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Raymonde Séchet et Despina Vasilcu

Physicians' migration from Romania to France: a brain drain into Europe?

- 1 Even if only 3% of the world's population are involved in international migration (Wihtol de Wenden, 2009), this international migration now concerns all social groups, among which elites and highly skilled workers. The most frequently and for a long time covered by media and researches have been physicians' migrations, probably because they have specific human and ethical dimensions. Most studies on health professionals and physicians' migration have either focused on the movement of health workers from developing to developed countries — a movement usually termed as 'brain drain' —, or were dedicated to the contribution of the foreign-trained people to the National Health System (NHS) in UK. Moreover, as observed by Dussault and al. (2009) and Wismar and al. (2011), little has been documented on the extent and impacts of migration and mobility of physicians between Eastern and Western Europe despite their growing significance.
- 2 With the harmonisation of migration policies within the European Union [EU], most countries in Europe have adopted measures to facilitate the entry of highly skilled workers while seeking to prevent the immigration of low skilled workers. This regulatory framework has facilitated the movements of medical professionals from Eastern towards Western Europe, including France where the shortage of physicians was presented at the end of the 1990s as a medical demographic crisis: on 1st January 2010, a little over 10 000 foreign doctors were practising in France, the Romanian doctors heading the list (Romestaing, 2010). For some years now, physicians' outmigration has been a widely debated and mediated issue in Romania, and still more recently these outgoing flows have caught the attention of the Romanian academic community (Boncea, 2014; Dornescu and Manea, 2013; Feraru, 2013). However, they mainly focus on factors that push Romanian physicians to emigrate whereas more individual centred approaches would allow a better understanding of dynamics at work.
- 3 This paper provides a specific overview on physicians' migrations between Romania and France within the context of the EU enlargement. While outflows of Romanian health professionals have been increasing since EU accession in January 2007, France is, with Germany and UK, one of the three main destination countries¹. Romanian physicians now rank first in all foreign medical physicians with a European degree working in France. Why do so many Romanian physicians come to France; what needs are they fulfilling, and to what extent can this migration be regarded as part of the globalisation of healthcare? After two sections presenting the theoretical context and the methodology used for the research, the third part assesses the factors supporting the immigration of Romanian doctors whereas the fourth presents the main trends relative to the place of Romanian doctors in the French healthcare system. In the end their reasons and motivations will be discussed with a view to establish the impact of these migrations on Romania. In providing answers to the questions specific to the study of the doctors' migrations between Romania and France, this paper is a contribution to the comprehension of some major trends in the current physicians' migration. While clearly not generalizable to other parts of the world, migration of physicians between Romania and France is an illustration of globalisation in medical labour markets.

Theoretical Context

- 4 The research on physicians' migration between Romania and France is undertaken in the context of increasing mobility in the EU, in the attempt to regulate the uneven spatial distribution of medical staff in France and in the fear of collapse of the Romanian healthcare system. This migration reflects the global shortage in healthcare that led to a debate on the negative and positive aspects of the migration of healthcare professionals. Globalisation has brought along deep changes to the international mobility of highly skilled workers — a mobility which has been made easier by the circulation of contents, values, teachers,

researchers and students between the academic systems. The American journalist L. Garret (*The Coming Plague: Newly Emerging Diseases in a World Out of Balance*, 1994) usefully contributed to the dissemination of the idea of global health and of the fact that health issues are dependent upon politics, exceeding the scope of medicine. This research also took place into the evolution of scientific debates on international migration.

5 As recalled by Weber (2009), the push and pull model, which see labour flows as the outcome of poverty and development discrepancies, has largely been struck down by almost every empirical study. However, it is with this classical model that Boncea (2014), Dornescu and Manea (2013), Feraru (2013) discuss the two subcomponents of the brain drain: is international migration mainly a consequence of push factors (level of payment and cost-benefit calculation) or of pull factors (professional factors and working conditions in the host country)?

6 Yet, theories of migration have been renewed since Massey and *al.*'s review of knowledge in 1993. Theories that are concerned with migration factors either approach processes related to the global economic and social context (such as the pull and push model already mentioned) or focus on individuals as actors, thus mobilising the social network theory and the conceptual framework of transnationalism and circular migration, *i.e.* temporary and repetitive movements between home and host countries. Appadurai (1996), and more generally cultural studies, invite to look at the world 'from below and elsewhere' in order to nuance the points of view. Theories dealing with what occurs during the migration (migratory experience as existential experience – Weber 2009, p. 62) concentrate less on factors, costs and risks of migration and more on the fulfilment of expectations, and therefore on the professional and social integration, keys to either success or failure. Network social theories are useful to understand how migration redefine social relations initially thought of as sedentary lifestyles (Faret and Cortes, 2009). A last set of theories deals with policies, regardless of their territory of implementation and whether they affect the countries of origin or of destination, and with the way health policies take into account the actors involved in policy reforms, their processes and context as well as the content of reform (Walt and Gilson, 1994).

7 In agreement with Massey et al. (1993) regarding the heuristic scope of integrating different theoretical schemes, we propose to introduce several elements related to social networks and integration in the framework developed by Castles and Miller (2009 — as quoted in Guo, 2010), which allows both to describe contemporary international migration and to explain how migration is related to broader social, cultural and political developments. Castles and Miller identified six trends in contemporary migration that can be used for reading the present international migration of physicians.

8 - As "*globalization*" and "*acceleration*" of migration mean that migratory movements are affecting an increasing number of countries, the physicians' migrations concern both migrations from developing to developed countries and the flows between developed countries, as well as both prestigious professors and general practitioners. Migrations of doctors are affected by economic shocks and by inequalities in socio-economic opportunities (Astor and al., 2005; Brown and Connell, 2004; Okele, 2013).

9 - The "*differentiation of migration indicates that more countries have diversified their intake of immigrants to include a whole range of types*" (Guo, 2010). The number of highly skilled migrants has been growing steadily since the 1960s, in a context of international competition for skilled workers. This skill drain (Brown and Connell, 2004) has exacerbated the debate on impacts of doctors' migration in sending countries. Indeed, migrations of doctors are surrounded by ethical issues (Raghuram, 2009) and have harmful ramifications for society as a whole (Brown and Connell, 2004). While Beine and *al.* (2001) defended the hypothesis of 'beneficial brain drain' *i.e.* 'brain gain', Hagopian and al. (2005) firmly argued that doctors' mobility benefits mainly rich countries at the expense of the poor ones. Lowell and *al.* (2004) introduced the term of 'brain strain' to describe the effect that migration of highly skilled people can have on the sending countries, stating the principle of both positive and adverse consequences.

10 - When speaking of the "*feminization of migration*", Castles and Miller (2009) emphasized that women play a significant role in migrations. Women account for an increasing proportion

of physicians, especially among students completing their medical training. In UK, as early as 2002, about 54% of new full registrants to the General Medical Council were women (Kofman and Raghuram, 2006). Hence, we can no longer ignore gender issues in physicians' migrations.

11 - The growing "*politicization of migration*" suggests that domestic politics, bilateral and regional relationships, as well as national security policies of states are increasingly affected by international migration (Guo, 2010). In the specific case of health migrations, some elements of national and supranational (i.e. EU as well as World Health Organization — WHO) policies must be taken into consideration. Besides the question of the recognition of foreign credentials (Kofman and Raghuram, 2006; Raghuram, 2009) and of devaluation of cultural capital and why not of 'brain waste' (Raghuram, 2009), the politicization of migrations includes issues such as specific programs of recruitment of doctors or the incentives and implementations to mitigate the negative impacts of migrations. This political dimension of physicians' migrations has to be extended to institutional processes and professional organizations such as the *Conseil national de l'Ordre des Médecins* [CNOM], the French equivalent of the UK General Medical Council.

12 - The "*proliferation of migration transition*" occurs when traditional lands of emigration become lands of transit for both migration and immigration (Guo, 2010). It relates to the "*acceleration*" when countries allow the arrival of foreign-trained doctors to limit the impact of outward migrations. In Romania, this process has been sharply reduced by constraints introduced by "Fortress Europe".

Methods and data

13 The analysis of physicians' migrations between Romania and France is mainly based on the results of a survey carried out in 2011 and 2012, and consisting in close and open-ended questions, the latter providing participants with the possibility to comment on some points, heightening the qualitative side of the study. In total, 182 Romanian physicians practising in the West of France (n= 75), Alsace and Lorraine (n= 72), as well as in Paris (n= 35) were interviewed. Western France is interesting for the key issue of the shortage of physicians in rural areas and small towns. In Alsace and Lorraine, the Romanian doctors represent a particularly important part of the total of physicians. In Paris, which is the gateway for many migrants to France, the grouping of all hospitals in the APHP (the Public Hospitals of Paris) facilitates access to employment for Romanian doctors. The gender distribution (male: 55, female: n: 127) is fully representative: women represent 70% of all Romanian physicians practising in France. At the same time, the average age was 38.6, the group 31-40 being best represented with 63.8% of the total number of doctors; finally 54% were living in France with their family.

14 A snowball technique of sampling was used. Building upon data provided by national health and social affairs institutions (ADELI file from the French ministry for social affairs and health which give information on each healthcare professional: civil status, professional situation, activities carried out) and relating to the more interesting places for the study, we first contacted Romanian physicians in several hospitals, asking each respondent to give us the names of other Romanian physicians working in the same or an other hospital in France, as well in office practices. This technique enabled the survey to be carried out as doctors willingly agreed to the interview knowing that one of their acquaintances had already agreed to do it. It also made possible the over-representation of physicians working in France for several years, which is useful to the study of the integration pathways. The interviews were undertaken in the workplace, which facilitated the process. Conversely, due to medical professionals' time constraints, the questioning had to be focused on some of the major aspects of their migration and professional careers in Romania and in France. The grid of the survey consisted of six parts dealing with the medical studies and qualifications, the career before and during the stay in France, the motivations and conditions of the mobility (family circumstances, in connection or not with a recruitment agency), job satisfaction and conditions of professional practice in the current situation at the time of the interview, links with Romania, and finally personal data. To ensure confidentiality, no mention was made of the names of interviewed people and

of their professional location. The statistical treatment of closed questions proceeded to basic sorting and cross tabulations. The open-ended questions inquired whether or not the social, material and professional expectations were met in France.

- 15 A corpus of national and local newspapers articles was created in order to analyse what had been written about Romanian doctors setting up in France, notably in rural areas. While the national newspapers articles are informative, the local newspapers present it more as an achievement, aiming to show inhabitants that local politicians are working hard to meet their healthcare needs and to convince them to go to the new doctor, even when this latter is Romanian. The main source was *Ouest France*, a French local newspaper that covers 12 *départements* in the western part of France. The grid used for analyzing this corpus highlighted the professional skills of the doctors, the involvement of local actors and recruitment agency in their coming to France, the response to the needs of the local inhabitants.

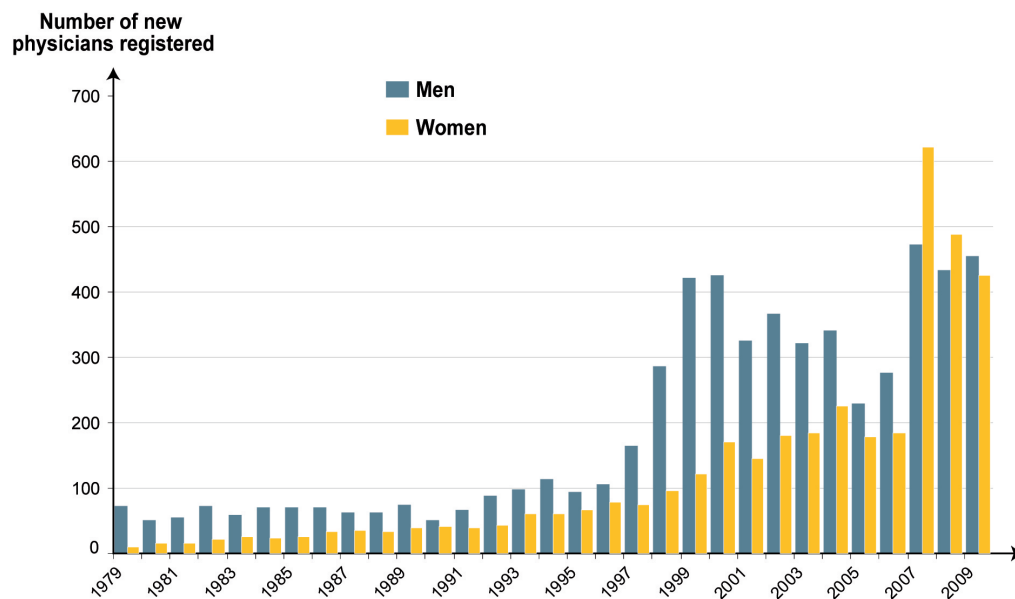
Opportunities for a greater presence of foreign physicians in France

- 16 In Europe, the increased mobility of physicians coincides with the change in workforce migration flows resulting from the geopolitical context: the end of the separation into two blocks and the expansion of the EU have led to a growth in migration flows between the East and the West. The possibility of transferring qualifications within the EU favoured this migration. The first measures supporting the mutual recognition of diplomas, certificates and other medical qualifications date back to council directives 75/362/EEC and 75/363/EEC of June 1975 that included measures aimed at facilitating the effective exercise of the right of settlement and freedom to provide services. More recently, the directive 2005/36/EC of the 7th September 2005 established a system of automatic recognition of qualifications or diplomas on the basis of a coordination of the minimal conditions of training for doctors. This directive, which came into force in 2007, allows the transfer of any medical diploma obtained after at least six years of studies or 5500 hours of theoretical and practical training in a university and additional training of a minimum of two years for general practitioners and five years for those specialising in general surgery. This recognition of diplomas obtained in the EU limits the risk of downward social mobility observed in Canada by Bauder (2003). It help to make the EU one of the main areas of mobility of physicians in the world and enabled Romanian physicians to be a part of these migrations.
- 17 With less than 10% of foreign physicians², France does not seem, at first glance, to be a country reliant on foreign doctors (Wismar *et al.*, 2011). However, its demographic context is favourable to the increase in healthcare demands. While the ageing of the French population was accelerating, medical demographics became a cause for concern. The fear of a shortage of doctors emerged at the beginning of the 2000s. And, above all, disparities in the distribution of doctors are such that the contribution of foreign-qualified doctors can be considered as strategic for some hospitals, geographical areas and specialities.
- 18 Forecasts established in 2002 confirmed that, due to the combined effect of the ageing of physicians and the *numerus clausus* quota system, the number of doctors would fall significantly by 2020: while the density of physicians had progressed from 263 for every 100 000 inhabitants in 1980 to 329 in 2000, it would be only 307 in 2010 and 250 in 2020 (Darriné, 2002). Created in 1971 and stable until 1983, with around 8000 places each year, the *numerus clausus* was then reduced to reach 3500 places in 1993 and subsequently remained low (4700 places in 2002)³. As it takes almost 10 years to train a doctor, in the 2000s very few physicians started practising at a time when the doctors belonging to the baby-boom generation were reaching retirement age. In 2007, it was recognized that in ten years' time around 75.000 doctors of the baby-boom generation would reach retirement age and that this number would be double the number of people likely to replace them; since then, each year, the CNOM has published in its successive Atlas detailed maps of 'medical deserts'. A steady decline in doctors' number therefore appeared inescapable for the decade following 2010.
- 19 The reduction of the *numerus clausus* in medical schools, which could be interpreted as a withdrawal on the part of the government with regard to the provision of medical training,

has led to the drop in the number of new physicians, with a time lag of around 10 years. Consequently, and although the use of emigrant physicians has never been explicitly presented as a solution for maintaining the healthcare provision in a context of increasing needs due to the ageing population, the number of foreign doctors practising in France has increased. The CNOM pointed out that around 8000 foreign-trained doctors were registered in France on 1st January 2001 while the figure reached 19.890, of which 18.642 were in active practice (7.4% of the total number of registered doctors), on 1st January 2012. During this time, the CNOM carried out two studies, in 2007 and 2010, but they focus on the doctor's nationality rather than on the country in which the medical qualification was obtained. Despite the lack of continuity in the data — Wismar et al. (2011) pointed the difficulties arising in EU from the insufficiency of the data —, some major trends can be identified.

20 The curve in the evolution of newly registered doctors with foreign qualifications shows the impact of the recognition of European diplomas and the opening up of the EU to Romania and Bulgaria. This has been even clearer that in the same time the legislation has been made more stringent for practitioners with Non-European Union diplomas (Cottreau, 2015). The increase in numbers was accompanied by a significant evolution in the nationalities and in the countries of graduation. On 1st January 2001, half of foreign doctors were European, the highest numbers being Belgian, and a third were from a North African country, mainly Algeria. While there was little change until 2006, 2007 was marked by a sharp increase in the number of foreign physicians registering at the CNOM, the majority of them being females (Figure 1). In 2010, for the first time, there were more Romanian doctors registered than Belgian ones. In 2012, 45% of physicians registered with a foreign qualification had a diploma of a EU country; a third of these were obtained in Romania.

Figure 1 : Newly registered physicians of European and extra-European nationality per year since 1979 (France)



Source: Conseil national de l'Ordre des médecins (National College of Physicians)

21 As a consequence of the *numerus clausus* system, we can argue that France is now a key player in the dynamics of medical brain drain. Not a brain drain between developing and developed countries but between centre and periphery into EU: in 2012, the gross domestic product per capita is \$36.460 in France while Romania occupies the second lowest rank with \$16.310 (Pison, 2013). The two countries also present widely different healthcare systems. Romanian healthcare system is a universal one. After the fall of Ceausescu in 1989, a system of social insurance has been set up for paying doctors and reorganizing hospitals. But, in the public sector, where the salaries of physicians are very low, payoffs and 'brown envelopes' are a systematic practice (Dumitrache, 2014). Finally, in hospitals, the number of beds remains in surplus and investment are insufficient to allow modernization and, therefore, the number and

popularity of private hospitals have risen. By contrast, the French healthcare system is seen as one of the world's most efficient. Care is provided whether in private doctors' office or in hospitals which are themselves either public or private.

Romanian physicians in the French healthcare system

Increasing inflows

- 22 Before 2007, many Romanian physicians came to do their specialist training in French hospitals (the possibility for foreigners with one of the diplomas sanctioning a specialist training to practise in France had been guaranteed by the decree of 23rd March 2000). For many young Romanian physicians, the preparation of an inter-university specialisation diploma (DIS) or the certification of specialised training (AFS) was a way to be recruited in France⁴. This concerns 124 respondents of our survey, 119 of whom arrived before 2007. The number of Romanian physicians present in France had therefore already increased significantly in the early 2000s. However, the strongest wave arrived in 2007. The number of Romanian doctors registered by the CNOM increased sharply in the years following Romania's entry into the EU, rising from 158 on 1st January 2007 to 1160 on 1st January 2009. The increase continued: in 2013, 3510 Romanian physicians were registered in France (CNOM, 2013).
- 23 In fact, after decrees of January 1990 and March 2000 establishing the conditions for access to postgraduate specialization in medical training for foreign physicians from outside the EU, French hospitals began to look for foreign practitioners. The Romanians who arrived in this context — which is also the moment of the transition towards democracy following the fall of Ceausescu which offered Romanians the possibility of emigrating — were less visible than the far higher numbers of practitioners trained in a North African or Near Eastern country. However these earlier migrants played an initiating role in the arrival of those who came afterwards. Thus, social networks dynamics demonstrate their effectiveness: 34 physicians came with the assistance of peers already settled in France whereas only 12 used the services of a recruitment agency (table 1).

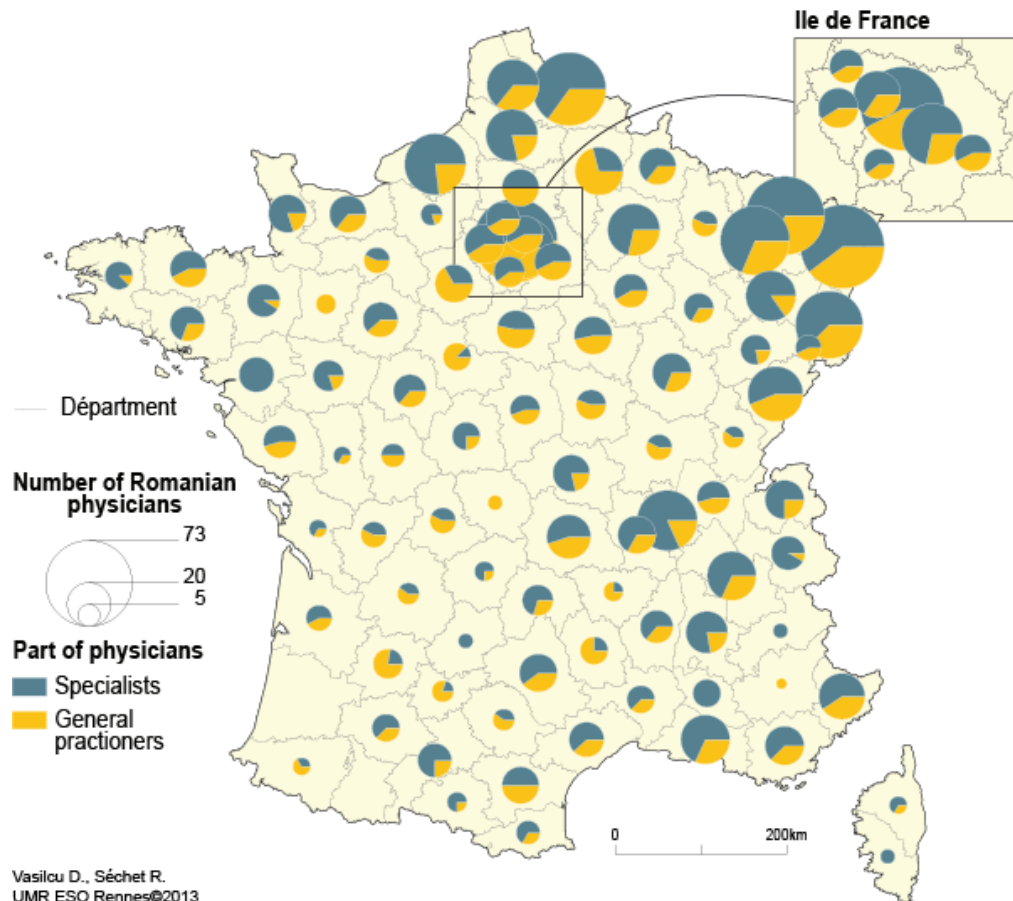
Table 1 : Conditions of migration of Romanian physicians in France before and after 2007

Conditions of migration	Date of arrival		Total
	Before 2007	2007 and after	
Specialization	56 (30,8%)	14 (7,7%)	70 (38,5%)
Recruitment agency	0 (0,0%)	12 (6,6%)	12 (6,6%)
Colleagues or friends already in France	27 (14,8%)	7 (3,9%)	34 (18,7%)
Individual actions	32 (17,6%)	24 (13,2%)	56 (30,8%)
Migrant parents and family reunification	9 (5,0%)	1 (0,6%)	10 (5,6%)
Total	124 (68,1%)	58 (31,9%)	182 (100%)

Source : Data from authors' survey

Romanian physicians in the French health care system

- 24 The place of Romanian practitioners in the French healthcare system should be considered from the perspective of the breakdown by general medicine and certain medical specialities, according to the setting of the professional practice and to location within France (for more details, see Séchet & Vasilcu, 2012). Romanian physicians are present across the whole country, with higher numbers in the North and Northeast, whose industrial shrinking cities are overall less popular with French doctors, as well as in the Paris region. As 68% of these Romanian physicians are employed in public hospitals (compared to 32% in the private sector), they mainly work in urban areas. Since the shortage of doctors is most blatant in the most remote rural areas and in deprived suburban areas, in some regions, mainly rural and with no major towns, the proportion of Romanian physicians practising in rural communities can be relatively high (some *départements* in the south of the Massif Central or in the West of France) (Figure 2).

Figure 2 : Distribution by French *départements* of Romanian physicians (2009)

Source: Ministère de la Santé et des Affaires sociales, DREES, 2009

- 25 Practice in the public sector is related to the preponderance of paid employment. Variations in the distribution by status across a French *département* are dependent, among others factors, on the presence of university teaching hospitals [CHU], on the proportion of private facilities and on the setting-up of independent general practitioners in rural areas (Séchet, Vasilcu, 2012). University hospitals employ senior practitioners as well as trainee interns. There are significant numbers of Romanian practitioners in these hospitals. This is the case in Parisian hospitals as well as in the different university hospitals where the survey has been carried out. Romanian practitioners are also numerous in hospitals located in small towns, where they alleviate the problems of recruiting staff and thereby help to ensure the survival of departments under threat of closure.
- 26 Romanian physicians are also especially numerous in specialties experiencing particular recruitment difficulties — such as anaesthetics-intensive care (9,3% of Romanian physicians in France) or radiology and medical imaging (7,7%) or in hospitals specialised in psychiatry (10,4%). The provision of psychiatric care has undergone fundamental changes that reduced the appeal of the former ‘lunatic asylums’ created in rural areas in the 19th century (Coldefy and Curtis, 2010): in 2010, Plouguernevel hospital in Brittany had 5 Romanian psychiatrists.
- 27 If migrants as a whole "are primarily valued for their embodiment of human capital and instrumental to the goal of economic growth and their contribution to the knowledge society" (Kofman and Raghuram, 2006), the extent to which physicians are valued depends on the structure in which they practise. In university centre and largest hospitals, Romanian doctors are in high demand as they are of no concern for the recognition of qualifications (unlike the practitioners with a diploma from outside the EU), and they are employed on temporary contracts with all the associated disadvantages, including restrictive on-call duties. In small and medium-sized towns, the use of foreign practitioners can ensure the survival of the hospital facing major recruitment difficulties. In rural areas, the long-awaited Romanian doctor can ensure the continuity of a medical practice following a departure, a planned retirement

or work overload, and is then expected to be permanently available to meet the demands of local populations, like the country doctor of the past. Local newspapers, which announce these arrivals, emphasise the fact that these Romanian doctors can speak French, that their practices are similar to those of French doctors even going so far as to showing them holding a copy of the Vidal medical dictionary, which is the bible for all French doctors.

28 People want to have a doctor close to home, so that local politicians fear the constitution of medical deserts. It looks like the provision of healthcare becomes a key part of politics. The issue of recruitment and retention of GPs in rural areas is complex (Scott and al., 2013); it seems clear that financial incentives alone are not able to solve the problem and that more appropriately supported practices are needed. Three extracts from newspapers testify to these expectations:

- "Long awaited like the Messiah, she will finally arrive on Monday morning. After almost one year without a doctor, the village has finally found a replacement: Iulia Sandu, arriving straight from Romania. Mayor Alain Buot is delighted at the prospect. "It is a relief for the village. After the departure of Isabelle Derycke, a doctor came to replace her in February but only stayed for three weeks. The situation for the inhabitants of Trinité-Porhoët, as well as those of the surrounding villages, who used the doctor here, became difficult as they had to go all the way to Josselin or Mauron to find a doctor. It also had an impact on the activity of the pharmacy and other health care professionals." (Ouest-France, 1st October 2012)

- "Dr Jean-Claude Corbel will soon be retiring. Aged 65, he has worked in Melrand for thirty-six years. This doctor tried in vain to find a successor. The municipal council signed an agreement with the agency XP-consultant, specialised in the recruitment of doctors, in an attempt to find a replacement. The agency soon put forward a candidate, a female doctor aged 56, who lives in the region of Bucharest and speaks good French. The new doctor will arrive in the village mid-November" (Ouest-France, 7th October 2012).

- "Bogdan Coman, a young Romanian doctor has just arrived at the health care centre, where he will partner Marie-Annick Miniscloux, a doctor already established there. "This is the result of a search for a doctor which has lasted several years," admits Hervé Dechangy, the village's mayor. "After four years without success, we turned to a specialised agency, Médecis Consulte in Paris. One year later, we are delighted to welcome Bogdan Coman to the health care centre". Dr Miniscloux who was struggling alone to cope with the workload also appreciates his arrival. Bogdan Coman is a young doctor aged 36 who came straight from Romania" (Sud-Ouest, 15th October 2012).

Far from the expectations of stakeholders

29 The analysis of the national data suggests that Romanian physicians are not alleviating fears of medical deserts, even though avoiding these deserts is the very *raison d'être* of recruitment agencies appointed to put into practice the policy of quest for doctors carried out by hospitals and French local political leaders. They are expected to find the specialist or general practitioner so desperately needed by the hospital's medical team or to ensure the survival of an independent practice. Romanian doctors do not necessarily set up practice where they are most needed. In their defence, it should be said that hospitals offer a professional environment more favourable to their integration. In the independent practice, they can be quite isolated and even encounter reactions bordering on intolerance. A Romanian female doctor working in a rural village of Brittany talked to us about the ostracism displayed by his colleague in the place. Stating that the new arrival had fewer qualifications than him, he advised patients against going to her. Similar stories are regularly reported in the press:

"Then, in January 2008, a Romanian doctor arrived. "We were delighted, and she was perfect," remembers Jean-Claude Lécugy, who says he has "still not recovered", from this doctor's departure, four months later, for another village in the Loiret. "My belief is that some Romanian doctors are used to work in a state-run system, as civil servants, and they don't always appreciate the constraints of independent practice with no fixed hours"; a statement that annoys Doctor Olga Djamo, this GP who, in 2008, left Bonny-sur-Loire for Nogent-sur-Vernisson. /.... "If I changed the location of my practice, it was precisely because I did not have enough work," she claims. "Although I was told that the area had a shortage of doctors, I only saw three patients a day on average. I spoke about it with my Romanian colleagues, who were undergoing the same kind of experience. Once arrived, local doctors would leave them very few patients." Dr Olga Djamo says

that she is now very happy in her new practice. "In 2009, I had an average of 17 patients a day", she says." ("La France recrute ses médecins en Roumanie", *La Croix*, 10th March 2010).

30 We have seen that the issue of politicization of migration should include the professional organizations in the analysis. More clearly, in the question of the integration of Romanian physicians, the CNOM warns against the use of recruitment agencies:

"With regard to the use of "specialised agencies" offering their services to local authorities for the recruitment of doctors (more specifically Romanian doctors), the CNOM, once again⁵, expresses serious concern regarding these practices and calls on local authorities to exercise extreme caution, examples of disappointment being, unfortunately, all too frequent." (Romestaing, 2010)

31 Finally, this analysis on the place of Romanian physicians in the French healthcare system shows that the realities are far from the expectations of policy makers and local actors. Romanian doctors are awaited to compensate for the shortage of doctors, to fill the gaps in certain specialties or certain locations, and therefore to go where French doctors are less inclined to practise and to care people disregarded by other doctors (like insane or older patients with multiple pathologies). In short, and more particularly in public hospitals, are they not seen as the reserve army of medical labour? The idea have been suggested by Raghuram (2009) speaking about the NHS in the post-war period: *"There was a chronic underproduction of local doctors and use of a mobile army of migrant labour with no access to private work to fill the shortages"*. One may fear that this will continue in the current context of budgetary austerity and reduction in public spending. French health policies are consistent with the objectives of healthcare systems reforms, which tend towards financial sustainability (and freedom of choice of healthcare for professionals and patients) rather than the improvement of quality of care and even more the equal access to healthcare (Palier, 2012). Once again, in April 2014, the French Prime Minister, Manuel Valls, called for a special effort to reduce healthcare costs.

Understanding the motivations to analyse professional mobility

Professional and personal motivations

32 Far from the simple determinism of the pull and push model and then in a more individual centred approach, each case of a Romanian doctor setting up in France has to be considered as a mix between professional, personal and family considerations, and how each doctor manages the change in his or her career is the result of the matching between this mix and the professional and institutional contexts.

33 The difference in professional revenues between Romania and France motivates many departures, even more so, as Romanian doctors' salaries were cut by 25% in 2010. More than these financial motivations, there are those relating to healthcare conditions: 157 of the 182 Romanian doctors interviewed cited socio-professional factors as a motivation of their emigration project. According to some of them, the current healthcare system in Romania does not offer good working and treatment conditions and it is not possible to properly fulfil their obligations with regard to patients, confirming the observation already made in 2008 by Delautre *et al* and repeated by Boncea in 2014. Conversely, the French medical system is perceived as being able to offer greater job satisfaction with modern medical equipment and materials, ensuring medical procedures are safe and carried out within a well-financed healthcare system and a stimulating professional environment. Therefore, Romanians physicians can believe they will be more able to fulfil the Hippocratic oath in migrating to France rather than continuing to serve Romanian population.

34 It is difficult to disentangle professional motivations and personal and family strategies aiming for financial success and social promotion. In our survey, women particularly expressed this. The quest for a better quality of life and more specifically better education and training opportunities for their children were evoked as decisive factors in the migration of 99 of the 182 doctors interviewed. These figures suggest that the departures abroad are positive ruptures carried out in order to fulfil a life project. Although, according to Eurostat data,

Romania is one of the countries in the EU where the gaps between men and women are smallest, Romania is also the EU country where average wages are the lowest, and a country where gender relationships are very demanding on women (Boulineau and Bonerandi-Richard, 2014). Thus, migration can give rise to the creation of an area of empowerment for women (Potot, 2005). Female physicians who aspire to improve their family situation are often the driving forces behind the decision to emigrate. Then, they do not enter as dependant of male migrants (Kofman and Raghuram, 2006). However, although 7 of the 109 married women interviewed came without their children, most (102) have emigrated with their whole family, intending from the outset to settle here long term or even permanently.

Some conditions for the success of Romanian doctors' integration in France

- 35 After this analysis of motivations, attention must be paid to the way Romanian physicians seek to limit the risks of deskilling, to advance in their career and to fulfil their expectations. Romanian doctors frequently change their place of practice, at the risk, as earlier seen, of irritating French recruiters (hospital directors and local politicians). For example, one of the interviewed physicians spoke of her propensity to move: *"I was in ... [a small town with a psychiatric hospital] for the last year and a half and I feel I want to leave"*. Since her arrival to France, she has worked in more than seven hospitals in northeast of France, Reunion Island, Brittany. She arrived thirteen years ago, in 1997, to prepare an interuniversity specialisation diploma and was joined one year later by her husband, also a doctor who came for a DIS, and then they chose not to return to Romania.
- 36 This instability is linked both to the conditions of Romanian physicians' setting up in practice, initial difficulties (short term contracts, replacements, setting up in an unprofitable practice) and to their desire to pursue their career. Once the arrival and adaptation period has passed, they seek to enhance their professional skills or to find the environment which best meets their expectations and those of their family. This can lead to new changes to their location, or, conversely, to the decision to 'downgrade' in order to stay close to a spouse who has established him or herself professionally. It is only when the balance between the place in the healthcare system, the location within France and the professional and social environments is considered to satisfy personal expectations that the career can stabilize.
- 37 Our research allowed the identification of the most significant conditions that can ensure the successful setting-up of Romanian physicians where they are most awaited. Given the proportion of women among Romanian doctors practising in France, the first one is the need to be gender sensitive. The lack of attention paid to this gender dimension by local politicians or hospitals directors, who complain of the instability of Romanian doctors, can be presented as a hindrance to the success of their integration into their new professional and social environment. Local politicians have to break with their representations of the countryside doctor always available for his patients whatever the time, day or season. This is linked to the challenge of avoiding the isolation of the practitioner. Setting up in a medical centre incorporating several practitioners and other healthcare providers is an advantage. The support of the physician who the new arrival is replacing is an additional asset. These conditions are in fact the same as those that might convince young French physicians to set themselves up in few attractive areas. Romanian doctors are they not physicians like the others?

Some points on the impact of physicians' emigration on Romania

- 38 All the physicians who achieve successful integration in France are so many doctors removed from Romania. Considering the micro-social impacts for migrants and their families, our results are clearly heading in the same direction as Connell and al. (2007): *"Since migrants move to improve their own and their families' livelihoods, they are usually the key beneficiaries of migration"*. The differential of income is substantial, even though a distinction must be made between nominal and real terms (Kangasniemi and al., 2007). For their part, remittances have to be analysed through the perspective of the physicians' personal projects. Of course, some physicians, especially those who claim to intend to return to Romania, transfer large amounts of money to invest in property. Owning a house in the country do indeed facilitate temporary

returns for holidays and helps to maintain the perspective of a hypothetical definitive return. However, 72% of the Romanian physicians interviewed are ready to settle permanently or for an extended period (131 out of 182 talked of a long-term or definitive migration project). They tend to invest their money in France rather than in Romania. All in all, 65% of them send money to Romania, but only a quarter of this group do so on a monthly basis. Physicians who make regular remittances are mainly people who have been in France for a short time, and people whose spouse or adult children have stayed in Romania or having specific family situations: support of elderly relatives, illness or incapacity for work of close family members. These remittances that aim to cover daily needs and this long-distance caregiving are forms of intergenerational solidarities.

39 Keeping or acquisition of real properties, sending of money to family members who remain in the country, temporary returns for holidays (everyone interviewed confirmed that they return to Romania at least once a year): the links that Romanian physicians maintain with their home country are, at the end, quite traditional. The impacts of physicians' migration on the Romanian healthcare system are clearly negative.

40 The contribution of migrations, which depends on the practices of international migrants after leaving their country, has largely been discussed under the beneficial brain drain hypothesis. For Kangasniemi and al. (2007), this hypothesis "*is unlikely to carry much relevance in practice, at least in sectors such as health where the profession itself, as well migration, are heavily regulated*". Because of these regulations of the medical labour force and of migrations, the level of the state remains a useful analytical level for understanding the skilled migration of doctors and their impacts (Raghuram and Kofman, 2002). It should obviously be noted that at the top of the social hierarchy of physicians, for those with considerable experience gained abroad and who master cutting edge techniques, situations of dual working locations exist: examples of doctors with a practice in Paris and another in Bucharest could be cited, as we meet one and as it can be read in magazines on cheap airlines flights. Nevertheless, such cases based on permanent mobility between two countries and no on migration are too infrequent for a successful transformation of brain drain into a "*highly beneficial brain circulation*" (Kangasniemi and al., 2007). Quite the contrary, Romania is faced with the mass departure of its physicians (Table 2), so that "*the number of physicians departed each year in the last period of time exceeds the number of specialists that the Romanian school produces each year*" (Dornescu, Manea, 2013).

Table 2 : Romanian physicians who requested a certification to practice abroad (2008-2014)

Year	2008	2009	2010	2011	2012	2013	2014
Number of people	1 155	1 401	2 879	2 982	2 640	2 995	2 450

Source: Colegiul medicilor din România

41 Therefore, not only the brain drain is particularly costly for Romania that trained its doctors, but it also has significant effects on the healthcare provision in the country. Romania is facing with a drastic diminution of its medical staff: the number of physicians would have decreased from 52.541 in 2011 to 39.896 in 2013 (Dumitrache p. 38, following CMR). The medical brain drain then results into issues of spatial inequity. The shortage of physicians is particularly acute in the more remote rural areas: Feraru (2013) notes that in 2011 the number of inhabitants per one rural doctor is more than 6 times higher than in urban areas. Some rural communities do not have a general practitioner even though they are located more than 50 or 100 km from the nearest hospital and more than 200 km from a university hospital.

42 For trying to find a solution, Romania, in its turn, attempts to attract physicians rather than increase the level of public health funding. Feraru (2013.27) considers that "*the reduced level of public resources allocated to health directly affects the quality of the medical act and determines more and more Romanian doctors to emigrate*". The Romanian law no. 95/2006 allows doctors from the European economic area, as well as citizens from outside Europe whose spouse or parents are Romanian and those who have completed their medical studies in Romania and have Romanian nationality, to exercise their profession in the country. The

country is now open to physicians from third EU countries, beneficiaries of permanent resident status in Romania and of course to any EU physician. But in making easier the migration of Romanian physicians, the accession of Romania to EU also constrained the possibility of access into Romania for physicians trained outside EU. Then, the limitation of impacts of outward migration of physicians is difficult. Similarly, the specific programs for international students, including French students victims of the *numerus clausus* in our country, offered by the main Romanian medical schools may well reinforce the desire, already strong, of Romanian students to leave their country (Popa, Luches, 2014).

43 The Romanian healthcare system is currently facing a double challenge: the shortage of healthcare professionals and the improvement of the health of Romanian population, the country having some of the poorest health indicators among EU countries (WHO, 2012): in 2013, the life expectancy at birth was estimated to be 70 for males (79 in mainland France) and the infant mortality rate was estimated to be 9 (compared to 3 in France and 4 in EU) (Pison, 2013).

Conclusion

44 The European and Romanian context has been favourable to the departure of Romanian physicians who are now very present in the French healthcare landscape where they alleviate shortages in certain specialities. The intensive movement of Romanian physicians to France is leading to the creation of a migratory space that is part of the emergence of a global market for medical professionals in which mobility is a response to professional objectives relating to the competitiveness of medical skills as well as to personal and family objectives. In France, the lowering of the *numerus clausus*, and consequently the decrease in the numbers of new doctors, is largely responsible for the medical demographic crisis recorded since the beginning of the 2000s. While the employment of migrant workers is not explicitly put forward as a solution for maintaining the level of healthcare provision, the number of foreign physicians has increased. For Romania, the brain drain of its doctors constitutes a dramatic loss for the healthcare provision and the development of the country. It is clear that the hypothesis of a brain strain, and moreover of a brain gain cannot be retained.

45 It is not so much by their number as by their presence in some places, hospitals and specialties disdained by French physicians that Romanian doctors have become essential for French healthcare system. National and local French actors use them as gap-fillers. Their services and skills are requested to specially ensure continuity of care in emergencies, in remote rural areas, in psychiatric hospitals inherited from lunatic asylums. The high level of professional and personal motivations of the Romanian physicians who chose to leave their country and are ready to accept harsh working conditions, at least in an early stage, has to be recalled. The instability of the work situations relates to both precariousness of employment contracts in hospitals and coping strategies for improving professional and family situation. Already essential in some specialties, Romanian physicians could perhaps take the chance to advance professionally in developing specific 'niches', on the model of geriatric medicine for South Asians doctors in the NHS (Bornat and al., 2011).

46 Our study contributes to theories of globalisation in the specific labour market of medical professions. While confirming the main trends of highly skilled migrations, they highlight the importance of political regulations inherent to physicians, specifically into the EU framework. Romanian physicians' migration corresponds to four of the six trends identified by Castles and Miller (2009): globalisation, acceleration, differentiation, and feminization of migration. It is more complex for the two others — politicization and proliferation of migration transition —, particularly because of the EU management of migrations. If personal strategies and agency are key determinants in the comprehension of careers, we should also consider what falls under the scope of local, national and European policies. To understand the great diversity of careers and how they are built, how forms of hierarchy are produced within the supposed 'medical community', complementary research studies are required. Attention should also be paid to the stages prior to migration, especially to the formative years in the faculty of medicine. Because it may be easier to retain physicians in training rather than doctors already established abroad,

47 it would be, for example, useful to know the projects and career intentions of the medical students trained in Romania, be they Romanian, French or coming from emerging countries. Many things have been said on the joint responsibility for the brain drain of physicians from both the host and home countries, and on the weakness of their scope for action. The Romanian healthcare system is experiencing difficulties of the same type as many other developing countries suffering of brain drain, but a brain drain that operates in the very specific framework of relations between the periphery and the centre within the EU. Therefore, only an improvement in the country's living standard might slow down the pace of outmigration and incite physicians to reconsider their projects. This can only be achieved through the redefinition of national choices, through the policy of cohesion of the EU and through the consideration of individual motivations, in other words, through a search for convergences between political logics and individual strategies. It is hoped that EU will play its full role as a space for regulations in providing the so needed reliable data and in fostering approaches based on the ideals of regional integration rather than on national egoisms.

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Notes

1 According to Vasile Astărăstoie, president of the Colegiul medicilor din România, 21.000 Romanian physicians would have emigrated since 1990, in which 14.100 since 2007. Romanian physicians would be about 4300 in France, 4000 in UK, 3100 in Germany, 2600 in Belgium (April 2014, www.timponline.ro).

2 Particularly when compared with New Zealand, Ireland, United Kingdom, United States, Switzerland, Australia where foreign born physicians or with foreign diplomas represent more than 25% of practising physicians.

3 From 2002 to 2007, the number of places opened for students in 2nd year of medical studies has been increased to around 7500 and then stabilized at that level.

4 For more details on the legal framework before 2007, see Cottureau, 2015.

5 In bold in the original text.

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Résumés

The migration of highly skilled workers and more specifically of physicians has been a component of the globalisation of the recent few decades. In Europe, these physicians' migration and mobility has increased with the dynamics of expansion of EU. Since 2007, many Romanian doctors have left their country to work in Western European Countries, especially in France where they either help to alleviate the lack of general practitioners in isolated rural areas, or work as specialists in hospitals. This paper analyses the results of a survey carried out on 182 Romanian physicians in three areas in France, national data, and a corpus of national and local newspaper articles. It appears that physicians' motivations are both professional and familial, most of them, mainly women, having a long-term or a definitive migration project. The brain drain of Romanian doctors constitutes such a dramatic loss for the national healthcare provision that the hypothesis of a brain strain or of a brain gain cannot be retained. While clearly not generalizable to other parts of the world, the study of physicians' migration from Romania to France has international significance as an illustration of globalisation in medical labour markets and of theories relating to migration of highly skilled workers, as well as spatial inequalities in healthcare.

Les migrations de médecins de la Roumanie vers la France: un 'brain drain' en Europe?

Les migrations des élites hautement qualifiées et plus spécifiquement des médecins a été une des composantes de la mondialisation au cours des dernières décennies. En Europe, l'élargissement de l'UE a offert un contexte favorable à l'accroissement des migrations et de la mobilité des médecins. Depuis 2007, de nombreux médecins roumains ont quitté leur pays pour travailler en Europe de l'Ouest, et notamment en France où ils contribuent soit à réduire le déficit de médecins généralistes dans des espaces ruraux isolés, soit à exercer comme spécialistes dans les hôpitaux. L'article analyse les résultats d'une enquête menée auprès de 182 médecins roumains exerçant dans trois régions françaises, des données nationales, un corpus d'articles de journaux nationaux et régionaux. Il apparaît que les motivations de ces médecins sont à la fois professionnelles et familiales, la plupart d'entre eux, surtout les femmes, souhaitant s'installer durablement ou définitivement. Le 'brain drain' des médecins roumains constitue une telle perte pour le système de santé roumain que les hypothèses de gain et de circulation des cerveaux ne peuvent être envisagées. Bien qu'elle ne soit pas généralisable à d'autres contextes internationaux, l'étude des migrations des médecins roumains vers la France est une contribution réelle à la connaissance de la mondialisation du marché du travail médical, aux théories relatives aux migrations internationales de personnels hautement qualifiés, ainsi qu'aux inégalités spatiales dans l'offre de soins.

Entrées d'index

Mots-clés : Roumanie, France, médecins, brain drain, migrations internationales

Keywords : Romania, France, brain drain, physician, international migration