CASE STUDY

Civil society contributions to a sustainable health workforce in the European Union

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ABSTRACT

Background: Following the adoption of the World Health Organization's Global Code of Practice on the International Recruitment of Health Personnel (WHO Code), eight civil society organizations implemented the European Union (EU) funded project "Health Workers for All and All for Health Workers" (2013–2016).

Investing in a sustainable health workforce requires long-term action at country and international level as part of an intersectoral effort. Both the Global Strategy on Human Resources for Health and the resolution of the UN General Assembly on Health Employment and Economic Growth anticipate an active role for civil society as change agents in this process.

Approach: This paper uses the approach and rich experiences of the project to provide case studies, an analysis of governance and accountability developments in the EU, the contribution of civil society (including its limitations) and lessons learned by the project.

Findings: The analysis indicates that civil society has been a driving force in holding the WHO Code under the attention of European policy-makers.

Conclusions: The WHO Code remains a relevant and efficient tool for guiding policy principles which address the mobility of health personnel within and beyond the EU. A governance mechanism based on shared responsibility is paramount to counteract widening disparities between health systems.

Keywords: CIVIL SOCIETY, HUMAN RESOURCES FOR HEALTH, GOVERNANCE, CAREER MOBILITY AND MIGRATION, INTERSECTORAL COLLABORATION

BACKGROUND

Following the adoption of the World Health Organization's Global Code of Practice on the International Recruitment of Health Personnel (WHO Code) by the World Health Assembly in 2010, eight civil society organizations (CSOs) implemented the European Union funded project, "Health Workers for All and All for Health Workers" (HW4All, 2013–2016).

As the labour market becomes more globalized, rising demand is driving migration and mobility amongst health personnel. The recruitment of health workers from abroad is a way of meeting domestic demand, but can worsen the shortage of qualified personnel in both low- and middle-income countries. The CSOs conceived the H4WAll project with the aim of addressing this ethical dilemma. HW4All aims to contribute to a sustainable health workforce worldwide by increasing coherence between development cooperation policies, domestic health policies,

and practices of EU member States with regard to the strengthening of the health workforce. HW4All aims to achieve this via analysis, advocacy, cooperation and implementation of the WHO Code at national and EU level.

The World Health Assembly adopted the WHO Code in May 2010 and it forms an integral part of the Global Strategy on Human Resources for Health (GSHRH 2030, adopted by the Health Assembly in May 2016). One of the guiding principles of the WHO Code states, "that an appropriate health workforce should be educated, retained and sustained for the specific conditions of each country, including areas of greatest needs, and that all Member States should strive to meet their health personnel requirements with their own human resources for health".

Sufficient financing, effective governance and shared responsibility are required to attain these principles in current globalized economies and societies. This not only needs to be achieved at country level, but at regional and global level, and should include the promotion of equitable socioeconomic development through employment opportunities. Moreover, a skilled health workforce is key to protecting global health security *(1)*.

In 2016 the United Nations Commission on Health Employment and Economic Growth (UNComHEEG) published recommendations and proposed a five-year implementation plan. The recommendations build towards the creation of approximately 40 million new health worker jobs by 2030, while addressing the current projected shortfall of 18 million health workers needed to achieve and sustain universal health coverage, primarily in low- and lower-middle-income countries (in line with the Sustainable Development Goals (SDGs)). The UNComHEEG reported, "The Commission recognizes that the international mobility of health workers may bring numerous benefits to source and destination nations and health workers themselves. However, the adverse effects of migration must be mitigated. An updated broader international agreement on health workforce migration should include provisions to maximize mutuality of benefits" *(2)*. In conjunction with the UNComHEEG, the 71st session of the UN General Assembly adopted the resolution "Global Health and Foreign Policy: Health Employment and Economic Growth" *(3)*.

Health workforce challenges in the EU include: skills shortages, unbalanced geographic distribution, workforce sustainability, transforming health workforce education to meet population health needs and addressing health worker mobility and migration *(4)*. In the EU's commitment to the UNComHEEG, it states, "Policy coherence is a priority to address the push and pull factors of health workforce migration and to reduce Europe's reliance on health workers from countries with fragile health systems, in line with the WHO Code" *(5)*.

Investing in sustainable health workforces requires long-term action at country level as part of an intersectoral effort. Both the GSHRH 2030 and the resolution of the UN General Assembly anticipate an active role for civil society as change agents. One of the recommendations of the GSHRH 2030 states, "Parliaments and civil society to contribute to sustained momentum of the human resources for health (HRH) agenda. This can be achieved through oversight of government activities and accountability mechanisms to monitor performance, and by advocating the improvement of both public and private sector educational institutions and employers. Social accountability mechanisms should be encouraged" *(6)*.

APPROACH

This paper reflects on the role of civil society in developing and maintaining a sustainable health workforce, by providing case studies on the strategies, successes and challenges at the EU level. It uses the approach and rich experiences of the HW4All project to provide an analysis of governance and accountability developments in the region, an account of the contribution of civil society (including their limitations) and the lessons learned during the process. These reflections are relevant for implementing the GSHRH 2030 and the UNComHEEG action plan in the EU context. The paper ends with proposing policy pathways and institutional capacity-building for effective public policy stewardship, leadership and governance of actions on HRH at national and EU level.

THE HW4ALL PROJECT

HW4All brought together civil society actors from eight EU countries[1] in a coordinated action to exchange relevant data, tools, understanding and advocacy on health workforce mobility.[2] Among the CSOs working on WHO Code implementation were both organizations with a background in international development cooperation and organizations that work on health system sustainability at national level (including patient groups, labour unions, professional organizations and public health NGOs). These CSOs also urged their governments to involve several ministries to address health workforce governance complexity in an intersectoral manner, for example by involving ministries of foreign affairs, health, education, finance, labour and migration.

Between 2013 and early 2016 the HW4All partnership carried out advocacy activities in full alignment with the WHO Code, involving the development and dissemination of tools for policy analysis. These tools included: the translation of the WHO Code and its user's guide into the national language(s) of partner countries, a stakeholder analysis for each country and at EU-level, a collection of case studies and a call to action. The case studies included a description of intersectoral/multi-actor collaboration on WHO Code implementation and health workforce strengthening.[3] These case studies functioned as a so-called shadow report to the formal WHO Code monitoring by the WHO and its Member States.

The HW4All partnership also organized workshops at national and EU level, which included health workers' representative bodies. The purpose was to create a community of shared practice involving national and international stakeholders in order to achieve a sustainable health workforce based on the national and regional context. In order to achieve this at the EU level, the HW4All partnership collaborated with the European Public Health Alliance (EPHA) and the European Public Services Union (EPSU).

The WHO Code promotes a public health approach to health workforce mobility, which makes EPHA an important actor in the implementation process. EPHA is a member-led organization made up of public health non-governmental organizations (NGOs), patient groups, health professionals and disease-specific organizations, working to improve health and strengthen the voice of public health in Europe. The WHO Code emphasizes the importance of equal treatment for migrant health workers and the domestically trained health workforce in all terms of employment and conditions of work. This makes EPSU an ally, as it is a federation of more than 250 independent trade union organizations representing more than 8 million workers in public services in Europe.

HW4All also became a collaborating and active partner in the Joint Action on Health Workforce Planning and Forecasting, an EU-wide health project with the aim of improving capacity for health workforce planning and forecasting by supporting European collaboration.[4] HW4All maintained a dynamic website and reported on the country studies and intersectoral actions while remaining engaged in relevant health policy dialogues in the respective countries. HW4All organized several project disseminations and policy dialogues in Geneva and Brussels that involved members of the World Health Assembly, WHO Regional Committee for Europe and the European Parliament. A final conference was held in December 2015 in which a European Call to Action and a list

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[1] The civil society organizations and their respective countries that constituted the HW4All partnership are the following; Memisa, Belgium; Terre des hommes, Germany; Amref Health Africa, Italy; Wemos, the Netherlands; Humanitarian Aid Foundation Redemptoris Missio, Poland; Centre for Health Policies and Services, Romania; Federation of Associations of Medicus Mundi, Spain; Health Poverty Action, the United Kingdom and Medicus Mundi International – Network Health for All.

[2] For a full account of the HW4all project, its activities and project outcomes visit: http://www.healthworkers4all.eu/fileadmin/docs/eu/hw4all_papers/PUBL-HW4All_def.pdf, accessed 16 July 2017

[3] For example including different ministries, health authorities, civil society, labour unions, social partners, recruitment agencies, development cooperation partners and health professional organizations.

[4] EU Joint Action on Health Workforce Planning & Forecasting. (http://healthworkforce.eu/, accessed 16 July 2017)

of 175 signatures of European and national key actors were handed over to the representatives of the European Commission *(7)*.

FINDINGS

CASE STUDIES FROM THE HW4ALL PROJECT

HW4All engaged in a policy dialogue at EU level, building on the Action Plan for the EU Health Workforce, launched by the European Commission in 2012 *(8)*. In particular, it monitored the way in which EU Member States foresee future shortages of health workers and plan accordingly, to create a sustainable domestic health workforce as envisaged by the WHO Code *(9)*. HW4All partners actively contributed to and reported about the Joint Action on Health Workforce Planning and Forecasting, which initiated discussions of the applicability of the WHO Code within a European context, including the mapping of best practices *(10)*. This topic was also part of a May 2015 workshop, including Members of the European Parliament, that the HW4All project organized in collaboration with EPHA and EPSU *(11)*. As noted in the workshop, the Joint Action found that stakeholders are particularly concerned about challenges related to health worker retention, achieving solidarity and equal access (see Box 1), and encouraging circular migration. A contextualized European version of the WHO Code, focusing on retention of the health workforce, incentives for leaving, integration practices, distribution, planning and mobility data would be relevant to develop *(10)* (see Box 2).

HW4All (Centre for Health Policies and Services, Romania) noted that by recruiting Bulgarian medical specialists from across the border, a southern Romanian hospital helped fill crucial shortages and successfully integrated Bulgarian cross-border workers who remained living and part-time working in their own country. This strategy was successful because the Romanian hospital provided the same salaries and working conditions they offer to Romanian workers, and in return they were rewarded with the Bulgarian workers' enthusiasm to learn the language quickly, share their expertise and adapt to the working culture. This represents a win for South-Eastern Europe given that both health systems are under pressure due to severe out-migration of health professionals to other EU countries where remuneration is much better *(12)*.

HW4All (Health Poverty Action, United Kingdom) also illustrated the importance of having accurate data available for better health workforce planning and taking informed policy decisions. It described efforts undertaken in Poland and in the United Kingdom to collect the best possible data on so-called stocks and flows of nurses. In the UK case, the Royal College of Nurses (RCN, also active EPHA member) set out to produce a comprehensive annual labour market review based on data compiled from different sources, including the Nursing and Midwifery Council register, the Office for National Statistics and data on the number of training places commissioned by universities. This covered both the domestic nursing workforce as well as the internationally trained workforce. Moreover, the RCN released the "Frontline First Reports", which in 2013 uncovered the scale of the nursing shortage in the NHS. Combined, these reports act as a multipurpose tool for data analysis, policy-making, and advocacy *(12)*.

Parallel to this, HW4All advocated that health workers have every right to develop professionally and build long-term careers no matter where they live, which should also apply to migrant health workers trained outside Europe. National level discussions explored the challenges of providing decent working conditions for migrant health workers of both EU and non-EU origin, which should be equal to the provisions offered to domestic health professionals (see Box 3). Migrant health workers contribute to the effective functioning of EU health systems and their rights and professional competencies must be valued (see Box 4).

HW4All (Federation of Associations of Medicus Mundi, Spain) shed light on the plight of a number of Spanish nurses hired by a private German recruitment agency. The case made headlines across Europe, since the nurses (who, given their Spanish university education, were more highly educated than their German counterparts) were taken advantage of by German employers who placed them into positions below their skill level and with a lower salary. Promises regarding free choice of location and working conditions were also not kept. Disillusioned, many of the nurses set out to break their contracts but were forced to pay fines. Only a joint intervention effort by Spanish and German labour unions, supported by EPSU, helped rectify the situation somewhat *(12)*.

HW4All (Terre des hommes, Germany) made reference to the recent rise in recruitment from non-EU countries in Germany, including nurses from the Philippines. This is not only a German phenomenon, Filipino health workers can also be found working in the UK, Ireland, Italy, Netherlands and other countries. However, while some countries have shifted their recruitment to EU sources as a result of the economic crisis, in Germany non-EU recruitment is a fairly recent move. The German and Filipino Governments negotiated a bilateral agreement to formalize the migration of nurses from the Philippines to Germany. The agreement was signed in March 2013. Both governments drafted the original text of the bilateral labour agreement without involvement of the International Labour Organization or trade unions. However, the first reporting cycle of the WHO Code triggered a debate and played a catalytic role in the process and in its implementation. Eventually the trade unions from the Philippines as well as from Germany were invited to become members of the Joint Committee and to monitor the implementation of the bilateral agreements. The Filipino newcomers received an appropriate introduction before their arrival, which included language training *(12)*.

While professional mobility and migration are an integral part of the EU's single market and undoubtedly expand work opportunities for individuals, HW4All, EPSU and EPHA argued that in the health sector, close attention must be paid to the potential unintended consequences of unbalanced professional mobility. Unequal distribution can amplify health inequalities and create problems with access to health care, especially in times of crisis. In cases where health professional mobility is a viable option, the rights and conditions of migrant health workers must be safeguarded no matter where in Europe they are, as so-called social dumping (a practice where employers use cheaper labour than is usually available) and discrimination are unethical.

Given Europe's increasingly mobile health workforce, the WHO Code has a long-term role to play as a voluntary yet crucial instrument that can contribute to correct imbalances between countries and help create (self)sustainable health systems (see Box 5).

In Romania, HW4All partner Centre for Health Policies and Services (CHPS) collaborated with SANITAS Health Union Federation and the International Organisation for Migration (IOM) in setting up a think tank as a platform for discussion on HRH. In addition, collaboration with the Department of Public Health of the Romanian Presidential Administration was established. CHPS/HW4All took steps via the organization of two policy dialogues on HRH (in 2014 and 2015) at national level, followed by an action plan for implementing change. In November 2015, the Romanian government took responsibility for redefining the socio-professional status of Romanian health workers through adequate salary management, performance assessment criteria, career pathways, and integrity. This project has had success in improving the quality of health services, reducing health workers' migration abroad and reducing personnel shortages in health units, especially in rural areas, through various incentives *(13)*.

CONCLUSIONS

ANALYSIS OF THE PROJECT AND LESSONS LEARNED

European civil society organizations, consolidated in HW4All and its allied networks, have created an engaged community of practice of national and international actors to achieve a sustainable health workforce. The project results provide clear indications that progress has been made at local and national level regarding the engagement of multiple actors in the implementation of the WHO Code and therefore also aspects of the GSHRH 2030. After the finalization of the HW4All project, some partners continued their advocacy as members or associates in the HRH working group of Medicus Mundi International – Network Health for All (MMI). Through this network, the collaboration with EPHA has continued.[5] However, there is a lack of a long-term policy vision and financial resources that would allow CSOs to continue to engage in effective promotion and accountability activities in support of WHO Code implementation at the EU level. Although the HW4All project was in general visible and well received by policy-makers, it also took place during the recovery phase of the European financial crisis and the related austerity measures resulted in diminished employment opportunities for the EU health workforce. During this period, there was less recruitment from outside the EU, and more mobility of health workers between EU member States. This context might explain why uptake of WHO Code implementation, and political attention to the issue, got less priority when compared with more stringent socioeconomic policy reforms such as the implementation of the European Union's economic governance framework, the so-called European semester *(14)*.

Civil society has been a driving force in holding the WHO Code under the attention of European policy-makers. The WHO Code remains a relevant and efficient tool for guiding policy principles addressing the mobility of health personnel within and beyond the EU. Civil society was able to fulfil its advocacy role because it received appropriate EU funding,[6] allowing it to stimulate policy dialogue and democratic deliberation. Lack of funding and political engagement is one of the reasons why the uptake of the WHO Code has been limited in other regions of the world *(14)*.

In hindsight, three issues could have been integrated into the inception of the project. Firstly, the project did not include a formal research component and a committed academic organization to systematically analyse and compare the country case studies and policy development at the EU level. The project led to relevant advocacy briefs and policy outcomes but was limited in generating the evidence-based knowledge to understand the complex policy pathways required to govern health workforce mobility. For this purpose, it would have been useful to include a research organization as an associate partner.

Secondly, HW4All would have similarly benefitted from engaging a health employer's organization or network as an associate partner. An employer's perspective on decent employment in the care sector would have added strength to the legitimacy of a social dialogue approach with governments, civil society and labour unions. Their involvement would have deepened the intersectoral policy dialogues and its uptake at the national and EU levels.

Thirdly, the project could have integrated actions and an approach to deepen governance and accountability mechanisms at the EU level. The Joint Action on Health Workforce Planning and Forecasting deepened the collaboration on data exchange and uniform monitoring mechanisms of mobility patterns between EU Member States. Currently, there is no governance institution or HRH observatory at the European level that specifically addresses health workforce mobility issues and has the mandate to initiate policy dialogue on mitigating potential side effects of migration. The European Observatory on Health Systems and Policies is hosted by the WHO

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[5]   MMI Human Resources for Health working group (MMI HRH) (http://www.medicusmundi.org/mmi-hrh, accessed 2 February 2017)

[6]   The European Commission finances amongst others the 'Brain Drain to Brain Gain' research project (http://www.who.int/workforcealliance/brain-drain_brain-gain/en/, accessed 16 July 2017)

Regional Office for Europe and monitors workforce mobility developments. However, it would be relevant to initiate a complementary multi-actor and multisectoral HRH observatory at the European level. This observatory would oversee health workforce trends across and beyond the EU, propose relevant policy discussions to redress imbalances and provide evidence-based scenarios to anticipate workforce needs and demands in the future. Examples from Latin-America and South-East Asia indicate the possibilities for developing such a collaborative platform.[7]

IMPLICATIONS FOR POLICY DEVELOPMENT

Since the expansion of the EU there is a clear trend of health workers from Eastern Europe seeking employment in the west of the region. These movements have been joined by south-to-north flows as health professionals from financial crisis-hit countries migrate to countries with stronger economies *(15)*. The impact of austerity measures and budgetary restrictions on the health care sector have contributed to encourage emigration. As health disparities in Europe are growing, so is the demand for health workers, with a widening gap between wealthier and poorer EU states. A changing labour mobility map in the health sector raises ethical and policy questions for EU Member States and whether there is, or should be, any scope for intra-EU solidarity *(15)*.

Workforce capacity must be developed to address European public health threats such as increased risks of vector and foodborne infectious diseases due to climate change *(16)*. In the east and south European countries, where there exists a relative lack of health workers, antimicrobial resistance is of serious concern *(17)*. Investment is needed to ensure basic public health functions and core capacities of countries are equipped to deal with these challenges. At the heart of this capacity is the financing and planning of a sustainable health workforce, which will be crucial in implementing the International Health Regulations *(1,18)*. Nevertheless, this demand should not exacerbate uneven EU workforce distribution and weaken fragile health systems in low income countries.

After several years of economic regression, the economies of the EU and its Member States are slowly recovering. In line with the recommendations of the UNcomHEEG, now is the time to invest European-wide in the education and employment of the health workforce. Such investment and planning should follow national priorities, be coherent with the broader European macroeconomic framework, and be closely coordinated between countries. An intra-European shared responsibility approach, as well as a dialogue on the flexibility of fiscal space required to invest in public goods such as health workforce employment is paramount to counteract widening disparities between health systems in the EU and beyond.

The UNcomHEEGs recommendations on investing in the workforce are in line with the European Commission's 2020 strategy on growth and jobs *(8)*. The health sector especially can contribute in reducing the gender employment gap by stimulating the employment rate for women, which is around 60% in the EU *(19)*. To be effective, investment in employment, governance of labour mobility and health system reform needs to be aligned with other EU-wide policy recommendations in the social sector. This includes the portability and standardization of unemployment benefits across EU Member States and an unemployment insurance scheme in the euro area, using the European Social Fund to ease integration of migrants into the labour market and society *(20)*. Some groups of the European Parliament have organized a policy dialogue and recommended the introduction of an EU law requiring a minimum wage threshold in every country. Such an initiative might lead to the retention of health workers in lower-paid parts of the care sector and hence impact on the mobility of care workers across

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[7]   See for example the Latin America and the Caribbean Regional Observatory (http://www.observatoriorh.org/) and the Asia Pacific Action Alliance on Human Resources for Health (http://aaahrh.net/).

Europe *(21)*. The successor to the Joint Action on Health Workforce Planning and Forecasting[8] should therefore be engaged in the analysis, dialogue and broader social policy development beyond the national state level, and seek coherence and European solidarity in reducing labour inequalities.

Health NGOs like the HW4All partnership must cooperate with civil society and labour movements outside the health sector to build a political mass for a broader policy dialogue on social reforms and stronger governance and accountability mechanisms in Europe. This requires a transnational and intersectoral social movement. Beyond the EU, there remains a need to address the governance of HRH migration within the context of global international labour migration frameworks, the sustainable development agenda and the development of global and regional free-trade agreements. A human rights based approach, focussing on universal access to health care and health equity, should underpin such a global governance regime *(14)*.

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8 On 29 November 2016, the European Commission announced a call for tender No Chafea/2016/Health/18 concerning the support for the health workforce planning and forecasting expert network (deadline: 30 January 2017). "The purpose of this contract is to sustain cross-country cooperation and provide support to Member States to increase their knowledge, improve their tools and succeed in achieving a higher effectiveness in health workforce planning processes and policy. It will serve to continue the work undertaken by the Joint Action on Health Workforce Planning and Forecasting and aims to be consistent with its achievements."

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