadvantaged environments and contribute to reducing health inequalities; however, many of them also felt the need to go back to grass roots and practice medicine without the use of sophisticated equipment and the pressures of bureaucracy, as Physician 1, who emigrated to the UK and India explained:

I felt like a machine for issuing prescriptions and referring patients to specialists. I did not feel like a doctor at all. It was not easy to find a placement in India but I eventually moved there and found work in a small local hospital in a remote area. It was very exciting to actually be able to practice medicine, to use my hands and my brain again, especially when encountering difficult cases. It was such an authentic experience.

For the healthcare workers, the need to help others was, in many cases, coupled with a strong urge to find comfort and feelings of self-fulfilment, a desire to be part of a close-knit community, to be appreciated and respected. These motivations for migrating were revealed by Malkki (2015) in her portrayal of international aid workers with the Finnish Red Cross and their need to alleviate their own neediness. In her book, she argues that their intense personal and professional engagement

with the world has become a way of losing themselves while paradoxically staying vitally alive. Aid workers are thus not portrayed by Malkki as self-sacrificing individuals performing heroic acts but, rather, as persons seeking to alleviate their own need to travel, give, help and be part of something bigger than themselves. The narratives shared by my respondents – here, Midwife 3, who went to the UK and Australia – are strongly aligned with this line of argumentation.

My children left for university and I felt a sudden loss of purpose. It was definitely a very persistent case of empty nest syndrome. I wanted to change the scenery, I wanted to lose myself in work but, most of all, I wanted to feel needed again. I took a job at a community-style healthcare centre in remote Australian aboriginal territory. I managed to overcome my personal crisis by immersing myself in work and helping others. I felt like I was going back to the roots of midwifery and it felt great. I was invited to peoples' homes and to their celebrations. I feel so happy that I took on this profession. It enabled me to move around the world and made me feel significant.

When asked how they felt about their patients left behind, the discussion turned to contemplating the ethical dilemma of the desire to move and the duty to remain. This issue is particularly controversial because it is causing a conflict between two sets of human rights: the right to health of patients in source countries and the right to the freedom of movement of healthcare workers. Alkire and Chen (2006) are among the most prominent scholars to acknowledge and throw light on this conflict. They argue that healthcare workers are themselves a locus of human rights that are to be protected, such as freedom of movement, the right to development, safe working conditions and a living wage; however, they argue that they are also a crucial instrument of the very health care to which others in a population have a right. In regard to this dilemma, some respondents noted that they struggled with guilt after moving abroad. They noted that they were the building blocks of the Slovenian healthcare system and that their emigration may have weakened healthcare delivery in their town or region. Other motivations prevailed, nevertheless, over the sense of patriotic obligation or obligation towards the state as a funder of their education, as Physicians 5 and 9, who moved to the US and Switzerland respectively, reveal:

I was once told that I should be ashamed of myself for leaving our own to take care of others. That I should be ashamed of taking money from the taxpayers to get my degree and then deciding not to serve the very people who paid for my education. However, it was that very system that was actually pushing me to move abroad. My choice to move abroad was not because of the incentives from the foreign countries that would pull me towards them. It was because I was pushed away by poor workforce management, an overly hierarchical structure, a lack of respect from supervisors in my hospital and a tremendous level of machoism that I could no longer take.

I was very emotional when I decided to leave my patients behind. At some point I contemplated if what I was doing was ethical. I asked my supervisor if he had found a good replacement for me and he told me not to worry, everyone is replaceable. I asked him if they would be recruiting new physicians from the former Yugoslavia and expressed my worry over recruiting from Serbia and Bosnia and Herzegovina because I knew they were lacking doctors and nurses there as well. However, I don't think he was bothered with the ethical issues of recruitment at all.

This dilemma has been discussed thoroughly by Shah (2010), who points out that opinions diverge considerably about what an ethical response to the international migration of healthcare workers would be.¹² There is ambiguity about the moral obligations of governments, individuals and health systems and the roles that global institutions should play. There are also apparent conflicts between the human rights of different parties and proposed responses can themselves appear discriminatory in the light of conflicting stakeholder interests. In practice, however, beyond ethical and policy conundrums, a relentless urgency surrounds the problem of the accessibility of health facilities and services if healthcare workers decide to emigrate in substantial numbers from the very welfare states of which they are the building blocks. The problem is exacerbated further when a country does not have any significant comparative advantage in relation to other recruiting countries that are experiencing a deficit of healthcare workers themselves.

8.5 Conclusions

The healthcare sector is considered and governed as a public service and is part of the welfare state in many countries of Europe and elsewhere. This means that governments have a responsibility to their citizens to provide healthcare (Glinos and Buchan 2014). In this chapter we have seen that Slovenia is committed to sustaining quality public healthcare but has been facing challenges in many areas, including healthcare workforce management. For a variety of reasons discussed in this chapter and due to the fact that healthcare as a welfare service is subject to global market forces and the globalisation of reproductive labour (Yeates 2009), Slovenia has been continuously struggling to achieve the sustainability of its healthcare workforce. It was argued that the Slovenian market for a healthcare workforce is particularly vulnerable because it is targeted by other countries, some in close proximity, that have significant competitive advantage over Slovenia in terms of providing better remuneration and working conditions. At the same time, historically established patterns of labour recruitment from Western Balkan countries were disrupted by strong incentives introduced by higher-income countries. While a turn towards sustainable healthcare workforce planning has been observed in recent years, the results have not yet been satisfactory and shortages continue to persist.

Poor strategies for workforce planning and retention are seen as one of the key reasons for emigration (Plotnikova 2018), which seems to be the case in Slovenia as well. When coupled with the demographic challenges which the country is facing, it becomes evident that firm policy action is required to mitigate the negative effects related to emigration and high turn-over rates. However, the vulnerability of the labour market for healthcare is exacerbated by the fact that the motivations for

¹²Although some soft regulatory mechanisms are in place, such as the WHO Global Code of Practice on the International Recruitment of Health Personnel (WHO 2010), their implementation is challenging due to the insufficient engagement of key policy decision-makers (Siyam et al. 2013).

healthcare workers' emigration vary significantly, which makes policymaking and healthcare-workforce planning challenging. As Plotnikova (2018) notes, policies are 'not always attuned to the individual creativity and imaginaries of health workers that ultimately affect their mobility' (Vindrola-Padros et al. 2018, 7). Migration as a physical movement is always accompanied by internal phenomena, the so-called inner negotiations in which people engage as they consider and employ mobility as a resource in their search for care and caring (Pfister 2018), welfare and wellbeing. Specific incentives may therefore either be a success with some healthcare workers or a failure with others. Some respondents participating in the study, for example, decided pragmatically to study medicine or nursing because they knew that these professions are in high demand globally and would, at some point, enable them to pursue a desired lifestyle outside Slovenia. Better management and remuneration might not, in their case, play an important factor in their decision to move abroad. Moreover, motivations to migrate change with age, vary according to life stages and are affected by unique life situations and desires. Thought processes and emotions that guide and affect the decision to migrate are always dynamic and perpetually evolving processes. At some stage in their lives, healthcare workers might be attracted by the prospect of low-cost housing, childcare or other job-related benefits offered to them while, at some other period in their life, they may be drawn by the need to provide care to disadvantaged people in poor regions or countries. Their narratives illustrate how unpredictable and intangible ground-level decisions to emigrate may be and what substantial effect they have on healthcare planning, provision and, subsequently, public health. That said, it should also be noted that the vulnerability of the healthcare sector, in terms of being constantly understaffed and under strain, should be perceived not only as a consequence of emigration but also as a cause. The relation between the two factors should therefore be conceived as circular.

Another finding stemming from this empirical research is that the generosity of social benefits in destination countries is not a decisive factor for healthcare workers emigrating from Slovenia. This can be attributed to the fact that most of the respondents considered the Slovenian welfare state system as relatively generous in itself and to the firm conviction that their perpetually-in-demand profession is their most valuable and trusted financial safety net.

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