

# International mobility as a process

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## 2.1 Mobility of health workers: who, what, how?

As the goals of migration may differ, thus experiences during and after migration vary. For instance, German interviewees report language problems, especially in the beginning of their professional functioning in Germany, and, more for nurses than for doctors, 'social distinctions' made by patients. Probably the smaller 'social distance' between nurses and patients as opposed to doctors and patients, plays a part here, while one may assume more patient contacts with nurses than with doctors and, thus, more opportunities that such events occur. As a consequence, personal satisfaction after migration may be highly differentiated, even when the migrant is happy on a professional level. Yet that is not always the case: a political refugee among the German interviewees is totally dissatisfied but his decision to come to Germany was more to flee than a positive decision to come to Germany, hereby adding to a conclusion of ► Chap. 3 that often a push starts the process, rather than the pull.

As shown by studies conducted in countries that were to accede to the EU in 2004, many health workers in these countries indicated their intention to depart and work elsewhere in the EU; however, for most of these countries the outflows remained more limited than expected. Even in Ghana, where inclination to depart was extremely high, between 1999 and 2003 'only' 83% of those that requested verification of their qualification actually left the country to work elsewhere. A Lithuanian study, which validated the verification at the register of the country for which verification was requested, showed that in the year following EU-accession (April 2004–April 2005), 26% of the requests for verification by physicians were actually implemented; in the subsequent year 21%. For nurses for the two years, percentages were 75% and 43%, while for dentists shares were 75% and 71% (Starkiene, Padaiga, Reamy, & Pukas, 2008). These data imply that, between attitude and behaviour, many aspects can shape perceptions and perspectives, ultimately influencing the decisions about migration. Recruitment agencies can play a

role here but so can 'success-stories' from others or the existence of diaspora communities in recipient countries. Moreover, traditions may be relevant, as well as new schemes, varying from easy access to relevant positions abroad through the internet to modern migratory patterns. These are discussed in this section. This chapter follows a migrant's process before, during and after international mobility, including questions relating to integration, remittances and subsequent steps amongst which is possible return migration. The next chapter will shed light on the issues and themes that play a role in decisions about migration.

### 2.1.1 Commuting, locums, travelling, adventure, escape and emigration

Out-migration takes many shapes and forms. It varies from cross-border day-to-day or short term commuting, to temporary migration or 'travel', to migration with the purpose of establishment (and naturalisation). Egyptian medical professionals going abroad may consider this 'travel', which may last anything between a week to ten years. Only when one applies for citizenship in the host country is the move to be considered 'migration'.

In some cases, however, mobility, as discussed, follows the need to escape. Political factors may require fleeing to avoid threats to oneself. This may lead to asylum seeking. However, in such cases, options to practice as a health professional in the receiving country may be very limited due to the complexities involved with gaining legal residence, subsequently followed by assessment of one's health professional capacities (► overview).

#### Asylum and the right to practice in the new home country

The national reports do not provide much evidence on health workers entering a country as asylum seekers. One may expect that such flows are relatively small in most receiving countries. There may be others entering the country as a health worker but, who, in the

end, have a similar background of escaping personal or political dangers. Furthermore, asylum procedures can be lengthy and can lead those who were qualified in their country of origin, to lose experience and requirements to seek recognition of qualifications. Given most asylum procedures one must also take into account that requests for recognition of qualifications can be difficult.

- First, such requests can only be done *after* being accepted in the receiving country, which may take several years.
- Second, if and when accepted, the recognition procedure will require a case-by-case approach as, in the EU, the relevant Directive does not apply to non-EU qualifications.
- Finally, it is more likely than not that major differences will be perceived between qualifications and experience gained in the country of origin and those required in the receiving country.

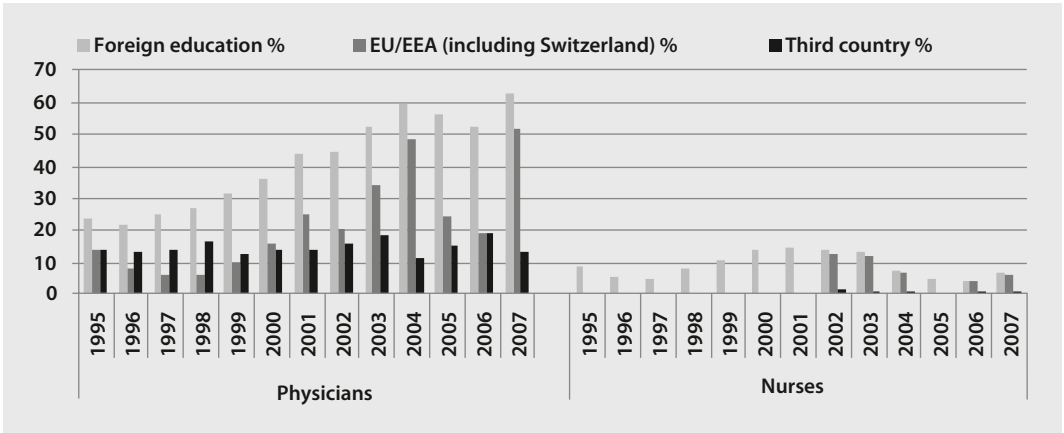
This will require the health professionals to regain qualifications by substantial additional studies, including internships. These may easily be hampered by language problems (when the procedure is ongoing it may be difficult for an asylum seeker to start learning the host country's language) as well as by possible caps on entry or lack of resources to pay for the education.

Furthermore, costs of re-education, as well as going through the procedures mentioned, can be high. Finally, in the process of escaping country A and asking for asylum in country B paperwork may be lost, leading to loss of evidence of qualifications. Moreover, it may be hard to check the validity of such qualifications in the country of origin. Thus, while asylum seeking may be a background for some of the internationally mobile health workers, it is likely that they do not show up in the data because of small numbers but also because of difficult recognition processes that are likely to lead them, when residence is granted, to need to find other jobs.

Polish doctors tend to do short shifts abroad and are, in the mean time, replaced by colleagues, others sign one-year contracts abroad. Shifts can vary from a weekend to three months. Many of those who went abroad after EU enlargement went to the UK; or rather, repeatedly go to the UK. Functioning as a residential medical officer is especially popular. Residential medical officers are found in private hospitals and aim to provide 24/7 care. The most common system is 2 weeks on and 1 week off. Residential medical officers function as 'internal GPs' under supervision of a consultant.

### 2.1.2 Mobility patterns for nurses and doctors are different

While doctors can build a future, amongst other things by further qualifying abroad, for nurses the main argument for mobility is more likely to be the option to earn (more) money than at home, to sustain a family back home. Moreover, in some countries nurses, more than doctors, are expected to return. For instance, Bulgarian data indicate that motivations for nurses to migrate differ from those of medical doctors. Whereas the latter move primarily for professional and economic reasons; nurses move especially because of their own family's welfare. Moreover, an albeit rather small percentage of nurses are motivated to migrate by the hope for a better future for their children. This explains why nurses may, more likely than doctors, seek 'cheap' mobility patterns. Their earning capacity is limited by their profession, whereas those of doctors can increase by adding skills by means of further qualifications. For this reason, for nurses, the cost of mobility must be as low as possible with a quick option to earn it back by rapid (higher) net earnings. This reasoning may explain why nurses, for instance from the EU12, are willing to seek temporary, sometimes illegal, working conditions in one of the EU15, preferably those close to their country of origin. Such patterns allow for a 'quick buck', while also not endangering options to travel back and forth as distances are not too long. However, as Poland reports, some nurses may lose their 'domestic' license due to EU-requirements of proof of continued practice as a nurse and subsequently find themselves in a



■ Fig. 2.1 Professional licences provided for non-Swedish education, as % of all licences in Sweden. (Source: National report Sweden; adaptation: MoHProf)

nasty situation after return. Both Canada and Bulgaria report that medical professionals leave permanently, while nurses and ‘some other health care professionals’ may be migrating on a temporary basis. The Ghanaian profile mentions returned nurses who mainly migrated to work or to join a spouse, preferably to the UK, while returned doctors are reported to have migrated for further studies even though several ‘ended up’ working afterwards. The doctors preferred the US as destination. Contrary to the signals from Canada and Bulgaria, however, Moroccan medical professionals travel abroad on a temporary basis, whereas nurses and paramedical professionals, due to lack of prospects in their own country, will cross borders permanently.

Moreover, receiving countries may differ in their requirements for health professionals. While shortages may exist in one profession these may not exist, or to a much lesser extent, for another. While Sweden recruits many foreign-trained doctors, not many non-Swedish trained nurses are licensed (■ Fig. 2.1).

However, on a global level, this is not the entire argument. The Philippines, for instance, reports that it is those with specific skills who that are most sought after in the global market. Intensive care nurses, those with experience in the emergency theatre, or with neonatal ICU or cardiac care experience are in high demand abroad. Still, Philippine doctors, too, tend to migrate for career advancement, amongst which is post-graduate training, while nurses migrate for economic purposes and

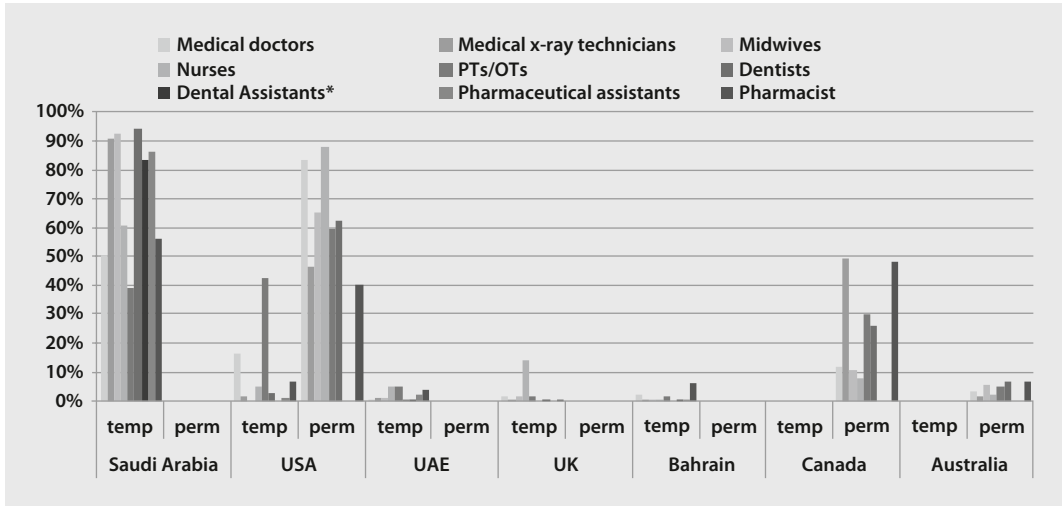
therapists for career prospects and acquisition of new skills even when some Philippine physicians ‘de-trained’ to get a nurses’ license in order to earn more abroad.

Differences in migration patterns between doctors and nurses can, furthermore, also hold a gender component. For instance, female Romanian doctors are more likely than their male colleagues to migrate on a temporary basis, whereas their male colleagues will tend to move permanently.

### 2.1.3 Migration patterns may be different for different purposes

Depending on one’s profession, opportunities and desires, different migration patterns can emerge. Data from the Philippines clearly suggest that migration with the purpose, or option, of staying in the receiving country, leads to different flows than migration with the purpose of return (■ Fig. 2.2).

Of those health professionals migrating with the purpose of return, Saudi-Arabia, Canada and Australia (and, in Europe, mainly nurses and mainly to the UK) are most likely candidates. This may also be related to immigration policies in these countries. Israel, for instance, depends to a large degree on foreign workers in its long-term care system but provides a maximum five years access to its labour market to foreign workers (OECD, 2010). Those migrating with the purpose of permanency over-



■ Fig. 2.2 Out-migration of health professionals from the Philippines, 1997–2007. Note: Data for permanent migration relate to top three countries in period 1998–2008 (Source: National report the Philippines. Adaptation: MoHProf)

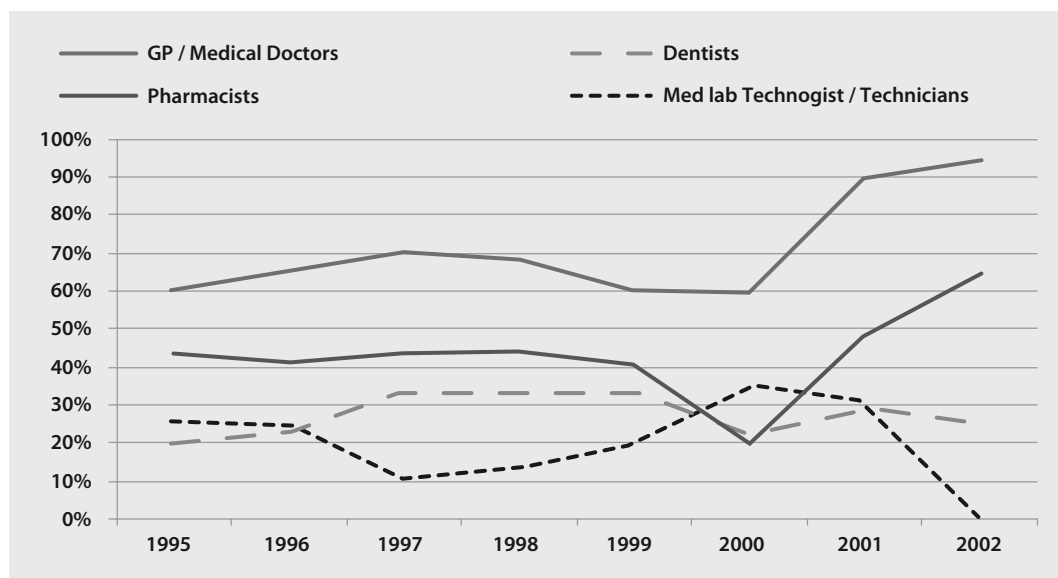
whelmingly travel to the US. This is also affected by the heavy influence of the US on Philippine health workforce education as a result of post-World War 2 general influence of the US on the Philippines. Due to harmonized education, Philippine health workers can gain easy access to the labour market in the US<sup>4</sup>.

#### 2.1.4 It is often the young, with new knowledge, that will move

In general, for medical professionals, the age of those migrating tends to be below 40 years, although final and hard evidence is absent in several countries. Available evidence does seem to suggest, though, that it is especially the young that tend to migrate. For young people the cost of migrating can be earned back by income earned in the receiving country (European Commission, DG Employment

and Social Affairs and Inclusion, 2012). However, for those of middle age, the step is often also more difficult because of personal, social, professional and material costs. Not only can it be more burdensome to acquire the relevant language capacities, they will also tend to have built some sort of professional and social life (marriage, children), which leads them to experience higher transaction costs in leaving that behind by migration. Moreover, migration often implies having to ‘start from scratch’, if only because of the process required for recognition of qualifications and entering an unfamiliar labour market and health system. For older health professionals this may be difficult, as is reported, by France, about Romanian medical doctors, while it may be perceived as an opportunity and challenge for younger people. Even Australia, a country that is, according to most, desirable for quality of living and climate, experiences an outflow of what is called the young and better educated. Similarly, 60% of the Irish fully registered doctors with overseas addresses are younger than 45 years of age. And it appears that in some cases ever younger professionals migrate. For instance Ireland (for undergraduate medical students), Romania and Ghana (for graduate students) report, that medical students already develop strategies to go abroad while being trained. The cumulative effect of this may be devastating, as

4 As a side remark it, moreover, becomes clear from (■ Fig. 2.2 that the EU plays a very limited role in migration patterns of Philippine health workers. Only the United Kingdom stands out, followed at much lower level, by Ireland. In both these countries, recent trends have severely affected pulls for non-domestic health workers, especially nurses, suggesting that relative importance is shrinking even further.



■ Fig. 2.3 Newly qualified outflow, as share of all newly qualified in their profession. Ghana, 1995–2002 (Source: Ghana national report; adaptation MoHProf)

sending countries such as Romania may easily get into the position of losing subsequent years of newly trained health professionals, leading to a demographic time bomb in the health workforce. For this will not only lead to an increasingly ageing workforce but also to a massive lack of replacement of retiring medical workers, let alone required growth to adjust to needs. Such an effect is also reported by Poland and can lead to a self-propelled process of outflow of the few remaining scholars, as Ghana experienced in the early 2000 s (■ Fig. 2.3).

### 2.1.5 It is those with access to (future) resources who move

Ghana reports that doctors, more than nurses, are likely to (consider a) move abroad. One of the reasons is that lack of money is an obstacle for putting plans into practice. In a similar manner, Egypt reports that it is the medical professionals with (financial) resources who will manage to study, or even to further qualify themselves abroad. This leads to a migrating elite and, as reported, to many problems in the system, which seems hardly merit-based. From a different perspective, the argument is also made by South African medical nursing stu-

dents, of whom many intend to work abroad, but only after a period of working domestically, to gain not only relevant experiences but also the means associated with the cost of migration. In the Philippine culture, out-migration is actively promoted and families will incur substantial debts to allow (or even push) a person to pursue work elsewhere in the world. Of course, for the migrant, this will imply a need to send remittances, first of all to repay the debt and second, to sustain the family. As a consequence, options for return of these health worker migrants may be limited by financial pressures.

Angola reports its medical education to be below international standards, thereby keeping its physicians in the country. The same applies to most of Egypt's nurses, whose qualifications do not comply with Western standards but are, in some cases, accepted for services in the Gulf region.

### 2.1.6 Networks play a substantial role in decisions about mobility

#### Family plays an important role in and after decision taking

A decision to move to another country is not often made in social isolation. Family members,

especially the nuclear family or family of origin (fathers/mothers but in some cultures also wider family members) are very much involved in the decision making process, not only in the 'whether to move' decision but also in the 'where to' decision. Moreover, such decisions may be taken aiming to support the family. For South African nurses who moved to the UK a major reason for the move was the ability to earn enough to pay for the material and educational needs of their children or their study loans. It led many of them, contrary to previous remarks, to migrate at a later age, when the costs of children go up, to the UK, while their younger colleagues may stay in South Africa, because of the needs of their children. For some Romanian doctors, the family is a reason *not* to migrate, even though many more options may exist abroad. This may also be connected to the over-representation of women in the Romanian health care workforce, with most doctors being female (and possibly mother). It may well be that decisions to move, whether on a permanent or temporary basis, are closely connected with motherhood. Furthermore the need to care for one's ageing parents is also a reason *not* to migrate and, for some, a reason to return.

The German profile also stresses the importance of acquiring a decent work-life balance including a better social and family life as a motivator for migration. In the Philippines, on the other hand, there is an overall culture of out-migration. Its government encourages labour migration as remittances are a major component of its Gross Domestic Product (GDP) and family members impose pressure on young people to choose 'marketable' professions, even leading health care managers and doctors to move abroad (in part after also acquiring nursing licenses as international demand for Philippine nurses was much bigger than for their own profession) for additional earnings (see ► Chap. 6.6). Moreover, family members are likely to take major loans enabling migration. In Ghana, family members are likely to have co-paid for the tuition and they expect returns on investment, which, in the recent past, could not be made while in Ghana or were bleak as compared to the remittances sent by migrant health workers. Moreover, as in the Philippines, Ghanaian parents or migrant family members, upon temporary return, may push youngsters into a health qualification as a guarantee for a better

future, also for themselves. In other cases, migrant health workers may ask family members to pay for the 'bond', the contract they signed with government to work in a designated area for a number of years. This is likely to incur a financial obligation upon the migrants to pay off this debt.

One of the major reasons for the role of the family in decision taking is that (temporary) migration will disrupt family life, which, of course, is a bigger issue if the decision is one not taken lightly in a given culture, or if such a decision not only affects one's parents but also one's own nuclear family (spouse or children). On the other side, the decision to migrate may also be taken to become reunited with family members, as reported by Germany.

In other cases, however, migration is simply a question of following one's heart: the spouse or lover lives in the receiving country and the choice is made to follow him or her. Many MoHProf reports mention this as a push factor (see also ► Chap. 3).

## The diaspora

Migrant communities are important to get a foothold in a host country. They can play a role in providing information about job opportunities, as reported by Lithuania and can act as a bridge for the newcomers between society of origin and the new society and prevent full social isolation, as was reported by South African nurses in the United Kingdom. For instance, the major Irish outflow of doctors to the US in the past, grew to a community of now senior officials in the American health system and can act as a bridge for Irish (under-)graduates wishing to pursue a foreign career or additional specialisation. As Ireland's health system does not allow for all major sub-specialisations, these Irish-background seniors not only still understand the broad outlines of the Irish health system but also the need for young Irish professionals to go abroad, even when they want to apply, later on in their career, for a post as a consultant in the Irish system. The sheer presence of a migrant community of the same background can, however, also act as a factor leading to migration, as is reported by India.

## Active recruitment

Active recruitment plays a major role in the migration of health professionals. The MoHProf data support this notion, although it differs from



country to country. For instance, the German profile reports no substantial active involvement of recruiters; apparently flows are directed more informally or not directed by employers with a need for health workers. This is also reflected by the very diverse and personal experiences of migrant health workers in their integration in the German system. In part, though, it may also link to little attention for those working in the black labour market in German long-term care, especially in home care. However, German data do not permit any conclusion about active recruitment. Given the fact that Slovak recruiters are active for Austrian home care, similar experiences could be expected for Germany (as well as for non-MoHProf country Italy).

In some countries, activities of international recruiters are part of the 'overall existing infrastructure', and seen as such a fact of life that they are not even reported by the country teams. For instance, reports from some sending countries suggest that many migrants find their way across the globe by 'personal initiative', but do not always explain *how* that works, nor what this means. Recruiters can play a role in this process, just as social experiences can. For instance, chain migration or word of mouth or cultural bias (the Philippines is a major exporter of human resources to many economic sectors and countries, including the health care sector) play a major role. However, as advertising may affect the way one sees things, experiences societies and shapes priorities and consumer behaviour, public relations campaigns by recruiters can influence personal initiative. However, as these agencies are private players, interest in participating in research is limited. This makes it difficult to analyse their roles. Canada, for instance, reports active recruitment but evidence is anecdotal, although there are signs that such recruitment can include bilateral agreements between a specific hospital or region in Canada, on the one hand, and a facility in a sending country, on the other. For Egyptian doctors, informal networks serve as the key behind Egypt's internationally mobile health workforce. Still, other means, amongst which recruitment agencies and governmental agencies (for scholarships) are also used. Australia's States themselves are acting as recruitment agencies and its Commonwealth subsidises the expenses made in recruiting over-

seas-trained doctors. Ghana, however, reports differentiated roles of recruitment agencies. Medical graduates seem to find their own way, while nurses, to some extent, depend on recruitment agencies, although in recent years many have stopped business due to stricter requirements in the UK. Signals are that the remaining organisations are active in preparing prospective migrants to manage the stricter requirements (preparing for language test IELTS, as well as TOEFL. Agencies make themselves known in nursing schools. The Irish, however, similar to the US, have been using recruitment agencies to recruit non-consultant hospital doctors, mostly from East European countries like Romania, Hungary, Slovakia, Lithuania and Poland as well as from India. Recruited nurses originate mainly from the Philippines, India, the Middle East and countries across Europe including predominantly Finland, Norway and the UK. East European nurses are not desired due to poor language skills.

#### Active recruitment abroad: United States\*

Because recruiting foreign-educated nurses is costly in terms of time, money and efforts, only big healthcare organisations recruit directly, others use recruitment agencies. Among the costs mentioned for recruiters are processing charges, the cost of taking the NCLEX and English language examinations, credentialing, air travel to the US and sometimes additional training.

Nevertheless, 2003 data suggest that only 35% of the foreign-educated registered nurses (RNs) and 17% of licensed practice nurses (LPNs) had used a recruiter, suggesting that other channels are at least as important. However, the database may also have included 'older' foreign educated RNs and LPNs, from a period before recruitment agencies increased their activities.

Sometimes agencies work in a single country, but most work in several countries. In 2008, 18 agencies were identified as working in Latin America, 11 in the Caribbean. In total 273 agencies were found with internet presence and the 147 agencies participating in a study were active in 74 countries, of which 35% were in areas



that are resource poor such as Africa, Latina America, Pakistan and Sri Lanka. Plans existed to expand efforts to other countries, such as the EU, amongst which were the UK, Poland, the Czech Republic, and Sweden. Other European countries that could be targeted are Russia, the Ukraine, and Norway. Outside Europe, Israel, India, China, Colombia, Brazil, Argentina, and South Africa could become 'targets'.

\* Source: National report United States.

Private recruitment agencies are not always considered to be the best channel, given their two-way profit strategy without always caring about proper information, labour conditions and rights in case of conflict. After the entry into the internal European Market in 2007 of Bulgaria and Rumania, France reported a steep increase in Rumanian physicians entering the French health care system. Some recruiters were perceived not to communicate clearly, completely and fully honestly with the persons recruited, which led to the migrant health workers being disappointed and in some cases returning to Romania. From the other side, Romania reports an 'important role' played by 'foreign agencies' in the recruitment of Romanian health professionals, especially physicians, dentists and nurses. Ghana reports activities of 'fraudsters', especially, but not only, outside Accra.

Australia, however, strongly relying on foreign health workers, has implemented a list of 'preferred providers' among recruiters and Ireland reports that, in 2008, 87% of the requests for verification of qualifications of nurses were made for Australia, as a result of active recruitment by Australian employers. However, Ireland also reports its own active recruitment for foreign nurses since the mid-1990 s, especially from other English speaking countries like the UK, South Africa and the Philippines. India reports the active roles of recruitment agencies especially for nurses. The Philippines reports more than 3,300 known and accredited recruitment agencies, implying that probably many more, but not accredited, are active.

More than anything, the Internet is also changing recruitment. In Portugal thirteen recruitment

agencies were counted on the Internet, specially for health professionals, most of which are involved in international recruitment, not guided by an ethical code. Kenya reports that recruitment agencies are hardly known to play a role in recruiting health workers. Kenya does say, though, that the Internet, to some extent, replaces or changes the roles of recruiters as health professionals can directly access information about possible vacancies and opportunities abroad. Australia reports usage of Facebook and MySpace as a means to connect with networks and opportunities. As a consequence, more than ever before, local vacancies, reported on the Internet, may have an international impact.

### 2.1.7 Differentiated pictures over time and between flows and countries

Overall, a differentiated picture emerges of mobile health workers. Countries may be both sending and receiving countries and will, in such cases, tend to be so for different professions, and may exert a strong pull for one health profession but not for another. Some countries will be sending countries for only a small group of professionals while others will appear to send many (types of) health workers. Other countries, like Egypt, may be entirely focused on temporary migration. Egypt enables 'temporary migration', which may last anything between a week and ten years. It also has systems in place to keep the diaspora in touch with the home country. Mobility patterns can also change quickly over time. For instance, Poland reports that out-migration of physicians, which increased immediately after Poland's EU-entry, changed after the EU15 entered a recession and after increases in physician's earnings, thus affecting both pull and push. Due to these changes circular mobility has become the predominant mode. Romania, while experiencing substantial outflows of health workers, experienced major changes in (preferred) destinations, with destinations varying according to what became the easiest to reach. EU-entry also had different consequences for Romania's doctors than it had for nurses, as Romania already had several bilateral agreements with EU countries like Greece, Spain and Italy. These agreements implied that Romanian nurses

■ Tab. 2.1 Trends in preferred destinations for Romanian health professionals

General out-migration*	Health professionals out-migration			
	Doctors	Nurses	Dentists	Pharmacists
1990s				
Italy, Hungary, USA Austria. Also Canada France	US* Hungary* Canada* France* Australia*	No data	No data	No data
Early 2000s				
Permanent USA, Canada, Germany Italy	US Hungary Canada France Sweden Austria Switzerland	US Hungary Canada Australia Greece Sweden	US Hungary Canada Australia	Hungary US Canada
2004-2007 (Romania enters Schengen in 2002)				
Temporary: Italy (50%), Spain (24%), Germany (5%) Hungary (4%) Portugal United Kingdom	US Germany UK France Italy	Greece, Spain Italy	No data.	No data
2007 and later: EU entry				
Spain Italy	France Germany UK Italy Belgium	Spain Italy Germany UK France	No data	No data.
(Source: National report Romania)				

could practice their profession in these countries, whereas such options were not available for physicians. This freedom came for Romanian doctors only after entry into the EU in 2007 (■ Tab. 2.1).

Similarly, but in a different context, Australia's inflow of health workers differs in numbers and trends in terms of background, depending on the type of health worker (■ Fig. 2.4).

## 2.2 Entering the country

### 2.2.1 Perceived costs and benefits

Thinking about mobility, for a health worker, implies balancing related costs and potential benefits. This applies to internal mobility but also to international mobility. When earnings are quick or quickly needed, for instance, Polish nurses may abstain from wanting to be recognised in Germany,

Mobility of Health Professionals

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