

# ONE BSR Case study

The Estonian case – talent retention in the health care system



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### **Authors:**

**Vootele Veldre** is an analyst in Health Policy Programme at Praxis since 2010. Before coming to Praxis, Vootele has worked in Statistics Estonia and in Estonian Health Insurance Fund

**Priit Kruus** is the Acting Director of the Health Policy Programme at Praxis and has more than five years' analytical experience in the area of health systems and e-health. Priit obtained his Bachelor's degree in Economics at the University of Tartu and Master's degree (cum laude) at Tallinn University of Technology in Health Care Technology.

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### **Praxis Center for Policy Studies**

Tornimäe St 5  
10145 Tallinn, Estonia  
Ph +372 640 8000  
[www.praxis.ee](http://www.praxis.ee)  
[praxis@praxis.ee](mailto:praxis@praxis.ee)

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## Introduction

Medical doctors and nurses are knowledge workers whose attainments are universal and can be used around the world. The provision of health services is based on universal scientific knowledge and technical skills, unlike providing legal aid, accounting or other services that rely on context-specific knowledge.

Universal education makes the graduates of high-quality health programmes a desirable labour force both in their homeland and in foreign countries. Retention of health care workers is becoming an essential piece of the health care puzzle. As the large cohorts born in the 1950s and 1960s are entering retirement age across Europe, rapid aging is taking place and increasingly effective health services are needed. The growing demand offers more choices for health care workers but also pressures policymakers to introduce and fine-tune the measures and incentives to ensure equitable geographical and organisational distribution of health care professionals.

It is estimated that by 2020 there will be a shortfall of 1,000,000 health professionals in the European Union (Wismar et al. 2011). The richer countries actively attract the health professionals from countries with lower standards of living to overcome medical personnel shortages (Saar and Habicht 2011). The emigration of health care workers is normally useful both for the migrant and the country of destination. However, it may become a matter of great concern for the source country.

The benefits of emigration are, from the perspective of a migrant, related to the conditions unlikely obtainable in the home country, e.g. a significant increase in income, rewarding working conditions conducive to self-realisation, the public recognition for the work, better habitat for offspring and significant others. In destination countries the immigration of professionals helps reduce labour shortages. Immigrants are often more willing to work in locations (in the periphery) or in working conditions not welcomed by locals (e.g. night shifts).

In the case of temporary emigration, positive effects may come about also for the source country of the migrants. Temporary migration may enhance the quality of human capital and labour (World Bank 2009), and the temporary movement of workers contributes to the improvement of their level of expertise (Cali et al. 2008). Stronger ties with foreign research institutes facilitate knowledge transfer and scientific collaboration (European Union and European Commission 2007). Contacts abroad increase opportunities for technology export. Money transfers to the homeland may help to accumulate venture capital (Ratha 2011) and support innovative start-ups, successful managers and entrepreneurs may return with significant managerial skills (Batista, McIndoe Calder, and Vicente 2014) and access to transnational networks (Poros 2014).

If the emigration of health care workers occurs on a large scale, the ensuing labour shortage in the sector may affect the quality and quantity of health services. Even the emigration of a few doctors can cause immense problems and shrinkage of services offered in some specialties. For those who do not emigrate, working condition may deteriorate as the workload increases. All this may worsen the population's access to high-quality health services.

In most countries the education of health personnel is largely subsidised by the public sector and, therefore, requires a significant investment; training doctors is one of the most expensive and prolonged programmes. If the state pays for the education of a person who leaves to work abroad, the

investment is lost and the country is left without a planned expensive resource, while the destination country is subsidised instead.

The source countries of health care personnel can apply four major measures to answer these unfavourable circumstances: 1) train more health personnel, 2) keep and use existing resource better, 3) invite emigrants to return to their homeland, or 4) bring in workers from abroad where the living standards are lower.

The state's ability to respond in time and increase the health care staff by **schooling more health care workers** is somewhat limited. As health care is a highly regulated area, new personnel can enter the sector only through training and certification in higher education. The schooling of health workers is expensive; a training cycle of medical doctors lasts around ten years, for nurses around 3–4 years.

To **keep existing human resources** from emigrating, the state must respond to push and pull factors that influence migration. Common factors are income gap between the source and destination countries, difference in working conditions, gap between expected and actual living standard, and job opportunities. Addressing these factors, a variety of steps could be taken: promoting faster development of the health sector, supporting a wage increase, providing loans on easy terms to support investments in working conditions, reforming the management structures in the health sector, increasing the efficiency in service delivery, regulating the working hours.

For EU countries, the possibility to use negative measures like taxing migration (to oblige the leaving employee or destination country to partially or fully compensate the training costs) and requiring a certain employment time after graduation in the home country is somewhat limited as according to the principle of free movement, the citizens of EU have right to learn, work and live freely within the EU.

Regarding **inviting emigrants to return** to their homeland, in addition to dealing with gaps mentioned above, special incentives could be provided for returning health workers, e.g. tax incentives or free housing. However, the key issue is to ensure that the positions for returning workers match their human capital.

One solution is also to support **active recruitment from foreign countries**. Questions about cultural and language barriers but also ethical dilemmas will rise as all these negative influences may spread to the countries that are less competitive. Benefits from the recruitment of foreign workers may have only temporary positive effects. For example, in the EU foreign-trained health professionals may use the newer EU countries as mere transition points and other EU countries with higher salary levels are their actual desired destination points. Gaining some work experience in a low or middle income EU member state can be beneficial for achieving recognition in other more attractive target countries (Saar and Habicht 2011).

In the following chapters, a case analysis on the retention of Estonian health care workers is presented. Trends and bottlenecks are shown, but opportunities for fruitful talent retention policies are also demonstrated.

# 1. Estonia – a country losing health care workers

The organisation of Estonian health care system emerged from the health care reform of the 1990s, the aim of which was to develop a modern and efficient health care system. The provision of health services and funding are strictly separated in Estonia. The financing of health care services is the responsibility of the Estonian Health Insurance Fund (EHIF) that operates within the area of administration of the Ministry of Social Affairs, but as an independent public legal body under public law. (Lai et al. 2013) The services and their maximum rates covered by EHIF are regulated by Estonian government.

All health care providers in Estonia operate under private law and in economic and financial terms are fully responsible for their operations, including managing debts and making investment decisions (*ibid.*). Hospitals of strategic importance are owned by the public sector. Through their representatives in the hospitals' supervisory boards the owners (state, and local government) ensure that public interests are met and operating goals set to serve the public interests are fulfilled by the executives of the hospitals. Combining public ownership and operation under private law is seen as a means to add flexibility and efficiency to the management; in operational decision-making all providers are relatively independent.

## 1.1. Emigration of the health care work force

Estonia is clearly a source country of health care workers (Saar and Habicht 2011). Since EU accession in 2004, the Estonian Health Care Board has issued nearly 3,000 mutual recognition of diploma certificates to health care workers to prove their educational attainment abroad (Health Board 2012; Kiivet, Visk, and Asser 2012; Kiivet, Visk, and Raag 2013). That corresponds to 15% of nearly 18,000 health care workers on the official health workers register in 2012. While some doctors and nurses have permanently left, some have left and later returned, some work in Estonia and abroad alternately, while some migrating professionals provide cross-border health care services (Saar and Habicht 2011). Attempts to get a clearer picture show that in 2012 7.4 % of physicians in the official register were likely working only abroad (Kiivet, Visk, and Asser 2012), while for nurses the percentage was 4.7% (Kiivet, Visk, and Raag 2013).

Of doctors, the largest numbers of emigrants are doctors with no specialisation (including resident doctors). These are followed by family physicians, anaesthetists, radiologists and general surgeons. The doctors with no specialisation are usually residents studying for specialisation and practising medicine after basic studies. It has been hypothesised that certificates are requested mostly by residents interested in practising abroad before acquiring their diplomas (Saar and Habicht 2011).

The number of doctors working in Estonia is estimated to decrease at 1–2% per year and that of nurses twice as fast (Lai et al. 2013). Currently, the number of doctors working in Estonia on a population basis is at a similar level to the OECD average – there are 3.3 medical doctors per 1,000 inhabitants, compared to 3.2 in the OECD (OECD 2013). However, the ratio of nurses is considerably below the average in the OECD – there are 8.8 nurses per 1,000 inhabitants in OECD countries on average, but the ratio in Estonia is 6.2. The shortage hampers the provision of acute care and the further development of nursing care (Lai et al. 2013). The Estonian National Health Plan 2009–2020 sets the target to hold the level of practising physicians at 3.2 in 2020. According to the plan the ratio of nurses should increase from the current level to 9 nurses per 1,000 inhabitants. Considering the high emigration

rates, insufficient supply from medical schools and age structure of doctors, these targets are hard to reach with current policies (see e.g. Lai et al. 2013; Kiivet, Visk & Asser 2012; Kiivet, Visk, and Raag 2013).

As the emigrating contingent is inclined to young people, the inflow to the health care sector by recently graduated young professionals is lower than the outflow from emigration and retirement. For example, between 2002 and 2011, on average 248 nurses graduated from the educational system annually. From 2010 to 2012 Estonian Health Care Board issued certificates for 204 nurses annually on average to allow proving their educational attainment abroad (Kiivet, Visk, and Raag 2013). Although the vast majority of medical doctors continue working after reaching the official retirement age, it is not so common among nurses. Of the doctors, 15% are over 65, while among the nurses the share is only 5%.

It has been projected that to achieve the targets mentioned above by 2032, the emigration of the medical doctors must be reduced by half and at least 43% more students must start their medical studies (at least 200 instead of 140) (Kiivet, Visk, and Asser 2012). The admission of nurses must be more than doubled – 2.3–2.6 times more students (700–800 nurses) must start their studies every year to guarantee that 450–500 nurses start working every year in Estonia (Kiivet, Visk, and Raag 2013).<sup>1</sup>

## 1.2. Push-pull factors

The reasons why doctors and nurses are leaving Estonia at the levels described above, are widely treated by mainstream media; a number of analytical approaches have been meagre. Estonia adopted liberal policies during its statehood reforms in the nineties and early 2000'nds, so there are no formal agreements that shape or restrict mobility either with other countries or within the country (Tamaru and Viies 2012). Workers are free to choose without any constraints the most suitable employment solutions for them in the homeland or abroad.

The better remuneration of health care workers is presented as the main pull factor in almost all approaches dealing with the subject. A comparison of the salary levels between Estonia and Finland reveals that in Finland health care workers are better paid because of the higher living standard of the society, and the work of physicians is relatively more valued in society. In 2011 the average salary in Estonia was € 839 per month (Statistics Estonia 2014), with practicing physicians earning 2.1 times the average wage (OECD 2013). In Finland the average salary was € 3,080 in 2011 (Statistics Finland 2013), with medical doctors earning 2.6 times the average wage (OECD 2013). Nurses in both countries earned roughly the average wage (OECD 2013). In 2011, only 34.6% of Estonian doctors were very or quite satisfied with their salary, 53.2% were very or quite unsatisfied (Sepp 2012).

Another widely discussed aspect that pushes Estonian health care workers to leave and work abroad is disaffection with the working culture and working conditions. The employment in the Estonian health care system has been described as stressful, prone to overload, and working climate is seen as unfriendly. According to Sepp (2012), more than half of the doctors had a workload of over 40 hours a

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<sup>1</sup> According to Saar and Habicht (2011), a large number of registered nurses work outside the health care sector (25% in 2009). Despite increases in health professional salaries between 2004 and 2008, many nurses choose to work in spas, beauty salons or elsewhere in the service sector.

week. In contrast, the working conditions are seen as less stressful in the main destination countries, the working culture in Finland and Sweden have been presented as examples.

Both the salary and workload were the focus of a three-week long strike of health care workers that took place in Estonia in the autumn of 2012. According to the organisers (the Estonian Medical Association and Professional Union of Estonian Health Care Professionals), the objective of the strike was to “deter doctors and nurses from leaving Estonia and stop the degradation of the health care system”, which could be met by implementing the following three measures:

- Collective agreements for doctors, nurses and caregivers on raising the minimum wage and improving working conditions;
- Implementing limits on the workload of specialists and standards on the workload for nurses and caregivers;
- Initiating changes for increasing the financing of the health care system and improving access to medical care.

The goodwill agreement “Guaranteeing the Sustainability of the Health Care System” was signed between the parties as a compromise ending the strike. It lists nine central goals and takes on the responsibility for contributing to solving these goals. One of the objectives of the agreement is to guarantee the influx of health care professionals. In order to achieve that the parties take on the following responsibilities:

- Review the current agreements on state-financed places for medical students and the necessary number of residency positions;
- Specify the principles on the extent of activities for medical students in providing health care services;
- Update the principles of practical work for medical students;
- Review the principles of further training and reorganisation of competency assessment for doctors;
- Agree on principles that guarantee that in the new system of financing, the education of doctors, dentists and pharmacists receives targeted financing and doctors-faculty members receive competitive salaries.

Similar agreements were concluded with nurses, midwives and other health care professionals to guarantee the influx of workers. It is yet unknown if and how the results of the strike have affected the emigration or remigration of health care workers.

The major destination country of emigrating health care workers has always been Finland, others are Sweden, the United Kingdom and Germany (Tammaru and Viies 2012). The distance between the Estonian and Finnish capitals, Tallinn and Helsinki, is only eighty kilometres across the Finnish Gulf. The two countries are linked by frequent ferry and air traffic. As Estonian and Finnish belong to the same language group, it may be somewhat easier for Estonians to learn Finnish than other languages. However, the language barrier is minimal with two other popular destination countries, the United Kingdom and Germany. English and German are the main foreign languages taught in the education system, often at primary level.

The decisions to leave Estonia are strongly shaped by active and targeted recruitment of foreign human resources agencies that focus on recruiting medical personnel mostly to Finland but also to Germany and other countries. These companies diminish the burden of commitment for potential emi-



grates, provide information on working conditions abroad, offer free (or low cost) language courses (these are offered already to medical students), and negotiate the exact terms with the hospitals. If recruitment is successful, companies support their recruits with contact persons who help to fit in comfortably to the new living and working environment. In Tartu, a university town with 100,000 inhabitants, six HR agencies are operating to allure appropriate medical personnel to leave their home country.

Emigration to Finland is also convenient due to the growing Estonian diaspora there. According to crude estimates, the total net emigration to Finland between 2000 and 2010 was 35,000–40,000 people or 2.6% of the population of Estonia (Tammaru and Viies 2012). Diasporas provide a well-functioning network of information flows about job vacancies and working conditions in the destination country, making leaving Estonia and adaptation abroad increasingly easier (*Ibid.*)

Inflows from other countries have been insignificant – only a small number of medical doctors and dentists have migrated to Estonia in recent years, mostly from the Russian Federation (Saar and Habicht 2011) and Ukraine.

## 2. A case analysis of talent retention in the Estonian health sector

The issue of doctors' emigration from Estonia has been widely discussed in the Estonian media, but the research based on scientific methods has been rather scarce during the past ten years. Võrk, Priinits, and Kallaste (2004) have analysed the potential for emigration among health workers in conjunction with Estonia's accession to the European Union. There is a detailed country report by Saar and Habicht (2011), where the situation was thoroughly analysed based on administrative data. Alar Sepp (2012) has analysed the job satisfaction of Estonian physicians, including the subject of emigration. Kiivet et al. (2012) projected the physician workforce in Estonia to 2032, considering both the age structure of health workers and the recruitment of physicians to work abroad. Tammaru & Viies (2012) gave considerable attention to the migration of Estonian health care workers in their country report on Social Impact of Emigration and Rural-Urban Migration in Central and Eastern Europe.

This case study focuses on the talent retention policies in the Estonian health care sector. As Estonia belongs among the countries that lose their trained health personnel to richer countries, steps are needed to guarantee maintaining at least a minimum level of health workers. In order to allow policymakers to keep the career choices of the medical doctors' and nurses favourable from the state's perspective, it is necessary to be acquainted with the expectations, values, satisfaction and dissatisfaction factors of the health professionals as a group.

### 2.1. Methodology

To examine the Estonian health care system from the perspective of talent retention, a case analysis was carried out. The work comprised desk research, an e-survey among medical students and young doctors, interviews with shareholders and a synthesis of the results (Figure 1).

To get an up-to-date picture on the subject, a special module was designed for the e-survey "Becoming a doctor in Estonia 2013" to gather data on the perspectives of young doctors and medical students on emigration and push-pull factors affecting it (see Box 1). As the younger age group is the most prone to migrate and leave the home country, when designing measures and incentives for talent retention this target group should always be considered central.

The e-survey consisted of three modules: a) the factors for choosing a speciality, b) satisfaction with medical training at the University of Tartu<sup>2</sup>, and c) intention to go to work abroad and the factors affecting it. In the latter module, respondents were asked to describe the possible reasons for leaving Estonia to work abroad, or vice versa, the reasons that motivate to stay and work in Estonia.

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<sup>2</sup> The University of Tartu is the only university in Estonia offering a training programme to become a medical doctor.

**Figure 1.** Methodology for the case analysis on the talent retention of medical doctors in Estonia



Altogether, 519 free answers given by 171 medical students and young doctors were identified, where one or several reasons to stay or leave the homeland were explicitly provided (other answers provided as free text to other questions that included the reasons named above were also included in the analysis). The data were qualitatively analysed and mapped into 109 impeding and facilitating factors affecting students and young physicians' willingness to stay or leave. These were grouped into five main domains (see Table 1).

This taxonomy of facilitating and impeding factors provided a conceptual framework for subsequent research. The established categories of factors were assessed in terms of whether, and to what extent, it is possible to influence them at national, local or organisation level considering the current health care system in Estonia. Extended desk research and in-depth interviews with state and hospital representatives were conducted based on the framework.<sup>3</sup>

## 2.2. Domains of factors influencing the migration of young doctors

### WORKING CONDITIONS

The group *working conditions* comprises all the standard features of a relationship between employer and employee, usually stipulated in a labour agreement. Significant subcategories are remuneration, working environment and workload.

<sup>3</sup> Three in-depth interviews were conducted after the e-survey to gather additional information on talent retention policies: one with a senior official of Estonian Ministry of Social Affairs, two with the representatives of two hospitals.

**Box 1: E-survey “Becoming a doctor in Estonia in 2013”**

*Survey period:* 17.06–29.07.2013

*Target group:* medical students at the University of Tartu; graduates from the University of Tartu who were working as resident physicians, non-specialised physicians or were studying for a doctorate; graduates from the University of Tartu who had fully completed the medical programmes within three years and were working as specialised physicians in Estonia or abroad.

*Method:* a questionnaire form in the web environment [www.surveymonkey.com](http://www.surveymonkey.com); to recruit the respondents the information about the survey was spread through e-mail lists and social networks; answering the questionnaire was voluntary and anonymous, no data except age, sex, training or acquired education level and speciality were collected that would have allowed to identify the respondent.

*Respondents:* 374 responses were received, 288 filled out questionnaires were included in the data analysis, 85 questionnaires were excluded as they included only mandatory data (age, sex, training or acquired education level) or were likely incomplete duplicates of filled out questionnaires. 223 (77.4%) of the respondents were women, 65 (23.6%) men.

**Table 1.** Push-pull factors according to main domains

Main domain	Subdomain	Named by respondents, %
Working conditions		77.8
	<i>Remuneration</i>	63.2
	<i>Working environment</i>	33.3
	<i>Workload</i>	26.3
Professional growth		31.0
	<i>Professional development</i>	29.8
	<i>Academic/scientific development</i>	2.9
Personal/family factors		40.9
Organisation of the health care system		27.5
Societal factors		14.0

The **remuneration** is a multi-faceted issue. In the e-survey several narratives were reflected in responses linked to salary. Dominating narrative centred on the comparison with other countries – “the wage in Estonia is significantly lower than other countries”. As shown earlier, the difference between the salary of doctors in the two neighbouring countries, Estonia and Finland, is fourfold. This wage gap is emphasised in the media, therefore it is hard to ignore. Another narrative, which is closely related to the previous, is centred on the fairness aspect – the wage of doctors is seen as unfairly low in Estonia, considering the role of the doctors in society and limitations that accompany the profession.

*Considering the complexity of the work and responsibility that comes along, the salary is too low.*

24-year-old recent graduate

Other sub-narratives rise from the person-centred context: “wage as not allowing normal coping” and “earning higher salary in foreign countries as a solution to increase economic security”. As minimum salary of resident physicians is significantly higher than average wage in Estonia, these narratives are probably dependent on liabilities of households and values of the respondents.

Working as a doctor was presented as stressful, with a **workload** typically higher than the normal load stipulated in legislation. Several respondents presented emigration from Estonia as the solution to prevent imminent burnout.

*/---/ If I continue working like that I will burn out by the age of thirty. I don't have time for my children and my family because I'm working all the time. If I want to have a private life, I have to work in another social system. The moment I'm answering this survey, I have worked 22 days in a row, including six nightshifts. The salary I will get for this as a resident is ridiculous.<sup>4</sup> I have taken the Hippocratic Oath and swore to help all the patients needing help, but I will not allow ruining the life of my children and spouse by society that is abusing my oath.*

Resident working as a non-specialised doctor<sup>5</sup>

*There are not enough doctors and considering my dispositions I know that I will probably burn out.*

24-year-old medical student

#### PROFESSIONAL GROWTH

The domain *professional growth* can be separated into two subdomains: professional development and academic development. The first is connected with a wish to become a highly skilled medical

<sup>4</sup> In the summer of 2013 the minimum wage for resident physicians was 7.6 euros per hour. Hospitals may have paid more than minimum wage.

<sup>5</sup> To protect the identity of the respondents, only two characteristics per respondent are revealed.

doctor, the second with a wish to acquire doctoral level education and/or to start or continue scientific work in the field.

**Professional development** was presented as a significant reason to work abroad, at least temporarily. Gaining experience in a foreign country was seen as a part of contemporary education by several respondents.

*Working abroad is a part of education; it helps to see new perspectives in work, promote co-operation between domestic and foreign hospitals and research centres.*

24-year-old medical student

Another argument was the size of the populations; according to some opinions medical centres in countries with larger populations offer more cases of pathology, allowing young doctors to learn more of their speciality.

*There are more patients with certain pathologies in countries with a larger population, therefore allowing to establish specialised centres where know-how about the pathology is higher than anywhere else.*

28-year-old resident

Hesitations were shown concerning **academic/scientific development**. Respondents answered that conditions for obtaining a doctorate degree were exclusively seen as weaker in the homeland.

*[In Estonia] the choices of research topics are limited as the capacity of local centres is constrained.*

Orthopaedic resident

#### PERSONAL /FAMILY FACTORS

Several respondents brought up different personal or family centred factors that were seen to affect substantially (possible) decisions to leave or stay in the homeland. The decisions and intentions of the spouse were presented as both a pulling and inhibiting factor. Cultural arguments were brought up, for example the preference that the children should go to school in Estonia was presented as a reason to return.

According to some students, the geographical location of residency or working place was also relevant. Several respondents claimed that if they cannot continue their residency or work near their principal residence and a change of residence is required, they would rather move abroad.

*I would like to work in Tartu where the number of jobs for medical doctors is limited. If I cannot work here, I'd rather go to work abroad.*

Resident physician in medical rehabilitation

#### ORGANISATION OF HEALTH CARE SYSTEM

The domain *organisation of health care system* includes organisational aspects of providing health care services, but also organisation of the educational system preparing doctors. It was perceived that health care is not a priority sector in Estonia, and necessary changes are unlikely to happen soon enough.

*/---/The general medical system is on the brink of a disaster and collapse. Working elsewhere helps to understand the situation. The difference is in the attitudes, working conditions and wages. The current system is unable to stop a young doctor from going abroad.*

25-year-old resident

The transition to residency after basic training was presented as a dominating bottleneck by medical students. As the number of places in residency is limited, there is the possibility that recent graduates are not able to start the residency in their preferred speciality. Without the completion of residency they are only able to work as a non-specialised physician – a position that is low-valued in Estonian hospitals.

*[Going abroad] depends on if I can enter the residency in my chosen speciality. If not, I'm going to study abroad. I will not certainly stay to work or rest for a year.*

24-year-old recent graduate

#### SOCIETAL FACTORS

The domain *societal factors* included the general factors like attitudes towards the doctors among patients and policymakers and living standard in society.

## 2.3. Retention practices in Estonia

Different retention policies in different levels are used in Estonia to motivate the health care workers to stay in the organisation, region or the state. To map the practices currently in use in Estonia, desk research and in-depth interviews with state and hospital representatives were conducted. To illustrate the context of the Estonian health care system, the research team subjectively assessed the affectability of the push-pull factors treated above, considering the organisation of the health care system but also the policies discovered and their implementation rationales. These results are shown in Table 2. The retention policies and the context are described in the following subchapters.

#### ORGANISATIONAL LEVEL

An organisation offering health care services can control almost all the aspects of working conditions, and factors connected with professional growth of its workers. The affectability of other factors is poor.

**Table 2.** The framework of push-pull factors and the assessment of the affectability of these factors at different policy levels

Main domain	Subdomain	Policy level		
		Organisation	Local	State
Working conditions	Remuneration	Medium (strong)	Low	Strong
	Workload	Strong	Low	Strong
	Working environment	Strong	Medium (strong)	Medium (strong)
Professional growth	Academic/scientific development	strong (medium)	Low	Strong
	Professional development	Strong	Medium	Low
Personal/family factors		Low	Low	Low
Organisation of the health care system		Low	Low	(Strong)
Societal factors		Low	Low	Medium/low

The salary paid by the health care organisation is the subject of negotiations between a worker and the management of an organisation. However, the salary range depends on the minimum wages agreed upon in collective bargaining on the one hand and the price list of Estonian Health Insurance Fund on the other. The latter is confirmed and signed as a government act. When calculating the wages, the organisation must consider current commitments with the Health Insurance Fund and potential contract volumes in the future, the investment needs of facilities, staff turnover, and other variables.

The remuneration policies in different organisations vary greatly. In several hospitals the information on the ranges of salaries is publicly available for the staff. Some providers offer bonuses for key employees. However, the issue is complex regarding the workload. Although normative work time and remuneration of extra working hours are stipulated in legislation, according the health care workers it does not apply in the practice of health care organisations. Sometimes barely legal solutions and verbal agreements are used to overcome staff shortages. It is speculated that if the fully legal limits were used, the service providers would be unable to perform the contracts and would not be able to offer the salary levels they are offering now. Therefore, attempts to comply with the law would result in worsening the remuneration of workers and accelerate the emigration of health care workers. The



aspirations to stipulate strict workload standards in collective agreements have not yet reached the desired results.

To keep highly professional health care workers from fully emigrating, part-time positions are offered. There are medical doctors who work in Finland during weekends and in Estonia during the week, while some radiologists residing in Estonia provide cross-border services abroad over the Internet (Saar and Habicht 2011). There are hospitals that offer stipends to the residents and trainee nurses. In return, the latter are obliged to come to work in the hospital for the certain period after graduation.

#### LOCAL GOVERNMENT LEVEL

At local level the possibilities to affect talent retention are rather weak. Although representatives of local government are usually represented in the boards of local hospitals, the differentiation of management puts the levers to shape working conditions in the hands of organisation management. Local governments can affect environmental aspects of working conditions only indirectly, by supporting renovation or constructing new buildings for providing health care services.

In Estonia, mostly supportive measures are offered by local governments to health care workers. For example, low-priced (temporary) accommodation is offered to health care workers who start working in a hospital or family physician practice within local government. In Pärnu (a town in western part of Estonia), which provides municipality kindergarten services, the children of health care workers (but also policemen and rescuers) are put in priority status.

#### STATE LEVEL

At state level, there are several general levers to respond to the factors affecting the motivation of health care workers to stay in their homeland. As in many other countries with public health care systems, the main state level policies to support the working conditions of doctors are the funding of health care and the legal framework regulating the provision of health care services. In the context of prudent fiscal policy, the government's chances to increase vigorously the wages of health care workers are clearly limited. However, as natural experiments in Estonia and Poland have demonstrated, emigration has slowed down after advance in salary – increased levels of salaries coincided with a significant fall in health professionals applying for recognition of qualifications in subsequent years, implying a causal relationship (Ognyanova et al. 2014; Kautsch and Czabanowska 2011; Saar and Habicht 2011).

In Estonia the financing of public health care goes through taxes, namely through social tax – 13% of workers' salary go directly to national Health Insurance Fund. This tax rate has remained unchanged for two decades. With minor exceptions, no additional funding through other taxes is used in Estonia. The regulation of provision of health services has undergone minor edits after Estonia joined the European Union.

Currently, there is only one measure at state level that directly addresses the emigration of doctors from a remuneration aspect – a beginner's allowance for young doctors that was implemented in the end of 2012. This allowance is meant for young doctors who have completed the residency and are starting their work as a doctor outside the two largest cities, Tallinn and Tartu. The size of the allowance is 15,000 euros (it is taxed with 20% income tax), for which the beneficiary must work for five years in Estonia as a doctor or the allowance is to be returned.

To support professional growth the state could promote teaching and academic studies using different incentives. However, lecturing for medical students in Estonia is less well paid than practicing as a

doctor. As respondents of the survey expressed, there are several high-quality lecturers with super teaching skills for whom the teaching is their mission but some of the lecturers are clearly burned-out practitioners and/or without adequate teaching skills. No steps at state level have yet been made to harmonise the quality of basic training or tutoring at residency level.

Another bottleneck in academic growth is acquiring a doctoral degree in Estonia. As residency cannot be passed part-time, a medical student interested in an academic career must choose between becoming a practitioner and becoming a scientist after passing basic training. Mixing both in Estonia presumes ultimate devotion, in several other countries in the Baltic Sea Region such a choice can be put into practice without superhuman skills.

Although the state has all the levers to organise the health care system, it is clear that there is not one right solution. As the Estonian health care system is assessed as one of the most effective systems in the world, only fine tuning of the provision of services is topical.

The measure not yet fully discussed in Estonia is to adapt national legislation as well as enter into bilateral and multilateral agreements on workforce migration following the WHO Global Code of Practice on the International Recruitment of Health Personnel. The Code establishes and promotes voluntary principles and practices for the ethical international recruitment of health personnel and the strengthening of health systems. It is a multilateral framework for tackling shortages in the global health workforce and addressing challenges associated with the international mobility of health workers (WHO 2014).

## 2.4. Summary

As the Estonian health care personnel case has demonstrated, talent retention is a complex issue for an EU country where living standards are significantly lower than in several other countries in the Baltic Sea Region. The need for talent retention in the health care sector has reached the consciousness of the Estonian policymakers. However, a plan of action is still missing. The elaboration and implementation of a human resource strategy is vital for the proper functioning of the health care system.

As shown, the potential measures for talent retention are at the state level and the capability of the organisations depends strongly on the steps taken at state level. At local government level supportive measures can be provided. However, more holistic and proactive cooperation is needed between different levels to ensure fruitful policies.

First of all, the bottlenecks that push away knowledge workers who are always welcomed abroad should be eliminated. Career paths should be backed up and acceptable second options in the homeland presented. In the case of the transition to the residency after graduation – the restricted access to the residency in the context of the looming shortage of doctors is clearly not in accordance with the principle that countries should protect their investments. It is paradoxical that in a country where there is a sharp shortage of doctors looming, the organisation of the training process is designed in a way that a pause in the process may occur for some recent graduates. Uncertainty about their future may affect some medical students to think early on about going abroad, where the process of becoming a doctor is solved with more flexibility.

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