A Health Worker
for everyone, everywhere!
2014

HealthWorkers 4all

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A Call to Action for EUROPEAN DECISION-MAKERS

For strong health workforces and sustainable health systems around the world

The world is 7.2 million health workers short. The health worker crisis is one of the biggest threats to global health today, and it is having a particularly detrimental impact on people's fundamental right to health in a number of medium and low-income countries. Europe is part of the problem, because various European countries recruit trained health personnel from abroad, a practice that is unsustainable, increases inequality and further weakens health systems in and outside Europe.

Europe could be part of the solution, however, by implementing globally agreed practices for the recruitment of health workers.

In 2010, the international community and the World Health Organisation (WHO) framed a roadmap for developing the global health workforce. Called the 'WHO Global Code of Practice on the International Recruitment of Health Personnel' (the Code), it addresses the root causes of migration and brain drain, including health worker training, retention, working conditions and remuneration, financing and rights. Despite this Code, political consensus on the sustainable management of health workforces and of health worker migration at the regional and global level is still a long way off. There are powerful – albeit sometimes short-sighted – conflicting interests, and in many countries austerity measures have put a damper on health expenditures and limited the implementation of policy options.

The European Union and its member states must take a firm stance in this debate. As a fundamental element in the social and welfare model that underpins European identity, the existence of a health workforce is a public good that must also be upheld at the global level. The Code should therefore be used as a framework to regulate the pan-regional approach to human resources for health and to strengthen health systems not only in Europe but also globally.

We hereby call on European and national decision-makers to show leadership in this issue and to apply a coherent approach to the sector policies currently in place in order to develop and maintain sustainable health workforces both in and outside Europe. This Call to Action provides recommendations to EU institutions and member states in achieving this aim.

01. PLAN LONG TERM AND TRAIN SELF-SUSTAINABLE HEALTH WORKFORCES

Planning, forecasting and providing for domestic health workforces without resorting to international recruitment are key to the development of sustainable health workforces globally, and a fundamental step towards reducing brain drain.

WE CALL ON
the EU and its Member States to:

- Develop and implement health workforce planning and forecasting processes. This should involve multiple sectors, institutions and stakeholders – such as professional associations and training institutions, and patient and civil society representatives – and connect with decision-making in the health and education systems.
- Develop and implement comprehensive national health sector and health workforce strategies. This should link planning to a long-term goal of non-reliance on internationally-trained health personnel, through high-quality training programmes focussed on goal-oriented rather than disease-oriented care.
- Strengthen research and data collection on stock and flows of human resources for health at a national level. To improve collaboration and data exchange at the bilateral, regional and global level, the 'EU Joint Action on Health Workforce Planning and Forecasting' can serve as a reference for collaboration platforms, which should receive adequate follow-up.

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PLANNING, FORECASTING AND PROVIDING FOR DOMESTIC HEALTH PERSONNEL WITHOUT RESORTING TO INTERNATIONAL RECRUITMENT ARE KEY TO THE DEVELOPMENT OF SUSTAINABLE HEALTH WORKFORCES GLOBALLY, AND A FUNDAMENTAL STEP TOWARDS AVOIDING BRAIN DRAIN.

As planning and training for self-sustainability requires the mobilisation of significant resources and technical skills, it is not an easy path politically. Addressing brain drain brings benefits to both source and destination countries.

For example, it avoids the risks of instability: flows of foreign-trained health workers can be 'volatile' in that they may disappear when conditions in source countries change. In the last twenty years, Spain went from being a sending country to being a receiving one, to reverting to sending again. Similarly, brain drain from eastern and southern European countries to western European countries may in some cases be part of a trend away from recruiting non-EU health workers.

It is estimated that Europe may have an overall shortfall of around one million health care workers by 2020, and as many as two million if long-term care and ancillary professions are taken into account. Many European countries still lack the tools to anticipate their health workforce needs, with indicators, data and planning tools not always available or scarcely used. The 'Action Plan for the EU Health Workforce' sets out actions to foster European cooperation at this level. Beyond addressing this shortage, there also needs to be a discussion about the roles and contributions of different health professions in delivering the much-needed skills mix and in effecting a paradigm shift from treatment to prevention and from disease-orientation to goal-orientation, given the new challenges European health systems face.

02. INVEST IN THE HEALTH WORKFORCE

Public expenditure in the health sector is a necessary investment. It can support health workforce development and has a positive impact on the health of populations, which are to be considered a global public good. It also tends to strengthen countries' capacity to deal with the impact of the current economic crisis; in fact, investments in health – and in social protection – can accelerate economic recovery.

WE CALL ON
the EU and its Member States to:

- Protect cost-effective public health services – particularly preventive services and primary care – from budget cuts. European countries striving to recover from economic downturns and recession must increase investments in their public health systems and health workforces.
- Implement mechanisms for health impact assessments of fiscal policies. Health ministers should be co-accountable for decisions related to public expenditure, both in national and EU-level negotiations.
- Take funding for public investments – and for health and social expenditure in particular – out of the national basis for calculating the deficit. This will ensure that the implementation of recent European fiscal policies, including Six Pack and Fiscal Compact, will not reduce productive social expenditure beyond a sensible level.
- Include investment in the health workforce in the 'Reflection process on modern, responsive and sustainable health systems', as based on the 'investing in health' approach put forward by the European Commission.

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UNDER THE AUSTERITY PACKAGES IMPLEMENTED SINCE 2009, PUBLIC SPENDING ON HEALTH HAS DROPPED AND MANY COUNTRIES HAVE CUT HEALTH WORKFORCE SALARIES AND INCENTIVES.

Apparently, pressure to achieve short-term savings has exceeded the desire to attain long-term equity and efficiency. Austerity measures are altering the relationship between health workforce development investments and health workforce mobility, which is at the heart of the Code: new wage imbalances between countries or within countries are being shaped and have the potential to increase health worker brain drain and the volatility of health workforce mobility.

Fiscal tightening may also affect European member states' capacity to educate and retain a self-sustainable health workforce, which is a vital requisite of the Code.

This could lead to an increase in the global shortfall. With recent EU fiscal policies – including Six Pack and Fiscal Compact – compelling almost all member states to further reduce public expenditure, it is inevitable that health systems and the health workforce will soon become central to discussions about public expenditure in Europe, given that they account for so much public spending that they cannot be ignored.

It is all troublingly reminiscent of the structural adjustments imposed on African countries in the 1980s, which led to the dismantling of existing health services in those countries.

Research demonstrates that counter-cyclical public expenditure tends to place countries in a stronger position not only in terms of population health indicators, but also in dealing with the impacts of economic crises; in fact, investments in health – and in social protection – can accelerate economic recovery.[1]

Overall, the capacity of Europe and its member states to provide for sustainable health workforces in times of crisis is closely linked to the political issue of their capacity to claim fiscal space for health. As resources are scarce, this effort should go hand in hand with more progressive national taxation, financial transactions taxation, reduced defence budgets and the fight against capital flight and tax evasion.

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1 Reeves Aaron, Basu S., McKee M., Meissner C., Stuckler D., 2013, Does investment in the health sector promote or inhibit economic growth? Globalization & Health. 9:43. doi:10.1186/1744-8603-9-43, http://www.globalizationandhealth.com/content/9/1/43.

03. RESPECT THE RIGHTS OF MIGRANT HEALTH WORKERS

Health workers have every right to develop professionally and build long-term careers no matter where they live – and that also applies to migrant health workers trained outside Europe. Their presence benefits European health systems and their rights and professional competencies must be valued.

WE CALL ON
the EU and its Member States to:

- Grant equal treatment and equal rights to migrant health workers – including to workers with Intra-Corporate Transfers Permits – in both recruitment and employment, and ensure the full portability of social security and pension rights.
- Make recruiters the legal duty-bearers for fully informing migrants about their rights.
- Integrate the voices of health care workers in policymaking at EU and national levels. This must include migrant health care workers, their representative bodies and labour unions.
- Make the EU Global Approach to Migration and Mobility (GAMM) – and, more broadly, the entire New Agenda for Home Affairs currently under discussion – development-sensitive. In its provisions for both highly skilled and low-skilled workers, the EU should ensure that existing and future mobility partnerships, Common Agendas on Migration and Mobility, circular migration schemes, the Blue Card scheme and other relevant directives and tools are all coherent with the Code. They should allow facilitated re-entry rights to the EU and contain tangible incentives whereby health workers can resettle in their countries of origin after a period of work in the EU under good conditions, with portability of social security and pension rights acquired in the EU.

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IN MANY COUNTRIES, THE PARTICIPATION OF FOREIGN-TRAINED EU AND NON-EU HEALTH PROFESSIONALS IN THE PUBLIC LABOUR MARKET IS MADE DIFFICULT BY DISCRIMINATORY PROVISIONS AND/OR PRACTICES.

Migrant health workers often work in the private sector, under temporary contracts, at lower wages and with less social protection than their native colleagues. This is particularly true of the grey labour market of home care, in which large numbers of women are employed.

Foreign-trained health workers have every right to develop professionally and build long-term careers no matter where they live. It should be recognised that their presence benefits European health systems and could even be considered as something of an unintended 'subsidy' in the form of ready, skilled professionals who come with no training costs attached.

The complicated immigration system proposed in the European Global Approach to Migration and Mobility (GAMM) intends to open avenues for the legal migration of professionals. On the one hand, however, it risks creating a class of low-skilled 'guest health workers' who are called in temporarily but can be sent home or become undocumented when they are no longer needed. On the other hand, schemes for highly skilled health workers – including the Blue Card – are often too restrictive in their requirements and contain no incentives for migrants to return to their countries of origin under good conditions. Finally, evidence of successful circular migration schemes remains limited, particularly in terms of their impact on the right to health of populations in countries of origin.

The discourse on the migration of health personnel needs to be closely tied to that about decent work conditions and health care job profiles in destination countries: deteriorating work conditions can lead to high dropout rates among students and trainees and, thus, to insufficient numbers of new recruits in the nursing and care sector (Germany is an example). This, in turn, is a pull factor for foreign-trained health workers and leads to chain migration flows.

04.

THINK AND ACT COHERENTLY AT NATIONAL, REGIONAL AND GLOBAL LEVEL

Policy coherence with development objectives is a legal obligation enshrined in the Lisbon Treaty. The intersections between migration, health, development cooperation, fiscal and employment policies discussed here must be addressed in a consistent manner, while the impact of policy incoherencies must be redressed.

WE CALL ON
the EU and its Member States to:

- Design and adopt a policy coherence framework for developing sustainable health workforces in and outside Europe. This must align EU public health policies with development objectives, include the migration dimension and contain clear political goals and concrete actions.
- Develop implementation mechanisms for this framework. These should be inter-institutional and cross-sector and be framed within larger implementation mechanisms for Policy Coherence for Development as pursued at EU level, including: ex-ante health impact assessments of policies, an arbitration system operated by the president of the Commission, policy monitoring and ex-post assessments, multi-stakeholder dialogues extending to include EU delegations, a complaints mechanism open to non-EU actors and a clear policy review process.
- Reverse the current trend to contain or reduce development aid for health. The EU and its member states should ensure that 50% of aid for health is directed towards strengthening health systems, with 25% impacting directly on health workforce training and retention – as recommended by the WHO – by channelling funds through national health plans and related health workforce strategies.
- Develop a political dialogue with source countries of migration. This should explore the loss of investment and skills versus the benefit to destination countries, and aim to redress this loss.
- Foster research and policy elaboration on viable compensation mechanisms. This should clarify the actors to be compensated, the nature of the loss, the rationale and methods for calculating how much is due and channels for administrating compensation funds.
- Fully exploit the potential of European Structural Funds to re-orient health and social systems towards equity and to improve the distribution of health workers within the EU. This can be achieved through targeted measures to support health workforce retention measures in European sending countries and through the exchange of good practices between professionals in sending and host countries. At the national level, a long-term strategic approach and intensive capacity building are needed to exploit this potential.
- Promote adherence to codes of conduct with a view to protecting public health systems. This should include all development actors, including NGOs and multilateral initiatives, with a view to the protection of public health systems.

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How can we address global health inequalities caused by the migration of health workers from poor to rich countries?

Policy coherence with development objectives – therefore including global health objectives – is a legal obligation enshrined in the Lisbon Treaty and thus applies to the EU and all its member states. All of the intersections between migration, health, development cooperation, fiscal and employment policies discussed here must be addressed in a consistent manner.

This means drawing attention to cases of injustice. For example, a 2006 study estimated that the amount of money the UK saved by recruiting health workers from Ghana may actually have exceeded that given to Ghana in aid for health.[2]

It is vital that the EU and its member states do not give with one hand while taking away with the other. Coherence must not be limited to government policies but must be required of all development actors. For instance, in terms of the action needed to tackle the brain drain from the public to the private sector, NGOs attracting health workers to their own programmes in low-income countries may be draining the best brains from public health facilities.

Besides seeking coherence, there is also the need to redress. The outsourcing of the costs of education and training of foreign-trained health workers to other EU and non-EU countries should be seen as a negative externality from poor to rich countries. The costs of this externality should be addressed in part through development aid, but also through compensation mechanisms supporting the education and health systems of non-EU source countries and as part of wider agreements with the countries of origin of health personnel.

In the case of the EU – where the free mobility of health workers is already a reality – its high-income member states must recognise their responsibilities. Compensation mechanisms for EU source countries are already available, such as the EU Cohesion Policy, which shapes the programming and deployment of Structural Funds and can be strengthened as a tool to increase support for an equitable internal distribution of the health workforce.

2 Mackintosh M, Mensah K, Henry, L and Rowson M (2006) Aid, restitution and international fiscal redistribution in health care: implications of health professionals' migration. Journal of International Development 18, 757-770.

05. PLAY YOUR PART IN CODE IMPLEMENTATION

European actors must take a firm stand in the global health workforce debate, putting the quest for equity in health in all countries front and centre.

WE CALL ON
the EU and its Member States to:

- Endorse statements at the highest political level (where these do not yet exist) orienting public sector leadership and stewardship towards equity in health.
- Widely disseminate and discuss the Code and translate key elements of it into enforceable national and regional legislation, including to discourage active recruitment from countries with a critical shortage of health personnel or where this might become an issue in the near future.
- Develop and implement sound accountability mechanisms. These should include stakeholder consultations at national and regional level and transparent reporting on Code implementation by the World Health Assembly, the European Parliament and national parliaments.

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POLITICAL CONSENSUS ON THE SUSTAINABLE MANAGEMENT OF HEALTH WORKFORCE MIGRATION AT THE GLOBAL LEVEL IS STILL A LONG WAY OFF.

There are powerful – albeit sometimes short-sighted – conflicting interests at play. Countries that are expanding their health coverage (such as Ecuador and the USA) or dealing with ageing societies (such as Germany and the UK) are on a global quest for trained health workers, keen for a quick and cheap fix to emerging shortages.

Other countries (such as the Philippines and various African countries) see the earnings sent back home by their health workers abroad as a crucial priority. This has led to paradoxical situations in which a Canadian province with a nurse-to-population ratio of more than 8:1000 asserts it has a shortage and hence recruits nurses in the Philippines, while the Philippines, with a ratio of 1.7:1000, asserts it has a large number of nurses and is therefore willing to 'export' them to Canada.

In keeping with the policy document 'The EU Role in Global Health', Europe and its member states must now take a firm stand in this debate, putting the quest for equity in health in both origin and receiving countries front and centre.

www.healthworkers4all.eu

How do we address global health inequalities caused by the migration of health workers from poor to rich countries?

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