THE MIGRATION OF THE ROMANIAN PHYSICIANS: SOCIO-DEMOGRAPHIC AND ECONOMICAL DIMENSIONS

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Summary
The migration of the Romanian physicians is a very actual part of the more general labor force migration phenomenon in Romania, and its socio-economical relevance regards its effects on the public health system. The magnitude of the phenomenon is difficult to be outlined only in the light of the current official statistics that do not encompass all its aspects and cannot provide a complete and exact image of it. The analysis and the interpretation of the statistical data provided by the most important institutions of Romania, by the international organisms and by some studies published in this field of activity at national and regional level, and also of the information offered by the media have allowed us to have a better knowledge of the socio-demographic and economical dimensions of the Romanian medical migration phenomenon. Using different statistical sources, we have tried to avoid the possible unilateral intentions that could have be contained in some studies, so because of this fact we have made the analysis complete by using for this purpose the interpretative method inspired by social constructivism, hermeneutics and phenomenology. The results obtained in this study are represented by the emphasis on the current characteristics of the Romanian public health system and the implications of the current level of financing on the stability of the system in the light of the medical migration.

Key words: medical system, sanitary system, the human resource in the sanitary system, the financing of the sanitary system

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1. The characteristics of the Romanian public health system in the light of the existent medical resources and the current financing level of the system

1.1. The polarization of physicians in the urban areas

The statistical data (from the National Institute for Statistics 2012) showed a high level of polarization among the physicians from the urban areas. In the year 2011, for example, the number of physicians from the urban area was 46,949 (89 percent), and there were 5,592 physicians in the rural area (11 percent), this fact showing serious regional imbalances. Therefore, the number of inhabitants for one doctor in the rural area is currently over six times higher than in the urban area, and approx. 100 rural villages do not have any available doctor. The explanation is given by the fact that the urban areas – and especially the university centers – are absorbing the physicians from the neighboring or rural areas, which makes them even more disadvantaged.

The distribution of physicians in the development regions of Romania is also imbalanced, as it can be seen in the data presented in the table below:

**Table no. 1. Distribution of physicians (excluding dentists) per development regions in the year 2011**[1]

<table>
<thead>
<tr>
<th>Number of physicians</th>
<th>Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total country: 52,541(public and private sector) of which, per regions:</td>
<td>52,541</td>
</tr>
<tr>
<td>- NORTH-WEST</td>
<td>7,714</td>
</tr>
<tr>
<td>- CENTER</td>
<td>6,039</td>
</tr>
<tr>
<td>- NORTH-EAST</td>
<td>6,765</td>
</tr>
<tr>
<td>- SOUTH-EAST</td>
<td>4,763</td>
</tr>
<tr>
<td>- BUCHAREST-ILFOV</td>
<td>11,825</td>
</tr>
<tr>
<td>- SOUTH-MUNtenia</td>
<td>4,499</td>
</tr>
<tr>
<td>- SOUTH-WEST OLTENIA</td>
<td>4,636</td>
</tr>
<tr>
<td>- WEST</td>
<td>6,300</td>
</tr>
</tbody>
</table>

This present state of affairs has negative influences on the way in which the medical services demand is met in these regions. For example, in the regions SOUTH and SOUTH-EAST there are 773, respectively 655 inhabitants for one physician, while in the region NORTH-EAST there is one physician for 2.778 inhabitants. We can observe a major lack of medical personnel in many counties, such as Alba, Maramureș, Vaslui, Suceava, Arad and Constanța. The external migration of the Romanian physicians has amplified and tends to amplify even more the lack of physician per total, per regions and for certain specializations that are very much demanded in the EU (anesthesia, intensive care, surgery, family physicians etc.)

1.2. The level of allocated resources

The financing amount of the sanitary system can be followed by analyzing two important indicators: the total expenses for health and the public expenses for health/inhabitant.

The total expenses for health, expressed as percentage level from the GDP for the years 2000 and 2007 in Romania were of 5,2 percent, the lowest level in the European Union, while the average recorded in the 27 EU countries has known much higher and increasing values, of 8,4 percent in the year 2000 and 8,8 percent in the year 2007. The highest values of the total expenses for health in the GDP were recorded in this period in Germany (10,3 percent), France (10,1 percent), Austria (9,9 percent), Belgium (9,1 percent), Sweden (8,2 percent) and so on (WHO «Global Health Organization» 2010).

Public expenses for health/inhabitant in the same period were also the lowest in comparison with the EU countries (202 $/inh., respectively 475$/inh.), while the average in the European area was 901 $/inh., respectively 1.401 $/inh. Much higher and increasing levels were recorded in countries like Luxembourg (2.800 $/inh., respectively 5.212 $/inh.), Austria (2.169 $/inh., respectively 2.875 $/inh.), Germany (2.128 $/inh., respectively 2.758 $/inh.), France (2.076 $/inh., respectively 2.930 $/inh.), Malta (2.104 $/inh., respectively 3.140 $/inh.), Denmark (1.960 $/inh., respectively 2.968 $/inh.), Sweden (1.938 $/inh., respectively 2.716 $/inh.) and so on (WHO 2010). Although there are economical delays within the European Union
countries, the data that were presented, as percentages from the gross
domestic product, show how much from the GDP is allocated by each
government for health expenses. If we would go further with our
analysis, we could say that this data can have different and opposite
meanings and interpretations: they can show how much does the
government care to ensure the right to health care for the citizens or,
taking into account the international pressure regarding the budgetary
restrictions etc., how much a government can afford to allocate for
health. Therefore, the level of public expenses for health can be
transformed in a political weapon that can be used either by the
government or by the opposition parties as critics to the government.
But behind these political games there is the citizen, who has to fight for
his fundamental right to health care and who will perceive the weak
financing of the system as a political act of indifference regarding the
quality of his life. Also, the political combats and the unsuccessful
reform of the sanitary system increase the mistrust that the young
physicians have in their professional future in Romania (Manea 2011).
The financing amount of the sanitary system directly influences also the
professional satisfaction of the physicians, fact that is visible through
indicators such as: the type of activity performed, the work volume, the
income obtained, the relationships with the coworkers, the work
conditions, the grant of awards/incentives, the policy of promotion and
professional development and so on (Moldovan 2006, pp. 155-190). The
remuneration level of the medical personnel in Romania can be
considered a factor of type “push” for migration, valid not just for
physicians but also for the other categories of medical personnel. The
physicians’ professional satisfaction in the light of the income obtained
is dependent on the level of the country’s economical development and
can be determined by comparing the individual gross income of the
physicians with the average level of the salaries per total economy. The
international statistics show big differences between countries (OECD
2009). Therefore, in the year 2009, the relation between the gross
income of a physician and the average income was 1,4 in Hungary, 2,6
in France, 3,1 in Holland, 3,3 in Germany, 3,7 in the USA, 4,3 in the
United Kingdom etc. In the case of specialist physicians, this relation is
much higher. In Romania, the relation between the basic salary (no
additions) and the average gross income at national level in the year 2009 was 1,003 for attending physicians and 0,53 for 1st year resident physicians (National Institute for Statistics, 2010). This data emphasize what was stated previously and that is the feeling of the physicians that their social value is ignored, through the "salary message", which could be interpreted like this: this is how much your education values in relation with the level of the society. An extremely disadvantaged situation is seen among young employed physicians. For example, the salary of a first year resident physician is around 1.000 lei (Government’s Ordinance nr. 17 for the amendment and addition of Government Emergency Ordinance nr. 115/2004 regarding the salaries and other rights of the personnel contracted in the public health medical units from the medical sector 2008). The level – already low – of the medical personnel salaries was affected in the following years by the austerity measures taken by the Government (Law nr. 18 regarding some necessary measures to be taken in order to re-establish the budgetary equilibrium 2010), when all salaries from the budgetary sector were reduced with 25 percent and the meal tickets started to be taxed. Currently, according to the international statistics, the average salary of the physicians from the European Union is approx. 3.500 Euro, which is approx. 10 times higher than the salary in Romania. If we are to consider only these raw numbers, we can understand why the level of the average salary from the EU acts as a “pull” factor of the migration from the perspective of a Romanian physician. The marketing of the health care services (Held 2006, pp. 106-128) at the level of EU shall determine the Romanian physician to trade the cultural capital – the medical studies, the learned skills – for an economical capital (salary fees) and a social capital (a better social status) (Bourdieu 1986, pp. 241–258).

The physicians’ professional satisfaction depends also on the conditions of performing the work: endowments, adequate personal protective equipment, and so on. Many Romanian physicians work in unfavorable conditions, not having even medicines or certain consumables (gloves, bandages etc.) necessary for giving the patients an adequate treatment. If we add to these issues, which are caused by the weak financing of the public health system, other specific factors, such as the stress conditions, overworking, lack of appraisal and respect
for the importance of the work they perform and the *corruption* within the system, the choice of emigration becomes fully motivated act.

As a conclusion, the money invested in the health system must be considered a *long term investment* and not a simple expense. Likewise, there should be a greater transparency regarding the spending of public money within the health system and money waste should be stopped. The maximum necessity would mean finding some urgent solutions for increasing the financing in the public health system, because the reduced level of the public resources allocated for health directly influences the quality of the medical performance and represents an important motivational factor of the medical migration.

2. The evolution of the Romanian physicians’ migration abroad

According to the data owned by the College of Physicians, the departures of the Romanian physicians abroad are quite significant, if we compare them with the number of people employed in the national health system, which was, in average, in the last years of approx. 50.000 (52.541 physicians in the year 2011, of which 41.171 physicians in the public sector (National Institute of Statistics 2011). The most departures of Romanian physicians was from the university centers of the country (Bucharest, Cluj, Iaşi, Timiş), and the most frequent countries were France, the United Kingdom, Germany, Italy, Spain, Sweden, Ireland, Holland, Canada, Belgium, Austria, Portugal and Cyprus. We can also see the fact that the specializations most demanded by the employers from abroad were general medicine, family medicine, general surgery, anesthesia and intensive care. According to the statistics (Romanian College of Physicians 2012), the number of physicians departed so far is approx. 20.000, of which 10.000 physicians have departed before Romania joined the European Union, and approx. 10.000 physicians left in the next 5 years, as it can be seen in the data presented below:
Table no. 2. The number of physicians departed from Romania between 2007-2011 \[1\]

<table>
<thead>
<tr>
<th>Years</th>
<th>Nr. of people</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>2.200</td>
</tr>
<tr>
<td>2008</td>
<td>1.252</td>
</tr>
<tr>
<td>2009</td>
<td>1.900</td>
</tr>
<tr>
<td>2010</td>
<td>2.779</td>
</tr>
<tr>
<td>2011-first 8 months</td>
<td>1.700</td>
</tr>
</tbody>
</table>

It is of concern 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 (curs de guvernare.ro). Because of this reason, some pessimist scenarios lead to the idea that if the current situation of physicians’ migration remains as it is, there shall be no doctors left in Romania in the year 2012 (News.ro 2011). The future seems dark, as the requests from the Minister of Health to issue the documents necessary to recognize the official qualification titles for the profession of physician obtained in Romania (“the conformity certificates” or the so-called “good standing”) are increasing each year, their number reaching the record figure of 6.160 requests in the year 2011 (Ministry of Health 2011). We must notice here the fact that the Ministry of Health is not aware whether the conformity certificates are used by the ones that requested them, the respective persons could choose to leave abroad or keep them in order to use them when the favorable opportunity comes up, but they show the intention, even if it is a latent one, to emigrate. Despite all these, we believe that this phenomenon is alarming, fact that is resulted also from the studies made lately. For example, following a study made by the Federation “Sanitary Solidarity” in the year 2010 in the region SOUTH-EAST, the results showed that 38 percent are determined to leave abroad, and 30 percent of the medical staff has already made undertakings to leave or they are about to (Federation “Sanitary Solidarity” from Romania 2010).

From the data presented in table 3 we can observe that the percentage of physicians that left during the last years from the total of Romanian

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\[1\] Source: the Romanian College of Physicians, available at: http://www.cmr.ro
physicians is higher in the counties of Iaşi, Arad, Bihor, Cluj, Constanţa, Timiş and the county of Bucharest (cursdeguvernare.ro). The fact that many physicians from big cities are leaving can also be explained by the fact that there are many migration networks (Ryan 2007, pp. 295-312), and some traditional institutional exchanges between university centers or a better access to the information regarding emigration, such as the job fairs etc.

**Table no. 3. The percentage of physicians emigrated from the total of physicians, per county**

<table>
<thead>
<tr>
<th>Percentage (%)</th>
<th>Counties</th>
</tr>
</thead>
<tbody>
<tr>
<td>- under 1 %</td>
<td>Argeş, Bistriţa-Năsăud, Brăila, Braşov, Călăraşi, Dolj, Galaţi, Ialomiţa, Mureş, Prahova, Suceava, Tulcea, Vaslui, Vrancea</td>
</tr>
<tr>
<td>- 1-2 %</td>
<td>Botoşani, Caraş-Severin, Covasna, Dâmboviţa, Gorj, Harghita, Mehedinţi, Olt, Teleorman, Vâlcea</td>
</tr>
<tr>
<td>- 2-3 %</td>
<td>Alba, Bacău, Buzău, Giurgiu, Maramureş, Neamţ, Sâlaj, Satu-Mare, Sibiu, the agricultural sector Ilfov</td>
</tr>
<tr>
<td>- 3-4 %</td>
<td>Bihor, Cluj, Constanţa, Timiş, Bucharest</td>
</tr>
<tr>
<td>- 4-5 %</td>
<td>Arad</td>
</tr>
<tr>
<td>- over 5 %</td>
<td>Iaşi</td>
</tr>
</tbody>
</table>

Another major problem linked to the migration of Romanian physicians is that some physicians are famous specialists in some fields, but also they are prestigious university professors, therefore their departure means also losing super qualified professionals and losing some mentors for the future generation of physicians. This phenomena risks, also, to damage even more the level reached by the indicator *medical density ratio (physicians/10.000 inhabitants)* in Romania, indicator that is already at a very low level in comparison with the one recorded in the countries from the European region. Therefore, in the period 2000-2009, when the average number of Romanian physicians from the public health system was 41.456, the level of the indicator was 19 physicians/10.000 inhabitants, as opposed to 33 physicians/10.000 inhabitants. A higher level of the indicator for this period was recorded in countries such as Belgium (42 physicians /10.000 inhabitants), Lithuania (40 physicians /10.000 inhabitants), Holland (39 physicians

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/10,000 inhabitants), Spain and Austria (38 physicians /10,000 inhabitants) and so on (World Health Organization 2010). Although in the year 2011 the level of the indicator for Romania reached 25 physicians/10,000 inhabitants, our country is currently holding the last place in Europe (National Institute for Statistics 2011). The dimension of the negative number of the medical migration has transformed Romania in the “biggest exporter of doctors”. Theoretically, this situation should not be considered a danger, because migrations can be considered a normal phenomenon, especially in the light of globalization. But the proportions of this phenomenon are alarming for Romania, because they affect the provision of the right to health care for the citizen, as a fundamental right.

3. The negative effects of the labor force migration

Although there are also positive effects of the labor force migration, such as the deliveries, the formation of some connections with the diasporas and the facilitation of experience exchanges, or in some moments even the provision of jobs for some professional categories that cannot be absorbed by the internal market, we shall enumerate some of the negative effects of the labor force migration in general.

An important effect is represented by the modification of the demographic structure of the population: the continuous decrease of the young population, the acceleration of the aging process of the population, the decrease of the birth rate and of the fertility following the growth of the number of migrant women.

The negative consequences at the level of the family, such as the imbalances in the couple relationship (including divorces), child abandonment, school abandonment are added up to the list of social problems created by the massive migration. The loss of an important segment of the cultural capital by losing specialists should also not be ignored. Another consequence is the diminution of the labor force potential and the effect on the economic growth in general. The resorbence of the unemployed people at a given time can be considered a short term advantage for the labor market, but with possible severe long term imbalances for it.
4. The socio-demographic and economic dimensions of migration

4.1. Socio-demographic dimension

4.1.1. Decrease in the population number, decrease in the number of young population and the aging of the population

The population of Romania was reduced dramatically after the year 1989, more precisely with approx. 3 million inhabitants, due to the influence of three major factors, which are: the negative external migration (which is higher than the natural growth), an increased death rate (that exceeds the level of the birth rate) and the return of the birth rate, which is under the level of the death rate. We can also observe a decrease in the number of the young population that narrowed even more the base of the age pyramid (the National Institute for Statistics 2011). This phenomenon was determined also by the evolution of the gender structure of the emigrants that was and still is dominated by women, them representing in the year 2007 over 65 percent of the total number of emigrants. Comparing the structure of the emigrants per age groups with the one of the total population we can notice that the migration tendency reaches maximum levels among people between 26 and 40 years old and is very reduced after the age of 50 years old (National Institute for Statistics from Romania 2008, p. 37). These evolutions can also be found among the medical personnel that faces an aging phenomenon. In the year 2011, for example, of the total number of physicians existent in the Romanian health system– 52.541 physicians, of which 41.171 in the public sector – the number of physicians over 45 years old was 23.583, representing 45 percent of the total (National Institute for Statistics 2012). Likewise, the percentage of women in the total number of Romanian physicians for the year 2011 was 69 percent, and the total number of pharmacists was 90,1 percent (National Institute for Statistics 2012). We cannot state that the migration of the Romanian physicians has an overwhelming influence on the current demographic situation. In comparison with the total number of emigrants, estimated at approximately 3 million people, the number of emigrant physicians is extremely small, of approx. 20 thou-
sands, but the migration of physicians is part of a whole and evolves in the same direction. We could think of the indirect demographic effects, such as a possible inadequate quality of the health services could affect the death rate, or that the social disappointments are not an encouragement factor for birth. The emigration of women, especially in the areas of high qualification that require a continuous professional learning, are also, a negative influence factor on the birth rate.

4.1.2. The endanger to the operation of the health system from Romania

At a first glance, the diseases that cause most deaths among the population of Romania seem to be connected to the specializations affected by the physicians’ migration: cardiology, anesthesia and intensive care, internal medicine, emergency medicine and surgery. It is difficult to make a categorical statement regarding these issues, because the factors that intervene in the occurrence, evolution and the treatment of a disease are much more complicated. The influence of the environment, sedentariness, pollution, inadequate food, the life style, alcohol or nicotine abuse are important factors on the health conditions and are difficult to monitor. On the other hand, the costs of the medical treatments, the access to medication and to adequate treatments are directly linked to an unsatisfactory reform of the medical system. If we add to this the loss of human resources, because of the medical migration, we can outline an immediate danger of the MM on the health system and on the general health condition of the population. As a raw fact, Romania is currently holding the last places in Europe for most indicators regarding the health state of the population (death rate, morbidity, unjustified death rate, and so on). A policy to attract and maintain the human resources could be a first step in the healing of the Romanian health system, especially because the physicians that would come back from abroad would benefit of a trans-cultural experience useful to the medical reform.

4.2. Economical dimensions

As we previously stated, a general consequence of the labor force migrations is the bear on the long term economic growth. There is a
direct and positive link between the education degree of the population of a country and the long term economic growth. Therefore, the migration of qualified and highly qualified persons, category that includes also the physicians, represents a negative externality for the country of origin. The loss of the cultural capital and the loss of public resources invested in the professional formation of the physicians bear on the society in general (Bourdieu 1986, pp. 241–258). Part of a larger phenomenon, met under the name “the migration of brains”, the migration of the physicians has important economical connotations, because it represents a loss for the country of origin, more precisely the cost to form human capital. The size of this cost differs from one country to another and depends, mainly, on the economic development extent and on the organization of the social system (Simion 2010). This loss has two components, which are the “formation cost” and the “specialization cost”. The “formation cost” is represented by the public expenses (education, health etc.) that a state must pay in order to produce a “trained adult” for the labor force, until the age of 18, of full age. It is observed that this cost does not include the money for the care services provided by the family. According to Alfred Sauvy, a famous demographer and economical analyst, this cost can be estimated to 5.5 years of national production per an active person. The “specialization cost” reflects the public resources invested in the superior professional formation, as it is the also the case of physicians. In Romania, for example, the annual expenses for preparing a medicine student are currently of approx. 8.000 RON, and for one year of residency the Romanian state spends approx. 21.000 RON. The result is that for the formation and the specialization of a physician for a period of 6-11 years (6 years of college and 3-5 years of residency) the Romanian state spends approximately 70.000 RON (approx. 20.000 EURO). If until now approx. 20.000 physicians left Romania, this means that the Romanian state lost so far approx. 400 million EURO, an amount that could be considered small, if we did not know the fact that Romania is currently the European country with the smallest level regarding the indicators “the percentage of total expenses for health in the GDP” and “public expenses for health per inhabitant”. Each year, the value of these losses amount to a few tens of millions of Euro, calculated for the entire
country. Therefore, the total loss for an emigrant becomes much higher, being made out of two types of public expenses (“the formation cost” and the “specialization cost”) and the private expenses of the family (the money for the care services provided by the family until the age of 18 years old for that person). Also, the state budget is deprived of a series of incomes from taxes and contributions (tax on incomes/salaries, contributions to the retirement fund and social security, various taxes and local taxes etc.).

The medical migration leads to an erosion of the middle class, which is considered the cornerstone of any modern society.

In order to outline an image of the MM phenomenon that is as realistic as possible, we must remind of the money flow that is represented by the transfer of funds from abroad to the families or to the relatives left in the country (deliveries). These amounts represent for some developing countries – after the direct foreign investments – the second important source of external funds, with powerful implications both at micro economical level and at macro economical level. The international statistics (World Bank2011) show that the value of these transfers for Romania has continuously increased in the last years, having a return moment after the world financial crisis broke out in 2009:

**Table nr. 4. The value of deliveries for the period 2003–2010 (mil. USD)[1]**

<table>
<thead>
<tr>
<th></th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value</td>
<td>124</td>
<td>132</td>
<td>4,733</td>
<td>6,718</td>
<td>8,542</td>
<td>9,381</td>
<td>4,928</td>
<td>4,517</td>
</tr>
</tbody>
</table>

The effects of the money transfer at macro economical level are quite difficult to measure because of the multiple interactions at the level of the macro economic variables. The considerable effects are the investments and the savings. The most visible impact of these transfers is recorded on the consumption of the households, so important at macro economical level, being recorded in the internal cumulated demand, part of the GDP. The money transfers towards households represent direct sources to increase their incomes, which leads to the

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increase of consumption and implicitly to the temporary reduction of poverty and social polarization, due to the redistribution effects. The statistics at national level show that, in the last years, a significant part of the Romanian population has purchased long lasting goods (appliances, houses, cars etc.) or has chosen to extend/modernize their house, but the deliveries represented a quite reduced percentage among the financing sources of these activities (Roman and Voicu 2010, pp. 50-65). Reality shows that in many countries, of which Romania also, these amounts are not directly reinvested in productive activities or in the human capital that exists in the public health system. As a consequence, these transfers cannot, on short term, compensate the losses suffered due to the departure of the experienced medical personnel from the public health service. In many countries, the accumulation of financial, human, relational capital can become for emigrants – including for the medical personnel involved in this phenomenon – an intermediary strategy for an entrepreneurship strategy. The strategy is possible by promoting some fiscal and budgetary policies to stimulate the investment of these resources with a productive purpose. Unfortunately, it is difficult to know the real value of the external financial resources in Romania because of many reasons: the statistical data are incomplete and insufficient, the deliveries announced by the BNR refer only to the bank transfers and do not include the amounts in cash brought in the country by the emigrants, the methodology used by the BNR is not identical with the one used by the World Bank and there are no national statistics regarding the size of the amounts sent by the emigrant physicians to their families.

**Conclusions**

The migration of the brains from Romania, including the medical personnel, is a phenomenon that cannot be stopped, but can be controlled and used for the national interest. This is more necessary and more urgent as many developed countries currently use various levers of economical, budgetary and fiscal type in order to attract specialist from all fields that come from the countries less economically
developed. Some recent studies (Giannoccolo 2003) talk about a true “fiscal competition” that currently takes place between the European developed countries and the developing countries from Central and Eastern Europe, as it is the case of Romania, with regards to attracting specialists from various areas, including physicians. The “weapons” used by the public authorities from these countries are diverse: salaries growth and/or diminish of taxes for intellectual researchers (in the United Kingdom, Austria, Sweden, Holland, France), reductions or exemptions of taxes for the companies that invest in research (Ireland), the carrying out of public investments in research (Ireland, Germany, France, United Kingdom) and so on.

The ethical codes to recruit the medical personnel should function as an instrument that protects the medical resource from the developing countries, or from wherever the human resources are lacking (Cehan and Manea 2012, Dornescu 2012).

These codes are a beginning to approach the problem of a global moral responsibility that the rich countries have for the poor ones. The emphasis on global responsibility is an alternative to excessive marketing, especially of the global marketing of the health services (Held 2006, p. 106-128). The economical and demographical data that we have presented encompass a few of the negative dimensions of the medical migration. The message conveyed by this data especially indicate the sub financing of the health system and the negative consequences of this sub financing.

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References


Statistical data


**Legislative documents**