



HealthWorkers4All: Collection of case studies

**Practices of WHO Code implementation in
Europe: the role of non-governmental actors**



The project ‘Health workers for all and all for health workers’ is a European civil society initiative that contributes to a sustainable health workforce worldwide. The project is funded by the European Union.

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Introduction

Everyone should have access to health workers and functioning health systems, and yet there are still shortages of health personnel throughout the world. This affects far-off countries as well as the European Union (EU). Significant shortages of health workers represent a major threat to otherwise effective health systems.

When a country's demand for health personnel exceeds its own internal supply, a vacuum may be created, leading to migration flows from other countries. This vacuum is not usually influenced by the burden of disease in the country in question. Migration flows commonly move from low-income countries to more affluent countries and regions, where working and living conditions may be more attractive. Migration may exacerbate global imbalances in the distribution of health personnel, while at the same time weakening health systems and amplifying inequities in health.

In this context, non-governmental actors in Europe – including health professionals' organizations, trade unions, NGOs, Universities and local health authorities – are taking steps to implement the public health approach to health workforce mobility promoted by the WHO *Global Code of Practice on the International Recruitment of Health Personnel*, both autonomously and in collaboration with Governments.

The 'Health Workers for All' partnership has been involved in documenting this effort in eight European countries, as an indication of the relevance of the Code to actors on the ground. This collection of studies focuses on key areas, such as 'mobility, migration, recruitment', 'planning and forecasting', 'rights, working conditions, protection' and 'coherence, collaboration, solidarity'. Its aims are to share details of lessons learned, to increase mutual learning, and to spread innovation among stakeholders. These case studies have shown that the Code is already being translated into practical measures in many local and national contexts. These studies also confirm that the multi-stakeholder approach promoted by the Code is key to its implementation.

Non-governmental actors are also actively demanding that efforts to implement the Code, which are currently very fragmented, be organized into a system. To this end, a civil society initiative – the Call to Action "*A health worker for everyone, everywhere*" (www.bit.ly/hw4all-call) – is advising policymakers at EU and Member State level to develop and maintain strong health systems and sustainable health workforces both within Europe and elsewhere. The Call to Action – which is being endorsed by an increasing number of institutions – indicates that there is a constituency of non-governmental actors across Europe who are sufficiently committed to the Code to 'walk the talk' and to demand that it be implemented in full.

Mobility, migration, recruitment



Health workers for all - CASE STUDY

THE NETHERLANDS

**Caring for carers
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WHO Code* correspondence:

Article 4.4. Member States should, to the extent possible under applicable laws, ensure that recruiters and employers observe fair and just recruitment and contractual practices in the employment of migrant health personnel and that migrant health personnel are not subject to illegal or fraudulent conduct. Migrant health personnel should be hired, promoted and remunerated based on objective criteria, such as levels of qualification, years of experience and degrees of professional responsibility on the basis of equality of treatment with the domestically trained health workforce. Recruiters and employers should provide migrant health personnel with relevant and accurate information about all health personnel positions that they are offered.

* WHO Global Code of Practice on the International Recruitment of Health Personnel

Providing care in a changing context

Warnings about an impending shortage of health professionals have sounded for years in the Netherlands. Like other Western countries, the Netherlands has an ageing population, meaning that demand for care is increasing while the working-age population is shrinking.¹ Nevertheless, at this point in time, health care supply still exceeds health care demand. This situation can be attributed partly to the economic crisis: people are working longer and the austerity measures currently being implemented by the Dutch government are contributing to a surplus of health personnel in the short term.² Over the longer term, however, the health care sector is likely to face a serious shortage of health personnel. Demographic change – an ageing population and fewer young people joining the health workforce – is inevitable. Forecasts suggest that by 2020 Europe will need one to two million additional health workers.³

The national government's policy is geared towards decentralisation, which means that the government itself can exert little direct influence. Decentralisation has already led to a transfer of certain responsibilities to the municipalities, such as providing care for the chronically ill or elderly, or dealing with employment, and income, and youth welfare, and this process is only set to continue under the latest plans. This will put much of the responsibility for health care and welfare in the hands of municipalities. In parallel with these developments, the economic crisis is putting the Dutch health care system under pressure. There is a trend towards encouraging patients and clients to accept more responsibility, alongside an associated shift from institutional care towards care in the home environment. The Dutch government is a proponent of informal care for the chronically ill and elderly, for example, by non-trained family members or volunteers. However, not all chronically ill or elderly people have family members that are willing and/or able to provide care. In this arena of change and economisation, hiring cheap personnel from other European countries or beyond seems an attractive option, both for home care provided via municipalities and for private (24-hour) home-based care. Recent reports on the exploitation of cheap foreign labour in the 24-hour home care sector corroborate these concerns and underline the need to remain alert.⁴

As little is known about this trend with regard to the lower cadres of the care sector, the Amsterdam-based organisation Wemos carried out research to gain more insight into this relatively new phenomenon in Dutch home-based care. It conducted an initial investigation⁵ on the extent of the sector, the process of recruiting and deployment, the rights of the caregivers, the benefits for the caregiver, the quality of care, and the current state of monitoring of this home-based care (private or otherwise). Judging by recruitment organisations encountered on the internet, it is estimated that 'only' 300 patients in the Netherlands have employed a foreign live-in caregiver, mainly from Eastern and Southern European countries, to provide 24-hour home care. However, the real number is probably higher, since not all recruitment and employment agencies advertise on the internet and they are therefore hard to find. Based on this first investigation, it can be tentatively concluded that the trend towards the international recruitment of live-in caregivers is on the rise.

¹ http://www.zorgvoorinnovoren.nl/upload/file/ZIP_Zorg_voor_mensen-mensen_voor_de_zorg.pdf [Care for people, people for care] Trends in arbeidsmarkt voor zorg en welzijn: <http://www.zorghulpAtlas.nl/zorgwereld/trends-in-de-zorg/trends-in-de-arbeidsmarkt-voor-zorg-en-welzijn/> [Trends in labour market for care and welfare]

² <http://www.oxfam.org/sites/www.oxfam.org/files/cs-true-cost-austerity-inequality-netherlands-120913-en.pdf>

³ European Union (2012). COMMISSION STAFF WORKING DOCUMENT on an Action Plan for the EU Health Workforce. http://ec.europa.eu/dgs/health_consumer/docs/swd_ap_eu_healthcare_workforce_en.pdf

⁴ E.g. http://www.rtlnieuws.nl/nieuws/buitenland/geen-nederlanders-bij-thuiszorg#node_444881 [No Dutch employees in home care]

⁵ Wemos (2014). Verantwoorde buitenlandse zorg aan huis: Een verkennend onderzoek naar inwonende buitenlandse zorgverleners in Nederland.

'The majority of the agencies have been established during the past one to two years' (Wemos, 2014). Newly established recruitment agencies are a response to the government's policy to encourage care in the home environment, as was explained by different founders of these agencies. This is a worrying trend, especially since the monitoring of the situation and the labour conditions of caregivers working at the household level is lacking. Some workers testified that they were on duty for 24 hours a day. A caregiver claimed: 'I worked for a woman in a wheelchair who was very demanding. I had to work seven days a week, 24 hours a day. During the night, I had to reposition her in her bed every three hours'. Some of the caregivers are paid for 40 hours per week, while they actually work twice the number of hours. The lack of collective labour agreements leaves room for this kind of 'misconduct'. In sum, international caregivers working in the home-based and 24-hour care sector are at risk of exploitation.

Efforts for change

Applying the principles of the WHO Global Code of Practice on the International Recruitment of Health Personnel (WHO CoP), there should be equivalent benefits from international migration for both source and destination countries as well as the individual health worker. Article 4 of this Code of Practice emphasises the importance of the fair and equal treatment (same legal rights and responsibilities as domestically trained health workers) of international health personnel in terms of employment and conditions of work.

Within the framework of the principles of the Code, different actors in the Netherlands can work together to meet the challenge of ensuring fair recruitment in home-based care. Currently, different civil society organisations, such as Wemos, Fairwork and trade unions, including Abvakabo FNV, are seeking collaboration between recruitment agencies, Dutch inspectorates, the Ministry of Health, the Ministry of Social Affairs and Employment, municipalities and other trade unions. Through dialogue, various civil society organisations and trade unions have made the other actors involved aware of the trend in the lower cadres of the health care sector and the possible detrimental effects on both the health system in the source country and the well-being and situation of individual health workers in the Netherlands. The actors involved are urged to remain alert and to collectively take action from their own perspectives and in accord with their responsibilities.

One case in point is that various organisations with a background in labour/human rights are now working on an advice for municipalities on how to ensure fair and ethical recruitment of caregivers from abroad for the home-based private care sector. This advice recommends that municipalities work closely with the recruitment agencies, the Dutch inspectorates and trade unions to make sure the recruitment – and employment process – is adequately monitored and rights are guaranteed. Municipalities can also play an important role in the retention of caregivers whose jobs are currently at risk. In an online article,⁶ Actiz, the Dutch association of residential and home care health care providers, emphasised that appropriate measures such as maintaining employment levels are necessary to avoid people hiring care workers on the black market.

⁶ Actiz (2014). Decentralisatie kan ook met behoud van werkgelegenheid. <http://www.skipr.nl/blogs/id1774-decentralisatie-zorg-kan-ook-mt-behoud-van-werkgelegenheid.html> [Decentralisation of care can also be done while preserving jobs]

Wemos also recommends that the Social Affairs and Employment Inspectorate closely monitors recruitment and employment agencies to prevent exploitation and malpractice, particularly in the lower cadres of the health care system.⁷ The Health Care Inspectorate can monitor how international recruitment and staffing agency activities in the health sector affect the quality of care. In cases of noncompliance with employment rules, it is crucial that the Health Care Inspectorate collaborates with relevant bodies such as the Social Affairs and Employment Inspectorate. The Ministry of Social Affairs and Employment also plays an indispensable role in this. The Ministry can ask the Social Affairs and Employment Inspectorate to step up its enforcement of international health professionals' rights to fair and equal treatment and to safe and healthy working conditions. Moreover, the Ministry can join forces with European counterparts to put the problem of exploitation at the top of the European agenda and undertake adequate action. Recently, the Dutch Minister of Social Affairs and Employment, Lodewijk Asscher, emphasised the need to push the issue of the exploitation of migrant workers at the EU level, as cross-border wrongdoing can only be addressed collectively. The Minister stated that ensuring equal pay and labour conditions for equal work should be a top priority of the European Commission. The European Parliament has agreed on proposals to address exploitation, underpayment and unfair labour competition. As a consequence, EU Member States have to improve their monitoring of employers and increasingly check whether these employers abide by the law if they have employees working across borders. In addition, inspectorate agencies should exchange relevant information more frequently, as the monitoring remains in the hands of the countries themselves. In Brussels, a platform against undeclared work is about to be established. The Dutch Minister of Social Affairs and Employment suggested to extend the function of this platform, proposing the establishment of an EU coordination centre where agreements on joint monitoring can be made and where all EU countries can join forces and share knowledge. It is crucial that the Dutch Minister also take into account the situation of international care workers in the 24-hour home care sector while advocating equal salaries and labour conditions at EU level. At present, civil society organisations are further exploring the possible actions that the Ministry of Social Affairs and Employment might take.

Trade unions also have an important role to play in the process of ensuring the rights of international health workers. They can identify rights' violations and gaps in the current legal framework, and continue advocating an ethical approach to the recruitment of international health personnel, for example in their social dialogue with the Ministry of Health, Welfare and Sports and the Ministry of Social Affairs and Employment. Currently, the Scientific Bureau of the Dutch Trade Union Movement and the trade union Abvakabo FNV are actively engaged in studying this topic of recruiting caregivers from abroad to address financial/labour gaps in the Dutch care sector.⁸

The Scientific Bureau of the Dutch Trade Union Movement are carrying out a study on European migration and labour market dynamics with the aim to investigate the interrelation between the two and on this basis to provide recommendations to the trade union movement. As little is known about the recruitment of European migrant workers for 24-hour home care and the phenomenon seems to be growing, it will be used as a case study in this investigation of migration and labour market dynamics. In this research, the

⁷ <http://www.wemos.nl/news/?v=6&cid=3&id=300&lid=2>

⁸ Wemos et al. (2014). Fair health workforce policies at municipal level. Forthcoming.

trend of hiring migrant care workers using various labour recruitment configurations such as posting and recruitment offices will be described to illustrate how the lack of adequate regulations, the absence of collective labour agreements, and inadequate enforcement leave room for exploitation of international caregivers. The research will elaborate on the situation regarding the international recruitment of caregivers in the lower cadres of the health care sector and a comparison will be made between the situation in the Netherlands and Germany.

This research is of great importance. As Marco Borsboom (Abvakabo FNV) states: 'The hiring of migrant caregivers when the rights of these workers may be at risk is an unacceptable situation. This development needs to be closely monitored and when necessary steps need to be taken to avoid exploitation'. Wilma Roos, researcher at Scientific Bureau of the Dutch Trade Union Movement and policy officer at FNV Mondiaal, adds: 'We strongly feel that more needs to be done to prevent unfair recruitment practices in the (private) home care sector. All of the actors involved should profit from recruitment abroad. My research, together with the research by Wemos, is a crucial first step. This investigation can play a role in gaining insight into the developments in the lower cadres of the health care sector and in putting this issue on the political map. Depending on the outcome of the research, recommendations will be suggested to the trade union concerning the possibilities for an active follow-up of this research. For this reason, we intend to organise an expert meeting, bringing together key actors such as civil society organisations, policymakers and scientists as soon as the outcomes of the research are available. Collaboration between different actors is key'.

What is to be learned?

The health sector in the Netherlands can benefit from the free movement of services and people in the European Union. Health care providers are allowed to hire staff from other countries and health professionals are free to look for a job abroad. However, if recruitment of international care workers (caregivers) is not carried out in a responsible way, it can have serious repercussions. People who work in unfamiliar settings are vulnerable to various forms of exploitation, such as underpayment and violation of the working hours act. It is likely that these international health workers will end up in the grey or black market, where there is little monitoring and a legal framework is lacking – making the exploitation of cheap international labour a major risk. Relying on people from abroad is therefore not a structural solution to the anticipated shortages of health professionals in the (private) home-care sector.

So, does this mean that the recruitment of caregivers and health workers from other countries should be prohibited? No, that is not a desirable solution. The exchange of international caregivers can also bring benefits to the caregiver and the source country. Research shows that international caregivers value the relatively high salary and free room and board as a great benefit of their work in the Dutch home-based care sector (Wemos, 2014). Furthermore, they also gain experience, which can enhance the quality of care in the source country when they return home. A complete ban on international recruitment would eliminate such benefits. Therefore, it is desirable to strike a fair deal for the work being delivered and to balance the gains and losses of the situation. In order to realise a fair deal, adequate regulations to ensure fair

recruitment and the rights of international health workers in the Dutch (home-based) care sector are needed. The WHO CoP provides a straightforward framework and guidance to ensure the ethical recruitment of international health personnel, including private providers of care to elderly and chronically ill people.

By applying the principles set out in the WHO CoP as a framework for dialogue in the private home-based care sector, it becomes evident it is of utmost importance to keep an eye on the developments in this particular part of the care sector. At present, little is known about the mobility of international health workers in the lower cadres of the private health care sector and the hiring of health workers on the grey and black market, which makes these health workers highly vulnerable to exploitation. More must be done to map this trend and to implement and/or adjust policies to prevent the exploitation of international health personnel. The issue should receive more attention at policy level, deserves to be placed higher on the policy/political agenda and requires fair labour agreements and decent regulation. All of the actors involved can collectively contribute to a fair deal, ensuring that none of the parties involved are negatively affected by recruitment abroad.



Health workers for all - CASE STUDY

UK

Implementation of Department of Health's Code of Practice (2001 and 2004)

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Photo

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WHO Code* correspondence:

Article 3.2. Addressing present and expected shortages in the health workforce is crucial to protecting global health. International migration of health personnel can make a sound contribution to the development and strengthening of health systems, if recruitment is properly managed. However, the setting of voluntary international principles and the coordination of national policies on international health personnel recruitment are desirable in order to advance frameworks to equitably strengthen health systems worldwide, to mitigate the negative effects of health personnel migration on the health systems of developing countries and to safeguard the rights of health personnel.

Article 3.6. Member States should strive, to the extent possible, to create a sustainable health workforce and work towards establishing effective health workforce planning, education and training, and retention strategies that will reduce their need to recruit migrant health personnel. Policies and measures to strengthen the health workforce should be appropriate for the specific conditions of each country and should be integrated within national development programmes.

* WHO Global Code of Practice on the International Recruitment of Health Personnel

The UK was the first nation to produce international recruitment guidance based on ethical principles and the first nation to develop a 'robust Code of Practice for International Recruitment'.¹

1) The national/regional context of which the case studies are part

Between the late 1990s and the mid-2000s, the UK actively² recruited international health workers to fill shortages in the National Health Service (NHS). In 2000-2001 a total of 9,694 initial entrants on the UK Register were from overseas. This figure rose to approximately 15,000 in 2001-2002, which equated to almost half of all new nurses entering the UK Register that year.³ Despite a decline in new registrations of internationally trained nurses from 2003, the UK remains one of the largest destination countries for migrant health workers. More than 36 percent of all doctors and 10 percent of all nurses⁴ in the UK are trained outside the UK, with 25.6 percent of doctors trained outside the European Economic Area (EEA).⁵ In 2012, 4.3 percent of new nurse registrants were from outside the EEA.⁶ This outflow of health professionals from low and middle-income countries is having a devastating impact on global health.

In 1999, the Department of Health in England developed guidelines for all National Health Service (NHS) employees, responding to growing concern about the active recruitment of health workers from low and middle-income countries. The guidelines indicated specifically that NHS employers should avoid direct employment from countries such as South Africa and parts of the Caribbean, and set out good practice guidelines for international recruitment. European countries were identified as suitable targets for active recruitment to make up the shortfall.

A report by Professor James Buchan found that 'new nurse registrants from both South Africa and Caribbean countries decreased in 2000/01 from the level in the previous year by 25% and 39% respectively',⁷ illustrating a reverse in the upward trend in registrations. However, data also showed an increase in recruitment from South Africa a year later, suggesting that while the guidelines had some short-term impact, this was not sustained. Additionally, during the same period there were also continuing increases in the number of nurse registrants from countries such as Nigeria, Ghana, India and Zimbabwe, suggesting that any progress in targeted countries was offset to other countries in the Global South.

2) Description of the practice

In 2001, the guidelines were replaced by a Code of Practice introduced by the DoH which banned NHS employers from actively recruiting from developing countries unless a bilateral agreement between governments was in place. These existed between the UK and India, the Philippines and China. A full list

of the 'proscribed' countries was made available in early 2003.⁸ This list was developed by the DoH and the Department for International Development (DFID), based upon the Organisation for Economic Cooperation and Development (OECD) and the Development Assistance Committee list of aid recipients. 'The rationale for the list is based upon the economic status of the country and how many healthcare professionals are available'.⁹ At the time of writing, the list contained 154 countries, three of which have bilateral agreements and caveats to the ban, namely China, India and the Philippines.¹⁰

In 2004, the Code was strengthened to include recruitment agencies working for NHS employers, temporary staff working for the NHS, and private sector organisations who provide services directly to the NHS.¹¹ The Code also sets out guidelines for good practice on international recruitment for UK employers, covering aspects of recruitment, selection, induction and equal opportunities in employment, pay and career prospects.¹²

NHS Employers, the employers' organisation for the NHS in England, is responsible for the implementation of the UK Code by health care organisations involved in the international recruitment of health care professionals. The organisation still views the active recruitment of health care professionals from abroad as a 'legitimate solution', due to various NHS workforce shortages across the country.¹³ This international recruitment of health workers tends to be an attractive policy due to the rapid nature of recruitment and the ability to forego training costs.

Despite the decline in international recruitment since 2003, it may rise again. The 2012 UK Nursing Labour Market Review by the Royal College of Nursing (RCN) identified an overall staffing decline in nursing,¹⁴ with a growing risk of insecurity in the future, driven by reduced funding for intake and training combined with diminished levels of international recruitment.¹⁵ The UK has moved from a situation of a net inflow of nurses to a net outflow of nurses since 2006-2007,¹⁶ illustrating the 'boom and bust' cycle of 'reduced intakes to training creating staff shortages and the subsequent need to scale up training and rely on high levels of active international recruitment to make up for domestic training capacity shortfalls'.¹⁷ This is likely to be compounded by the onset of the Affordable Care Act in the US and the consequent 1.2 million job openings for nurses projected by 2020, which are likely to attract nurses from the UK.¹⁸

¹ Department of Health, 'Code of Practice for the International Recruitment of Healthcare Professionals', 2004, p. 3.

² 'Active' recruitment refers to a situation in which an employer takes the lead to stimulate interest and recruit health staff from another country.

³ Department of Health, 'Code of Practice for the International Recruitment of Healthcare Professionals', 2004, p. 2.

⁴ Nursing and Midwifery Council 2013, cited in Health Poverty Action 2013, 'The Health Worker Crisis: an analysis of the issues and main international responses'.

⁵ GMC, 'List of Registered Medical Practitioners – statistics [online] UK GMC. Available at http://www.gmc-uk.org/doctors/register/search_stats.asp [Accessed 6 October 2014].

⁶ Nursing and Midwifery Council 2013, cited in Health Poverty Action 2013, 'The Health Worker Crisis: an analysis of the issues and main international responses'.

⁷ Buchan, J., 'International Recruitment of Nurses: United Kingdom Case Study', Queen Margaret University College, July 2002, p. 18.

⁸ Buchan, J. and Dovlo, D., DFID Health Systems Resource Centre, 'International Recruitment of Health Workers to the UK: A Report for DFID, FINAL REPORT', February 2004, p. 15.

⁹ NHS Employers, 'Developing countries – recruitment', March 2014, Online, <http://www.nhsemployers.org/your-workforce/recruit/employer-led-recruitment/international-recruitment/uk-code-of-practice-for-international-recruitment/list-of-developing-countries> [Accessed 20-5-2014].

¹⁰ NHS England, 'Developing Countries – Recruitment', March 2014, Online <http://www.nhsemployers.org/RecruitmentAndRetention/Internationalrecruitment/code-of-practice> [Accessed 22-05-2014].

¹¹ Department of Health, Code of Practice for the International Recruitment of Healthcare Professionals, 2004, p. 4.

¹² Buchan, J. et al., 'Does a code make a difference – assessing the English Code of Practice on international recruitment', *Human Resources for Health*, 7:33, 2009, p. 3.

¹³ NHS Employers, 'Overseas recruitment – Kings College Hospital FT', Jan 2014, Online <http://www.nhsemployers.org/case-studies-and-resources/2014/01/overseas-nurse-recruitment> [Accessed 22-05-2014].

¹⁴ See <http://www.nhs.uk/news/2012/03march/Pages/nursing-staff-levels-elderly-care.aspx> for impact.

¹⁵ Royal College of Nursing, 'RCN Labour Market Review: Overstretched. Under-resourced. The UK nursing labour market review 2012', 2012, p. 1.

¹⁶ Centre for Workforce Intelligence, Future nursing work projections: Starting the discussion, June 2013, Available at <http://www.cfw.org.uk/publications/future-nursing-workforce-projections-starting-the-discussion/> p. 7.

¹⁷ Royal College of Nursing, 'RCN Labour Market Review: Overstretched. Under-resourced. The UK nursing labour market review 2012', 2012, p. 2.

¹⁸ United States Department of Labor, Bureau of Labour Statistics, 'Economic News Release: Table 6. Employment by major occupational group, 2012 and projected 2022', Online <http://www.bls.gov/news.release/ecopro.t06.htm> [Accessed 27-05-2014].

¹⁹ Royal College of Nursing, 'RCN Labour Market Review: Overstretched. Under-resourced. The UK nursing labour market review 2012', 2012, p. 14.

²⁰ *Ibid.*, p. 14.

Since 2010 the international contribution of nurses to the UK has grown, reaching about 4,000 new registrants in 2011-2012, double the number two years earlier, and representing about 18 percent of the registrants that year.¹⁹ A comparison must be drawn between migration from EU and non-EU countries: the latest nurse workforce figures indicate the number of EU nurses entering Britain is now outstripping non-EU nurses, although migration from both is increasing from its lowest level in 2010 (see Figure 1).²⁰ This shift towards EU recruitment can be attributed to a series of UK immigration policy changes²¹ that have made it increasingly difficult for non-EU nurses to enter the UK, while EU nurses enjoy freedom of movement under EU directives. This, teamed with the economic crisis, has led to an increase in nurses registering in the UK from countries in the EU experiencing labour market problems. For example, the number of nurses entering the UK from Portugal, a crisis country, grew from 20 in 2006-2007 to more than 550 in 2011-2012.²²

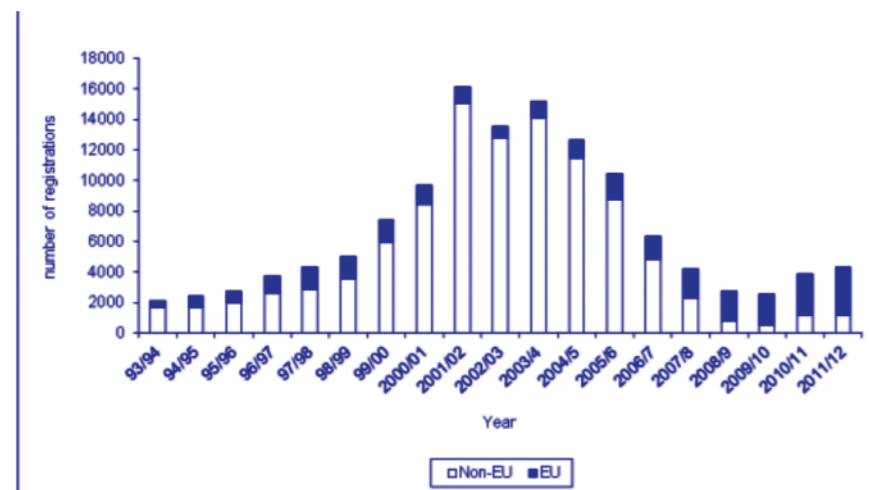


Fig. 1. Admissions to the UK nursing register from EU countries and other (non-EU) countries 1993/1994 to 2011/2012

EU nurses are effectively ‘unmanaged’, they cannot be directed and the length of their stay cannot be controlled.²³ This unrestricted flow of nurses from the EU is having a negative impact on the health systems of some poorer European countries. A European Union Joint Action on Health Workforce Planning estimates that Europe is facing a shortage of one million health professionals by 2020, with the weaker economies fearing a loss of their best and brightest workers.²⁴

¹⁹ Royal College of Nursing, ‘RCN Labour Market Review: Overstretched. Under-resourced. The UK nursing labour market review 2012’, 2012, p. 14.

²⁰ Ibid., p. 14.

²¹ For more on these changes see RCN https://www.rcn.org.uk/_data/assets/pdf_file/0016/482200/004332.pdf p. 13 [Accessed 6-5-2014].

²² Royal College of Nursing, ‘RCN Labour Market Review: Overstretched. Under-resourced. The UK nursing labour market review 2012’, 2012, p. 16.

²³ Ibid., p. 15.

²⁴ Joint Action Health Workforce Planning and Forecasting, ‘Welcome to the pages of the EU Joint Action on Health Workforce Planning & Forecasting’, Online: <http://euworkforce.weebly.com/> [Accessed 28-05-2014].

Despite progress in restricting the active recruitment of international health workers, the Code has limitations.

Firstly, while the number of international health workers entering the UK health system has decreased, this is likely to have been influenced by a series of changes affecting non-EU health workers entering the UK, separate to the Code. These include increasingly restrictive immigration controls by the UK Government since 2008, changes to the Nursing and Midwifery Council guidelines, and the onset of the financial crisis and consequential health service cuts. Research by Buchan et al. in 2009 found that a reduction in the recruitment of health workers from Kenya was rarely attributed to the Code of Practice, with the main factor identified as the ‘greater difficulties in achieving access to the UK’s labour market’.²⁵

Secondly, although it bans ‘active’ recruitment, the Code does not address so-called ‘passive’ recruitment. As the Code excludes the private sector (with the exception of those supplying the NHS), health workers initially recruited for the private sector may later end up working in the NHS, thus bypassing the Code’s restrictions through a practice that has been termed ‘back door’ recruitment. In addition, restrictions have led to a de-skilling of health workers as they are forced to take jobs in care homes in order to gain entry into the UK. As Adhikari and Grigulis found (2013), these care homes are often unregulated and unprofessional, with limited professional development, leading many health care workers to lose their valuable professional skills, even though, paradoxically, some of them are required by the NHS.²⁶

Thirdly, the Code is focused on international recruitment and overlooks the issue of domestic workforce planning, which has significance in terms of addressing the underlying drivers of international recruitment.

Finally, while the Code offers ‘principles and best practice benchmarks to be met’,²⁷ they are not legally binding.

3) What can we learn from the practice described?

With the continued impact of the economic crisis it is evident that there will be little, if any, growth in spending on the NHS in the next few years, which is likely to increase the instability of health workforces and increase demand for active recruitment from abroad. Within this context it is important that adequate data collection and ‘workforce planning’ are prioritised to allow the NHS to meet the needs of its populations in a sustainable and independent way, without a reliance on international health workers. Accordingly, it is important that issues of domestic workforce planning are factored into solutions to reduce the need for mass international recruitment.

²⁵ Buchan, J. et al., ‘Does a code make a difference – assessing the English Code of Practice on international recruitment’, *Human Resources for Health*, 7:33, 2009, p. 5.

²⁶ Adhikari, R. and Grigulis, A., ‘Through the back door: nurse migration to the UK from Malawi and Nepal, a policy critique’, *Health and Policy Planning*, p. 5.

²⁷ Ibid., p. 4.

DFID should champion robust action across all government departments to remedy the damage already done to health systems in low and middle-income countries as a result of active international recruitment. Currently, however, there is little obvious evidence of joint working between DFID and the DoH on the issue, illustrated by the fact that DFID did not have any input into the UK's reporting on implementation of the WHO Global Code, led by the DoH.

If the situation remains as it is today, one billion people will never see a health worker in their life. The aging population of the UK is fuelling demand for health workers as the number of people needing long-term care grows. While it is important that we balance the right of individuals to migrate with ensuring equitable and ethical recruitment practices, we may need to consider more radical solutions to the crisis, such as financial compensation for source countries.

Planning and forecasting



Health workers for all - CASE STUDY

POLAND

Attempt to obtain reliable data on the scale of migration of Polish medical personnel

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WHO Code* correspondence:

Article 3.7 Effective gathering of national and international data, research and sharing of information on international recruitment of health personnel are needed to achieve the objectives of this Code.

Article 7.1 Member States are encouraged to, as appropriate and subject to national law, promote the establishment or strengthening of information exchange on international health personnel migration and health systems, nationally and internationally, through public agencies, academic and research institutions, health professional organizations, and subregional, regional and international organizations, whether governmental or non-governmental.

** WHO Global Code of Practice on the International Recruitment of Health Personnel*

1) The context

One of the most effective ways of addressing the shortage of medical personnel is the proper planning of resources, which is clearly indicated in Article 5 of the WHO Global Code of Practice on the International Recruitment of Health Personnel. However, developing medical personnel resources and thus sustainable health systems must be done through evidence-based data and a well-functioning system that allows the gathering of such information. This problem was highlighted in Article 6 of the WHO Code of Practice. Recognition of the scale of health personnel shortages in different countries should be based on an analysis of the processes related to the education of new medical staff, as well as on decreasing resources related to demographic change and migration. The shortages of medical personnel can be considered to be the result of these processes.

In Poland, the number of candidates admitted each year to medical school and the number of graduates entering the labour market are known. However, it should be noted that, especially in the case of the nursing staff, graduation is not synonymous with finding a job in the profession, a fact that has been highlighted by the Polish National Chamber of Nurses and Midwives.¹ In the opinion of the professional accreditation body, the number of medical personnel currently being educated is still inadequate to the needs of the Polish health system, which will undoubtedly result in the strong deterioration of medical services for an aging Polish society in the future.

The number of medical staff presently working in the health system is also widely known. According to the OECD, the number of doctors per 1,000 people in Poland differs significantly from other European countries.² The real scale of the migration of medical personnel and how it is contributing to deepening shortages remains unclear. In the analyses of the health system, indirect indicators of medical staff migration are taken into consideration: the number of certificates issued by the professional accreditation body in Poland for recognition of Polish qualifications outside Poland, are necessary to work in other European countries. According to the Polish Chamber of Medical Practitioners, since Polish accession to the European Union at the beginning of 2004, 9,082 certificates have been issued, representing 7.11 percent of doctors practising in the country.³

A bigger problem appears in relation to nursing personnel. According to the National Chamber of Nurses and Midwives, on March 2013, 212,638 nurses and 24,137 midwives were employed in the Polish system.⁴ The same source reports that since Polish accession to the European Union, up to 31 December 2013, 16,115 certificates of professional qualifications were issued.⁵ In its report on the number of registered and employed nurses and midwives in Poland from 2013, the National Chamber of Nurses and Midwives stated that the average age of nurses registered in the Central Register of Nurses and Midwives is 45.6 years.

¹ <http://www.nipip.pl/attachments/article/1782/Wstepna.ocena.zasobow.kadrowych.pdf>

² <http://data.oecd.org/healthres/doctors.htm#indicator-chart>

³ http://www.nil.org.pl/_data/assets/pdf_file/0005/97862/Zestawienie-nr-06a.pdf

⁴ <http://www.nipip.pl/index.php/samorzad/stat/1919-liczba-pielegniarek-i-polozonych-zarejestrowanych-i-zatrudnionych>

⁵ http://www.nipip.pl/attachments/article/2622/Wydane_za%C5%9Bwiadczenia_2004-2013.pdf

In a preliminary analysis of nursing staff resources, it is predicted that in 2010-2020, almost 30 percent of registered nurses will reach retirement age, which at the date of the report was 60 years of age for women. Comparing the figures on the number of nurses reaching retirement age in the coming years and the numbers of newly educated medical staff demonstrates the difficulties of ensuring generational replacement. Thus, it is predicted that by 2035 the number of nurses will fall to 5.48 per 1,000 inhabitants, while in 2011 it was 7.33.⁶ Clearly, this analysis demonstrates how important it is to take into account an aging Polish society.

2) Description of the case

The migration of health professionals, including doctors, nurses and midwives, is a potential secondary cause of a health personnel shortage in the Polish health care system. In this regard, it is important to keep in mind that migration can be effectively addressed, above all by implementing the principles of the WHO Code of Practice, which also makes reference to the collection and exchange of statistical data between countries and across all of the relevant institutions with the potential to influence migration policy and affect medical personnel resources. To efficiently address the issue of migration there is a need to first understand its precise impact on the levels of domestic medical personnel.

The National Chamber of Nurses and Midwives has attempted to determine the actual scale of migration using direct requests for the average number of Polish nursing personnel registered with the appropriate authorities (mainly professional associations) and working in the respective health care systems of other Member States of the European Union (including Germany, Greece, the United Kingdom, Sweden and Portugal). The most reliable feedback, offered by the Nursing and Midwifery Council of the United Kingdom (NMC), indicated that there are 1,775 nursing staff with Polish origin on the British Register of Nurses and Midwives.⁷ It was remarked, however, that the number of registered nurses and midwives is not equivalent to the number actually working in the British health care system overall, information that the NMC was not able to provide. Similar problems were also pointed out by representatives of other bodies questioned in other countries.

Despite these initial set backs, there is little doubt that the attempts of the Polish National Chamber of Nurses and Midwives to obtain accurate figures should be considered good practice, as it seeks to establish reliable data which can be used as the basis for further action, and also to raise the awareness of other stakeholders who can in turn influence human resource policy in the Polish health system. For this reason, the innovative nature of the initiative taken by the National Chamber of Nurses and Midwives, not to mention the difficulties it faced, should be recognised.

⁶ <http://www.nipip.pl/attachments/article/2010/Prognoza%20liczby%20zarejetrowanych%20i%20zatrudnionych%202015-2035.pdf>

⁷ <http://www.nipip.pl/attachments/article/1790/Liczba%20piel%C4%99gniarek%20pracuj%C4%85cych%20w%20UE.pdf>

3) What is to be learned?

The creation of a well-functioning system that can provide reliable data on the real scale of migration across the European Union is required. Such data should be publicly available and its exchange between the institutions concerned should not be made difficult. The attempt to institute good practices presented here can offer a starting point for the creation of such a system, for which, first and foremost, good cooperation at the national and international levels is essential. The creation of such a system should involve all of the professional associations in the field of health in the countries concerned, who are responsible for the recognition of professional qualifications and are the central registers of practising medical staff. The methods for obtaining the necessary information should be widely discussed. It seems that the call for professional associations to properly establish and maintain regularly updated systems for data collection, storage and dissemination, including migration statistics, may be a good option.



Health workers for all - CASE STUDY

UK

**Royal College of Nursing (RCN) Labour
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WHO Code* correspondence:

Article 6.1 Member States should recognize that the formulation of effective policies and plans on the health workforce requires a sound evidence base.

Article 6.2 Taking into account characteristics of national health systems, Member States are encouraged to establish or strengthen and maintain, as appropriate, health personnel information systems, including health personnel migration, and its impact on health systems. Member States are encouraged to collect, analyse and translate data into effective health workforce policies and planning.

* WHO Global Code of Practice on the International Recruitment of Health Personnel

1) The national/regional context of which the case studies are part

Between the late 1990s and mid-2000s, the UK actively recruited international health workers to fill staff shortages in the NHS following a political commitment to expand NHS services in the UK.¹ New full registrations of internationally trained health workers peaked in 2003, yet despite the subsequent decline, the UK remains one of the largest destination countries for migrant health workers. More than 36 percent of all doctors and 10 percent of all nurses² in the UK are trained outside the UK, with 25.6 percent of doctors trained outside the European Economic Area.³

Notwithstanding the negative effects of active international recruitment on the health systems of source countries, a key concern is the lack of data on exactly how many international health workers are being recruited, and what this means for health workforce planning policies both in the UK and globally.

2) Description of the practice

Founded in 1916 as a professional organisation for trained nurses, the Royal College of Nursing (RCN) has evolved into a professional union that 'represents nurses and nursing, promotes excellence in practice and shapes health policies'.⁴ Today, the RCN has over 400,000 members, and is uniquely acknowledged as the 'voice of nursing' by both the government and the public.

In order to achieve its mission, the organisation aims to:⁵

- Represent the interests of nurses and nursing, and be their voice locally, nationally and internationally.
- Influence and lobby governments and others to develop and implement policy that improves the quality of patient care, and builds on the importance of nurses, health care assistants and nursing students to health outcomes.
- Support and protect the value of nurses and nursing staff in all their diversity, and their terms and conditions of employment in all employment sectors.
- Develop and educate nurses professionally and academically, building our resource of professional expertise and leadership, and the science and art of nursing and its professional practice.
- Build a sustainable, member-led organisation with the capacity to deliver our mission effectively, efficiently and in accordance with our values, and the systems, attitudes and resources to offer the best possible support and development to our staff.

The World Health Organization's Global Code of Practice on the International Recruitment of Health Workers states that:

*...as the health workforce is central to sustainable health systems, Member States should take effective measures to educate, retain and sustain a health workforce that is appropriate for the specific conditions of each country, including areas of greatest need, and is built upon an evidence-based health workforce plan. All Member States should strive to meet their health personnel needs with their own human resources for health as far as possible.*⁶

The Nursing and Midwifery Council is the nursing and midwifery regulator for England, Wales, Scotland and Northern Ireland. It maintains the largest register of health care professionals anywhere in the world – with 670,000 nurses and midwives currently registered.⁷ Started in 2000, the RCN's annual Labour Market Review draws on the information provided in this register, alongside other data, including the Labour Force Survey from the Office for National Statistics and the numbers of training places commissioned by universities, to provide 'an objective and succinct briefing on the UK nursing labour market'.⁸ The review includes key facts, figures and analysis on the main factors driving changes in the number of nurses and midwives registering, while highlighting factors that may influence future recruitment activity, in order to provide a strong evidence-base to inform health worker policies.

The latest workforce review, 'Safe staffing levels – a national imperative', released in September 2013, warns of an 'urgent need to address both the national security of the supply of nurses, and the local ability to determine evidence-based nurse staff levels'.⁹ As well as information on the overall UK nursing workforce, the Labour Market Review also contains information on the number of internationally recruited nurses in the UK and the wider implications of this on a global level.

The RCN's Policy and International Development Department works on a number of areas, including identifying the future needs of the nursing workforce, informing and learning from best practices around the world, and responding to government and international consultations on health and social care reform, as well as policy work on EU issues and the international mobility of nurses.

The Labour Market Review is used as one source of information in policy and advocacy work with the UK Governments, including the Department of Health, Health Education England, commissioners of nursing education, as well as EU and international institutions. It is also used by organisations lobbying for greater coordination between the Department of Health and the Department of International Development.

¹ Adhikari, R. and Grigulis, A. 'Through the back door: nurse migration to the UK from Malawi and Nepal, a policy critique', Health Policy and Planning, 2013, p. 3.

² Nursing and Midwifery Council 2013, cited in Health Poverty Action 2013, 'The Health Worker Crisis: an analysis of the issues and main international responses'.

³ GMC, 'List of Registered Medical Practitioners – statistics [online] UK GMC. Available at http://www.gmc-uk.org/doctors/register/search_stats.asp [Accessed 6 October 2014].

⁴ Royal College of Nursing, 'About us', Available at <http://www.rcn.org.uk/aboutus> [Accessed 30 July 2014].

⁵ Ibid.

⁶ World Health Organization, 'The WHO Global Code of Practice on the International Recruitment of Health Personnel', p. 7.

⁷ Nursing and Midwifery Council, 'Our Register; an NMC factsheet', p. 1 available online <http://www.nmc-uk.org/Documents/Factsheets/NMC%20factsheet%20-%20Register.pdf> [Accessed 21 August 2014].

⁸ Royal College of Nursing, 'RCN Labour Market Review – Behind the headlines: A review of the UK nursing labour market in 2001', 2002, p. 1.

⁹ RCN, 'Safe staffing levels – a national imperative, the UK nursing labour market review 2013, 2013, p. 3.

In addition, it is used by the Centre for Workforce Intelligence (CfWI), which is 'commissioned by the Department of Health, as well as Health Education England and Public Health England, to look at specific workforce groups and pathways, and to provide materials, tools and resources to inform workforce planning policy decisions at a national and local level',¹⁰ as well as a number of other organisations that work on workforce planning issues.

3) What can we learn from the practice described?

While used widely within the sector for influencing politicians and key stakeholders to help ensure that nursing provision matches need, the Annual Review is limited to a certain extent by the data that it can access. As NHS data is collated separately by the four UK countries, it can be a challenge to obtain a consistent picture of the NHS workforce across the UK. The UK Government also does not collect data on the current and future workforce needs of private sector health and social care. The Nursing and Midwifery Council data reports on the number of new registrants but it does not say if they are working or where (e.g. NHS, private sector, care homes). Accordingly, by not providing information on the workplace of nurses, the data does little to address the complaint that nurses recruited from abroad tend to experience de-skilling when they are unable to work in jobs that match their skill levels and do not benefit from the opportunities given to UK trained nurses.

In addition, while the review reports whether new registrants are from the EU or outside the EU, because of data limitations, it does not give any further information on the source country of new registrants.

As a result, the true impact of the international recruitment on developing countries cannot be established, since it is not possible to distinguish those nurses recruited from countries with a critical shortage of health workers. The Code highlights the importance of taking into account the specific needs and circumstances of individual countries, but this is currently not possible with the data being used.

UK bodies should look at means to overcome these data limitations, in line with the recommendations of the WHO Code of Practice, to enable efficient and effective workforce planning policies.

Rights, working conditions, protection

¹⁰ For more information on the Centre for Workforce Intelligence see: <http://www.cfwi.org.uk/about>



HW4all Case studies

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Title page: 162,000 nurses missing in German hospitals. Manifestation of the trade union ver.di for decent work in nursing Sept. 2013 in front of the German parliament. © Heino Güllemann

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Introduction

Everyone should have access to health workers and functioning health systems but shortages of health personnel are experienced worldwide. They exist in far-off countries as well as in Germany and the European Union (EU) and significant shortages of health workers are a major threat to potentially well-functioning health systems.

When one country's demand for health personnel exceeds its supply, a pull may be exerted leading to migration flows from other countries. This pull is not usually shaped by the burden of disease in a country. Migration flows are commonly directed from low income countries towards more affluent countries and regions. Migration increases the global misdistribution of health personnel, weakens health systems and amplifies inequities in health.

terre des hommes calls upon politicians and policymakers to implement the Code of Practice on the International Recruitment of Health Personnel.¹ We do this within a European network of civil society organisations and in collaboration with African Medical and Research Foundation (Italy), Centre for Health Policies and Services (Romania), Humanitarian Aid Foundation Redemptoris Missio (Poland), Health Poverty Action (UK), Medicus Mundi International Network, Memisa Belgium, Federation of Associations of Medicus Mundi Spain and Wemos (Netherlands).

We develop and share tools for policy analysis and (inter)action to increase knowledge and understanding of human resources for health from a global health perspective. In this context we produced this collection of best practices from Germany. A similar collection has been compiled by our European partner countries and serves our advocacy work at national, European and global levels.

The Germany-Philippines Bilateral Agreement about the Recruitment of Nurses

In March 2013 Germany and the Philippines signed a bilateral agreement to formalise the procedures of recruiting Filipino nurses to Germany. The agreement and the process that led to it shall be presented here in some detail, as it is considered a promising practice by observers as e.g. the International Labour Organisation (ILO).²

The Context

The Philippines is known as a country with a long tradition in the governance of migration dating back into the 1970s. More than a million Filipinos every year leave to work abroad. From 2004 to 2010, nurses comprised an average of 19% of all emigrating Filipino professional, medical and technical workers³. In previous times the emigrants often went to the US and the United Kingdom. This pattern is now changing as more and more states including Germany recruit health personnel from abroad. The Philippine Government has a genuine interest to proceed with this practice as the remittances of workers abroad play an important role in the domestic economy. In 2012 the central bank of the Philippines, estimated the official

remittances of all Filipino workers abroad – not only health workers - at an amount of US\$21 billion.

However, in the last years some difficulties surfaced as well: The "Reformulated Human Resources for Health Master Plan" from 2013 observes an "alarming migration of health workers, particularly nurses and doctors" leaving the country. The result is that even in the Philippines "many areas outside Metro Manila and urban centres suffer from lack of professional health service providers." Another consequence of emigration is that the authorities issued a lot of licenses to open up private health science schools in order to cope with the increasing outflow of health workers. But the report states that, "This has resulted in the proliferation of sub-standard schools, e.g., nursing schools, the result of which is low quality of education among health professionals in the country. Ironically, this has not stopped other countries from recruiting Filipino health professionals." (Department of Health, 2013: Reformulated Human Resources for Health Master Plan – HRH Strategy for the Philippines 2014 – 2030).

At the same time, reports on the bad treatment and exploitation of overseas Filipinos – particularly in the middle east - made it back to the Philippines and into international headlines and sensitised the wider public for risks that these migration patterns may hold. The phenomenon of exploitation and abuse of migrant workers is not new, but in mid-2013 the so-called sex-for-flight scandal ignited further public debate: It was reported that Filipina overseas workers were sexually abused by officials from Philippine Overseas Labour Offices (POLO), when they requested protection from abusive employers. The POLO currently has offices in 34 countries around the world to protect overseas workers.

2011 and 2012 were also marked by activities for the first reporting cycle for the WHO Code of Practice; in the Philippines as well as in Germany. In the Philippines the reporting triggered a multi-stakeholder coordination process. On the Philippines the Department of Health (DOH) is the designated national authority for the WHO Code monitoring. The ILO Decent Work Across Border (DWAB) Project gathered the representatives of four Filipino organizations—the DOH, Department of Labour and Employment, ILO and WHO Philippines and Western Pacific Region (WPRO) in early 2012. The partners discussed the WHO Code and its National Reporting Instrument and agreed to engage a wide range of stakeholders including employers, trade union organizations and hospitals. In a first step data were collected from a wide range of stakeholders (government, employers-hospitals, private recruitment agencies, trade unions, professional associations) and the draft country report was discussed in multi-stakeholders workshops.

As a coincidence in this phase the German and Filipino authorities first met to discuss their future bilateral agreement on the recruitment of Filipina nurses for the German labour market. As an outcome to the multi-stakeholder process described above the Filipino stakeholders at this point in time already had solid knowledge of the WHO Code, ethical recruitment and the roles and responsibilities of each stakeholder in the promotion of ethical recruitment practices.

A second outcome was that during the first reporting cycle of the WHO Code of Practice it became obvious that the WHO National Reporting Instrument had a certain bias to the situation in destination countries. It was recommended that the reporting instrument and more generally the Code be reviewed and reformulated to be more relevant to source countries as

¹ World Health Organisation (2010). WHO Global Code of Practice on the International Recruitment of Health Personnel, WHA63.16. Genf. (http://www.who.int/hrh/migration/code/code_en.pdf).

² Visit: http://www.ilo.org/manila/info/public/pr/WCMS_173607/lang-en/index.htm

³ Dimaya, Roland M. et al.: Managing health worker migration: a qualitative study of the Philippine response to nurse brain drain, Philadelphia, 2012.

well. In the workshops, the multistakeholders' sectoral and cross-sectoral discussions helped to clarify this issue and situate the Philippines as a source country of migrant health personnel in the reporting context.

As thanks to the dissemination efforts of WHO and ILO during this process the stakeholders have had exposure to the WHO Code and the issue of ethical recruitment of health professionals, they will in the future be able to engage in similar multi-stakeholders initiatives and request to be included in such discussions. This latter outcome is directly linked to engaging the trade unions PS Link (Philippines) and ver.di (Germany) in the Joint Monitoring Committee to be described further below.

The Bilateral Agreement

In this context the German and Filipino Governments negotiated their bilateral agreement to formalise the migration of nurses from the Philippines to Germany. The agreement was signed in March 2013. The agreement is rich in details and in particular the following points should be taken into consideration for other governments negotiating similar treaties:

- Clear regulation on the deployment of Filipino health care professionals, including full pre-departure briefing about relevant laws, regulations, policies, procedures, norms, cultures and practices in both, their countries of origin and destination.
- Preservation, promotion, and development of Filipino workers' welfare. The agreement states clearly that the health care professionals get their work contract before departure and that the working conditions that are to be offered to Filipino nurses in these contracts are to be "comparable" to German workers and not "less favourable" than those for similar German workers. As such, it includes coverage (but not necessarily portability) of all social protection entitlements, encompassing health and long-term care insurance, pension, accident and unemployment insurance.
- The agreement promotes exchange of ideas and information with the aim of improving and simplifying job placement procedures.
- The agreement stipulates the promotion of human resource development in the Philippines.
- The agreement also very importantly contains a section on the set up of a Joint Committee (Article V), which inter alia has the task to monitor the implementation of the agreement. In the meantime the Committee was composed. Members are not only the signing parties but also relevant stakeholders as e.g. trade union representatives from the Philippines and from Germany as well.

With regard to the latter point, past research, including research carried out by the ILO DWAB project, have pointed to the lack of implementation and follow up mechanisms, including the lack of multi stakeholders' involvement, in the negotiated agreements. In too many cases across the globe, otherwise sound agreements remain unimplemented. And here the ILO and DWAB played an important role in bringing the existence of this agreement to the attention of the trade union PS Link and the international federation PSI. PS Link got in contact with the German trade union ver.di and both approached their respective governments. 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.

Another remarkable outcome is that the contacts in between the trade unions PS Link and ver.di prompted activities to warmly welcome the migrants and accompany them upon arrival at the university hospitals in Heidelberg and Tübingen. The migrants – expected to arrive in autumn 2014 - will get guidance from trade union representatives upon arrival and specific advice with regard to labour law and working conditions from the workers' council. This clearly shows an open attitude towards migration and the willingness to constructively participate in the process from the side of the trade union.

What is to be Learned?

In the first place it is to be mentioned that the original text of the bilateral labour agreement was drafted without contributions of the ILO or Unions. It was the product of negotiations between the two governments. However, the debate triggered by the first reporting cycle of the WHO Code of Practice played a catalytic role in the process and in its implementation. On the one hand this shows that enough information is available for willing and well-meaning governments to design comprehensive agreements. On the other hand it also shows the added value of bringing the right stakeholders together at the right time.

Secondly the high sensitivity about issues of global mobility of health workers on both sides facilitated the integration of the social partners as most importantly the trade unions from both sides in the monitoring of the agreement. Potentially this is the point that may turn the agreement from theory into a real good practice. An effective way to ensure that the provisions of the code are respected is to have social partners around the table, monitoring the situation.

The Struggle for Decent Work in Nursing at the Berlin Hospital Charité

The Context

Traditionally, German nurses are NOT amongst the best organised professions in terms of collective bargaining and effective representation in the political arena. This becomes even more evident when comparing nurses to the other big lobby groups competing for their share in the German health system: professional associations of physicians and medical doctors, hospitals, health insurances and, last not least, the pharmaceutical industry. In fact, professional associations and trade unions for nurses do exist, but membership rate and degree of organisation are low in nursing and their representation is comparatively weak. If at all, nurses are in a secondary role.

The reasons behind this flaw are manifold and comprise - amongst others - the rather recent development of nursing work towards a recognised profession. Up to the recent past and partly even today nursing and care work, more than other health professions, have been the domain of nun-nurses. But within Christian organisations and churches the so-called church labour law is in force, which is limited with regard to self-organisation and collective bargaining. For example strikes are prohibited in Christian organisations, though a final decision from the German constitutional court is still pending and might change the situation. Another often cited argument for the low level of organisation amongst nurses is the so-perceived altruistic character of the work.

Keeping this in mind it becomes clearer why the nursing profession was so severely hit by the recent wave of privatisation and economisation in the German health system: In between 2002 and 2004 Germany reformed its hospital financing scheme. Before that, hospitals were financed on a needs based system. Since 2004 hospital financing has been based on a case based lump-compensation according to the so called Diagnosis Related Groups (DRG). Hospitals receive a lump-sum for each case according to the diagnosis. And they are free in allocating this budget to treatment and therapy. A major argument for the introduction of the DRG-system was to enhance competition and entrepreneurial spirit in Germany's hospitals.

To date, the new DRG-based system led to an increase in the number of medical doctors employed in German hospitals by 27 per cent (since those are the ones, who primarily make the diagnosis) and was accompanied by a 10 per cent decrease of the employees in nursing, therapeutic work and housekeeping. At the same time the number of patients rose by 15 per cent. Whilst the German hospital system prior to the introduction of the DRG system was characterised by long in-patient periods, nowadays, the debate rather centres about premature discharges, the so called "bloody discharges". As a consequence, shorter in-patient periods led to less overall demand for nursing in hospitals and this may explain some of the decrease in the number of nurses. But it is also true that over the last decade the work-load and the work-intensity for the remaining nurses increased sharply. Nowadays the accumulation of vast amounts of overtime is rather the rule than the exception. The current nurse-patient ratio in German hospitals is at 1:12. This is the worst ratio across Western Europe. The ever increasing work load and the growing pressure on the nurses consequently leads to high dropout rates and decreasing numbers of job starters. Ultimately, this results in the present paradox situation that despite high structural unemployment rates in Germany a lack of qualified nurses – or more

precisely: a lack of qualified nurses still willing to work in their job - is manifest. The common term paraphrasing the issue in the German media is "Pflegenotstand" (Nursing crisis).

In this situation, employers, hospital management and even the German government have started to recruit nurses from abroad and are doing so with increasing intensity. This means the numbers of positions for nurses in German hospitals are declining, but simultaneously the recruitment from abroad takes off.

Here lies a significant difference to the first wave of so-called "guest workers" recruited in the 1960s and early 1970s in former West-Germany: whilst at the time the recruitment from abroad was a reaction to full employment in times of a soaring economic growth, currently, the employers are rather looking for anyone from wherever, whoever is still willing to work under the current insufficient working conditions.

A newly emerging and promising practice in this context is the nurses' fight for decent work in the biggest German university hospital Charité.

The Struggle for Decent Work at the Charité University Clinics in Berlin

With 13,000 employees and over 3,200 beds, the Charité is Europe's biggest university hospital and is owned by the city of Berlin. For many years staffs were not paid the legal salaries agreed between the unions and management. Only after yearlong struggles and two strikes – in 2006 and in 2011 – the nurses were eventually paid according to their collective labour agreements. This successful struggle strengthened the nurses' trade union ver.di in the hospital and led to an exceptionally high degree in organisation and self-confidence amongst the staff in this specific hospital.

Simultaneously, in 2010, the national headquarters of the trade union ver.di started the nationwide campaign "Der Druck muss raus!" (to be translated as "relieve the pressure") fighting the difficult working conditions and the high workload for nurses in German hospitals. Initially the campaign focussed on occupational health and protection against work overload for nurses in 2010 and 2011. In 2012 the focus of the campaign shifted and rather argued towards defining a more favourable patient-nurse ratio. ver.di calculated a gap of 162,000 nurses currently missing in the hospitals.

At the same time the debates in the workers' council of the Charité centred on a fixed patient-nurse ratio as a central claim, in order to get back to decent work. Both the ver.di headquarters as well as Charité's workers' council are pursuing the same goal, but whereas the headquarters struggle in the political arena is for a regulation by law, the workers' council of the Charité's nurses are pursuing the goal via negotiations with the employers.

In June 2012 the workers' council invited the employers to negotiations about a fixed nurse-patient ratio. Until now this is the first time that German nurses have put the question of decent work on the agenda of collective bargaining.

First the employers evaded the negotiations by stating that the topic is not legally covered by the mandate of collective bargaining, but in July the board of the hospital agreed to enter into negotiations. Since July 2013, several rounds of negotiations took place, so far with no concrete outcome. At the time of authoring this article the negotiations were in a deadlock but the nurses

clearly communicated that they would be willing to go for a strike to achieve their goal of decent work.

Why this is to be Considered a Best Practice?

Traditionally the German nurses are more poorly represented in the German health system than other parties such as e.g. the hospitals, physicians or the pharmaceuticals. Moreover, the German health system over the last decade has opened up towards free market structures and competition. But, at the same time, the health systems remains largely regulated. In this situation, nurses, as the weakest element in the system, became the victim of the intended "free interplay of market forces". Consequently more and more nurses quit their jobs and open positions remain vacant for longer periods. This in turn, increases the incentive for international recruitment of nurses.

Whereas, in well-functioning markets the market forces should balance the decreasing supply by rising salaries or more attractive work conditions this is not the case in the German health system, simply for the reason that it is not a free market but an externally regulated system. Instead of addressing the root problem by improving working conditions for nurses, German employers and government are, for the first time since 1973, again recruiting nurses from abroad. The rather cynical assumption behind: Asian nurses are still willing to work under the conditions, which are chasing away the domestic work force.

But a Vietnamese nurse is most needed back home in Vietnam, where the coverage rates are still ten times lower than in Germany. Thus, the current failure of the German health system in the field of nursing even threatens the health systems of the source countries.

Instead of exporting the German homemade problems to the developing world, the domestic root causes of the problem are to be addressed: The imbalances of the German health system by and large stem from the decreasing quality of work and conditions for nurses. This results from the comparatively weak representation of the nurses' interests within the German health system.

This is why the wakeup call, which the nurses in the Charité are currently sending out, is so important: whilst developing agency, whilst struggling for their own personal interests, these nurses potentially and in the long term will strengthen the nurses' role in the German health system and they will create decent work in nursing, which will potentially benefit the society at large, as it brings the system back into balance. And therefore, these nurses deserve all support in their struggle.



Health workers for all - CASE STUDY

SPAIN

The migration experience of Spanish nurses in Germany

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WHO Code* correspondence:

Article 4.5. Member States should ensure that, subject to applicable laws, including relevant international legal instruments to which they are a party, migrant health personnel enjoy the same legal rights and responsibilities as the domestically trained health workforce in all terms of employment and conditions of work.

Article 4.7. Recruiters and employers should understand that the Code applies equally to those recruited to work on a temporary or permanent basis.

* WHO Global Code of Practice on the International Recruitment of Health Personnel

1) The national/regional context of the case

As a result of the economic crisis in Spain a significant part of the Spanish health workforce have considered the option of seeking a professional future outside the country, mainly in European Union countries, as there are no impediments to labour mobility and working conditions are expected to be attractive, or, at least, to offer better prospects than in Spain. One of the most frequent destinations for nurses is Germany, as the situation in the latter demands qualified personnel in the health sector. In 1996, Germany reformed its health system, which led to a huge reduction in nursing personnel. In total, it is estimated that at least 40,000 nurses left the German health system. In addition to this reduction, the remainder of the workforce faced different conditions. This led some to choose part-time employment, others to leave the country looking for more profitable and quieter destinations, and fewer young Germans choosing this career due to the simple equation 'less nurses plus more patients equals a bigger workload'. Needless to say, this has created favourable conditions for health workforce importation.

2) Description of the practice

In Spain there are private companies that seek health workers with the objective of covering positions in the German health system. One of them, dedicated mainly to intensive home care, has a programme called 'Work & Travel Europe', which hires nurses in Spain and other European countries. This programme was created, according to the company, to 'offer to qualified nursing personnel from a country that cannot provide them with the expected job opportunities, the chance to enter the German job market, which needs to cover such positions urgently'.

To do this, the company looked for nurses in countries such as Spain, Portugal and Greece and facilitated 'the accreditation of their nursing qualifications for Germany, together with economic support and subsidised accommodation', according to the company, which managed offices in Madrid that recruited around ten nurses every month for this programme.

The conditions discussed in the interviews seemed more or less acceptable: a German language course would be provided, and a contract was offered for 1.5 to 2 years. This contract was signed under the German labour law. Depending on the conditions offered, it appeared possible to choose between working in a big city or in a rural area. However, one major condition was that because of the company's support at the start, if a nurse left before completing their contract, he or she would have to pay a fine of between EUR 6,000 and EUR 10,000 due to breach of contract.

The real conditions on arrival in Germany were, however, very different. There was no choice about where to work and the main destinations were small towns with no chance of changing the destination. 'Our salary was between 20-40 percent lower than our colleagues, they did not give us the option to negotiate it; the working day was 12 hours without a right to have a break; and we often did the job of a nursing

assistant', reported Natalia Sierra, one Spanish nurses who entered the programme. If a person did not agree with these conditions, he or she would have to pay more than EUR 6,000, which was the main reason nobody left the programme.

Of course, the problem not only affected the workers hired by this programme: the salary conditions, so different from their fellow German workforce, caused a phenomenon that is known as 'a race to the bottom', with relationship problems between the local and international workforce, and locals seeing their international colleagues as cheap labour, which impeded the latter's social improvement. In light of this situation, the German labour union ver.di outlined a campaign with the nurses involved in the programme, and had a meeting with the German company recruiting in Spain on 26 May 2014. The company's response was to close the programme on 13 June 2014, respecting the ongoing contracts but ceasing, in principle, to hire more health workers outside Germany. This case has become public in Germany and in Spain, and in July the European Federation of Public Service Unions (EPSU), the biggest trade union federation in Europe for health workers, and its affiliates in Germany (ver.di) and Spain (FES-CCOO and FSP-UGT) called on health workers to no longer accept such conditions and to report such cases.

3) What can we learn from this experience

There is a lack of regulation at the European level regarding the basic conditions that must be respected by all companies (especially private intermediary companies) involved in the hiring of health workers for positions in other EU countries. The WHO Code specifies that there cannot be differences in labour conditions for workers coming from different countries, and the Recife Declaration confirms this in stipulating that it will: 'promote equal opportunities in education, development, management and career advancement for all health workers, with no form of discrimination based on gender, race, ethnicity or any other basis'.

Therefore, even if health sector and public sector work are national rather than European-defined competences, there must be a common European approach that clarifies the legal requirements and labour conditions that these companies must respect when hiring personnel (for example, same job, same salary). This common approach can be supported through voluntary codes such as EPSU-HOSPEEM, but this should be extended to home-based care workers and not only apply to the hospital sector. The EU must also make greater efforts to regulate the behaviour of these companies, as well as improve knowledge about the rights and duties of health workers wishing to work in another EU country.

¹ http://sociedad.elpais.com/sociedad/2014/06/29/actualidad/1404060780_813802.html

² <http://www.epsu.org/a/10605>

³ http://www.who.int/workforcealliance/forum/2013/recife_declaration_17nov.pdf?ua=1



Health workers for all - CASE STUDY

SPAIN

**The experience of non-EU member MIR in
the Navarra Community: Labour inequity**

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WHO Code* correspondence:

Article 4.5. Member States should ensure that, subject to applicable laws, including relevant international legal instruments to which they are a party, migrant health personnel enjoy the same legal rights and responsibilities as the domestically trained health workforce in all terms of employment and conditions of work.

Article 4.7. Recruiters and employers should understand that the Code applies equally to those recruited to work on a temporary or permanent basis.

* WHO Global Code of Practice on the International Recruitment of Health Personnel

1) The national/regional context of the case

Until recently, the main gateway for international doctors in Spain has been the specialised residency programme called MIR (*Médico Interno Residente*; there are also specialised residency programmes for pharmacists and nurses). Since 1978, the completion of this programme has been mandatory to be able to work in the Spanish public health system. In Navarra, as well as all other Autonomous Communities in Spain, MIRs are educated in the different health institutions of their territory. Every year, the national health authorities publish a new official announcement of vacancies in the health system, for which there is a quota for non-EU health workers. This has decreased in recent years, from 20 percent in 2009-2010 to 4 percent in 2013-2014. The reason for this reduction is the socioeconomic situation of the country.

Between 2006 and 2009, there was an increase in the demand for health workers in Spain due to the decentralisation of and a consistent increase in health services; an increase in the population, primarily the result of an increase in the migrant population; and the retirement of a massive number of health workers who began work in the 1970s when the current Spanish public health system was created. As a consequence, there was also an increase in MIR places. For a number of years, the number of vacancies for MIR candidates was higher than the number of MIR graduates and this favoured the recruitment of international health workers coming from both EU and non-EU countries.

The economic crisis and the end of demographic growth led to the end of this practice: the Ministry of Education has since reduced the number of vacancies in the health system for both university and MIR graduates, which explains part of the decrease in the current number of vacancies for non-EU personnel. We should keep in mind that training each specialised doctor costs around EUR 200,000. However, as we saw above, the percentage of non-EU MIR candidates has also been reduced, which can only be explained as a political decision.

2) Description of the practice

Every MIR is a trainee employee and provides medical health care services. Once they have been given a position, non-EU MIR students who do not already have a study permit or a residency and employment permit, must apply for a visa through the Spanish consulate in their country of origin. Instead of a work permit, they will be granted a visa for Study Purposes only, legally endorsed by the Real Decreto 557/2011 del 20 April, Article 43.¹ Once they arrive at the hospital to start their MIR period they must sign a similar employment contract to that signed by other new medical residents (nationals, EU members and non-EU members with residency and employment permits), regardless of their different status.

Before 2013, and once the requirements that the law demanded were fulfilled, personnel in an MIR programme who wished to change their residency status (from stay for study purposes to residence and

employment) could do so. In 2013, a group in Navarra that fulfilled these requirements applied to change their status, directed by the personnel department of the hospital in Navarra. However, the Aliens Office refused to grant the change in status because of guidelines stipulated by the Health Services of Navarra (the health authority in this Autonomous Community). Thus, it appeared that the health authorities now wanted to apply the regulation under the Real Decreto 557/2011 in a more strict way.

The group of international doctors subsequently spoke with political representatives, and this case was discussed in the Navarra Parliament at the end of 2013. During the first term of parliament in 2014, the majority of the parliamentary parties supported the motion to return to the previous interpretation of employment status (except two, who abstained). However, the motion was not carried because the main political party did not support it.

The change seems unlikely to be reversed. While the non-EU member MIR employees (with a student card) have had social security contributions subtracted from their salary, as do all employees, including the contribution to unemployment benefits, in their salary for April 2014 the entire amount subtracted and related to unemployment benefits since the beginning of their MIR contract was returned. This means that they do not have any rights to unemployment benefits, unlike other MIR participants, including non-EU MIR who changed their residency status in previous years.

Although non-EU member MIR participants are in a special situation with regard to Spanish employment legislation and do not need a work permit to be able to work in the Spanish health care system, this case of the application of the legislation implies clear discrimination, since not having a work permit directly impacts on the rights of MIR employees from non-EU countries. In comparison with Spanish nationals and others who hold work permits:

1. They do not have a right to unemployment benefits.
2. It 'forces' them to leave Spanish territory once their studies are finalised and their student card expires, since to change their residency status, at least a one-year contract is required and it is not possible to obtain a temporary work permit as a migrant.
3. They face inequality of opportunity in finding a job.

This discrimination has a direct impact related to two aspects of the Global Code of Practice on the International Recruitment of Health Personnel signed by Spain in 2010, and in particular:

Article 4.5.: Member States should ensure that, subject to applicable laws, including relevant international legal instruments to which they are a party, migrant health personnel enjoy the same legal rights and responsibilities as the domestically trained health workforce in all terms of employment and conditions of work.

¹ <https://www.boe.es/buscar/pdf/2011/BOE-A-2011-7703-consolidado.pdf>

Article 4.7.: Recruiters and employers should understand that the Code applies equally to those recruited to work on a temporary or permanent basis.

3) What can we learn from this experience

An MIR is a health professional who works while receiving training. For this reason he/she should have equal legal working conditions as health workers with Spanish nationality. To comply with the WHO Code it is therefore necessary that laws and rules that could interfere with the equality of rights between non-EU and EU health workers and community health workers are revised.

Furthermore, in a country with highly decentralised health services such as Spain, it is important to ensure that every authority that is involved in the recruitment of health care workers is aware of the WHO Code of Practice and supports its implementation.

Unfortunately, we do not have the data necessary to precisely determine the impact of these restricted policies on non-EU health workers and in turn the health of the population. In fact, we have no accurate data on how many health workers (including doctors) are working in Spain (migrant or not), or how many of them are leaving the country. However, estimations suggest that due to the economic crisis in Spain, an increasing number of Spanish doctors want to work abroad, and by 2025 there will be a 14 percent deficit in the optimal number of doctors.²



Health workers for all - CASE STUDY

ITALY

The Contact Point for migrant health workers organised by IPASVI Florence



² [https://www.msssi.gob.es/profesionales/formacion/necesidadEspecialistas/doc/13-NecesidadesMEspecialistas\(2008-2025\).pdf](https://www.msssi.gob.es/profesionales/formacion/necesidadEspecialistas/doc/13-NecesidadesMEspecialistas(2008-2025).pdf)

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Get Active! Register at the EU collaboration platform and sign the Call to Action for European decision-makers for strong health workforces and sustainable health systems around the world.

Web: <https://interact.healthworkers4all.eu>

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WHO Code* correspondence:

Article 4.1. Member States and other stakeholders should take measures to ensure that migrant health personnel enjoy opportunities and incentives to strengthen their professional education, qualifications and career progression, on the basis of equal treatment with the domestically trained health workforce subject to applicable laws. All migrant health personnel should be offered appropriate induction and orientation programmes that enable them to operate safely and effectively within the health system of the destination country".

* WHO Global Code of Practice on the International Recruitment of Health Personnel

Introduction

Health coverage, and particularly access to health care when it is needed, is crucial for human well-being. In addition, of all the elements of social protection, health care is most essential to the economy as a whole and to economic recovery in particular. In Italy, Article 32 of the Constitution, enshrining the protection of health as a 'fundamental right of the individual and collective interest', in fact 'obliges' the State to support all appropriate steps that may be useful to ensure better protection of the 'value' of health. The national health service is, today, one of the most relevant social safety nets in a country where 8.3 million people live in poverty and 15 million are at risk of poverty or social exclusion, and youth unemployment is at 27.8 percent. Financing the national health service accounts for about 25 percent of total expenditure on social welfare covered by the State.¹

While over the past decade public health expenditure increased² faster than economic growth, it remains extremely limited in Italy. The increase in life expectancy of the population, which in Italy is among the highest in Europe, has generated the need for better targeted strategic intervention. We need to advance a political vision that accords primary importance to innovative health services for elderly and fragile patients, who are not necessarily outcasts and marginalised members of society but very often middle-class workers with poor or intermittent salaries or pensions, exposed to social determinants of illness and with no capacity for private health expenditure.

This new approach to public health services requires well-trained and organised health workers; the financial crisis, however, is leading Italian decision-makers to drastically curb public spending in the belief that health care is essentially a cost that must be controlled and reduced. This is not only affecting the right to health protection for citizens, but also the potential for health workers to be a part of the solution to the present crisis.

It is therefore clear that in order to limit expenditure without losing sight of rights, we need to create a new alliance between health personnel and patients, with everyone considered first and foremost citizens, especially if they belong to the most vulnerable sections of society – immigrants, temporary workers, the unemployed, the disabled, the elderly – whose future health is strongly determined by the negative social conditions in which they live daily.

In this context, it is important that health professionals – increasingly at risk of cuts and shortages – fully demonstrate the significance of their role in the health care system, acquire awareness of the importance of defending and promoting global health, and are also able to identify and tackle underlying processes in their advocacy activity, engaging with national and EU institutions, as well as in daily professional relationship with patients.

¹ It was equal to EUR 412,255 million in 2010. The 'Social Security/Pensions' element, which represents the most significant component, accounts for 66.4% of total expenditure, followed by 'Social assistance' at 8% (Italian Health Policy Brief, 2013).

² Public health expenditure increased overall by EUR 61.8 billion, rising from EUR 51.7 billion to EUR 113.5 billion (with the out-of-pocket private expenditure at EUR 144 billion).

The context

The low level of public health financing in times of crisis is also reflected in the low numbers of health workers. Skilled health workers are the backbone of any health system (Global Health Workforce Alliance and WHO, 2014); however, health workers are currently experiencing a global crisis. Their numbers are much too small to deliver the services needed, they are unequally distributed and they often lack decent working conditions. As a result, in many countries, health workers are stretched beyond their limits and seek jobs elsewhere. This, in turn, often further reduces the availability of health services, especially in rural areas, and contributes to a 'drain' of skills and of public investment in education in these skills.

Public expenditure for health personnel in Italy went from an annual average increase of 2.4 percent in 2006-2010 to a reduction of 1.4 percent in the period 2010-2013, reducing its average share of total health expenditure from 33.2 percent in 2010 to 32.2 percent in 2013. A blocking of turnover for the regions under a national debt repayment plan, the blocking of contractual procedures for the 2010-2012 period, and the freezing of salary levels to those in force in 2010 were the major measures implemented to deal with public debt.

This created a harsh rebound effect in employment levels. In six years, 25 percent of health professionals lost their jobs. The report by the Consortium AlmaLaurea in Bologna highlighted a further worsening of the employment trend in the last year: the survey involved 64 universities and nearly 450,000 graduates and stated that the 'occupational performance' of the health professions for the period 2007-2012 is in crisis in all four areas, albeit to different degrees: dropping from 88 to 78 percent (-10%) in rehabilitation; from 74 to 50 percent (-23%) in the area of prevention; from 90 to 60 percent (-30%) in nursing-midwifery; and from 81 to 50 percent (-31%) in technical areas (AlmaLaurea, 2014).

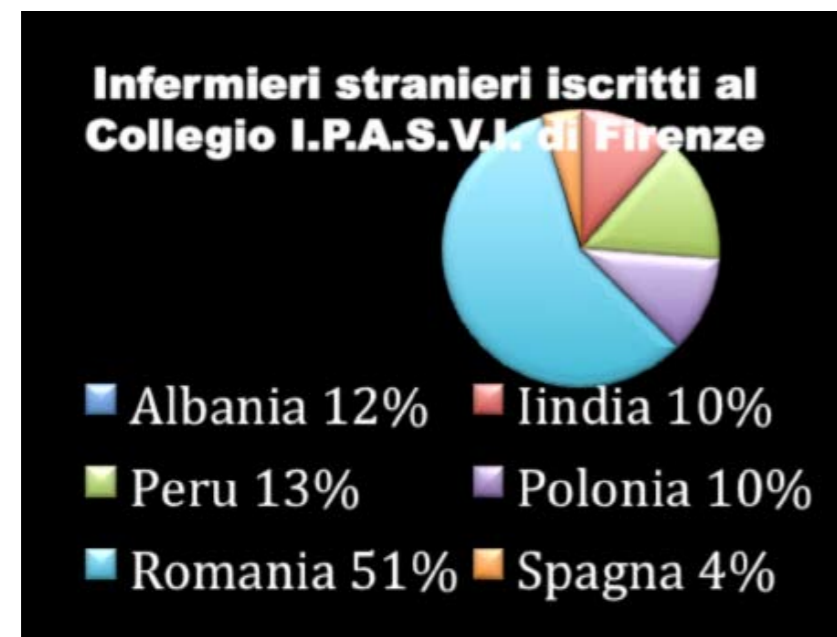
This crisis is wide and deep: delays in payment are frequent, the consequences include absenteeism, requests for informal payments and a brain drain of workers seeking better wages outside the country. In addition, job and wage cuts for health workers due to fiscal adjustments in the framework of austerity measures has significantly reduced access to health services, and is transforming Italy into a country of departure as health workers look for more attractive job locations (ILO, 2014).

Description of the practice

Italy used to be a desirable place to live and operate for health workers from many countries in the world. The nursing shortage in the country changed the recruitment of personnel in the health care sector, and from the end of the 1990s the legislation at the national and EU levels also opened the way to the health professions. However, strict regulations introduced by the Bossi-Fini law on migration, and by its proceedings in more recent years, have pushed professional organisations to put in place focused measures to support international colleagues, many of whom saw their presence in Italy jeopardised by the changes in the rules for obtaining their work and residence permits in 2007. In the province of Florence, the IPASVI (the national professional federation of nurses) put in place the first Contact Point for international health workers at the national level to address their concerns and concrete problems.

The Contact Point is accessible via email and phone, and it is possible to book an appointment with an expert or an IPASVI representative to obtain concrete assistance on issues such as the recognition of professional qualifications, contract and working conditions, as well as other general living and employment issues. The four pillars of the Contact Point are: 'Welcoming/Listening/Directing/Tutoring'. According to research undertaken at the School of Nursing Education, University of Florence (Codella, V. 2012), in 2010-2011, 789 international nurses in the province of Florence were assisted by the Contact Point and almost two-thirds of the requests received positive support. The principal needs which were addressed were the recognition of national degrees; renewal of residence permits; access to post-basic training courses; searches for work; but also salary not received for 4-5 months; and 'atypical' employment contracts.

The Contact Point has also supported IPASVI in achieving a clearer vision of the nature and needs of international health workers operating in the province of Florence.



Nationality of international nurses affiliated with IPASVI (2012)

IPASVI also used the information collected through the Contact Point as a test of the needs of health workers generally, including the most vulnerable, that is, their affiliated members arriving from abroad. The broader picture described in the national report released by IPASVI at the national level at the end of 2013 confirms the evidence which had already emerged at the local level.

The report confirms that in the nursing profession there has been a sharp drop in the number of international nurses, with a substantial and progressive decrease from 35.3 percent in 2007 to 15.3 percent in 2012. Significant, however, is the data related to the place where international nurses gain their professional qualification, with only 50.3 percent having graduated abroad (the number was 70.4% five years earlier).

In 2012, 2,152 new registrations concerned international health workers, equivalent to 15.3 percent of new IPASVI members. With regard to the international presence, Italy is divided into three distinct areas: the northwest, where they account for a very significant component of new students (28.3%, with a peak of 36% in Liguria); the centre-northeast, where the international presence is important, but does not reach the levels recorded in the northwest (16-19%); and the south, where the international component is almost negligible (4.5-5.0%).

The most significant evidence remains the major decrease in the registration of international nurses in recent years. As mentioned above, since 2007, the international share of new IPASVI members has decreased from 35.3 to 15.3 percent. Apart from a few isolated and episodic exceptions, the decreasing trend characterises all locations, where the weight of international nurses among new members has essentially halved. Slightly less than half of all newly registered international health workers (46.4%) are from outside the EU (IPASVI 2013–data from 2012).

What is to be learned?

The IPASVI Contact Point proved to be a valuable tool in providing concrete support to international health workers in Florence, but also confirmed that in the context of a general crisis, the promotion of health personnel is a strategic element in the defence of the health system as a whole. AMREF Italy, as part of the 'Health workers for all' coalition, and in collaboration with IPASVI, has also promoted a seminar in Florence to exchange information and views with and among health worker representatives and relevant local stakeholders, on the issue of the more sustainable management of international health worker recruitment, in line with the proposal made by the WHO Code of Conduct.³ In this context, the Contact Point of IPASVI Florence emerged as a good practice, offering professional support to international health workers, as proposed by the Code. However, it also clearly emerged that there was a lack of policy coherence between employment provisions and measures related to security and migration, at both the national and European levels.

³ <http://www.amref.it/locator.cfm?PagelD=9189>

Today, the experience of the Contact Point reveals some difficulties, as reported by IPASVI Florence, which is in contact with the authors of this study. Fewer people are accessing the Contact Point, and it seems that this is because international nurses are reluctant, if not frightened to do so, too often because of the precarious and difficult working conditions in which they operate.

According to ILO, collective bargaining is the best way to negotiate workplace arrangements that attract the necessary number and quality of health care workers. Furthermore, public authorities need to be exemplary employers. Thus, the expenditure of public funds and any contract for health care provision must include clauses ensuring decent wages. Key instruments to achieve the necessary conditions include laws and regulations, collective agreements and other mechanisms for negotiation between employers' and workers' representatives, and arbitration awards. Finally, with respect to the migration of health workers, bilateral and multilateral arrangements are needed with a view to compensate for training costs and avoiding brain drain (ILO 2014).

All of these elements are included in the Call to Action launched by the 'Health workers for all' coalition to address growing concerns regarding health worker recruitment and working conditions in Europe in times of crisis. Specifically, the Call to Action demands respect for the rights of migrant health workers (3rd Recommendation), pointing out that the voices of migrant health care workers, their organisations and the trade unions must be heard by institutions and stakeholders at both the national and EU levels. This is required to shape effective action and plans that avoid exploitation and the violation of their rights. The experience and work of organisations such as the Florence Contact Point must be supported and replicated to ensure this happens. In this way we can learn from those who are at the forefront of the health services and thus better respond to the need for equity that is growing all around the world.

Coherence, collaboration, solidarity



Health workers for all - CASE STUDY

BELGIUM

**Memisa 'HOSPITAL FOR HOSPITAL'
twinning programme**

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WHO Code* correspondence:

Article 5.3. Member States should recognize the value both to their health systems and to health personnel themselves of professional exchanges between countries and of opportunities to work and train abroad. Member States in both source and destination countries should encourage and support health personnel to utilize work experience gained abroad for the benefit of their home country.

** WHO Global Code of Practice on the International Recruitment of Health Personnel*

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1) National and international context

This programme started ten years ago as a way of bringing health workers from different Belgian hospitals into close contact with colleagues in similar situations (e.g. working in a rural district hospital) in the South, in order to stimulate solidarity. This was done in the context of the WHO Code of Practice, especially Article 5, in which Member States are invited ‘to promote international cooperation ... recognize the value both to their health system and to health personnel themselves of professional exchanges between countries’.

2) Description

Through a better understanding of the reality of the PHC structural programme within different rural health districts in Congo (and later on also Burundi), and within the structural Memisa health programmes of the Northern and Southern partners, a mutual awareness was gradually established regarding the different challenges that had to be faced (including the lack of sufficient and motivated medical personnel, especially in public health care in remote rural regions). In general, in the rural health districts which are supported by Memisa, only two medical doctors are responsible for the health care of 100,000-150,000 people. In order to assure, nevertheless, good medical care, much accent is put on the formative supervision of the first-line care given by trained nurses and midwives in the 10-15 peripheral health centres. Up to 90 percent of all medical complaints, as well as natural births are handled at this level, severe cases are referred to the level of the general hospital.

Participating hospitals in the North signed a partnership contract with Memisa, committing themselves for at least five years to follow and support the evolution of medical care within ‘their’ partner health districts (through ‘immersion’ – missions in the field, regular reports on the evolution of the different indicators, correspondence etc.). They were also invited to inform and sensitize their ‘stakeholders’ (medical personnel in the Northern hospital, management staff, patients, visitors, suppliers, etc.) about the situation faced by their partner hospital and health district in the South, about the medical personnel involved and about the challenges of medical care worldwide.

This initiative was a real eye-opener for the working groups and respective hospitals in the North involved, dealing with elements such as: the ‘privileged’ situation in the North, for example, easy access to and even sometimes ‘overconsumption’ of medical care; the involvement of Southern colleagues in ensuring every day – in spite of the lack of means and sufficient HR – primary health care for the population under very difficult (sometimes even dangerous) circumstances; the possibility of having direct personal exchanges concerning this challenge; as an excellent form of teambuilding within the medical and paramedical

staff and a form of genuine and practical engagement and involvement; as a sign of corporate responsibility from Northern hospitals towards the challenges of global medical care and a way to inform other stakeholder groups on another reality with the same perspective; and ensuring quality care everywhere through motivated personnel.

For the partners in the South, the HRH initiative meant a real boost because their colleagues in the North showed greater interest in their work, endeavours and the challenges they faced. Solidarity grew gradually but concretely. This was realized through exchanges on medical subjects, training during and after immersion missions (e.g. on preventive medical care, hygiene, new medical techniques, transmission of articles and recent medical literature, etc.), financial support to the Memisa structural multi-annual medical programme within the different health districts, and in some cases initiatives that went well beyond the perspectives of the structural programme (such as the installation of additional solar-energy systems (for lighting, conservation of vaccines, the procurement of additional medical equipment, specific missions, etc.). Memisa’s added value consisted in the establishment of direct links between medical personnel in the North and the South, the contact with management teams from various hospitals and the organization of information sessions on the objectives of the support of the working groups here in the North. This was done, for example, through the production of didactic materials (leaflets, photos, videos, etc.), through regular updates and reports on the evolution of medical care in ‘their’ health district, and through the organization of immersion missions in the field. For Memisa, the feedback from the participating workgroups was also very useful in updating its approach to the health district, with our policy paying specific attention to the recruitment of medical personnel within our programmes as well as ways to improve job satisfaction in the field (and in that way, retention in the job).

3) Results: lessons to be learned

The fact that during the ten years that this programme has been running, eighteen hospitals and hospital groups in Belgium joined the HRH initiative and that every hospital has renewed their agreement at the end of their first five-year contract suggests some success. The HRH project reflects a symbiosis between an NGO programme and specific grass-root initiatives, with different groups actively requesting participation at a particular time. These are all indicators that these kinds of initiatives respond to a growing and felt need to link health professionals in the North and the South to promote professional and personal exchanges and grasp the broader picture, thus responding to the need for greater numbers and more motivated medical personnel to ensure good medical care everywhere on this planet!!

4) Individual stories

Johan Swinnen, Former Belgian Ambassador to Congo, Kinshasa: 'You [volunteers from different Northern hospitals visiting their partner hospitals in Congo] are symbols of the voluntary spirit and desire for genuine involvement, prepared to assist a population that needs a better quality of life and also better medical care. You are the ambassadors of our Belgian hospitals. You come here with the aim of giving but also receiving, by coming into contact with this Congolese reality'.

After visiting the Pawa district in the Province of Orientale in DRC, Virginie Groulard and Nicole Bairolle, nurses from CHC in Liege, stated: 'In Pawa, the nurses are totally different but at the same time identical to us. We had the opportunity to meet them during our mission, which our hospital asked us to undertake. We were in the bush in this part of northeast Congo as part of the Hospital for Hospital project promoted by Memisa. On our arrival we were given a very warm welcome from the local population and medical staff which made an impression on us. The welcome reassured us, because we were away from our usual environment. The medical and other personnel had to explain to us how the hospital functioned, without even water or electricity. The interaction between us seemed to work well and, above all, they had plenty of ideas and projects in mind and, in that way, promises for a better future!!'

Some of the teams from the Belgian hospitals who visited their twin health districts in the South were so motivated after their immersion mission that they took the initiative to provide supplementary support in addition to the structural medical aid provided within the Memisa programme. Thanks to fundraising activities among colleagues, relatives, etc., a number of hospitals received solar panels, water tanks and other additional equipment. Above all, the human factor, the solidarity in the challenge to provide good medical care everywhere, is the most motivating factor.



Health workers for all - CASE STUDY

BELGIUM

Charter proposed by Belgian development cooperation actors on the recruitment and support for the development of human resources for health (HRH) in partner countries – November 2012



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WHO Code* correspondence:

Article 4.1. Health personnel, health professional organizations, professional councils and recruiters should seek to cooperate fully with regulators, national and local authorities in the interests of patients, health systems, and of society in general.

** WHO Global Code of Practice on the International Recruitment of Health Personnel*

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1) The national/regional context of which the case study is part

Belgium supported the drafting and adoption of the WHO Global Code of Practice on the International Recruitment of Human Personnel (2010). Moreover, the 2008 Belgian policy note, 'The right to health and to health care', identified the shortage of HRH, in terms of numbers, competences and motivation, as one of the key challenges to be addressed. This policy recognizes that these problems are caused by external and internal migration, as well as problems in the various countries of origin, and that they have repercussions for the quality of services and programmes.

2) Description of the practice

The Be-cause Health Platform (www.be-causehealth.be) comprises key Belgian players active in health development cooperation and committed to promoting universal access to quality health care and health care services. The platform aims to create a bridge between academia and development cooperation actors, both at headquarters and in the field, through a process of consultation, coordination and the organization of common activities. Working groups on different themes are active under the umbrella of the Be-cause Health Platform.

The HRH Working Group (GT-HRH) of Be-cause Health has taken the initiative to elaborate a charter on the recruitment and support of the development of human resources for health (HRH) in partner countries, targeting various Belgian development cooperation actors engaged in the health sector. It aims to harmonize, increase efficiency and render more equitable the practices of Belgian development cooperation actors in the field of recruitment and support for the development of health workers from partner countries. By putting the topic on the agenda of the Belgian political scene, it is asking for real engagement by the actors involved. This charter aims to strengthen the institutional development of partner countries, which is vital to the process of strengthening health systems and the objective of universal health coverage. To this end, it seeks to translate several of the objectives of the WHO Code of Practice into concrete engagements.

In signing this charter, the organizations promise to respect, within the limits of their respective mandates, the principles described in it. These aim, on the one hand, to actively support health workers' capacity-building and to reinforce sustainable health systems, and, on the other, to limit the negative effects that the international recruitment of health workers from partner countries might have on local capacity. These guiding principles will be implemented taking due account of the fields of operation of the signatory organizations and do not constitute an obligation to achieve particular results. The principles are to guide the work of organizations involved, where appropriate, with regard to their interventions and their policy choices.

¹ http://diplomatie.belgium.be/en/binaries/policy_note_healthcare_tcm312-195597.pdf

The organizations adhering to this charter assume certain commitments in the following fields:²

- With regard to partnerships and harmonization
- With regard to policies and development plans for HRH
- With regard to training
- With regard to recruitment
- Within the health sector in Belgium

In November 2012, eighteen Belgian actors involved in development cooperation signed the Belgian Charter. The main actors are the Belgian Technical Cooperation, NGOs, academic institutions and private companies. The charter was presented at the WHO side event of the project 'HW4all' in May 2013.

To monitor how the charter influenced the daily practices of the signatories, the working group developed a matrix³ for follow-up and evaluation, which allowed the establishment of a reference base and the follow-up of the progress made over the years by the individual signatories. This matrix is actually in a test phase, currently being used by different actors within the working group, with the aim of improving it and ultimately developing a final 'user-friendly' version that can be used on a wider scale.

A Master's student in Population and Development Sciences at the University of Liège is writing her thesis on the subject and has been accompanying this process and the different actors involved. She has also spent several months in Kinshasa (DRC) on an internship at the Department of HRH in the Ministry of Health, developing a proposal for a charter to participate in the process of the development of human resources for health. This Congolese Charter is based on the Belgian Charter and aims to encourage development cooperation partners, as well as national institutions active in the health sector in DR Congo, to unite around a common HRH policy and stimulate them to implement national HRH policy.

² For the full text see charter document at: http://www.be-causehealth.be/media/37374/RHCharter%20English_FINAL%20revised%20accepted.pdf

³ <http://www.be-causehealth.be/en/member-area/human-resources-for-health/conferences-workshops/workshop-hrh-charter-on-the-recruitment-and-the-support-to-the-development-of-hrh-in-the-partner-countries>

3) What can we learn from the practice described?

The practice described was a success in bringing together different actors, all involved in human resources development, both in the North and the South. Academia, private actors, ministries, NGOs, and federal and regional agencies regularly met and shaped the Belgian Charter, with a specific focus on the interactions between developed and developing countries. The lessons learned were multiple, and some were striking. The WHO Code of Practice is usually ignored. The development of human resources by development partners in the partner countries is often done without alignment with the national planning context. Coordination between development partners is weak or non-existent, and last but not least, it should be emphasized that many development actors recruit the best national resources for the development of their projects, and while this allows them to successfully implement their projects, by doing so it weakens the national systems.

While the Charter does not pretend to solve all issues, the simple fact of creating consensus on how Belgian development partners can and will work together with their partner institutes is an enormous innovation. Placing emphasis on sound coordination, strengthening local planning in relation to human resources, improving the training capacities of the local institutes, and reducing the harmful effects of unethical recruitment in the partner countries, is an important first step in a long process of change.

4) Individual story

To illustrate the impact of the Belgian Charter and the way it is put into practice, we will look at the matrix for the follow-up and evaluation of the NGO Memisa.³

In summary, the following aspects have been strengthened and there is now enhanced focus on:

- Interventions supporting the implementation of national plans for the development of HRH
- Measures to make the profession of health workers more attractive
- Training for health workers
- Policy on recruitment and remuneration of HRH and measures taken to limit negative effects
- Sensitizing and informing the Belgian actors involved in recruitment of HRH from the South
- Production of documents/organization of events aimed at documenting and capitalizing on relevant experiences regarding support for the development



Health workers for all - CASE STUDY

ITALY

The FNOMCeO commission on development cooperation



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Get Active! Register at the EU collaboration platform and sign the Call to Action for European decision-makers for strong health workforces and sustainable health systems around the world.

Web: <https://interact.healthworkers4all.eu>

Pictures

Title page: Trainee doctors' strike, Rome 2012

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WHO Code* correspondence:

- Article 5.3.** Member States should recognize the value both to their health systems and to health personnel themselves of professional exchanges between countries and of opportunities to work and train abroad. Member States in both source and destination countries should encourage and support health personnel to utilize work experience gained abroad for the benefit of their home country.
- Article 8.2.** All stakeholders referred to in Article 2.2 should strive to work individually and collectively to achieve the objectives of this Code. All stakeholders should observe this Code, irrespective of the capacity of others to observe the Code.

* WHO Global Code of Practice on the International Recruitment of Health Personnel

Introduction

Health coverage, and particularly access to health care when it is needed, is crucial for human well-being. In addition, of all the elements of social protection, health care is most essential to the economy as a whole and to economic recovery in particular. In Italy, Article 32 of the Constitution, enshrining the protection of health as a ‘fundamental right of the individual and collective interest’, in fact ‘obliges’ the State to support all appropriate steps that may be useful to ensure better protection of the ‘value’ of health. The national health service is, today, one of the most relevant social safety nets in a country where 8.3 million people live in poverty and 15 million are at risk of poverty or social exclusion, and youth unemployment is at 27.8 percent. Financing the national health service accounts for about 25 percent of total expenditure on social welfare covered by the State.¹

While over the past decade public health expenditure increased² faster than economic growth, it remains extremely limited in Italy. The increase in life expectancy of the population, which in Italy is among the highest in Europe, has generated the need for better targeted strategic intervention. We need to advance a political vision that accords primary importance to innovative health services for elderly and fragile patients, who are not necessarily outcasts and marginalised members of society but very often middle-class workers with poor or intermittent salaries or pensions, exposed to social determinants of illness and with no capacity for private health expenditure.

This new approach to public health services requires well-trained and organised health workers; the financial crisis, however, is leading Italian decision-makers to drastically curb public spending in the belief that health care is essentially a cost that must be controlled and reduced. This is not only affecting the right to health protection for citizens, but also the potential for health workers to be a part of the solution to the present crisis.

It is therefore clear that in order to limit expenditure without losing sight of rights, we need to create a new alliance between health personnel and patients, with everyone considered first and foremost citizens, especially if they belong to the most vulnerable sections of society – immigrants, temporary workers, the unemployed, the disabled, the elderly – whose future health is strongly determined by the negative social conditions in which they live daily.

In this context, it is important that health professionals – increasingly at risk of cuts and shortages – fully demonstrate the significance of their role in the health care system, acquire awareness of the importance of defending and promoting global health, and are also able to identify and tackle underlying processes in their advocacy activity, engaging with national and EU institutions, as well as in daily professional relationship with patients.

¹ It was equal to EUR 412,255 million in 2010. The ‘Social Security/Pensions’ element, which represents the most significant component, accounts for 66.4% of total expenditure, followed by ‘Social assistance’ at 8% (Italian Health Policy Brief, 2013).

² Public health expenditure increased overall by EUR 61.8 billion, rising from EUR 51.7 billion to EUR 113.5 billion (with the out-of-pocket

The context

The Universal Declaration of Human Rights (UDHR, 1948) and the International Covenant on Economic, Social and Cultural Rights (ICESCR, 1966) set out:

- The right to the ‘highest attainable standard of physical and mental health’ (ICESCR, Art. 12(1)) and to ‘a standard of living adequate for the health and well-being of himself and his family, including ... medical care’ (UDHR, Art. 25(1)).
- The right to ‘social security, including social insurance’ (ICESCR, Art. 9), ‘in the event of ... sickness, disability ... or other lack of livelihood in circumstances beyond his control’ (UDHR, Art. 25(1)).
- The right to ‘conditions which would assure to all medical service and medical attention in the event of sickness’ (ICESCR, Art. 12(2d)).

The ILO Medical Care Recommendation, 1944 (No. 69) emphasises that ‘medical care service should cover all members of the community, whether or not they are gainfully occupied’ (para. 8) and provides comprehensive guidelines for the provision and delivery of medical care, particularly the essential features of a medical care service, the entitlement of persons covered, as well as the scope, organisation, quality, funding and administration of medical care.

To achieve these goals, it is crucial that health professionals are fully aware of their role as service providers but also as cultural and political sentinels ensuring the right to health in daily practice. In Italy, a large part of this awareness has been progressively achieved by health professionals through a process of the coding of professional ethics in health care, in which the public relevance of the medical profession within the national and international contexts has been gradually framed. This evolution accompanied the establishment of professional associations, created to guarantee the interests of those professionals they served, and also those of their patients. The institutional evolution in which doctors have been involved over the course of the twentieth century is reflected in the way medical knowledge has developed and enriched ethical and deontological aspects of the profession.

On 10 July 1910, provincial medical associations (called Orders) were established to create a national network of medical doctors. In 1912, the first unified ethical code, called the ‘Charter of Duties’ (Codice di deontologia medica) was sketched, to be fully approved and implemented in 1924. The Fascist regime subsequently delegitimised and ultimately suppressed the medical associations in 1935, and the debate on the ethical aspect of the profession had to be renewed in the Orders, which were reconstituted in September 1946 and combined into a National Federation of Provincial Orders, the FNOMCeO (Federazione Nazionale degli Ordini dei Medici e degli odontoiatri). The ‘Charter of Duties’ prepared in 1924 was then completely revised by the Federation.³

³ D. Lippi, G. F. Gensini, A. A. Conti, ‘Charter on medical professionalism: putting the charter into practice’, *Ann. Intern. Med.* 2003, 138, pp. 852-853.

Description of the practice

In 1958, the first Ministry of Health was established and the text of the new 'Charter of Duties' was also approved, in which doctors were required to conduct themselves according to 'science and conscience'. A Code of Ethics has evolved in more recent years, followed in 2006, for the first time, by changes to the text demonstrating an intention to avoid paternalism, using terms such as 'citizen', 'assisted person' and the 'sick' to invoke universal principles of reference. Moreover, in relation to the criterion of 'appropriate use of economic resources', which responds to the objective of the redistribution of resources in the interests of the entire community, a principle of quality of care was added, to address growing social inequalities that are evident in present times of crisis.

In the following years the medical profession paid increasing attention to global health as part of its cultural and ethical reflection. To emphasise the evolution of the profession required to meet the new challenges posed by an increasingly globalised society, in 2007 FNOMCeO launched its first 'Manifesto on multiculturalism in medicine and health care', approved and made mandatory for all Italian doctors. This document introduced the duty of the physician to 'recognise the diversity of cultural specificities of each patient by adapting each health intervention to specific needs and cultural connotations; preferring dialogue to reconcile freedom and common membership, with the aim of ensuring equal rights to those who are different'. Projecting the profession – little accustomed to thinking beyond the national context – towards a global context, which began knocking on the door of health facilities in the form of migrant patients and migrant health workers, the Manifesto has triggered a very positive process of contextualisation of each medical intervention in the context of promoting the right to health for all.

The Manifesto kick-started a very positive internal discussion on international development cooperation, global health and the protection of health in developing countries, supported by the fact that many Italian doctors and health workers volunteer in the frame of international health cooperation or solidarity projects. In this context, a second position paper was elaborated in 2008, entitled 'Manifesto sulla tutela della Salute globale', in which the Federation acknowledged that '[p]overty, exploitation, violence and injustice as well as socio-economic, political and cultural factors, internal and external to the country affected, foster inequalities in health', and that 'equity in health should be pursued by eliminating unnecessary and avoidable differences, favouring education, security and social and economic development'. According to this perspective, the international community must support health systems in their planning and regulation of public and private health services to ensure the protection of public health and the universality of access to services. International cooperation should promote policies that can ensure the permanent creation and maintenance of skills of health personnel, allocating adequate resources to ensure appropriate remuneration and to working conditions that ensure the retention of health workers in the health system of origin. Health services must promote universal access to health care by ensuring their gratuity and usability.

In this framework, physicians 'must also strive for policy creation and consolidation of a fiduciary relationship between local communities and health care systems, favouring interventions for prevention and the treatment of diseases responsible for the greater burden of disease and mortality'.

This opening of perspectives and the approach to the role of health professionals has facilitated renewed discussion on international cooperation, global health and the protection of health in developing countries by NGOs, universities, medical doctors, nurses, other health professionals and concerned institutions.

This debate has been formalised through the creation of an internal Committee on Global Health and Development Cooperation in which various stakeholders, in collaboration with institutional representatives from the Federation, share common positions and engage in common activities.

The effectiveness of this multi-stakeholder approach to global health, in which AMREF Italy has been involved since the beginning, was also confirmed by the launch in 2011 of the 'Manifesto per il rafforzamento del personale sanitario', which called on national authorities to give effect to the 'WHO Global Code of Conduct on the International Recruitment of Health Personnel' in Italy.⁴ The Manifesto was promoted by stakeholders such as AMREF, FNOMCeO and the National Association of Nurses (IPASVI). In December 2014, FNOMCeO organised a two-day national conference in Rome on development cooperation within the health sector, at which representatives from the Ministry of Health and other relevant national institutions were present, including the organisations participating in the work of the FNOMCeO Committee.⁵ The same organisations participated in the national seminar, 'Politiche di austerità in sanità: quale impatto sulle carenze di personale sanitario?', organised by AMREF Italy in the context of the 'Health workers for all' project, with the aim of reflecting on the impact of austerity on the Italian NHS, and to share common elements of a specific agenda to ensure a sufficient supply of health personnel to our system of care.

The Committee on Global Health and Development Cooperation elaborated and started to negotiate with local authorities on a 'Standard proposal for bilateral framework agreements and regional laws to facilitate the participation of nurses and medical doctors in cooperation activities for development projects and in the training of health personnel in the countries of origin', in order to facilitate the involvement of public health system employees in these activities. In consideration of the present budget constraints in development cooperation, both at the national and local levels, FNOMCeO mobilised its own resources in order to support the participation of Italian health workers in training projects in the South. In its 2014 budget, FNOMCeO contributed EUR 50,000 to the Global Health and Development Cooperation in accordance with progress made in the analysis and comprehension of global determinants of health.

Last but not the least, at its 2014 national congress, FNOMCeO renewed its Code of Medical Ethics,⁶ adding an article (Art. 5) in which the promotion of health beyond the health sector becomes one of the duties of the doctor, and a pillar of medical ethics. This puts Italy in the forefront of medical ethics at the international level and shows that only through the leading role of health professionals is it possible to successfully address the economic, cultural and institutional challenge of the right to health for all.

⁴ It can be found here <http://www.manifestopersonalesanitario.it/manifesto>

⁵ <http://www.manifestopersonalesanitario.it/amref-partecipa-alla-due-giorni-fnomceo-su-salute-e-cooperazione-internazionale>

⁶ <http://www.fnomceo.it/fnomceo/Codice+di+Deontologia+Medica+2014.html?t=a&id=115184>

Art. 5

Promozione della salute, ambiente e salute globale

Il medico, nel considerare l'ambiente di vita e di lavoro e i livelli di istruzione e di equità sociale quali determinanti fondamentali della salute individuale e collettiva, collabora all'attuazione di idonee politiche educative, di prevenzione e di contrasto alle disuguaglianze alla salute e promuove l'adozione di stili di vita salubri, informando sui principali fattori di rischio.
Il medico, sulla base delle conoscenze disponibili, si adopera per una pertinente comunicazione sull'esposizione e sulla vulnerabilità a fattori di rischio ambientale e favorisce un utilizzo appropriato delle risorse naturali, per un ecosistema equilibrato e vivibile anche dalle future generazioni.

The original text of Codice di Deontologia medica 2014

What is to be learned?

The first aspect we would like to emphasise in presenting this case study is that a multi-stakeholder dialogue can accelerate the cultural and concrete progress of a health profession towards a more comprehensive approach to its role in global health in general, and in health workforce development in particular. When this multi-stakeholder dialogue occurs, it can advance the knowledge of both the institutions and stakeholders, but it can also enable the health profession to support very specific aspects of policies and mobilise resources with a more targeted and determined approach, even in times of cultural and economic difficulty. With this critical mass within and beyond the professional association, it has been possible to propose regional level laws for the support of health development cooperation initiatives. It has also been possible for the organisation itself to set international cooperation in the development of a health workforce as a priority to be supported through internal funding.

The most important condition required for this to occur is the active participation of health workers in the promotion of global health. This is currently perceived and stated by medical doctors in Italy as part and parcel of the ethical framework of their work, also thanks to the strong solidarity exhibited by social stakeholders, creating a shared vision and strategy and also engaging in concrete campaigning to achieve this major goal.

The other relevant aspect of this case is that when a broader approach on health workforce development is set, and specifically set in the framework of global health, it is possible to see cultural as well as policy change towards inclusiveness and solidarity. In this process, the proactive engagement of health workers will enable them to be acknowledged as one of the key determinants of global health, and prevent them from being considered as merely a burden to public spending or, in the case of migrant workers, as an issue to be addressed by security measures alone.



Health workers for all - CASE STUDY

THE NETHERLANDS

**Corporate Social Responsibility
in favour of the global health
workforce**



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WHO Code* correspondence:

Article 4.1. Health personnel, health professional organizations, professional councils and recruiters should seek to cooperate fully with regulators, national and local authorities in the interests of patients, health systems, and of society in general.

Article 4.2. Recruiters and employers should, to the extent possible, be aware of and consider the outstanding legal responsibility of health personnel to the health system of their own country such as a fair and reasonable contract of service and not seek to recruit them.

** WHO Global Code of Practice on the International Recruitment of Health Personnel*

The context

If its policies remain unchanged, it is very likely that the Netherlands will face shortages of health workers who are capable of addressing twenty-first century health needs and challenges in the long term. A shortage of health workers in the Netherlands may lead to the recruitment of health personnel from abroad. However, if the recruitment is not carried out in a responsible way, it can have serious repercussions both for the individual worker and for the health system in the source country, which, with respect to the Netherlands, mainly concerns Eastern and Southern European countries such as Hungary, Romania, Spain and Slovakia. When health workers are recruited from already fragile health care systems, those systems can be dangerously undermined. Moreover, people who work in unfamiliar settings are vulnerable to various forms of exploitation. In short, relying on people from elsewhere is not a structural solution to the anticipated shortages of health professionals in the long term.

The Dutch government regards the health system as self-regulatory and takes a controlling, rather than a leading role in its development. The national government's role is primarily to define parameters and draw up an agenda.

In the Netherlands, health sector personnel policy is determined and implemented by a large array of actors. In other words, as a result of decentralisation, a wide range of actors must share responsibility for health personnel policy, each actor from their own angle. Therefore, a sustainable and globally responsible health personnel policy requires various actors, such as health care institutions, migrant organisations, recruitment organisations and labour unions, to contribute to developing solutions and methods for promoting a globally responsible and sustainable health personnel policy. Joint action to improve the training, recruitment, retention and deployment of personnel is key.

A case in point, for example, is that health care institutions are directly responsible for the recruitment and retention of personnel, as well as for defining their terms of employment, including for personnel from other countries. As a result, health care institutions may develop sustainable personnel policies, but that policy is only workable with cooperation from other parties, such as professional training institutions and actual recruitment agencies.

Collective efforts for socially responsible change

To avoid shortages at the national level, and beyond our borders, it is vital that Dutch stakeholders take the opportunity, while they still can, to work together to design their health personnel policies to ensure they are as sustainable as possible and do no harm to the access to health workers elsewhere in the world or to the individual situation of a health professional. In other words, globally sustainable and fair personnel policies for the health care sector are necessary and require collaborative and coordinated

action. This can all be done by linking the international guidelines on the recruitment of health workers to policies on the Corporate Social Responsibility of the actors involved, for which the Ruggie principles¹ could serve as an appropriate framework. From this CSR perspective, every actor can take on their share of the burden and contribute to a world in which everyone everywhere has access to health care.

The World Health Organization's Global Code of Practice on the International Recruitment of Health Personnel (WHO CoP) and the EPSU-HOSPEEM Code of Conduct on Ethical Cross-border Recruitment and Retention in the Hospital Sector, can both play an important facilitating role in realising sustainable and fair health personnel policies. The EPSU-HOSPEEM Code is intended to promote ethical and deter unethical health personnel recruitment practices in the EU, solely targeting hospitals in European countries, in contrast to the WHO CoP. It would be of great value to have both Codes translated into operational policies to achieve sustainable health personnel policies.

This can be done by integrating the principles of both Codes into Corporate Social Responsibility (CSR) and personnel and recruitment policies of the different actors involved (e.g. hospitals, recruitment agencies, social partners, etc.). The trend to CSR offers a perfect opportunity to link and foster the implementation of both Codes. CSR is becoming increasingly important in the health care sector, improving the social value of health care in the Netherlands. Health care actors are open to advice about ways to increase their social value and their status via CSR. As CSR is a 'fashionable' trend at the moment, it is a perfect vehicle to bring ethical recruitment into the limelight. Therefore, it is of utmost importance that the different organisations involved, such as civil society organisations, CSR advocates and trade unions, but also actors such as health care institutions or recruitment organisations who might play a role as 'good examples' and ambassadors, collectively raise awareness about the great opportunities to contribute to the global health workforce via CSR.

Collaborative efforts have already been made to generate publicity and an awareness of this topic. Through various endeavours, such as the publication of articles, reports, etc., various actors have attempted to focus attention on the possibility of enhancing CSR policies by integrating the Codes and to make actors aware that global responsibility can also be achieved through CSR. In the CSR transparency benchmark 2013, the consultancy firm Royal HaskoningDHV evaluated whether Dutch hospitals reported about or referred to one or both of the Codes in their (CSR) policies and annual reports. The main outcome of the evaluation was that in 2012 no hospital mentioned these Codes. The Amsterdam-based advocacy organisation Wemos and Royal HaskoningDHV have explicitly referred to this outcome in several publications in order to urge stakeholders such as hospitals and recruitment agencies to implement the principles set out in both Codes.

In December 2013, Skipr – an online magazine and platform for the health care sector – published an article² in which they elaborated on the results of the annual CSR benchmark evaluation by Royal HaskoningDHV and reflected in particular on how hospitals can integrate the WHO CoP and its European

¹ http://www.ohchr.org/Documents/Publications/GuidingPrinciplesBusinessHR_EN.pdf

² Skipr (2013). Ziekenhuis ziet ethische werving over het hoofd.

<http://www.skipr.nl/actueel/id16929-ziekenhuis-ziet-ethische-werving-over-het-hoofd.html> [Hospital overlooks ethical recruitment]

equivalent, the EPSU-HOSPEEM Code, into their policies on CSR. Another article³ addressed the reasons why a fair and future-proof health personnel policy is so important, pointing out the value of both Codes to actors in the Dutch health care sector. These efforts resulted in a greater awareness and subsequently encouraged several actors to contribute to the process of awareness raising.

For example, the Dutch trade union Abvakabo FNV was inspired to take action. Trade unions in the Netherlands are able to take advantage of the Dutch consultative framework to exercise influence at various levels, sitting down with employers, government departments, various social organisations and their international partners. These discussions provide them with the opportunity to call attention to sustainable and globally responsible personnel policies in the health sector. The promotion of such policies is in the interests of their own members, international health workers in the Netherlands and the citizens of countries with vulnerable health care systems. The outcomes of the evaluation by Royal HaskoningDHV offered valuable opportunities for discussions about the Codes and to incorporate them into already existing policies in collaboration with employers and other social partners, including the Dutch Hospital Association. AbvakaboFNV uses the outcomes to raise awareness about the fact that many Dutch hospitals barely comply with these Codes of Conduct and is calling on social partners to put them back on their agendas. In doing so, they can also refer to good examples.

The Radboud University Medical Center (Radboudumc) is a good example. They indicated in their strategy document ‘Sustainability in the genes’⁴ that they will apply a global perspective when recruiting personnel so that they do not inadvertently contribute to shortages of health personnel elsewhere. ‘Sufficient health personnel for anyone everywhere in the world is of utmost importance. We are therefore very keen to contribute to fair recruitment and distribution of health personnel worldwide by developing and implementing a globally sustainable health personnel policy’, says Harriette Laurijsen, Policy Officer Sustainability (Radboudumc). Their role as a frontrunner is highly valuable in the process of awareness raising, especially since the Radboudumc is a reputable and well-known hospital. Other hospitals and health care institutions, but also recruitment agencies and social partners, could follow the example of Radboudumc. All stakeholders could take the opportunity to expand their CSR scope and take responsibility for fair recruitment and distribution of health personnel at the global level. Every action we take, no matter how small, has ramifications. Together, these small acts can effect big change, building a world in which everyone has access to care.

³ Skipr (2013). Mondiale kijk op werving is geen sprookje. Author: Linda Mans. <http://www.skipr.nl/blogs/id1703-mondiale-kijk-op-werving-is-geen-sprookje.html> [Global perspective on recruitment is not a fairy tale]

⁴ Radboudumc (2013). Duurzaamheid in de genen. <https://www.radboudumc.nl/OverhetRadboudumc/duurzaamheid/Pages/default.aspx> [Sustainability in the genes]

Future possibilities

The principles of CSR are becoming increasingly important in the health care sector. CSR takes many forms, including consideration of sustainability, ecological impact and the effects of policy on local communities. Fair (ethical) international conduct is entirely in step with CSR thinking, which could be further enriched by adding a global perspective on health. In doing so, global responsibility will also be taken into account and be reflected in and through CSR policies. Actors in various fields must demonstrate their willingness to accept responsibility for their policies and operations and to care for carers, both here and around the world. For example, for health care institutions, CSR means – among other things – anticipating future shortages and seeking sustainable, globally viable solutions.

While CSR policies are not directly binding on the stakeholders, CSR policies that take the global context into consideration can serve as guidance to the actors involved on how to ensure globally responsible behaviour. CSR often provides a framework for an organisation-wide approach to act responsibly and ethically. To ensure CSR policy is brought into practice, it is vital that the principles of CSR policy are translated into concrete measures and/or converted into specific policies. A good example is the integration of the principles of the Code into HRM policies. The accountability, monitoring and follow-up of these CSR practices need to be guaranteed. CSR should thus be ‘embedded’ in national protective legislation and international agreements (e.g. the ILO’s Recommendation concerning National Floors of Social Protection).⁵

To ensure the different actors involved incorporate the principles of both the WHO CoP and the EPSU-HOSPEEM Code into their CSR policies, it is of decisive importance that they are aware of the possibilities of broadening their horizon. Various actors such as civil society organisations, trade unions, health care institutions and recruitment agencies can help collectively raise awareness.

⁵ http://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100_INSTRUMENT_ID:3065524



Health workers for all - CASE STUDY

ROMANIA

**Cross-border cooperation covering the need
need for human resources in Calarasi County
Emergency Hospital -
employing specialist MDs from Bulgaria**



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WHO Code* correspondence:

Article 3.8. Member States should facilitate circular migration of health personnel, so that skills and knowledge can be achieved to the benefit of both source and destination countries.

Article 4.5. Member States should ensure that, subject to applicable laws, including relevant international legal instruments to which they are a party, migrant health personnel enjoy the same legal rights and responsibilities as the domestically trained health workforce in all terms of employment and conditions of work.

** WHO Global Code of Practice on the International Recruitment of Health Personnel*

I. Regional Context

Călărași County lies in southeast Romania, on the left bank of the Danube, being neighbored in the south by Bulgaria. Having a population of 313,516 (1.5% of Romania's total population), the county is one of the poorest in Romania, with a high number of vulnerable groups (2). The most important medical provider is the County Emergency Hospital, built in the early 1980s and administered by Călărași County Council (Fig. 2).



Fig. 1. Geographical location of Călărași County

This hospital provides services for all patients in need, mainly from the municipal and surrounding areas – amounting to approximately 100,000 people. In providing the medical services, the hospital deals with many medical/surgical emergencies, casualties from car accidents or other accidents and injuries.



Fig. 2. Călărași Emergency Hospital

The hospital has 571 beds for inpatient hospitalisation, distributed across 21 sections and departments, an emergency unit, under modernisation, and an integrated ambulatory service (3). To ensure round-the-clock medical assistance, the hospital is organised into seven main sections (UEP, internal medicine, general surgery, obstetrics-gynaecology, paediatrics, AIT and clinical laboratory) (3). With regard to personnel deployment, the hospital has 73 full-time MDs, 6 part-time contracted MDs and 300 nurses.

In 2013, the hospital treated 22,471 external cases, of which 21,347 were in the acute sections and 1,124 in the chronic sections. These cases amounted to 128,666 hospitalisation days, of which 117,199 days in the acute sections. The average hospitalisation duration in 2013 was 5.5 days for acute and 10.2 days for chronic illnesses (4).

II. Description of the practice

Over the last ten years, health policy in Romania has been marked by two main trends: on the one hand, diminishing resources (including financial) in the hospital sector, which had played too great a role in the health system (5), and on the other hand, the decentralisation of the health system, involving the subordination of the public providers of medical services to the administration of the county and/or local public authorities (6). In this context, the functioning framework for hospitals was redefined, and a compulsory accreditation process was introduced, together with some competence-based classification criteria that influence hospital financing by the Health Insurance House (the public payer and the dominant source of income for hospitals) (7–9).

The County Călărași Emergency Hospital has an efficient infrastructure, but over the last five years it has faced a gap/deficit in MD personnel in several specialities (especially AIT) which has threatened both the hospital's classification/ranking in relation to an advantageous financing category, as well as the impending accreditation process and its current contract with the Health Insurance House. In this context, four years ago, the hospital identified an AIT specialist MD from Bulgaria who was interested in a part-time contract with the hospital to ensure AIT emergency cover. The MD was hired and thus started collaboration with the hospital. This proved to be mutually beneficial over the years, and therefore the hospital became interested in extending this model, by 2014 collaborating with five AIT MDs and one neurologist. All of the doctors have a basic full-time position in Bulgaria and additional contracts for shifts in Romania.

II.1. Key factors in developing the model

The main trigger for the model was the hospital's need for AIT practitioners to cover the necessary shifts in order to comply with the legal framework for accreditation, and to maintain its current level of classification/ranking (a decrease in ranking leads to an automatic decrease in financing from the Health Insurance House). In this context, the hospital management had the vision and the dynamism to find a local solution, to convince local and national stakeholders, and to put in place all the administrative arrangements required to implement the solution. The national legal framework, in line with the *aquis communautaire*, allowed for the mutual recognition of the Bulgarian Colleagues by the Romanian College of Physicians.

Most importantly, the willingness of the Bulgarian MDs to collaborate provided an excellent opportunity to develop the model. Furthermore, their professionalism and earnest attitude made a huge contribution to the extension of the collaboration.

In addition, it should be noted that the collaboration was possible due to the fact that Calarasi hospital is located close to the border with Bulgaria, and the physical distance is quite short.

Last, but not least, the employer attempted to maximise the satisfaction of the employees by providing them with similar remuneration, working conditions and opportunities as the Romanian doctors.

Concerning the remuneration, to begin with, the hospital proposed part-time contracts as the legal basis for the collaboration, but following a review of the situation – given the specificity of the activity – it proposed shift service contracts, thus ensuring a higher net income for the MDs. The payment terms, responsibilities and working environment remained identical to those offered to Romanian practitioners.

The collaborating MDs are insured against malpractice and are accredited by the County College of Physicians. The working background – as regards contractual rights and duties – is identical to that of the Romanian MDs. The actual work settings (organisation, place of work) are also the same as those of the Romanian MDs.

II.2. Profile of the MD collaborators

In an attempt to understand the reasons why the Bulgarian doctors are prepared to come to Romania and take on these part-time roles, we used two tools: a questionnaire addressed to the Bulgarian MDs, and an interview based on an Interview Guide used by the hospital management (details on the methods can be found in Annex 1, and on the tools in Annexes 2 and 3).

Based on these instruments, we ascertained the following: the Bulgarian MDs come from localities close to the border (Turtukaia, Silistra, Varna), they are aged 45–64 years old and have a full-time contract with a public unit (hospital type) in Bulgaria, and have a high level of seniority. As a rule, they have a double specialisation.

The reasons/motivation for the Bulgarian MDs accepting a contract in Romania were mainly – at least in the incipient stage – the need for additional income, backed up by professional interest. At a later stage, the work environment, self-valuation and relationships developed with the hospital influenced their willingness to continue the collaboration with the Romanian hospital. Almost all intend to continue this collaboration in the future, while maintaining their full-time position in Bulgaria. Most importantly, some of the Bulgarian colleagues told us that having a part-time job in Romania helped them to maintain a reasonable income and keep working in their own country, rather than having to look for jobs in other EU countries.

II.3. Challenges in developing the model

Due to the innovative character of the model, there was some degree of uncertainty when it was first presented to the stakeholders (especially to the Ministry of Health and the Romanian College of Physicians). The transparent, clear communication of all aspects, backed up by the need for health services for the local population and by the responsibility of ensuring appropriate access to services, finally convinced the authorities and the professional organisation to approve the solution.

The language barrier seemed a serious challenge at the beginning of the collaboration – as Bulgarian is a Slavic language, whereas Romanian is predominantly of Latin provenance, and the linguistic differences were huge. However, the hospital hired an interpreter from Bulgaria who currently works with the doctors.

At the same time, the Bulgarian MDs showed a great willingness to overcome this language barrier and started to learn Romanian (even if they were not of Romanian ethnicity, as can be the case in some Bulgarian border localities due to historical circumstances), which enabled them to work independently. Another challenge related to the possible impact of Romanian collaboration on the work of the Bulgarian doctors in their full-time positions back home. Despite the fact that the time in both contracts did not overlap, there could be possible effects such as stress or tiredness. To date, no collaboration has been initiated between the Romanian and Bulgarian employers, but this issue needs further investigation.

III. Opinions and lessons learned

The model is considered a win-win partnership by Calarasi hospital, the professionals from Romania and Bulgaria and the Romanian patients. Unfortunately, it was not possible to fully assess the impact of the model on the Bulgarian hospitals of origin of the MDs.

The management of the hospital provided very positive feedback and stated its interest in continuing the collaboration, emphasising that the Bulgarian MDs were very quickly integrated into the medical teams. Based on their experience in the Bulgarian hospitals, they contributed to the implementation of more efficient procedures, both in the field of anaesthesia as well as in case management and operational procedures.

The Bulgarian doctors' work model also generated an increase in the levels of dedication of the Romanian personnel, especially with regard to the provision of medical care services (closer communication with the patients and their families and a greater dedication in the provision of care services).

Both the hospital management and the Romanian personnel appreciated the professionalism, dedication and team spirit of the Bulgarian MDs; the fact that they quickly learned Romanian (and that an interpreter is always readily available), their permanent readiness to be involved in case management, especially in critical cases, and their capacity to manage any emergency situation. The Romanian team also appreciated that the Bulgarian MDs provide constant support, always showing up for scheduled emergency duty, even in bad weather (when the Danube is frozen or low and they have to take a longer route to work). The hospital management appreciated that the patients are satisfied with the services provided by the Bulgarian MDs, who communicate closely with them and contribute to their due care (including non-medical support).

The management also underlined that the Bulgarian MDs benefit from the same work and pay conditions as the Romanian doctors. As regards training opportunities, although there is no training plan that includes them, they are invited to join all scientific events organised by the hospital.

On their side, the Bulgarian MDs reported that the experience in Romania had helped them to improve their work processes in Bulgaria, where they contributed to more efficient procedures, especially in the provision of medical emergency assistance, which Romania sees as a model of success. The Bulgarian

MDs underlined that the opportunity identified in Romania (flexible collaboration with additional income) helped them to maintain their jobs in Bulgaria, meaning they could avoid leaving Bulgaria altogether to look for work in other countries, an option they were exploring at the time they started the collaboration with Romania. They stated that they intended to continue this collaboration while maintaining their jobs in Bulgaria and that, if they were at first attracted by the financial aspect of the collaboration, they now see it as a good opportunity to develop their careers.

In relation to the issue of how this collaboration affects their full-time positions in Bulgaria, they reported that their work has merely been positively influenced (as above) and that there is no negative impact/decrease in quality, given that they are busier now. However, they remained a little reluctant to provide contact details of their full-time employers in Bulgaria, in view of some discussion on this topic with the project team.

IV. Testimonials

A Romanian surgeon from CES Călărași – *'I was on emergency duty one day and a young woman came in who had been attacked during a robbery; she had been hit in the heart area. While talking, she lost consciousness before my very eyes. The AIT doctor intervened immediately and resuscitated her. It was a fast and very professional response'.*

Ward Nurse – *'I was on duty in the ward, the surgery was finished and I waited for the MD to leave the ward. But he did not leave. He started, together with the stretcher-bearer, to lift the patient, put him on a stretcher and left the ward with him'.*

Patient LV, 46 – *'I arrived at emergency; I had a heavy pain on the left side. I heard a Bulgarian doctor was on duty and I thought, I'd better leave and come back the next day. How was I to communicate with him? But I didn't feel very well, and stayed. That was the right thing, the doctor spoke Romanian as well as we do.'*

The methods used for this study are described in Annex 1.

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5. Government Ordinance No. 562/2009 on approving the decentralisation of the health system
6. Government Ordinance No. 303/2011 on approving the national strategy of hospital rationalisation

7. Law on reforming the health system No. 95/2006, subsequently amended and completed
8. Order No. 1408/2010 of Ministry of Health on approving hospital classification criteria based on competences
9. Order No. 323/2011 of the Minister of Health regarding the approval of the methodology and minimum criteria for hospital classification based on competences, with subsequent amendments and completions

Annex 1. Methodology

The following steps were involved in producing this study:

- Establishing a public health and management group of experts to determine the model.
- Reviewing the reference documentation for gathering information about the context (sources: general legislation on hospital functioning, websites of central and local institutions providing information about Călărași Emergency Hospital).
- Elaboration of the instruments for data gathering (questionnaire addressed to Bulgarian medical practitioners – Annex 1.2, and interviewing guide for the hospital management – Annex 1.3).
- Contacting the hospital management, presentation of the project, obtaining agreement to conduct the survey.
- Gathering data from the hospital management, the Bulgarian practitioners, the Romanian practitioners, patients.
- Elaboration of the report/study.

Annex 1.2. Questionnaire for the Bulgarian MD collaborators

Dear Colleagues,

The collaboration between you and Călărași Emergency Hospital is a model of good practice that we want to spread. To this aim, please kindly answer the questions below. Your answers are confidential and will be used solely for improving the model.

1. Age.....
2. Gender Female Male
3. Specialty 1..... 2.....
4. Did you have a full-time job in Bulgaria before the collaboration with Romania?
 - a. If yes, where (city).....
 - b. If yes, type of unit (with/without beds).....
 - c. If yes, is the unit: 1. Public 2. Private
 - d. How long have you been working in the respective job (in Bulgaria):
5. Why did you decide to work in Romania (you can choose one or more answers)?
 - a. Additional income (wages)
 - b. Desire for a professional career
 - c. Professional interest
 - d. I heard from other colleagues that the work environment in the hospital is good
 - e. Other reasons, please state:.....
.....

6. Do you still have a regular job in Bulgaria? ... Yes ... No
 - a. If yes, do you think that the current collaboration with Romania has influenced your work?

Positively	Negatively	No influence
Please state the reasons	Please state the reasons	Please state the reasons

- b. If not, please state why:.....
7. Would you agree to us asking your employers in Bulgaria whether your collaboration with Romania has affected them in any way? a. Yes b. No
8. If yes, please provide a contact person/email address
.....
9. How many days per month do you work in Romania?
10. Do you intend to continue your collaboration with Romania?
 - a. Yes b. No c. I don't know
 - If yes, for how long?
11. Do you want to share a personal experience related to your collaboration with Romania?
12. What did you enjoy the most in this collaboration?

Thank you for your responses!

Annex 1.3. Interview guide for the management of Călărași EH

Dear Medical Director,

Dear Care Director,

We would like to inform you that the WHO is implementing a project regarding the health workforce – Health Workers for All – in which Romania is taking part through the Centre for Health Policies and Health Services (<http://www.healthworkers4all.eu/ro/home/>).

Within this project we would like to present you with a model of good practice on the local level in Romania – the collaboration between Călărași County Emergency Hospital and medical practitioners from Bulgaria. To this aim, please kindly answer the questions below. Your answers are confidential and will be used solely for improving the model.

1. Do collaborating practitioners have a full-time job in Bulgaria?
2. Do you think the Bulgarian MDs brought in positive aspects to Călărași Emergency Hospital?
If yes, please provide examples.
3. What do you appreciate the most about the activity of the Bulgarian MDs?
4. How do other colleagues from Călărași EH perceive the collaboration with the Bulgarian MDs?
Please provide details.
5. Do you consider that the patients who come to Călărași EH are satisfied with the services provided by the Bulgarian MDs? Please provide details.
6. Do you consider that the experience gained by the Bulgarian MDs in Călărași EH helped them improve their performance at their jobs in Bulgaria? If yes, please provide details.

7. Do you consider that the Bulgarian MDs have the same remuneration level as their Romanian counterparts?
8. Do you consider that the Bulgarian MDs have the same working environment as their Romanian counterparts?
9. Do you consider that the Bulgarian MDs have the same training opportunities as their Romanian counterparts?
10. Do you want to share with us a personal experience regarding the collaboration with the Bulgarian medical practitioners?

Thank you for your responses!



Health workers for all - CASE STUDY

POLAND

The introduction of physicians and paediatricians into primary health care in Poland



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WHO Code* correspondence:

Article 3.1 The health of all people is fundamental to the attainment of peace and security and is dependent upon the fullest cooperation of individuals and states. Governments have a responsibility for the health of their people, which can be fulfilled only by the provision of adequate health and social measures. Member States should take the Code into account when developing their national health policies and cooperating with each other, as appropriate.

Article 5.4 As the health workforce is central to sustainable health systems, Member States should take effective measures to educate, retain and sustain a health workforce that is appropriate for the specific conditions of each country, including areas of greatest need, and is built upon an evidence-based health workforce plan. All Member States should strive to meet their health personnel needs with their own human resources for health, as far as possible.

* WHO Global Code of Practice on the International Recruitment of Health Personnel

1) The context

Article 5.4 of the WHO Global Code of Practice on the International Recruitment of Health Personnel states that: 'As the health workforce is central to sustainable health systems, Member States should take effective measures to educate, retain and sustain a health workforce that is appropriate for the specific conditions of each country, including areas of greatest need, and is built upon an evidence-based health workforce plan. All Member States should strive to meet their health personnel needs with their own human resources for health, as far as possible'. In response, in 2014, the Polish government adopted a new law on health care services, which allowed paediatricians and physicians (specialists in internal medicine) to open primary health care practices. This change, which was the result of public consultations, should lead to better access to primary health care, especially for children.

In Poland, there are currently a significant number of well-trained and experienced physicians and paediatricians. However, due to system solutions adopted years ago, physicians and paediatricians have been virtually excluded from primary care and outpatient specialist care, and limited in the practice of their profession to hospital wards for internal medicine and paediatrics. Primary health care practices could only be led by specialists in family medicine or by physicians and paediatricians who worked in primary health care for many years. While young physicians and paediatricians (after completing their specialisation) might gain employment in a hospital or even in an institution of primary health care, specialisation in family medicine was a precondition for the establishment of a primary health care practice. A lack of employment prospects thus discouraged medical graduates from undertaking specialisation in internal medicine and paediatrics. Such specialists are essential to ensure the smooth functioning of the entire health care system. In the field of primary health care for children, it is currently difficult to get access to a paediatrician in many situations. Although there are certain ideal primary health care institutions, where each child is examined by a paediatrician and subject to proper prevention, the majority of primary health care institutions do not employ paediatricians and children are treated by other specialists, such as a surgeon who becomes a family doctor after six months of training in family medicine.

It can be concluded that the previous law on public health care services drastically restricted the right to choose a doctor for one's child, with parents of a sick child generally not in the position to have a paediatrician treating their child. Experts also point out that as a result of the aging population, increasing numbers of people suffer from several diseases at any one time and thus require competent, comprehensive medical care. Such medical care can be ensured only by well-prepared specialists in internal medicine.

2) Description of the case

The new act, adopted in 2014, introduces changes to the provision of primary health care in terms of changes to the public health insurance system, which will now cover the provision of primary health care by paediatricians and physicians, and thus not only by doctors who specialise in the field of family medicine or who undergo specialist training in the field, or those with a second-degree specialisation in general medicine, as stated in the previous Act on public health care services.

According to the Ministry of Health, the change will encourage more doctors to work in primary care. Moreover, parents will be able to choose whether their child is treated by a family doctor or a paediatrician in a primary health care institution.

The Polish Ministry of Health believes that allowing primary health care practices to be established jointly by physicians and paediatricians, will not lead to a situation in which paediatricians treat adults and physicians treat children. In fact, the new Act explicitly states that within primary health care practice these doctors may perform duties only to the extent of their competence.

Polish family medicine specialists have tended to disapprove of the new law. They argue that the training of specialists in internal medicine and paediatrics occurs in hospitals and these specialists are not prepared to work in the field of primary care, which requires a holistic approach and a family and community-oriented perspective. According to them, the need for the recruitment of more specialists in family medicine should be strongly emphasised, and the quality of their training should be guaranteed.

However, the Polish population seems to be of a different opinion. According to a survey conducted by the Public Opinion Research Centre, commissioned by the Polish Paediatric Society, the Federation of Associations of Paediatricians and 111 associations of parents of sick children, as many as 96 percent of Poles would like paediatricians to work in primary health care. The study was conducted on a representative group of 2,000 people, excluding anyone involved in the medical field, and especially paediatricians and family doctors.

3) What is to be learned?

In a situation where there is disagreement between the parties affected by a new law such as this, one should not forget that it is the patient's welfare that is paramount, and the welfare of children should be undisputed. Changing the law undoubtedly leads to greater accessibility and effectiveness of services in the field of primary health care. However, this amendment has only just been introduced into Polish law and its effects can only be assessed further into the future.



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