North West Thames
REGIONAL HEALTH AUTHORITY

KING'S FUND CENTRE

Health and the Movement of Labour after 1992

Proceedings of a joint conference held by North West Thames Regional Health Authority and the King's Fund Centre for Health Services Development, 15 September 1989

Edited by Dr Ghada Karmi

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Published by the King's Fund Centre
126 Albert Street
London NW1 7NF
Tel: 071–267 6111

ISBN 0 903060 90 6

Distributed by Bailey Distribution Ltd
Dept KFP
Learoyd Road
Mountfield Industrial Estate
New Romney
Kent
TN28 8XU

The King's Fund Centre is a health services development agency which promotes improvements in health and social care. We do this by working with people in health services, in social services, in voluntary agencies, and with the users of their services. We encourage people to try out new ideas, provide financial or practical support to new developments, and enable experiences to be shared through workshops, conferences and publications. Our aim is to ensure that good developments in health and social care are widely taken up.

North West Thames Regional Health Authority, in association with North East Thames Regional Health Authority, has established an ethnic minority health and research services initiative which is developing this area of work with those two large London regions.

The initiative is headed by Dr Ghada Karmi, Consultant in Public Health Medicine.

The King's Fund Centre is a part of the
King Edward's Hospital Fund for London.

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ACKNOWLEDGEMENTS

My grateful thanks are due to Mr Geoffrey Martin of the European Commission Office in the UK, for his encouragement and support.

I would also like to thank Dr Sheila Adam, Regional Director of Public Health, North West Thames Regional Health Authority, and Mr David Kenny, then Regional General Manager of North West Thames Regional Health Authority, for their interest in the conference; and Barbara Stocking, Director of the King's Fund Centre, for her help with the organisation of the conference.

The conference and this publication were partly funded by a gift from the European Commission.

Dr Ghada Karmi
1991

INTRODUCTION

The current debate over the implications of the Single European Market, which is to be introduced on December 31 1992, has devoted little attention to one important aspect of the proposed changes that may have considerable implications for health services in Britain and other EC countries. This is the issue of potential labour migration within Europe. Although most commentators have emphasised the commercial aspects of the Single European Market, the legislation will also provide for the free movement of people throughout the EC, without the current limitations of border controls. According to the 1987 Single European Act (SEA), the EC Internal Single Market is defined as:

> . . . an area without internal frontiers in which the free movement of goods, persons, services and capital is ensured . . .

The Internal Market described by this definition has clear implications for health, because of the consequences of the removal of national fiscal barriers, such as VAT and excise duty, on commodities like alcohol and tobacco. The movement of persons across national frontiers may well be equally significant. If this movement were to lead to an increase in migration of unskilled workers between member states, then there would be clear consequences for health, not only for the migrants themselves, but also for the demand on health services in the receiving

countries. Furthermore, an increase in mobility of health professionals between Britain and the rest of Europe could affect the workforce at some or all levels within the National Health Service (NHS). However, this aspect of the Single Market has received little public analysis or assessment in Britain, and not much more outside.

In an attempt to investigate these potentially serious questions, a conference was organised under the auspices of the North West Thames Regional Health Authority and the King's Fund Centre. The conference, which was held on September 15, 1989, was the culmination of a year's effort to obtain information on the issue of labour mobility after 1992 and its effects on the NHS. The investigation had even included a visit to the offices of the European Commission in Brussels. Meetings and discussions held with officials there provided little enlightenment. It seemed that the accepted view with regard to labour migration after 1992 was that any increase would occur mainly among skilled or professional classes. Unskilled labour migration was discounted as an unlikely event, but no demographic projections to support either of these contentions were available. In Britain, the Department of Health agreed broadly with these views but had no clear guidelines on the projected numbers of medical personnel who might apply for work in Britain after 1992.

The conference, which was entitled *Labour Movement and Health: The Challenge of 1992*, focused on the health implications of labour migration and the consequences for the NHS. It aimed not so much to provide answers as to stimulate discussion and open up the issues for debate. The enthusiastic response for registration to attend gave a preliminary indication of the interest of health professionals, and the subsequent attendance and discussion were further proof of the relevance of the topic. Many participants put in requests at the end for another conference on the same theme. As might be expected, the audience was dominated by personnel managers and manpower executives, but it also included

service managers, directors of public health, nurses, social services managers, and others – including, significantly enough, a delegation from the Department of Health. The conference was well covered by the medical press.

The morning session, which was chaired by the Secretary of the King's Fund, Mr Robert Maxwell, focused on labour migration. Mrs Barbara Castle, MEP and former Secretary of State for Health, gave a spirited and provocative keynote address which set out her convictions about the future after 1992. 'The NHS is in danger', she said. 'If we are to save it, we must act now.' There were plans in Brussels, she believed, with the ultimate aim of full unification of the whole of Europe, economically and politically. Given the fact that the NHS is a unique institution in Europe, where most countries have some form of privatised medical service, the chances of its survival as a socialised system in a united Europe were minimal. Mrs Castle also drew attention to the social security disadvantages likely to be suffered by non-EC workers and their families, lacking the same rights as EC nationals. Mme Georgette Lalis, a member of the Cabinet of the European Commission for Health, Employment and Social Affairs (DG V), who had come from Brussels to address the conference, tried to respond to some of these points. The legislative background was given, and EC directives relating to the freedom of movement were detailed, beginning with the first, passed in 1968. The presence of Mme Lalis at the conference provided an unusual opportunity for information, not only about past EC policy but also on future directions.

Unfortunately, the first speaker of the morning session, Dr David Mayes, Senior Research Fellow at the National Institute of Economic and Social Research, was not able to deliver his paper at the conference as he was delayed abroad, so I am very fortunate in being able to include it in these proceedings.

Will the movement of unskilled labour pose a problem

after 1992? This central question was tackled in different ways by the last three speakers of the morning session. Jan Niessen, General Secretary of the Churches Committee for Migrants in Europe, who had also come from Brussels to participate in the conference, dealt with the issue directly. He held to the view that there would be no mass movement of unskilled migrants after 1992. This was due in part to the decline in Europe of 'pull' factors – that is, demand for unskilled labour – and in part to the steps that EC countries are taking to exclude non-EC nationals from gaining entry to work. The so-called TREVI group of EC ministers from all twelve member states was set up in 1980 to coordinate action against the entry of illegal migrants, terrorists and drug traffickers: in other words, to ensure that there would be no freedom of movement for non-EC citizens after 1992. Dr Niessen nevertheless conceded that there might be some migration from outside the EC, not because of the Internal Market but because of the 'push' factors of migration, chief among which are poverty and political repression. No amount of border controls will in the end keep out such migrants and asylum-seekers. On the contrary, such controls will almost certainly succeed only in pushing these illegal entrants into irregular positions, leaving them open to exploitation.

There are of course many precedents for this situation in most European countries at the present time. The so-called seasonal and temporary workers employed in the construction industry, farming, catering and cleaning are no more than illegal workers, usually on low wages and with no employment or social security rights of any kind. Jan Niessen deplored the EC policy of dealing with this situation by outlawing it still further, instead of trying to tackle the root causes of such migration. And of course, the implications for the health of such workers and their inevitable use of health services are considerable, as was pointed out by Dr Mark Johnson, Senior Research Fellow at the University of Warwick Centre for Research in Ethnic Relations. In an overview of the general health

problems of migrants, Dr Johnson dismissed the oft-quoted risks of imported infectious diseases, which he thought were no greater than those associated with tourists and holiday-makers. TB was an exception, but even this was mainly acquired in the unhealthy environment of the new country, rather than having been brought in from the country of origin. The real hazards faced by migrants were those associated with the stress of being in a new society, with deprivation, and above all with the effects of racism. Health services delivery often increased their difficulties, because of language and communication problems and the provision of irrelevant or inappropriate services. Dr Johnson suggested that there might be an increase in the numbers of refugees and unskilled workers in the UK after 1992, all tending to gravitate towards London.

This view was echoed in the paper I gave to the conference. The economic changes after 1992 would lead to uneven growth in the different regions of the Community, which must entail an increase in labour mobility; and there was no good reason for supposing that this would exclude the unskilled sector. Here, the demographic factor was relevant. As is well known, birthrates are declining throughout Europe at a time when they are unprecedentedly high in the countries of North Africa. The importance of this 'push' factor must not be under-estimated in attempts to determine the pattern of migration into Europe from outside. The immigration of Moroccans to Britain was a case in point, and I described a research survey which I had carried out among the Moroccan community in London. Most of the problems associated with migration were in evidence. Most of the subjects did not speak English and were poorly educated. They did not understand 'the system' in Britain, and were not using the health services appropriately. Women in particular were failing to take up preventive services, such as cervical screening. Most were employed in unskilled work, often with little time off. They were severely isolated and lived in a 'ghetto' in

the heart of London where they sought to recreate the atmosphere of their country of origin, to which they constantly aspired to return. My paper emphasised that these problems were not specifically 'Moroccan' but were common to many other migrant groups.

The effects of manpower in the NHS were anlaysed during the afternoon session of the conference, which was chaired by Sir William Doughty, Chairman of the North West Thames Regional Health Authority. The uncertainties about the future that had emerged during the morning were echoed in this session. What would be the effect of the freedom of movement after 1992 on medical, nursing and paramedical manpower? On the surface, the answer as far as doctors and nurses are concerned seemed not to cause undue mystification. Mr Douglas Gentleman, former member of the Standing Committee of Doctors of the EC and member of the EEC Committee of the British Medical Association, foresaw no dramatic changes following the establishment of the Internal Market, if past performance was anything to go by. After all, the Freedom of Movement Directive for doctors had been in operation since 1975, and yet by 1987 only 8000 doctors out of a total of 750,000 in nine member states had migrated. Why was this? In the view of Mr Gentleman, it was partly due to language and partly the result of there being no coordinated policy on health in the EC. Each member state retains its own medical practices and laws. And yet, against this, the effect of unemployment of doctors, which is particularly severe in Spain, Germany and Italy, cannot yet be estimated. Health workers and patients in Britain will not have failed to notice the increasing numbers of German and Dutch doctors already working over here, although admittedly on a short term basis for the moment.

The directives of freedom of movement for nurses have been in place since 1977, and yet to date they have had minimal effect. Dame Sheila Quinn, formerly President of the Royal College of Nursing and currently

President of the Standing Committee of Nurses of the EC, wondered whether this would change following the publicity which will accompany entry into the Internal Market. 'As to the future', she admitted, 'who can tell?'

Ancillary workers, such as physiotherapists, chiropodists and laboratory staff, do not yet have freedom of movement, but negotiations are underway to harmonise their diplomas throughout the EC. The future for these workers is indeed uncertain, as asserted by Mr Ron Keating, Assistant General Secretary of the largest health service trades union, the National Union of Public Employees (NUPE), in a lively speech that ended with conference. His was the only contribution to mention the Government White Paper on change in the health service (now the NHS and Community Act), which was at the time the subject of heated debate inside and outside the NHS. Mr Keating saw the proposals in the White Paper relating to self government of hospitals as posing a threat to ancillary workers, because hospitals setting their own pay structures would possibly recruit from outside Britain. But that aside, he could see little reason for anyone to wish to seek work in this country, given the low rates of pay for ancillary staff here. If anything, there would rather be an emigration of such workers to Europe. He viewed the demographic situation with alarm. A decline in the numbers of young people would lead to labour shortages. As a result, he concluded, the NHS must grasp the importance of development training of support staff as the only way of making the best use of existing resources. To that end, there must be better pay to help retain and recruit labour.

In the end, the conference raised many more questions than it could answer, which had been one of its aims. The discussion that took place throughout the day confirmed what had already been suspected, that such a momentous event as the establishment of a Single Market in Europe may have highly significant implications for health and for the health service, which need urgent attention. At the time of the conference, no one

foresaw the events now happening in eastern Europe, but these too will play their part in the process of migration. Managers and health professionals would do well to take up the challenge.

Dr Ghada Karmi
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1

THE IMPLICATIONS OF 1992 FOR LABOUR MOBILITY

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National Institute of Economic and Social
Research, London

I am delighted to have been asked to speak at this gathering because the topics chosen show that the organisers understand what is needed to encourage a good response to the proposals to complete the European internal market. The time for generalised awareness campaigns and enthusiastic propaganda to get people to take notice is past. It is clear that much of the proposed legislative programme is going to be enacted by the European Council roughly in accordance with the scheduled timetable. However, it is a huge and complex programme, and much of the detail is uncertain. Furthermore, legislation in Brussels is very different from what is going to happen on the ground. Much of the legislation has to be incorporated into national legislation and then monitored and enforced. We have yet to see what this will mean in practice, as according to the latest report from the European Commission only 2 of the 68 measures that should have been implemented in national legislation in all twelve member states have actually reached that stage.

What is needed now is detailed thought in individual industries and regions about the likely impact of the legislation and optimal responses to it. Health services will be substantially affected: through changes in the

rules of public procurement, particularly concerning pharmaceutical products; through the harmonisation of technical standards, regulation and certification; and through the removal of barriers to trade in services, which will have a number of implications for labour mobility. One is the freedom of labour and a second, the mutual recognition of qualifications. Perhaps we should add to this the right of establishment and the right to what is known as 'national treatment', i.e. treatment on the same terms as those who are residents in the country.

Focusing on the third of these categories gives us more than enough to look at on a single day, but we must bear in mind that many of the other parts of the programme, being realised simultaneously, have indirect impacts on labour mobility and vice versa. My task today is to paint the general picture, into which can be embedded more detailed discussion of specific areas of the market for health services skills.

I want to begin by making one or two remarks about the changes entailed in the move to the single market as they impinge on the labour market. I will then consider ways in which these relate to the determinants of labour mobility. Finally, I shall make some suggestions about what may happen.

1992 and the labour market

The 1992 programme makes three major steps forward over previous attempts at European integration: (i) it includes non-tariff as well as tariff barriers, (ii) it extends integration to include services as well as manufacturing, and (iii) it relates to freedom of movement of factor inputs – labour and capital – as well as products (goods and services).

In the case of goods we can argue that producers face a choice in selling to a foreign market. They can produce at home and export, or they can set up a plant in the

foreign country and produce there – indeed they can set up in a third country and export from there. With complex production processes different steps can be sited in different countries, to obtain the most benefit from access to components, purchasers, raw materials, infrastructure and human skills.

Traditional analysis of the gains from trade assumed that labour and capital could not move readily between countries. For some time now, movement of capital has been relatively easy, so direct foreign investment and multi-nationals have become commonplace. A fifth of our manufacturing output in the UK is produced by foreign-owned firms and our own ownership of companies in foreign countries is even larger. I am talking here only about *direct* investment. There is also extensive foreign investment, in both directions, known as *portfolio* investment, which does not result in foreign control of the enterprise. In 1988 UK portfolio investment abroad was worth nearly half as much again as direct investment. But taken together the two represent little more than half of our lending to foreigners. Since 1979 there have been no controls on foreign exchange in Britain, so the barriers to foreign investment have been those imposed by foreign countries plus restraints on inward investment through competition policy (the Monopolies and Mergers Commission) or for strategic/sensitive industries (for example, the restraints on the foreign ownership of British Petroleum, British Aerospace, and Plessey). Despite the aims of the European Community, it has been much easier for UK companies to make direct investment in North America than in Europe.

When it comes to considering mobile labour the picture is even more complex. The UK has strict controls on immigration from countries outside the Community and controls remain on Greece, Spain and Portugal as a transitional measure. There are no controls on emigration. The nature of the controls and flows is such that aggregate labour market analysis usually pays them only limited attention.

Table 1. *UK migration, 1987 (in thousands)*

	Inflow	Outflow	Balance
Total	212	210	+2
Commonwealth citizens (including British	146	160	−14
Of which last or next residence within EC	33	41	−9
Foreign nationals	66	50	+16
Of which last or next residence within EC	22	18	+4
Total movement w.r.t. EC	55	59	−4
Total by occupation			
Professional and managerial	63	64	−1
Manual/clerical	48	57	−8
Net migration 1978–87 per year			−4
w.r.t. EC			+1.5

According to the *Annual Abstract of Statistics* (see Table 1) net migration in 1987 was only 2,000, compared with a gross flow of around 200,000 in each direction, 0.4 per cent of the total population. A quarter of these movements relate to the EC. Again net figures are small: over the last ten years there was a net total outflow of 4,000 a year and a net inflow from the EC of 1,500 a year – not enough to cause great worries on their own. Of course the composition of the moving population by age, sex, skill and country of origin is important. An exodus of young, highly skilled males matched by an inflow of elderly, economically inactive, unskilled females would have a significant impact. However, we can see that the net flows are balanced at the first level of disaggregation, into professional and managerial workers on the one hand and manual and clerical staff on the other (and, similarly, by subtraction, for the economically inactive remainder). This is in contrast to, say, New Zealand, where emigration and immigration formed an important part of the process of economic development. Net immigration in a year often exceeded the total number of

unemployed in the economy. Questions of absorption were of major importance, and the free labour market with Australia meant that rapid changes could take place which the government was powerless to control.

Table 2. *Foreign employees in West Germany by nationality (in thousands)*

	1974	1981	1985
Total from member countries	718	558	498
Of which:			
Belgium	..	..	007
Italy	341	292	188
Irish Republic	..	..	1
Total from non-member countries	1,613	1,364	1,048
Of which:			
Algeria	..	..	2
Morocco	..	..	14
Portugal	82	56	35
Spain	159	83	65
Tunisia	..	..	8
Turkey	618	576	499
Yugoslavia	473	340	283
Total	2,331	1,922	1,547
Total as % of employees	9.0	7.5	6.9

The question at issue here is not so much 'Can labour move?', as 'Does it?' The answer in Europe has, with some specific exceptions, been 'no'. If we take the example of West Germany, in 1985 some 7 per cent of the workforce were from foreign countries, one third of these from other member states (Table 2). Over the previous ten years the numbers had actually fallen by a third.

The UK by contrast had half the amount of foreign employees, and a third of these came from Southern Ireland (Table 3). The numbers have changed relatively little over the last ten years. If we were to look at other countries we would find similar figures to the UK for the

Table 3. *Foreign employees in the UK by nationality (in thousands)*

	1975	1981	1986
Total from member countries	323	313	398
Of which:			
Belgium	..	..	3
Germany	..	..	18
Italy	..	..	57
Irish Republic	232	228	268
Total from non-member countries	468	447	423
Of which:			
Algeria	..	..	0
Morocco	..	..	4
Portugal	3	8	2
Spain	21	15	15
Tunisia	..	..	1
Turkey	4	6	7
Yugoslavia	..	..	4
Total	791	760	821
Total as % of employees	3.2	3.2	3.8

Netherlands and similar figures to West Germany for France and Belgium.

There are some differences, of course: Luxembourg, with its large share of EC institutions, has foreigners forming over a third of the workforce (Table 4). Thus while in theory people could move to take up job opportunities in other countries, in practice they have tended not to. This is not just an international phenomenon. There has been very little tendency towards the elimination of differences in unemployment rates among the regions of the UK. Indeed in the last decade the regional disparities have widened (Table 5), with rapid increases in unemployment, particularly in the North, at the beginning of the period, and substantial net increases in employment in the South in the second half of the decade, so that by 1988 employment in the South had risen by 600,000 compared with 1971, while in the North

Table 4. *Foreign employees in the UK by nationality (in thousands)*

	1975	1981	1986
Total from member countries	323	313	398
Of which:			
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Turkey	4	6	7
Yugoslavia	..	..	4
Total	791	760	821
Total as % of employees	3.2	3.2	3.8

Table 5. *Average differences between regional and national rates of unemployment (%)*

	1975–9	1980–4	1985–8
GB *rate*	3.9	8.5	10.0
South East	−1.1	−2.5	−2.7
East Anglia	−0.6	−2.0	−2.9
South West	0.4	−1.3	−1.5
West Midlands	−0.1	1.9	1.3
East Midlands	−0.6	−0.8	−0.9
Yorks and Humber	−0.1	0.8	1.5
North West	1.1	2.7	3.1
North	1.3	3.6	3.9
Wales	1.3	2.4	2.9
Scotland	1.3	2.0	2.7
Range	2.4	6.1	6.8

it had fallen by 600,000. Although the average level of unemployment rose from four to ten per cent over the decade, the spread also rose, from two and a half to seven per cent.

Thus even within a single market like the UK the labour market does not adjust rapidly to eliminate discrepancies. Labour does move, but slowly. The low rates of movement within the European Community should therefore not be taken *prima facie* to mean that there are barriers to a single market. They merely indicate that labour does not move a lot in Europe even when it can.

Nevertheless, there are several barriers to labour mobility which the Single Market programme hopes to remove. It is not that labour movement is prohibited, but that it is inhibited by differences between countries. This is bound up not just with the movement of people to produce goods in different countries, but also with trade in services, which has particular relevance to health care.

The simple model we described earlier of choosing between exporting and direct foreign investment is not so clear when it comes to services because no tangible item is exported, or at least not directly. Export of health care could, for example, involve the patient travelling to the UK, completing the course of treatment, paying for it in foreign currency, and returning home. Alternatively, those providing the treatment could travel or reside abroad and provide the service where the patient lives. However, these alternatives are not quite symmetrical, as in the first case the whole process is controlled, including ownership of the hospital or clinic, whereas in the second case this is not necessarily so. It would be possible to export by building or buying a hospital overseas, staffing it from the UK and providing the service overseas. Another possibility, of course, would be to run the hospital under UK ownership but using foreign staff. In that case the UK would receive the profits but the foreign country would benefit from much of the rest of the revenue.

It is immediately clear how barriers to trade in services and hence to mobility can occur. In the first place, even if there is freedom of entry, permission to work may be impossible or difficult to obtain because foreign qualifications to practise are not recognised. In order to start it would be necessary to qualify a second time. For many people this is effectively a prohibition. Even if qualifications are recognised it may be difficult to get a job with a foreign company. If UK companies are not permitted to set up overseas or they have constraints placed upon them by foreign authorities to employ local labour, again this inhibits trade and labour mobility. There is of course a third problem, stemming not from qualifications but from the ways of different countries and the standards and regulations they use. Thus if there is no objection to a UK firm operating in a foreign country, provided they follow all that country's norms and ways of behaviour, that may also be an effective barrier.

To take an elementary example, if the only way you can sell British beer in Germany is to make it the same as German beer, then this is tantamount to saying that you cannot export British beer. This also applies to services. If everything has to be done to the norms and customs of the importing country, then the learning cost may be so large that trade may be effectively inhibited.

It is these three aspects that the 1992 programme addresses:

i. mutual recognition of qualifications
ii. right of establishment and right to 'national treatment'
iii. mutual recognition of rules/standards and certification procedures in addition to
iv. right of residence which already exists for employees.

There are 14 measures in the 1992 programme which relate directly to the completion of a single market for labour and the professions. Seven of these have been passed by the Council, two have been submitted by the

Commission but not yet adopted, and five have yet to be tabled by the Commission. Of those which have been passed, two already admit that the 1992 deadline will be breached (ignoring transition arrangements for Greece, Portugal or Spain), and one of these (OJL 267 of 19/9/86) relates directly to health services as it refers to 'specific training in general medical practice'. This is not due for implementation until 1 January 1995.

Many of the inhibitions are minor: thus, different rights to social security benefits, differential tax treatment in transition years, etc. all inhibit movement.

The determinants of labour mobility

The legislation to create the single European market is permissive not compulsory. Some of the barriers inhibiting labour movement are being withdrawn but there is no guarantee that people will respond. Indeed if these restraints are not the binding ones, then no change will take place. For example, to do my job properly in Denmark I need to speak Danish. It is of no consequence whether or not my qualifications are recognised. It is not that I am not permitted to work there. I may be qualified to do it but I do not have the knowledge to do so efficiently so I will not try. Similarly, other factors not directly related to the job may be the inhibiting ones. My wife may not want to go and live in Dusseldorf whether or not I can get a satisfactory job there. Regular visits to friends or relatives may be impossible.

To see the impact of the 1992 measures we need to have some clear idea of what influences labour mobility. There are two simple models which are often used.

The first involves the combination of what are known as 'push' and 'pull' facors. I will use an example from one of my PhD students, Simon Jones-Henrickson, who was awarded his degree in 1976 for a thesis entitled 'The Dynamics of the Labour Market for Nurses from the Commonwealth Caribbean' (Table 6). Nurses came to the

UK in part because of problems at home. The population was growing too fast to cope, it was difficult to get a job, and many of the jobs that did exist were very unsatisfactory and badly paid. There were few opportunities for doing any better because of limited training and poor social conditions. Lastly he averred that people in the Caribbean want to travel and spend time abroad.

Table 6. *Push and pull factors for nurses from the Commonwealth Caribbean*

Push factors
1. High population growth (outstripping economic growth)
2. Economic and social underdevelopment
3. Chronic unemployment – actual and disguised
4. Low wages/salaries
5. Inadequate economic incentives
6. Inadequate opportunities for educational/vocational training
7. The 'exploratory nature' of the Caribbean people
Pull factors
1. Higher wages/salaries
2. Full employment
3. Non-seasonal, non-cyclical work
4. Better educational/vocational training opportunities
5. Cheap transport to UK
6. 'Open door' labour market
7. Wish to visit the 'mother country'
8. Popular belief in good economic and social conditions in UK
9. Extent of welfare benefits available

The other side of the coin was the attractiveness of the UK compared to both the Caribbean and other possible destinations such as the US and Canada. Clearly wages were much higher, there was little unemployment and jobs offered secure full-time employment, there were good opportunities for training (unlike many occupations in the UK this is undoubtedly true of nursing), the UK was cheap to get to and easy to get into, and it had the attraction of being 'home', with rumours of good

economic conditions and welfare benefits. It is important to note that it is not the truth of the situation which matters, but the beliefs of the potential migrants. Thus those who react worst to the conditions at home and have the rosiest view of the new country will be those most likely to move.

The problem about this sort of model is that it needs calibrating: we have to measure the factors and then try to sort out their relative importance. Some are standard economic variables that can be culled from published statistics. Others are opinions, which require more direct measurement, using questionnaires, say, or interviews, as for the present example. (I cannot help remarking that this study was restricted to female nurses, and I had some qualms at the time about the full range of motives for this interview programme!)

Clearly this model can be developed further. We can add more detailed questions about restraints, such as friendships and other social ties, language problems, customs, etc. Many of these are more striking in the European context, but the principle remains.

However, I found that to understand the forces at work it was better to try to convert this analysis into a more traditional demand and supply model – although as the title suggests this was a dynamic model, so we looked at the rate of flow of nurses to the UK over time (Table 7).

Some factors relate to the state of the labour market at the time. If there are labour shortages in the target country in the desired occupation, and surpluses at home, then migration is more likely. This involves more than just a head count, however: one must also consider the nature of the skills required, and the willingness of potential employees to participate in the labour force. Thus shortages of teachers in the UK may be solved more readily by attracting back married female teachers who have left the labour market than by bringing in teachers from abroad.

The second major factor is pay. This is not just a

Table 7. *A simple demand and supply model*

DEMAND FACTORS
Labour available in target country
• Participation rates
• Skills
Wage rates
• Social wage
Opportunities
SUPPLY FACTORS
Labour available in home country
• Skills
Wage rates
Opportunities
BARRIERS
Costs of change
Regulations
Cultural differences
SUBSTITUTES
Conditions in third countries
Alternative employment opportunities
Alternatives to employment

matter of immediate comparison; it requires consideration over the longer-term. Rates of pay in the UK may currently be lower than in France or West Germany – but will that always be true through the course of my career? Pay and conditions for young academics are better in Australia than they are in the UK, but by the time you become a professor there is much less in it – and for those with pretentions to consultancy the larger UK market may furnish a better pay-off. Thus the relative discounted values of future pay may vary with age.

Wages here include all the other benefits such as health insurance, social amenities, education for children, old age pensions, etc. Added to this is the scope for future choice.

Exactly the same factors apply but with the opposite sign for the home country.

It is at this stage that we consider the barriers to migration. Only some of these are within the control of governments or companies. Subsidised fares, tax breaks, language classes, accommodation, etc. all help to ease the transition. Regulations on age, health, who else can come, qualifications required, etc., which may inhibit the flow, are also subject to change. But factors such as climate, culture, loss of friends, etc. are not within the preview of governments or companies.

Lastly, it is important to recall that other choices are possible. There are other countries to go to: the US, Canada, Australia. And one alternative to performing the same job in another country may be to take another job in the same country: thus if retraining opportunities increase, the relative attraction of migration may decrease. Indeed in the modern labour market there are alternatives to continuing full-time employment. One is part-time employment, another is other members of the family working instead or as well.

This is only an outline but I want to end by asking how the 1992 programme affects these influences.

The likely impact of the 1992 programme on the mobility of labour

My clear answer is not a lot. Indeed, if it were likely to be substantial, governments would have reacted strongly rather than agreeing with such alacrity. Look, for example, at the worries about the potential entry of a large number of people from Hong Kong into the UK. The exodus from Eastern Europe is already beginning to bother West Germany, Austria and Turkey.

We have already seen that in the UK there are major regional discrepancies, not just because people are unwilling to move but because of a reluctance to implement changes which would make moving easier, such as greater differences in regional wages. The differences in wages would have to be very considerable. Arthur Brown suggested nearly twenty years ago, when the discrepancies between unemployment rates across the country were less than 2 per cent, that wage differentials of 20 per cent would be necessary to eliminate them. A differential more than three times as large may not imply wage differences of 60 per cent, but clearly very big differences are needed – and all this within a single economy where the costs of change are much less: the same language (roughly), largely the same culture, relatively low costs of change (housing to the contrary), ease of visiting friends and relatives, etc.

When it comes to the European context the required differences will be much larger. Returning to the tables given above, showing the small numbers of foreign nationals within domestic labour forces, the foreign workers who had migrated in were principally from Southern European and North African countries where the income differentials are largest. If we invert this and look at exits we can see that, again with the exception of Luxembourg, it tends to be the higher income states which have the lowest proportionate exodus to the rest of the community. The striking feature of course is the size of the Irish workforce working in the UK. Otherwise, within the Community it is Italy, Spain, Greece and Portugal which have the greatest income differentials/worst unemployment problems where the movements have been most substantial.

The measures in the Single Market proposals will have relatively little impact on costs or relative wages. The extra demand is unlikely to lead to great changes in labour market pressures as the increase in competitive pressures will probably push up labour productivity even faster. More serious are the impending falls in the

Table 8. *Foreign employees in the European Community, 1976 (in thousands)*

	Nationals working in other member states (1)	Domestic working population (2)	(1) as a percentage of (2)
Belgium	68	3,713	1.8
Denmark	7	2,293	0.2
West Germany	137	24,556	0.5
France	114	20,836	0.5
Irish Republic	455	1,021	44.6
Italy	694	18,930	3.6
Luxembourg	6	148	4.1
Netherlands	83	4,542	1.8
United Kingdom	61	24,425	0.2
Total EC	1,625	100,568	1.6
Spain	447	12,535	3.5
Greece	239	3,230	7.4
Portugal	569	3,279	17.4
Turkey	587	14,710	4.0
Yugoslavia	458		
Algeria	447		
Morocco	183		
Tunisia	85		
Others	1,392		
Total non-EC	4,407		
Total	6,032		

numbers of young people entering work, which have nothing to do with 1992, but are tied to longer-term factors. Rights of residence for the non-employed will help, allowing families to move with the wage-earner. In professions and crafts where qualifications are important there may be greater movement, but the problems of language and tradition remain. Progress on those fronts will be associated with a very gradual process of exposure to greater variety. It is only where shortages

are acute or wage differentials considerable that any serious moves will take place. Weakening trades union strength may enable more substitution, as has happened in the catering trades for example.

However, I leave detailed forecasts to those with greater knowledge. The point I am making is simple. The European market has already been open for labour mobility in many areas for some time and where there have been shortages employers have encouraged it. Now unemployment is much higher and there are no striking prospects for its rapid reduction. Thus the pull factors will not improve much, and the push factors have existed for many years. Except in certain professions and skills areas, the proposed changes in barriers are relatively small, and besides, the binding constraints are often nothing to do with regulations. Labour movement is not likely to be a major feature of the 1992 programme. Reorganisation of manufacturing production and some services such as distribution, transport and finance may be.

The impact on health services is likely to be more striking through public procurement. The opportunity to recruit overseas has been exercised frequently in the past. The 1992 programme will ease this process with respect to partner countries. However, much of the post entry and exit has not been from or to the EC. I look forward to hearing how others expect that balance to change given the determinants of labour mobility.

2

THE EUROPEAN COMMUNITY AFTER 1992 AND THE MOVEMENT OF UNSKILLED LABOUR

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Fiction and reality

'Under the Treaty of Rome every inhabitant of the Common Market Area, from Sicily to the Baltic, including also labour from the French West Indies and Guiana, could come to Britain without permit or entry-visa, and many would do so for the sake of social-security benefits which would give them even while unemployed a standard of living higher than they could achieve at home.'

You could have read these words in an advertisement in the *New Statesman*in 1971, but it could have been 1989 if you had replaced 'the Treaty of Rome' by 'the Single European Act'. The fear expressed was not typically British. It was also feared on the continent that thousands and thousands of Sikhs and Pakistanis would disembark at Calais and the Hoek of Holland, waving their British passports.[1]

The reality was, of course, different. Freedom of movement was and still is exclusively granted to Community citizens who wish to take up a gainful activity as employed or self-employed persons. Only if they succeed in doing so within three months are they

granted residence rights. Spouses, children and other family members are also granted the right of entry and residence. The permits are issued for a period of five years and are automatically renewable upon request. In other words, it is absolutely impossible that foreigners should start pouring in only to take advantage of the welfare state as soon as frontiers are lifted.

The Treaties establishing the European Communities are aimed at eliminating many different kinds of barrier so as to establish freedom of movement for persons pursuing economic activities, for goods, services and capital throughout the European Community. The 1992 operation is a step further down that road.[2] As far as principles are concerned, nothing has really changed between the Treaty of Rome of 1956 and the signing of the Single European Act in 1986. The founding of the Common Market as such did not give rise to a mass movement of migrants; neither, as I intend to show in this paper, will the lifting of the internal borders by 1992. In addition, my conclusion will suggest that any fear of mass movements as expressed in 1971 is unfounded.

To begin with, let us just look at the proposed and already implemented measures with regard to 'Europe 1992'. We can see a further liberalisation of economic life and a stagnation in the development of social policies. We can see that freedom of movement for goods, services and capital is encouraged. On the other hand, we see that freedom of movement for persons is dealt with in a very cautious way.

In 1986, the Ministers of Justice and/or Ministers of the Interior of the twelve EC States established the so-called TREVI group, which must be seen as part of the consultation process towards the establishment of the Single Market in 1992. This group is almost exclusively comprised of heads of police departments working together to formulate concerted action against terrorism, drug trafficking and illegal migration. Among the topics secretly discussed by the TREVI group are the harmonisation of visa policies, the improvement of cooperation

between the member States in recognising false identification and travel documents, and the introduction of common procedures dealing with asylum-seekers. Another major issue is the position of nationals from non-EC States who are legally residing within the Community. They still do not have freedom of movement. This might have been reasonable twenty years ago when migration was considered to be temporary. But now that the overwhelming majority of the immigrant population has settled permanently, why not consider them as Community citizens?[3]

Are current EC policies based on fear? Will the 1992 operation indeed give rise to a new wave of intra-Community migration or a new wave of immigrants from outside the Community? Let me try to answer these questions by dealing first with possible new waves of immigrants from outside the Community and then with intra-Community migration.

Migration today

Saying that the time European countries organised the recruitment of mostly unskilled foreign labour is far behind us is nothing new. The current increase of the immigrant population stems not from the arrival of new migrant workers, but from factors such as family reunification, natural increase and the admission of refugees and asylum-seekers.[4]

The economies of Western European countries may no longer be in need of migrant workers. However, the necessity for people in under-developed countries to earn a living elsewhere still exists. In other words, the so-called pull factor (labour shortages in receiving countries) is no longer there, but an important push factor (poverty in sending countries) is on the contrary still present. Poverty, in combination with regional and global disparities in wealth and job opportunities, is an incentive to migration.[5]

A former Swedish Under-Secretary for Immigration once said that 'the major problem lies in the lack of a joint concept and a joint strategy on how to tackle root causes of Third World migration'. He added that the general perspective of increased Third World inflows should urge European countries to reflect further on ways and means of implementing the many statements on a sustained effort in favour of the social and economic development of the countries of origin of migrants.[6]

Another important push factor is, of course, the political situation in the countries of origin. According to a consultant to the High Commissioner for Refugees, irregular movements of refugees and asylum-seekers take place mainly from developing countries towards industrialised countries.

> 'They have increased significantly in recent years. At world level the proportion of irregular movements would not exceed 2 per cent to 3 per cent of all refugee movements but the proportion reaches from 20 per cent to 30 per cent of unscheduled arrivals in industrialized countries.'

Reflecting upon possible solutions, the consultant stated in his report:

> 'In the long run, however, results will be achieved only by tackling the root causes of refugee problems and taking constructive measures to avert new flows of refugees. At that level the remedies are no longer of a technical nature but belong to the field of political co-operation between States.'[7]

I hope you do not mind that I leave aside the developments in Eastern Europe, which will certainly give rise to an increase of people who are willing and allowed to come to Western Europe. This will undoubtedly lead to more restrictive measures in the West. You may be disappointed that I shall not deal here with the problems arising in Great Britain as a result of developments in China and related to the situation in Hong

Kong. The discussion on the status of the inhabitants of that colony will go on in the near future, as will the discussion on the somewhat privileged position of citizens of certain countries with which one or more of the EC states concluded treaties.

To conclude, we may expect a continuing inflow of migrant workers, asylum-seekers and political refugees. However, this is due not to the lifting of the internal borders of the twelve EC countries, but to the gap between rich and poor countries. Many immigrants will not have the necessary documents to enter, to work and to remain in member states of the EC. The labour market for skilled and unskilled labour will not be able to absorb them all (it may be argued that skilled labour stands a better chance.) Restrictive policies and intensified border controls are not and never have been a solution to the problem of present migratory movements. The result is only that people are pushed into irregular situations in which they are extremely vulnerable to exploitation. Moreover, restrictive policies are ethically unacceptable as long as the disparities between rich and poor countries continue to exist and so many people have to fear persecution on political grounds.

Tackling the root causes of migration and refugee problems should be at the top of the agenda of the EC Member States when future policies in the field of migration are considered. As far as I can see, this important aspect of migration does not play a role at all in the TREVI discussions. Politicians and the public have begun to compare the position of the Maghreb countries vis-à-vis the Community with the position of Mexico vis-à-vis the United States. Such comparisons are, I believe, all based on fear.

Mobility

What can be said about the intra-European migratory movements of unskilled labour after 1992? Three sets of factors play a prominent role in the process of migration.

Political factors

There is evidence that changes in policies of individual countries, whether they involve tightening up or liberalising of measures, do influence the flows of migration from one country to another. But with the creation of free circulation zones, such as the Common Market and the Common Nordic Labour Market, differences in policies between the member countries are fading rapidly. Theoretically, this means that harmonised policies could lead to the neutralisation of migratory movements. But there is more to say here, based on the history of the Common Market.

The enlargement of the Community in 1973 (with the entry of the UK, Ireland and Denmark), in 1981 (Greece) and 1986 (Spain and Portugal) gave rise each time to fears of uncontrolled migration flows of mainly unskilled labour. It was expected that people from under-developed regions in the South of the Community would migrate to the more developed regions in the North. This turned out to be a false expectation, as the figures clearly show. There was indeed a general increase in mobility within the Community. However, South–North movement declined, while North–South movement and movement between developed countries increased.

Furthermore, there is evidence that the intensity of migration is determined by developments in the labour market. Political measures to bring about the free movement of workers are by themselves not sufficient to set into motion great flows of migration, but they can open the way to the supply of foreign labour in times of labour shortages. The same could be said of the situation in the member states of the Common Nordic Labour Market.[8]

Economic factors

There is a continuing or reviving demand for labour in

certain sectors and a specific demand for manpower to perform unskilled and socially disparaged tasks. This is also one of the pull factors of irregular or clandestine migration. The concentration of irregular foreign workers is largest in sectors where activity is affected by marked seasonal fluctuations and where there are many small establishments offering generally unskilled or arduous work. These sectors are in almost every EC country limited to construction, the textile industry, farming and services – among which catering, the hotel and tourist trade and cleaning predominate.

The use of unauthorised foreign manpower should not be regarded as merely a resurgence or simple continuation of older forms of manpower exploitation. Current practices seem to relate to new forms of labour organisation and manpower management.[9]

Particularly important is the so-called dual labour market, the functioning of which is no longer restricted to the aforementioned economic sectors. In one segment of the labour market demand and supply are directed towards skilled and reasonably paid jobs, and legal procedures are observed. In the other segment demand and supply are directed towards less skilled or unskilled and low paid jobs, and legal procedures are circumvented. In this sector you will find not only irregular migrants but also legally resident migrants and indigenous workers. This sector continues to gain in importance and is no longer merely an illegal fringe activity. The so-called formal and informal economies and the grey area in between them are interlinked, as a consequence some would say of the new demands of competition to be met by developed industrialised countries.

Owing to the high rates of unemployment in almost every EC member State, indigenous and migrant workers are more and more inclined to accept work that is below their own standards, qualifications and aspirations. This, coupled with the fact that in every EC country there is a small reserve army of migrants in irregular situations, makes it highly unlikely that after 1992 we

will see an increase in the flow of unskilled labour. What we most probably will see is an increase in the small flow of skilled labour from developed EC countries to less developed EC countries and between developed EC countries.

Social factors

It is well known that in every EC country communities of immigrants together provide a framework for the assistance, reception and let us say even the recruitment of newcomers. Many of these newcomers will try to find their way into the labour market, but if they do find a job, it is likely to involve unskilled work, even if the newcomers are qualified for better work.

Here we must make a clear distinction between family reunification through legal admittance and the reunification for whatever reason, not always legal, of fellow countrymen. The former factor, as stated above, is largely responsible for the observed increases in the immigrant population, and the lifting of the internal borders will have nothing to do with this. The latter may become easier after 1992, but we must bear in mind that an end will come to the capacity of absorption of new immigrants within the aforementioned framework. Moreover, protracted residence will be difficult without coming into contact with the various public or private services which are entitled to ask for residence and work permits and may report their findings to the police.

Europe – to become an economic and social fortress?

I now come to my final remarks and conclusions. I do not think that the 1992 operation as such will have an impact on the size of the flows of unskilled labour from one country to another. Only the prsent small-scale

exchange of unskilled labour between the member states will be faciltated. This is a great advantage for the persons involved.

The problems lie elsewhere. The outcomes of the TREVI discussions have so far given the impression that migration policies will be more restrictive than ever. The development of a common Community immigration and refugee policy will probably mean settling for the most restrictive of the current policies of the individual member states. This will make it more difficult for non-EC nationals to enter any EC country, even for those who want only to pay a short visit. Moreover, it will be difficult for non-EC nationals legally residing in a member state to travel freely throughout the Community.

The lifting of the internal borders will mean a greater reliance on internal immigration controls, including state checks at the workplace, in hospitals, schools, social security offices and by the police. It will lead to increased checks on people assumed to be immigrants.

Finally, I would like to point to the fact that the EC and its participating member states are not able or willing to cope with the gap between rich and poor countries and to put an end to the many wars and oppressive regimes in the world. I do not want to over-estimate the role the Community can play in world affairs, but I am convinced that the Community can do more than it does now.

Migratory movements are to a great extent caused by poverty, oppression and violence in the countries of origin. The Community must face this fact and accept its responsibility by tackling the root causes of migration. I have my doubts as to whether the 1992 operation is a step in that direction or in the direction of the shaping of an economic and social fortress. The results of the TREVI discussions have so far given the impression that migration policies will be more restrictive than ever.

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3

MIGRATION AND HEALTH: AN OVERVIEW

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Introduction

The theme of this publication is the challenge of 1992 and the implications for health of labour migration within that context. By health, we clearly mean both the WHO definition of health for the individual, and the traditional concerns of Medical Officers of Health for the well-being of the communities in their charge. To this we must attach a concern for the interests of those charged with delivering 'health care', which includes both staffing and service delivery issues. Necessarily, some of these issues will be connected. Quite apart from anything else, the financing of welfare state systems is predicated upon a 'closed' economy[1] – labour movements may require trans-border flows of funds. Further, migrants may present unfamiliar – or even threatening – conditions; they may suffer from the effects of migration and the disadvantages attached to the status of 'migrant labour' (compounded by cultural or ethnic and racial differences). Health maintenance services may be poorly attuned to these demands, or require staff who are trained or otherwise competent in the cultures and languages of the migrants. Health workers themselves may come from the migrant group, and management may then have to

attune itself to changes in its workforce. My theme will be the first part of this catalogue but cannot be complete without some reference to the changes that will be required in the system of 'care delivery'. The manpower consequences will be discussed later.

Migrants, health services and health

The question of migration is equally one which demands definition. I take it we here are referring to the movement and settlement of workes and their families across national borders. Regrettably, the movement of labour has historically been linked with opposition, and even downright hostility, from the resident (I dislike the term 'host') community. This does not always have to be expressed in outright ways. A degree of latent prejudice against 'foreigners' can be detected even in practitioners' textbooks about 'port medicine':[2] incomers had to be screened for the presence of tuberculosis, veneral diseases and so on, and then taught how to appreciate the more hygienic ways of the society they were entering together with the arcana of how precisely to obtain the benefits of the supportive and caring welfare system, its preventive and curative services and so forth. Then of course there are accusations of their over-utilising those very services! Or of their not using the preventive services and thus threatening the herd immunities. Yet such research as has been conducted actually seems to me to deny all of these stereotypes.

Migrants are a selected population, generally healthier and younger than their source community, and (it is said) more enterprising and able, in that they have managed to overcome the barriers to their travel. Consequently, there are considerable difficulties in researching their health, over and beyond the normal difficulty that we face in collating national data on this subject; in particular we have no satisfactory 'denominator' of expected values. Clearly a focus upon mortality is

of interest: classic studies of Japanese Americans have had their impact upon our approach to coronary disease, for example.[3] However, such studies are flawed by their reliance upon 'country of birth', by the significance of 'cohort of migration', and because they cannot tell us about the majority of ill-health which is expressed as 'morbidity' rather than death. Nor do they explain (or explore, in most cases) the relationship with health service delivery, and the frequent observation that migrants 'fail to use' services as those who deliver them would like. When they fail to use services, it is frequently because they have not had them explained adequately, or because those services are irrelevant to their needs, or inaccessible. When they do use services, it is because their situation places them in jeopardy through poor housing and relatively hazardous employment, or because, being younger and so on, they are in the fertile years of family creation. Sometimes of course migrants have services forced upon them – but that brings us back to where we started.

Given our focus on the issue of migration within Europe, perhaps I may be forgiven for leaving aside the question of 'imported exotic disease' and its control: I do not think migrant workers present any more risk in this respect, than the millions of tourists and business travellers, and certainly the data on such hazards as malaria, AIDS and cholera would substantiate this view. One disease which does appear to be significantly more common amongst migrants, tuberculosis, is found on analysis to be contracted locally rather than being imported, and its raised prevalence is linked to poor living conditions in Britain.[4] Nevertheless, there are reasons for concentrating upon the health situation of the so-called 'Thirteenth State', the fifteen million or so migrant workers of the European Community, whose numbers may well increase and whose distribution will certainly alter after the implementation of the 'Single European Act'. The situation with regard to the two million or so EC national migrants and their three million

dependants may also concern us: at least some of these may form or belong to ethnic minorities and suffer the effects of racism.[5]

Migration, stress and mental health

One theme above all others stands out in the literature on migration and health – even though it has to be admitted that the results are peculiarly inconclusive. This is that the experience of migration may predispose to mental disorder – indeed, the term 'nostalgia' was originally coined for this process. Depression, schizophrenia and alcoholism have all been described as features of migrant communities. Yet at the same time, other studies have found lower than expected prevalences of at least the first two of these conditions.[6] Manifestly, migrants may suffer from deracination, 'culture shock' and alienation, perhaps arising as much from the response of the society in which they find themselves as from internal processes. Equally, they will be isolated from their 'traditional' support mechanisms, familial and religious; yet they will struggle actively to recreate these forms of support; or substitutes for them.

Migrant labour, deprivation and illness

Other areas of importance include the socio-economic or labour-force position of migrants. Most notably, are generally concentrated in the most hazardous and undesirable jobs, housing, etc. These facts have implications for occupational health as well as for the public health worker.[7] The problem for the practitioner is that many, if not most, diseases are multi-factorial in their aetiology, and it is hard to know which factors are most amenable to intervention. A simple example may suffice: the case of rickets or osteomalacia. We know that this was a disease of the British slums before the World Wars

– and that it has resurfaced among British Asian populations. Low exposure to sunlight, clothing which screens from the sun, poor housing (small windows, no gardens) all contribute; but do does a diet high in fibre, especially chappati flour, and low in fortified margarine. Fortification of 'Asian' foods was ruled out by the Department of Health, which saw the solution in terms of vitamin drops and glossy leaflets. Certainly cultural and linguistic diversity will demand a response from the health education service which must include a sensitivity to the constraints of poverty as well as to cultural or religious preferences in diet. But we must also be aware that the process of migration brings new challenges to health – new or at least unexpected allergies, and unsuspected susceptibilities, which will require sensitive explanation to the patients and their families. At present, however, the provision in Britain of 'ethnically sensitive' (or at least translated) leaflets leaves much to be desired,[8] and the availability of appropriately qualified interpreters has yet to be considered a priority.

Migrants and health service delivery

Sensitivity, communication and understanding also arise in respect of the consultation and in the provision of direct medical services. While I have in general been sceptical about concentration on 'ethnic specific' diseases or studies of migrant mortality, there is some sense in the practitioner being well informed about such exotica: most doctors do know for example that 'Mongolian Blue Spot' should not be confused with bruising from child abuse. Perhaps fewer expect relatively high rates of liver or oesophageal cancer among migrants from the Indian sub-continent (including those of white British descent); and the problems of the haemoglobinopathies affecting migrants from most of the New Commonwealth (including, in this context significantly, the Mediterranean) will have their implications for diagnosis, and treatment. Per

contra, MS is common among German and Polish migrants but exceptionally infrequent among most black migrants.[3] However, there is more to health care than knowing about diseases!

The issue of 'ethnically sensitive' health education information, and interpretation, has been alluded to already. There is, it is true, an argument that written translation into minority languages is of itself no great advantage. Certainly studies of Asian migrants have demonstrated that literacy in Urdu, Gujerati, Panjabi, etc. is frequently coincident with literacy in English. Translation is however a way of showing the importance that the service places upon respecting minority culture, and a way of raising the possibility that the information may be discussed in family or community settings, if the translations are competently done. Equally as important is the need to pay attention to content, to pictorial presentation, and to availability. The same argument applies to services such as the 'well woman' clinic: if women work, or cannot come to a clinic unaccompanied (whether for reasons of culture or transport or fear of attack), timing and advertising must reflect these constraints.

Many migrants live in inner city areas, where there are problems of supply: poor recruitment of community nurses or health visitors; difficulties in attracting new GPs to practice, assaults on GPs carrying out visits; closure of hospitals and reallocation of resources following falls in population levels. All of these too affect access and uptake. Further, the evidence is that presently proposed changes in the NHS, through the White Paper and the new GP contract, may accentuate these difficulties. Migrants and their descendants may provide some solutions if health service recruitment and training opportunities are targeted upon these communities – but this will only be equitable if such workers are able to progress within the health service and are not confined to the lower grades of employment. Too often this has not been the case – and this may explain the reluctance

of, for instance, Asian and Afro-Caribbean young people to enter nursing as a career.

Involuntary migrants – and unwilling hosts

Finally, we cannot leave this discussion without reference to the situation of refugees. Recent headlines have reminded us how topical this issue is. While certain groups are seeking to prevent the accession of refugees to the Community, it needs to be recognised that there are many communities of refugees 'already here', and that others will come – and given a frontier-less Europe, many may move to places which have not previously met them. Certainly at present the majority of refugees in Britain settle initially in London. It might be as well to consider how we might improve our ability to meet the needs of refugees already in Britain,[9] as other European countries are doing.[10] For such groups, attention to language, housing and mental health problems is essential, together with recruitment of staff from within the groups, to provide understanding and deliver support.

The objection may be raised that I have not spoken about the migration of, let us say, French railway workers, Dutch teachers, or 'Auf Wiedersehen Pet' British builders: yet I would argue that in fact the situation of workers such as these will be improved if we take on board the issues that I have raised. The fact of the matter is that racism, or ethnocentricity, makes for bad medicine. If we develop a system that delivers for minorities who are discriminated against on the basis of belonging to a distant culture or having a far-off geographical origin, especially one demarcated by phenotypical differences of appearance, then we shall be better able to cope with relatively minor differentiations. If we do not, then even minor variations in presentation may become new shibboleths, new barriers to the receipt of adequate and equitable service.

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4

CASE STUDY OF A LONDON MIGRANT COMMUNITY

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Introduction

The association of migration with ill health is well known.[1] It would appear that, in spite of the so called healthy migrant effect, the stress of migration combined with the social and economic disadvantage which is so frequently the lot of many migrants on arrival in a new country can lead to both physical and mental ill health.[2] Thus, the health risks of migration may affect the migrant far more than the host community. A case in point is that of tuberculosis which, in Britain, is known to be significantly higher among migrants from the Indian sub-continent.[3] For a long time it was believed that this was a consequence of infection acquired in the home country, but the evidence is that it is far more likely to be directly linked to conditions of poor housing, over-crowding, and poverty in Britain.[4]

It is not altogether surprising that migration should exert these adverse effects on health, if one considers the typical history of migrant workers, who, in Britain, form the vast bulk of immigrants. The two major ethnic groups – Asians (which in the British context means people from India, Bangladesh, Pakistan and Sri Lanka) and Afro-Caribbeans – came to Britain from the 1950s

onwards to work in unskilled and unpopular jobs. They found themselves living in poor and dangerous parts of the inner city, with sub-standard housing, an insanitary environment, and when employed, working long hours for poor pay. They suffered from isolation, loneliness, and racial discrimination and harassment. When they were later joined by their spouses, it was only to subject these to unaccustomed work outside the home and to social adjustment in a situation where the wives had never had a public role and could not speak the language. Later, as the second generation grew up in the new country, there were the added problems of inter-generational conflict, where the parents wanted to preserve their traditional culture and the children wanted to integrate into the adopted society.[5] Given this cocktail of circumstances, it is not difficult to see how illness can ensue. Not that social deprivation has been the lot of all such immigrants into Britain. It must be said that many, particularly among the 'Asians', have succeeded in gaining material benefit and public standing in Britain, a trend which is almost certain to be continued by their descendants.

The issue of migration and health is likely to gain more prominence against the background of the Single European Market, to be completed at the end of 1992. As is well known, the Single European Act provides for the free movement of goods, services, capital and persons across frontiers. It is the last which is of particular interest here, since an increase in labour mobility between member states will lead to an increase in migration. There is no general agreement on the size and composition of this migration, and the accepted view is that it will involve mainly the skilled and professional sectors of the workforce. This view, however, is not based on specific studies and projections, and there is a degree of obscurity about the eventual outcome after 1992. The EC Commission argues that the number of migrant workers in Europe is declining and that migrants who have already arrived are unlikely to wish to disturb

their local residence and employment patterns by further migration.[6] However accurate this view may be, it does not resolve the question of labour mobility. For example, the differential opportunities for economic development in the EC will inevitably imply a demand for both skilled and unskilled labour. It would be surprising if unemployed or poorly paid workers in one EC country did not try to improve their lot by seeking work in another, even if transiently. More importantly, there is the effect of the demographic factor. Population growth rates in most European countries are already low, and are projected to decline further, and this will result in a net fall in the indigenous labour force in the foreseeable future. This must inevitably lead to a demand for young labour from among the so-called Third Countries, such as Turkey and Morocco, where the birthrate is considerably higher. Nor do the projections take into account the possible increases in illegal migrant workers, and temporary or seasonal workers.

The point here is that an increase in migration of unskilled workers, whether legal or not, temporary or permanent, will have important consequences for the health of migrants and for demands on the European health services. Furthermore, new migration movements will adversely affect existing migrant communities, particularly in major cities such as London. For all these reasons, no European health service can afford to ignore the potential change in migration patterns that might occur in the decades after 1992.

A London migrant community

Between 1987 and 1988 the author carried out a survey of the London Moroccan community. The Moroccans in Britain are mainly concentrated in London, and within London the vast majority live in the North Kensington area, which is new the city centre. Most arrived during the early 1970s as a result of specific recruitment for work

in the catering industry. The Moroccan community in Britain presents a fascinating subject for study, in that the great majority originate from a specific region in the north of Morocco, around the coastal town of Larache, and have ended up living in an equally specific part of London, in close proximity to each other. It was therefore easy to caryr out a comparative study of the community in its place of origin, as the author did in the summer of 1988. Not so easy was the task of studying the population in London, and previous workers had abandoned the attempt.[7] They were reported to be an inward-looking, isolated and suspicious community, fearful of authority and largely inaccessible. Unlike many other immigrant groups in the UK, they had no past colonialist link with Britain, and therefore had no shared language or familiarity with British institutions. There was an awareness on the part of health and social workers that they had considerable problems of adaptation, communication, and family breakdown, but few hard facts were available owing to the lack of research into the community. At the start of our study, therefore, they presented a considerable challenge.

This was a door-to-door survey with a questionnaire administered by three field workers, two female and one male. The total number of the community in London is not known, but is probably between 5,000 and 10,000. We were only able to sample 71 of them before the difficulties of continuing the work became prohibitive. Nevertheless, these interviews, which were very exhaustive and lengthy, provided valuable information from which to draw a picture of the community. The main features which emerged were virtually identical to those found by researchers who had studied Moroccan migrants in other European countries.[8] Local GPs, health clinic staff, school nurses and midwives were also asked for their views of the community. Respondents were asked for demographic details, and about their health and health beliefs; they were also asked about their use of some health services and their opinions of the

services. The results showed that this was a profoundly isolated and unintegrated community. The atmosphere and way of life in the North Kensington streets where they lived was far more evocative of a Moroccan village than of an inner city area of London. They planned their whole year around the annual summer holiday in Morocco, and they saved their earnings in order to invest them there. There was considerable inter-generational conflict, the children being more integrated into British society and beginning to reject their parents' values. Educational standards were poor, with a 48 per cent illiteracy rate and poor English. They lived in housing provided by the local council, and worked in semi- or unskilled jobs in cleaning, catering and portering.

As to health, there was a high degree of minor illness, for which they frequently consulted the GP. Unlike some other ethnic groups, they did not self-treat, although about half of them said they used simple traditional herbs for medicinal purposes. There was a high incidence of depression and anxiety, particularly among the women. There was also a high hospitalisation rate, although why this should have bee was not clear. Workers who have reported the same finding among other Moroccans in Europe have speculated that it may be due to a preponderance of single men, poor socio-economic status, and an increase in accidents at work.[9] There was little chronic or serious illness among them.

The main problem in using the National Health Service was communication and understanding the system. This was particularly the case for women, who relied on relatives, usually small children, to act as interpreters. The fact that this was an unsatisfactory solution was reflected by the universal desire of the people interviewed for interpreters and someone to help them understand the system. Many also requested women doctors or Arabic-speaking health staff. These difficulties in communication were almost certainly instrumental in limiting Moroccan women's uptake of some of the services. Of 38 women, only 13 had ever had a cervical

smear test, and the rest did not understand the question. Likewise, half the women had never heard of breast cancer screening. A third did not register at the ante-natal clinic until after 16 weeks. But the uptake of mësles and pertussis vaccine for children was high, at 89 per cent and 83 per cent, respectively.

Supernatural mechanisms played an important part in the causation of disease. For example, the majority thought that God's will was the cause of infertility, and the rest put it down to a spell. Insanity could be brought on by spirit possession, as was another disorder known by the name *laryah*, which manifested itself in epileptic seizures. Nearly half said they believed in the evil eye, which could cause a variety of ills, including bankruptcy, fever, family problems and death. As might be expected, the remedies for these illnesses were also magical or supernatural. Chief among these was the visiting of holy shrines in Morocco, and consulting the *fqih* or religious healer. Fumigation was also practised for the treatment of the evil eye. These beliefs and practices did not seem, however, to cause any harm or to interfere with their readiness to consult their GPs.

Conclusions

This survey serves to illustrate the conditions of a typical migrant community living in Britain. There was a marked lack of integration into British society. A significant minority did not speak English, and most spoke it poorly. The uptake of preventive health services among women was inadequate, and the reasons for this need elucidating. It may reflect a difference in attitude towards preventive medicine as a concept, as noted in other ethnic groups.[10] For example, as some of the Moroccan women in the survey told us when asked about attendance for screening, 'If I'm healthy, why should I go?' The reluctance to book into the ante-natal clinic may indicate a cultural attitude to pregnancy,

whereby this is viewed primarily as women's business in which formal institutional arrangements do not feature.

Considerable health education would be required to alter these perceptions, and the task among communities with such cultural and linguistic disparity will be enormous. Conventional methods, based on written material, are obviously not useful in a situation where illiteracy is a factor. In addition, there are cultural differences of perception and belief which transcend language. This community had distinctly non-Western ideas about health and disease; on the evidence of the survey, this seemed to have done no harm, yet a potential threat clearly exists.

A serious consequence of the present situation is that migrant communities such as this may well lose out in failing to take up some services. One simple example of this that emerged from the survey was the poor uptake of iron and vitamin supplements during pregnancy. Moroccan women could not see the relevance of taking tablets for a 'normal and ordinary' condition such as pregnancy.

Although we did not specifically inquire about AIDS, it is important to assess the degree of understanding among such communities about this condition and its prevention. The thrust of health education, in Britain at least, has not taken into account the special circumstances of many migrant groups.

It is obvious from the foregoing that the health problems migrants face are not confined to their initial entry into the new environment, and may persist for decades. Quite apart from any threat they may pose to the host society, in terms of imported disease and demand on the health services, they are themselves at risk from ill health because of differing culture and problems in communication. Any programme of health care, including health education, needs to take all these factors into account.

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5

MEDICAL MANPOWER AND MEDICAL EDUCATION AFTER 1992

Douglas Gentleman, Member of the Standing Committee of Doctors of the European Community

British doctors of my generation regard themselves as Europeans, and most thinking people in this country welcome the economic and social opportunities offered by the completion of the internal market in 1992. However, it will have no direct effect on medical manpower or education, and little impact on the movement of doctors between member countries of the Community. Doctors already enjoy the right of free establishment anywhere in the EEC, through the 'Doctors' Directors' of 1975. Few have exercised this right: in 1987, only 8,000 out of 750,000 dcotors in the nine EEC countries for whom figures were available had migrated from another EEC country (see Table 1). Does this reflect practical difficulties, or is it a question of attitudes?

Three factors are involved. The first applies particularly to the UK, and is the problem of language. Few British doctors are fluent enough in another EEC language to make it practical for them to migrate. This reinforces a general reluctance to move away from what is familiar, an attitude which will only be modified when we start to attach proper importance to foreign language fluency.

The second problem is the relative silence of the Treaty of Rome on health matters. The founding fathers of the EEC left health largely in the hands of the national

Table 1. *EEC authorisations of medical staff, 1983*

		Number from other EC countries		(*Approx*) total new entrants
FRG	1,011		5,000	
France		58		5,000
Italy		20		15,000 (?!)
Netherlands		28		?
Belgium		15		6,000
Luxembourg		7		?
UK		557		3,500
Ireland		35		400
Denmark		9		700
Greece		12		1,000

governments, and successive Commissions and Councils of Ministers have been content with this arrangement. Even the 1975 Directives made no provision for co-ordinating the right of access for doctors to practise in social security systems. There has never been a Directorate of Health in Brussels, and such responsibilities as the Commission has are dispersed over several Directorates: public health issues, the right of establishment, educational matters, etc. This disjointed approach to health took its first knock with Chernobyl and its second with AIDS; the realisation that pollution and infection respect no frontiers has helped to alter thinking, at least in public health. However, there is no plan to give the Commission powers in the organisation and delivery of health care.

The third factor is demography. The number of doctors in the countries which now form the EEC has grown far faster than the general population, from 101 doctors per 100,000 people in 1950 to almost 300 today. This has resulted from government social and educational policies; the economic growth of the 1960s which made these possible; technical advances in medicine; the growing demand for medical care from an increasingly

well informed and ageing public: and the high demand for medical school places. In many ways this expansion has been a good thing; more people have greater access to a higher standard of medical care now than in 1950. But there is a price to pay. Too many doctors are being produced relative to our capacity to use them, leaving aside any arguments about social need. Over-production raises issues of resource utilisation and quality of training, by diminishing opportunities for employment and promotion, reducing the experience of each working doctor, and fostering covert or overt protectionism. Doctors, especially young ones, become reluctant to be 'different', and only migrate when local employment pressures or salary differentials become very high, as we are now seeing with young German doctors working in the UK on short-term contracts.

The problem is unevenly distributed throughout Europe, and is worst where access to basic medical education is or has been unlimited, and where no attempt has been made to plan future manpower supply to match anticipated demand – admittedly an imprecise art because of the long time-scale involved. During the 1970s, some Italian medical schools had 2,000 students in the first year, and one in every 300 Italians was a medical student! By contrast, in countries which have always strictly rationed access to basic medical education, such as the UK, the over-supply is on a much smaller scale. The pendulum is now beginning to swing the other way; medical school applications are down in several EEC countries, as medicine comes to be seen as a less rewarding and more demanding career than before, and able school-leavers are attracted to other fields. Nevertheless the excess of doctors in Europe will be a problem for at least another 50 years.

Previous attempts to achieve co-ordination of medical manpower planning at an EEC level have failed, even when well intentioned and backed by the profession and some politicians, mainly because there is no framework for co-ordination within Community legislation. So

serious has the problem become, with its enormous potential implications for the maintenance of professional competence, that the Commission may soon have to review the 1975 Directives in this context.

In medical education there are naturally many similarities throughout the EEC, especially at the undergraduate level. There are also important differences, for example in the amount of exposure to clinical bedside teaching. Postgraduate medical education also varies widely in organisation, duration, content – and it has to be said – in standard. The Advisory Committee on Medical Training of the EEC has advised the Commission for some years on the harmonisation of training requirements, and minimum standards have been agreed. These now need to be looked at again. The glut of doctors in western Europe is posing a threat to the maintenance of professional standards, as doctors who do less than a certain amount of profession work suffer atrophy of their skills and a fall-off in their performance. Another important factor is what might be called heightened consumer awareness, where the young doctor is the consumer and the product is postgraduate medical education itself. Complaints are numerous and increasingly focussed on three areas: the short time which some senior doctors spend teaching and supervising the junior; the excessive hours and oppressive working conditions which often submerge education beneath service demands; and the haphazard, inappropriate, and often unfair methods of assessment which give the senior doctor vast power over the future of the younger one. These problems are being taken more and more seriously by the profession itself.

What would stimulate the migration of doctors across EEC frontiers? I am optimistic that migration will increase, especially among the doctors of my generation, who are well aware of the educational and mind-broadening opportunities it offers. It is no coincidence that the initiative to set up one of the first workable trans-national exchange schemes for young specialists

has come from the European organisation which represents young doctors. If 1992 will have a significance for the movement of doctors across European frontiers, it will be because it helps to break down mental barriers and stimulates debate about the changes which are necessary in medical manpower and education.

6

THE IMPACT OF LABOUR MOBILITY ON NURSING MANPOWER AND NURSING EDUCATION

Dame Sheila Quinn, Past President, Royal College of Nursing

Introduction

The two EC Directives on freedom of movement and mutual recognition of nurses responsible for general care were agreed in 1977 and implemented in 1979. The minimum content and duration of training were agreed by member states, and are linked to the directives as an annex. Nursing education throughout the member states has definitely been affected, but greater changes have occurred within individual member states, such as our own 'Project 2000'.

The Advisory Committee on Training in Nursing (ACTN) has made recommendations for separate directives for psychiatric and paediatric nurses, and these are on course for agreement before the end of 1990.

With major changes ahead in the field of nursing education, ACTN needs to look carefully at the training annex to the general care directives to establish whether it is still relevant. Work is already in progress on the primary health content in basic nurse training.

Movement of nurses: the current position

Movement of nurses was not significant in the first few years for various reasons, including lack of employment vacancies, language difficulties, and differences of professional attitudes. Migration has increased gradually: the figures given in Table 1 are of nurses moving into and out of the UK during the year 1988–89. By far the greatest number moved from Ireland. This is a traditional movement, although figures have only been available since the Nursing Directives came into force. Movement into the UK was largely from Denmark, West Germany and the Netherlands – countries where fluency in English is common – and again, we have always received some nurses from these countries. Movement out of the UK involves about half the number of incoming nurses. Most countries are now short of nurses, so employment opportunity are opening up. While the figures are small compared with the number of nurses in the EC, there is a definite upward trend, and the new generation of nurses is more interested in moving into Europe. On the

Table 1. *Movement of nurses into and out of the UK, 1988–89*

Movement out of the UK	*County*	*Movement into the UK*
1	*Belgium*	*14*
6	*Denmark*	*30*
170	*Eire*	*425*
10	*France*	*9*
7	*West Germany*	*54*
1	*Greece*	*1*
0	*Italy*	*5*
0	*Luxembourg*	*2*
19	*Netherlands*	*42*
1	*Portugal*	*1*
16	*Spain*	*3*
Total 221	*Total*	577

whole they are tooking for two or three years experience in a different country, and most return to the NHS. The experience they gain, however, is not always considered valuable on their return, and some find that their career suffers a set-back.

The New General System

Sectoral directives for the health professions have been cumbersome and lengthy in negotiations. A new General Educational System has now been agreed, and will take effect at the beginning of 1991. It will allow anyone with a professional diploma after higher education of three years to work anywhere in the EC. A second similar directive is proposed for diplomas involving less than three years of study.

There has been discussion as to whether nurses other than those covered by the General Care Nursing Directive should be able to move under the new General System, but even if nurses are deemed to qualify through their three year diploma, it seems to be an unnecessary complication.

With the exception of specialist psychiatric and paediatric nurses, and those caring for the mentally handicapped, who can in some countries, including our own; obtain the qualification and right to practise through a basic programme, all other nursing specialities are dependent upon a general nursing qualification.

Nursing is one profession and cannot be broken up into a collection of professions. (Midwifery is recognised as a separate profession, and has its own Directives and Advisory Committee.)

How will 1992 affect nursing?

The Medical Directives 'Article 8' provides a 'catch all' for future specialities not already included in the Directives.

There is a need for a similar statement to be made for nursing before the end of 1990. Manpower – who knows? There has been minimal movement to date, but publicity about the internal market could arouse a lot of interest. A figure of 13 per cent has been mentioned, but there does not appear to be any sound basis for this assumption. If there should be a large general movement of manpower, women may take advantage of the opportunity to move with their families and continue in their profession. On the other hand, there will be equal opportunity to recruit from other member states, as in the current initiatives in Spain.

We already have serious manpower shortages in nursing in the UK, and this will worsen over the next few years. It is unlikely that movement within the EC after 1992 will affect our situation greatly in either direction. There is some indication that Districts are moving into the type of recruitment overseas that was in vogue in the fifties and sixties. But many other countries also have severe nursing shortages, and are interested in recruiting from the few countries not affected in this way. The only really effective way of improving our own situation is by dealing with it within the country. There are a number of measures which Districts are being urged to take, such as recruiting more men and more mature students, encouraging 'back to nursing', and widening the entry gate. An important move is to train a new category of 'support worker' to assist the nurse. Another measure worth investigating is to encourage young men and women from ethnic minorities, who could fill a valuable role in working as professionals with their own groups – a need that has been identified.

As regards nurse education, we are about to launch Project 2000. The proposed content and structure of training will be well above the minimum required by the Directives, and much interest is being shown within other member states of the EC.

7

LABOUR MOBILITY AND 1992

Ron Keating, Assistant General Secretary, National Union of Public Employees

Introduction

The Single European Act offers freedom of labour movement within the EEC. Employed EC nationals already have the right of movement among other EC states, but a range of measures is proposed to transform this paper entitlement into a real one, including mutual recognition of qualifications and the harmonisation of income tax provisions.

It is very difficult, if not impossible, to forecast with any confidence the impact of the 1992 provisions for labour mobility on ancillary staff in the NHS because there are so many factors that will have a bearing on the labour market as we go into the 90s. For example, everybody acknowledges that there are likely to be considerable shortages of labour as the effects of the falling birthrate are felt. We have seen the movement in Europe of East Germans entering West Germany, and also ethnic Germans from Poland and the Soviet Union. This is obviously going to have some impact on the labour market in West Germany, with possible repercussions in other EC countries. At the present time the Government is refusing to give right of abode to people from Hong Kong, but it is possible that this might change, or at least loosen up. Coming closer to home, there are the implications of hospitals opting out. All of these factors will have an effect on labour mobility as we go into the single market.

Britain a magnet for EC labour?

Will Britain act as a magnet for EC labour? I suspect 1992 will show Britain to be the cheapskate, the underpayer of Europe. A Low Pay Unit survey found a generally high and binding level of minimum wage provision amongst our partners. Britain ranks (with Greece, Spain and Portugal) firmly in the second league. Only Spain ranks below. We compare shabbily with our neighbours. At Purchasing Power Parity, the UK gives those on minimum wages a paltry £338 per month, compared with France, £411 per month; Holland, £529 per month; and Germany, £653 per month. Wages in the UK ancillary sector are notoriously poor. With an average wage of £92 per week and hourly rates barely above £2, I hardly think that labour is going to swarm towards this island at the prospect of high wages.

The as yet nebulous and increasingly diluted social charter, offers hope for our ancillary staff, as it entails levelling up. Measures which have been fiercely resisted by Downing Street, like contract compliance, may become law via Brussels. Tenders – like that of Dystart in Glasgow, who won health contracts by offering ancillary workers a princely £1.60 per hour – will, hopefully, become a thing of the dark and dismal past.

Let us be topical and look at the ambulance service. International comparisons are not always straightforward, but in West Germany, ambulance staff – *Rettungsanitater* – cover a similar range of duties to their UK counterparts, namely, transporting patients and providing paramedical assistance. Working a 38.5 hour week, the basic ambulance grade is paid 34,562 DM per year. (This excludes overtime, which unlike in Britain is paid at above the basic rate.) At current exchange rates this works out at £10,800 a year; even after accounting for their higher cost of living, this rate is far higher than Britain's (£10,093). British ambulance staff earn 16 per cent below UK male average earnings.

We contrive to see an ever-widening gap between

people doing the same jobs in local government and the health service, with ancillary staff in the health service being £16 or £17 per week disadvantaged compared to their local government colleagues.

Other member states a magnet for UK labour?

This leads to the second question: How far will the richer EC countries prove to be a magnet for UK labour? Presently, we are embarking on formalisation of skills and experience with *NVQ* for ancillary workers. This will enable qualifications to be readily compared between member states, making the process of mobility easier (although UK NVQ's are liable to be pitched, initially at least, at lower levels than elsewhere in Western Europe).

Other EC nations pay higher wages and may better these as they are even more severely affected by the demographic time-bomb than the UK. But how alluring is this prospect?

Labour may prove to be more immobile in the ancillary sector than elsewhere. Language difficulties apart, with a typical worker being part-time, frequently a married woman with family commitment, one wonders whether better wages and so on will be sufficient to pull such workers across nations with all the upheaval this entails.

There may be political difficulties also. We are seeing the rebirth of extreme right-wing nationalist parties, especially in France, Norway and Germany, and any period of econoimic instability could provide fertile ground for such parties. Reactionary governments may impose restrictions on the movement of non-EC labour, particularly the movement of workers from the new Commonwealth and the Philippines. There are presently some 16 million non-EC nationals living and working in Community countries.

Conclusion

While there are many uncertainties which will affect the impact of the single market on employment, there is little doubt that we are entering a period of labour shortage, which means that the NHS must grasp the importance of development training of support staff as the only way of making the best of existing resources. This in turn must lead to a level of remuneration which will help to retain and recruit labour.

Printed by The College Hill Press Ltd, London and Worthing

The Single European Market is almost upon us, when we will experience freedom of movement of goods, services and people between the Member States of the European Community.

For the health service, this has two main concerns. First, the possible increase in the migration of unskilled labour will effect the health of those migrants and migrant communities already in Britain, and second, the potential increase in the numbers of health workers seeking employment in the NHS would have serious implications for the current NHS workforce.

This dimension of the changes after 1992 had not been sufficiently explored until this conference, when experts from Britain and from Europe gave their predictions and perspective on this issue.

The papers collected here represent an authoritative source of debate and information in a very poorly documented area.

ISBN 0-903060-90-6

9 780903 060905

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