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## The post-2004 migration of the Polish medical personnel to the United Kingdom and its impact on societies and economies. Preliminary remarks<sup>1</sup>

The paper aims at analysing the effects induced by the process of the Polish medical professionals' migration to the United Kingdom following Poland's accession to the European Union and their situation in the UK. Before all else, the major theories of migration will be presented in the context of the mobility of the Polish medical personnel. Then, the characteristics of the migrants and a sample will be presented. Finally, based on the conducted qualitative study, selected effects and consequences of their migration for societies and economies are going to be scrutinised.

### Migracje polskiego personelu medycznego do Wielkiej Brytanii po 2004 r. i ich wpływ na społeczeństwa i gospodarki

Celem artykułu jest poddanie analizie skutków wywoływanych przez procesy migracji polskich lekarzy do Wielkiej Brytanii po akcesji Polski do Unii Europejskiej i ich sytuacji w Wielkiej Brytanii. W pierwszej kolejności przedstawione zostaną główne teorie migracji w kontekście mobilności polskich pracowników medycznych. Następnie zaprezentowana będzie charakterystyka osób migrujących oraz dobór próby badawczej. W ostatniej kolejności, w oparciu o przeprowadzone badania jakościowe, omówione zostaną wybrane efekty i skutki migracji dla społeczeństw i gospodarek.

Keywords: international migration, brain drain, brain loss, transnationalism, social integration

JEL classification: P2

## Introduction

Recent years are characterised by a growing extent of the international migration accompanied by scholars' rising interest in this area. The Polish have been rather mobile through the last 200 years. Thus, there exists quite an extensive body of literature related to their migration out of the country [Stola, 2007].

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<sup>1</sup> Please note that this paper is a part of a research financed by the ERSTE Stiftung of Vienna, and some pieces draw on the paper commissioned there [Ślęzak, 2012].

It is interesting to note that the medical professionals analysed here make up a very special group, defying all the statistics. Their mobility in the world is very high, not only in Poland and other new member states, which indeed is a subject of many concerns amongst the decision-makers. Additionally, rich countries present a growing demand for medical professionals due to the ageing processes and greater ability to bear the expenses [Connell, 2010, p. 68].

In this paper the Authoress wishes to explore the issue of the effects and consequences of the medical professionals' migration after the EU accession (2004–2011) for societies and economies. Said professionals included mostly doctors, predominantly surgeons and dentists, as well as pharmacists and qualified nurses etc., who had migrated to the United Kingdom. Thus, a theoretical background in reference to migrations and this professional group will be laid down first. Then, the contemporary situation of the migrating Polish medical professionals and effects of their migration on both the receiving and sending countries will be discussed. The question posed in this paper is as follows: what are the effects and consequences of the Polish medical professionals' migration to the sending and receiving societies and economies?

## 1. The migration process and a theoretical explanation of medical professionals' mobility

To begin with, the phenomenon of migration is of complex and interdisciplinary nature; it refers to spatial mobility of individuals as well as groups of people [Niedźwiedzki, 2010, p. 20]. Since the time and space here is limited, the understanding of migration used in reference to migrations of medical professionals from Poland after 2004 is as follows: it is a phenomenon describing spatial mobility of individuals and groups involving changing a place of residence and engaging in employment in another country. The time frame of this engagement is not set, yet as seen in literature it usually exceeds 2 months and it might include temporary migration, circular migration, and regular longer stay, sometimes encompassing decision to emigrate for good.

With such an interest for migration issues, a number of related theoretical considerations can be found, which will be discussed. As there is no sufficient space here to present them even briefly, we will discuss their relevance to the Polish medical personnel's migration below. Please note that the matter of their migration is not simple to explain.

### 1.1. Theoretical explanations for the medical professionals' migration

The migration of the Polish medical professionals to the UK constitutes an interesting case. Since 2004 the UK has allowed migration of individuals from the new member states, attracting large number of migrants, including medical professionals of various experience, seniority, and specialisation. The migrants found attractive the possibility of gaining a higher income, improving their standard of living, and professional development. On the other hand, after the accession to the EU, particularly at first, migration was an obvious form of escape from low salaries – a pay unsuitable to their qualifications. Thus, the neoclassical macro theory and the existing wage differentials underpin our workers' decisions to move to the country of higher wages. As a result, the labour supply falls and wages increase in the capital-poor country, whereas in the capital-rich country the labour supply rises and wages decrease, leading, at equilibrium, to international wage differential, reflecting the costs of international migration, both monetary and psychological [Massey et al., 2001, pp. 3–4; Arango, 2011; Greco, 2010].

However, it would be unfair to underestimate the micro-perspective neoclassical theory. With the focus on the individual choices and perspectives, rational individuals make migration decisions using cost-benefit calculation that allows them to seek positive monetary returns – which is surely the case of the medical professionals. A peculiar form of individual investment in human capital is seen as every potential migrant analyses the costs and benefits in a certain time horizon. If the net returns of migration for a given destination prove to be positive, the rational potential migrant decided what many Polish doctors and nurses did. In theory, it is clear that individual characteristics such as skills, qualifications, and experience would have an impact on the probability of employment and remuneration in the destination country, thus increasing the probability of international migration levels (*ceteris paribus*). In fact, these elements usually gave certainty of employment prior to arrival to the UK. On the other hand, there were also elements that reduced migration costs, such as ICT, social conditions, and individual characteristics, as they have a positive effect on net returns. In the contexts of the two above statements, the individuals from the same country would display different propensity to migrate [Massey et al., 2001, pp. 4–6; Arango, 2011; Greco, 2010].

Medical professionals, just like any other migrants, attempted to estimate potential costs and benefits as well as to assign values to them. However, as the interviews proved, these were not purely individual decisions, made by potential migrants in the social vacuum, outside their family and household. That is why the new economics of migration theory can be seen as much more fit to the social reality of the analysed international migration. In fact, their migration appears to be a rational decision of the household or family as a whole and an example of

strategy aiming at maximising income and minimising risks. Surely, it may be seen as the household strategy to diversify its livelihood and decrease the risks of market failures, even in the context of the absence of wage differentials [Greco, 2010, p. 12]. This theory is strengthened by the fact that the Polish value their families very much. Hence, the doctors' migration decisions involve assigning responsibilities to individuals as well as weighing the risks associated with the migration to the UK, which was clearly confirmed by the undertaken research.

Interestingly enough, medical professionals who decide to move to the UK work in the high-skilled sectors where they can enjoy treatment similar to local medical personnel in terms of pay, stability, advancement possibilities, and other job characteristics. The only sign of duality of the labour market is visible in the location of the employment, which is often very far from London and from the south-east of the country, where the saturation of medical professionals and the interest amongst local doctors and other migrants is lower. In those places the Polish work alongside professionals originating from various, distant places.

Moreover, the first look at Immanuel Wallerstein's world system theory suggests that what drives migrants to migrate is the demand for labour expressed by capitalist economies. Hence, labour migration is a source of capital accumulation, with poorer countries losing citizens for the benefit of the wealthier ones [Greco, 2010, p. 14–15]. Be that as it may, it appears that this theory might be seen as irrelevant to international migration of the Polish medical professionals.

Moreover, the network theory addresses important issues related to the migration of the Polish medical professionals to the UK, as doctors and other medical specialists are active members of various professional networks, where the information regarding migration is being exchanged, discussed, and benefited from. Surely, functioning within said networks is based on various ties, such as kinship, friendship, and shared community origin. There is some evidence that such networks may reduce risks and costs associated with migration and increase expected net returns. Migration is seen here as a self-sustaining diffusion; a quasi-perpetual process expanding over time and place, aiming at building a quasi-spider web of connections and relations, so that almost all interested could move with not much difficulty [Massey et al., 2011, p. 19]. On top of the above issues, doctors do not lose contacts in Poland, they continue to be active in national professional network, as it is seen as a way to ascertain safe return to appropriate employment positions. When abroad, they also create certain social networks, usually together with people of the same nationality from their immediate working medical environment. Such networks serve as a replacement, sometimes permanent and sometimes temporary, for the community left in Poland.

Similarly, in the case of medical professionals, the institutional theory serves as an interesting example. With no barriers, the space is open to various institu-

tions, e.g. private employment agencies, which sustain international migration in different ways [Massey et al., 2001, pp. 20–21; Arango, 2011]. The recruitment procedures are carried out by specialised recruitment agencies of Polish and UK origin. Finally, the non-governmental organisations of professional character, such as the General Medical Council, rather than fight exploitation and victimisation of migrants, serve as consulting bodies for professionals.

Furthermore, in a process of cumulative causation, the growth of networks and the development of institutions supporting migrants' international migration sustain themselves in various progressing ways. It is cumulative, as every single case of migration changes the social context in which migration decisions are being made, usually in favour of additional mobility. As jobs and positions of doctors and nurses in the UK are not stigmatised, migration leads to further change of migrants' families' position in the local community, and it surely does impoverish some areas of highly skilled personnel which leads to certain shortages of available medical professionals and their services. On the other hand, the migration experience is associated with the witnessed change of values, beliefs, perceptions, and new perspectives introduced into the respondents' lives.

Finally, the multidimensional framework adopted by Giulia Greco [Greco, 2010, pp. 18–19] explains the issue of international migration by pointing out that the decision-making process commences within the household, which is subsequently complemented by other elements, such as social and kinship bonds, and other kinds of informal relations that tie the destination, the country of origin, and particular institutions together, thus shaping the global context. The migration process is regarded as a system of identified and stabilised networks that links the countries, which is composed of two or more countries that exchange migrants. Hence, the movements can be explained in terms of the interaction between microstructures and macrostructures, i.e. large scale institutions, e.g. global market forces, migration laws, and regulatory policies between involved countries. For some time now the attention has been focused on the role played in the shaping of migration flows by the microstructures such as kinship patterns and community ties. Migrants, once in a new place, try to construct networks of similar patterns. They try to reduce risks and costs associated with migration and increase expected net benefits. Thus, the process becomes safer and more reliable for the migrants and their families. When the first migrants set the networks and migration pathways, the process of self-sustaining migration can begin, because each movement builds its own migration structure. Of course, on the borders between macro- and microstructures, in the mezzo-structure, a niche develops, which is soon taken over by a number of intermediary institutions of both formal and informal, legal and illegal character, which support and foster migration. Medical professionals indeed focus on social bonds and create their own web of networks. The networks

also include mezzo-institutions of legal, formal or informal character. Surely, macrostructures comprising of regulatory framework and cultural aspects are elements that attract and foster migration of medical professionals to the UK.

## 2. Characteristics of medical professional migrants in the UK

For the purpose of this study, the qualitative study amongst the medical professionals was conducted. As many as 20 professionals engaging in various sub-disciplines of medical professions and of diversified experience and seniority were met and interviewed. These were semi-structured interviews during which selected professionals, who had previously agreed to be interviewed, shared their experiences, reflections, and plans related to their migration to the UK. The group was selected based on the initial contact with the medical professionals' recruiters and doctors already residing in the UK; then, the snowball principle was used. Two rounds of interviews were conducted amongst the Polish medical professionals in the UK (specifically in Plymouth, London, and Glasgow), to be later complemented by additional interviews with some returning migrants in Poland (specifically in Kraków, Gliwice, and Wrocław). The group consisted of doctors, mainly surgeons of various areas of expertise and anaesthetists, as well as several dentists, pharmacists, and qualified nurses. There was no balance in the number of males and females in the sample as there is no balance in the professional involvement and specialisation between genders. Furthermore, it should be emphasised that the topic related to family and relationships within the families turned out to be a very sensitive area. Some respondents treated the interviews as an opportunity to consider, analyse, and share their observations and reflections with an interviewer, who in this context was an outsider. Below, the main characteristics of the sample are described [Ślęzak, 2011].

Firstly, there were two main groups in the sample: those who have migrated for good, with their spouses and adolescent children, and those who chose temporal or circular migration, with their families and children left at home.

Secondly, there existed a clear gender gap – the majority of doctors were male, whereas the majority of women were qualified as nurses, dentists, or pharmacists. This pattern reflects a certain professional segregation in professional specialisation, which is observed in Poland. Additionally, the majority of female doctors have accompanied their husbands and partners, since the males were the ones to make the migration decisions. On the other hand, it must be noted that there were cases of female doctors being accompanied by partners or lovers, or travelling every other weekend to Poland to see their husbands and growing-up or adult children.

Thirdly, almost half of them had several migration experiences prior to their migration to the UK. Also, half of the sample was forced to return to Poland, usually due to family obligations or wife's request. There even was a "notorious migrant" – a lady who used to work in Tunisia in 1980s, in Malta in 1990s, and in the UK for the past 7 years, with short spells of work in Poland.

Fourthly, the circular or temporal migrants regarded their migration as a way to maximise their utility, thus maximising their resources and human capital, too. They were also very skilled in, i.a., finding extremely cheap plane tickets. Some of them presented strong organisational skills and excelled in planning a rota. Thus, they could spend in Poland even up to 3–4 months in a given year, which is much more than a regular vacation period.

Fifthly, some of the respondents expressed feelings of solitude and nostalgia evoked by their being away from Poland. One of the doctors, living in the UK on her own, made it very clear that it was difficult for her at the beginning. However, in time she got used to living abroad. The employment as a dentist in the UK ensured a very stable financial situation for her and her family. She also noticed that relations at her work were based on partnership. She visited her family as often as possible, even twice a month, and she enjoyed time spent there. Her husband and she cherished their time together, taking into account that it is something precious, so they should not spoil it by arguing.

Finally, whether temporal, circular, or quasi-emigrants, they did not plan their future too many steps ahead. They appreciated the very favourable conditions they lived in and the fact that they could enjoy their work for reasonable remuneration. If the favourable conditions prevailed, they would wish to stay as long as possible. They said that it was unknown what would happen in the future, what it would bring. As their retirement age and pension was a very distant matter, they did not make plans for it, but still expected to probably spend their old years in Poland.

Last but not least, as the sample may be regarded as not completely representative for the population of the medical professionals, it should be mentioned that the conclusions will refer to the experiences and reflections expressed by the respondents and only those identified effects will be discussed. Also, these conclusions can be seen as basis for further study [Ślęzak, 2012a].

### 3. Effects and consequences of migration for societies and economies

The medical professionals' migration process is multifaceted and can be explained in many different ways by various theories. On the other hand, looking at the outcomes induced, these can be many and their assessment can vary as well. Moreover, many phenomena might be seen as resulting from international migra-

tion. As feared by many, mainly by policy-makers and politicians, it involves a number of losses on the side of the receiving country, such as a shortage of labour, brain drain, Euro-orphanage, social costs, divorces, and splitting couples and families. Indeed, it is the side of the sending country, which is usually being analysed. However, there are always some benefits that the sending society and economy could encounter, such as language proficiency, cultural proximity, new integration practices, and positive changes with respect to the sense of belongingness. Moreover, the societies and economies of both the sending and the receiving countries participate in this process; a loss for one is a profit to the other, an access to a new pool of educated and experienced human resources that require no major and expensive training to begin their practice. Selected effects and consequences will be scrutinised below.

### 3.1. Economic effects and consequences

The medical professionals fall into the category of highly-educated specialists. For the majority of the interviewed professional migrants, the differences in wages, i.e. pecuniary reasons, were a dominating factor in their migration decision-making. This allowed them to improve their economic situation and quality of life, as well as their families' living conditions, whether they were staying in Poland or in the UK [Bera, 2011, p. 88]. One of the doctors stated clearly: "I did quite good in Poland, as I worked in a private hospital. The income was competitive... My income was rather high, but it was a horror time-wise... I used to spend all days at work, one of the three mentioned... Whereas I knew that work here would be less demanding in terms of time devoted, 9 a.m. to 5 p.m., that I will work only 40 hours per week" (anaesthetist B).

Some doctors argued that it was impossible to live well in Poland being a doctor working only one job in the public sector. The more specialised the doctors, the more they tended to work, some even up to 130–150 hours per week, which left them no space for life outside work. One of the outcomes was having more free time at their disposal, which they could dedicate to their family life: "My husband did not participate in a daily life of our family, I was in charge of all care... Our weekends are free, which was not the case in Poland. The only time free and together was during holidays, summer and winter, and we had always waited for it. Now we enjoy time together..." (pharmacists).

As a result of their migration decisions, their financial situation improved [Bera, 2011], which can be clearly seen in the remittances transferred to Poland [see e.g. Iglicka, 2008, p. 699]. Interestingly, free time availability raised as well. The consequent feeling of freshness and fulfilment also had some benefits for their professional life. Unfortunately, the receiving country was the main beneficiary of this rationalization of time spent at work.

On the other hand, there is no doubt that Poland experienced a phenomenon of brain drain, which was estimated by Anna Murdoch [Murdoch, 2011, p. 324]. Linking its loss with costs of education and loss of income in the country of origin, she estimates the costs of educating and training a doctor (6 years of the university education plus a year of traineeship) at PLN 275 310. Of course, this value would have to be multiplied by the number of migrants. The loss of experienced personnel and services offered forms an exchange mechanism between Poland and the UK, with a loss of Poland and benefit of the UK. Some doctors leave for good, viewing their migration as a one-way ticket, finding situation in Poland unbearable, which is a terrible loss for Poland. In other cases, when doctors treat migration to the UK as temporary, both countries benefit, since the migrants return more qualified and with another set of experience, which can be put to further use in Poland [Ślęzak, 2012a].

This migration is often shown as resulting from the work force shortages emerging, in particular, in sub-disciplines of professional training, such as anaesthesiology, plastic surgery, chest surgery, radiology, and orthopaedics<sup>2</sup> [Kaczmarczyk, 2010, p. 177; Ślęzak, 2012a, p. 28]. These surely require some immediate action in policy-making, which was initiated by the trade unions' actions. Following, doctors' financial situation improved; their income has been rising significantly in recent years. This mostly stopped the outflow of doctors, in particular those senior ones, as some circular migrants returned to Poland. It can obviously be seen as a victory of all – the state, the doctors, their families, and patients – and a loss of the receiving country, deprived of professionals who have already adapted to work there.

Finally, the remittances sent to the families staying in the sending country, must be mentioned in this section. Unfortunately, there are no estimates of the whole of these remittances. Obviously, the interviewed doctors and others mentioned them only in relation to their spouses or children residing in Poland. No single case of regular remittances being sent to parents and in-laws, who are often of medical background, was mentioned. The medical families living in Poland usually used this form of income for regular consumption, life at ease. Moreover, there were cases when money earned abroad was used to buy a new apartment or to build a house, support to education was listed; better and more opportunities for their children in terms of studying and travelling across the world were also mentioned. It is hence difficult to state whether the loss of experienced personnel is compensated by other elements, like experience or remittances [see Packer, Runnels, Labonte, 2010].

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<sup>2</sup> The highest shares of certificates issued in relation to active doctors in those medical sub-disciplines.

### 3.2. Social effects and consequences

Although the medical professionals are still in a better situation than other migrants, their situation is more complex; doctors in general enjoy a high social status and are appreciated in the UK, but there are some indications that they might be missing out on the fact that they are migrants and that some of them have not learnt the specifics of the receiving society and its culture, expecting the same type of relations which dominate in Poland. "I think that the Polish do not integrate well. But to be honest, I think this has to do with the receiving society. The English are not keen on integrating, they are very kind and pleasant, but this is all you can count on" (anaesthetist J). The Polish expect more dense interactions with the British, not superficial conversations on weather among neighbours [Ślęzak, 2012b]. Moreover, the majority of their interactions are related to the hospitals and institutions they work in. Being a temporal or circular migrant makes it even more difficult, as they notice that they are seen as travellers, who are keen on earning better money, not as much involved, always thinking about their family (anaesthetist-intensive therapist J). Moreover, some doctors see migration as a process that bonds people, creates ties – and, what is interesting, those ties relate them to other Polish doctors and their families. "It forces people to meet, to bring families together if there are no serious problems. But you tend to seek contact with your colleagues... We have formed some sort of the community with the other Polish doctors" (anaesthetist B).

Finally, migrants, particularly temporary or circular, are trapped between societies they live in, feeling marginalised. Not all migrants are willing to join those particular groups and not all would be as welcomed as the British. What dominates is a feeling of a double life, two worlds, two societies, and two groups, which makes it difficult to become a real member of any society.

One of the important outcomes of migration is its impact on the family. Families are experiencing various problems, from the shortage of time spent together and devoted to socialisation and upbringing of the children, to the phenomenon of Euro-orphans left behind by parents busy with working abroad and earning money [Ślęzak, 2012b].

"The family relations have changed since we have entered the EU... People leave and migrate, leaving children behind, hence orphans or, as they call it, Euro-orphans. Once my daughter approached me and asked:

- Dad, do you know that I am an Euro-orphan?

I said:

- A half-Euro-orphan, to be precise..." (anaesthetist-intensive therapist J).

There is often a case of material compensation at the expense of emotional support and involvement. The breakdowns of families living in two or more countries are also observed, and such was the case of one of the respondents. Dilip

Ratha [Ratha et al., 2010, p. 9] points to emotional costs of migrants and their families associated with the separation from the immediate family, in particular in regard to children growing up without any or with only one parent and experiencing consequent psychological trauma.

There was also a number of social problems encountered in various configurations. The families residing with their children in the UK observed that their children attending public schools there tended to lose their national identity. Some of the Polish children who had left the country as adolescents could not merge with the British, did not appreciate the new country, and left to study in Poland, e.g. in medical schools. The migrants obviously notice the deficiency in regular daily contact with their families, even though they try to cover it with regular internet or mobile communication.

“It is not the same as being close to your child... My children have their mobiles and they could call me anytime they had such a need... Of course it is not the same as a regular daily contact, but, as you know, children now spend many hours chatting... Also, they benefited as I earned more and I had more free time I could spend with both of them...” (anaesthetist-intensive therapist J).

Finally, medical professionals in the UK, just like any other migrants, leave behind their families, their parents, and parents-in-law. Their relationships with their children are determined by the age of the children and the place of their residence. The smaller the children living with their mothers in Poland, the more difficult the contact, although obviously every case has its own specific character, based on how the situation is experienced by the individuals.

## Conclusions

Even though there is no hard evidence, some important areas for policy-making can be spotted. Financial estimates on the migrating doctors' education are worrisome, as some costs are to be borne by each citizen of Poland. In the context of ageing, a growing labour shortage in these professions is to be expected. From this perspective, the UK economy and society benefit. However, it would be unfair not to mention the observed social facts and benefits, such as the improved well-being of migrants' families, their new experiences, financial stability and freedom, access to a new culture, travel possibilities etc. On the other hand, there are costs related to physical absence, mainly of fathers, disturbing schedules of visiting fathers, and new perspectives which might lead to traumas in communication on various levels of society, both in Poland and in the UK. Surely, this subject needs additional, thorough research, as the potential problems and concerns are mounting.

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