TMIEWHS/2017

International Labour Organization

Improving employment and working conditions in health services

Sectoral Policies Department

TMIEWHS/2017

INTERNATIONAL LABOUR ORGANIZATION

Sectoral Policies Department

Improving Employment and Working Conditions in Health Services

Report for discussion at the Tripartite Meeting on Improving Employment and Working Conditions in Health Services
(Geneva, 24–28 April 2017)

Geneva, 2017

INTERNATIONAL LABOUR OFFICE, GENEVA

First edition 2017

Improving Employment and Working Conditions in Health Services: Report for discussion at the Tripartite Meeting on Improving Employment and Working Conditions in Health Services, Geneva, 24–28 April 2017, International Labour Office, Sectoral Policies Department, Geneva, ILO, 2017.

ISBN 978-92-2-130532-3 (print)
ISBN 978-92-2-130533-0 (Web pdf)

Also available in French: *Améliorer les conditions d'emploi et de travail dans les services de santé:* Rapport pour discussion à la Réunion tripartite sur les moyens d'améliorer les conditions d'emploi et de travail dans les services de santé, Genève, 24–28 avril 2017, ISBN 978-92-2-231255-9 (print), 978-92-2-231256-6 (Web pdf), Geneva 2017; and in Spanish: *Mejora del empleo y las condiciones de trabajo en el ámbito de los servicios de salud:* Informe para la discusión en la Reunión tripartita sobre la mejora del empleo y las condiciones de trabajo en el ámbito de los servicios de salud, Ginebra, 24–28 de abril de 2017, ISBN 978-92-2-331350-0 (print), ISBN 978-92-2-331351-7 (Web pdf), Geneva, 2017.

health service / health policy / employment / skills development / social dialogue / role of ILO / ILO Meeting

02.07.5

ILO Cataloguing in Publication Data

Printed by the International Labour Office, Geneva, Switzerland

Preface

This report has been prepared by the International Labour Office as a basis for discussions at the Tripartite Meeting on Improving Employment and Working Conditions in Health Services, to be held from 24 to 28 April 2017 in Geneva. It provides an overview on recent developments in the health sector and reviews challenges and opportunities for enhancing decent work in health services.

Contents

Acknowledgements

The report has been prepared by Christiane Wiskow, Health Services Specialist, under the overall supervision of John Sendanyoye, Head of Public and Private Services Unit, and Alette van Leur, Director, Sectoral Policies Department. Substantial contributions were provided by Odile Frank, Devora Levakova, Nikolina Postic and Adame Traore. The report further benefited from inputs and comments provided by colleagues from various departments: David Hunter and Monica Castillo, Department of Statistics (STATISTICS); Claire Harasty and Olga Strietska-Ilina, Employment Policy Department (EMPLOYMENT); Xenia Scheil-Adlung, Social Protection Department (SOCPRO); Yuka Ujita, Governance and Tripartism Department (GOVERNANCE); Laura Addati, Patrick Belser, Maria Gallotti, Susan Maybud and Jon Messenger, Conditions of Work and Equality Department (WORKQUALITY); Karen Curtis, Tomi Kohiyama and Katerina Tsotroudi, International Labour Standards Department (NORMES); Ekkehard Ernst and Stefan Kuehn, Research Department (RESEARCH); Adam Greene, Bureau for Employers' Activities (ACT/EMP); Amrita Sietaram, Bureau for Workers' Activities (ACTRAV).

Background to the Meeting

At its 323rd Session (March 2015), the Governing Body of the International Labour Office decided that a meeting to address the challenges and opportunities for decent work in health services with a focus on employment and working conditions would be included in the programme of sectoral meetings for 2016–17. At its 326th Session (March 2016), the Governing Body decided on the dates and duration of the Meeting and determined the title to be "Tripartite Meeting on Improving Employment and Working Conditions in Health Services". The purpose would be to discuss decent work strategies that effectively address health workforce shortages, as a prerequisite to enable provision of equal access to health care for all in need. On the composition of the Meeting, the Governing Body decided to invite all interested governments and that eight Worker participants and eight Employer participants would be appointed on the basis of nominations made by the respective groups of the Governing Body. Further, intergovernmental organizations and non-governmental organizations would be invited as observers.

Introduction

1. Health and decent work are essential for social cohesion, human development and inclusive economic growth. Decent work in the health sector is fundamental to ensuring effective and resilient health systems, a prerequisite to addressing health workforce shortages, and to achieving the goal of equal access to quality health care. The health sector is essentially about people; without health workers there can be no health care.

2. Recent global policy initiatives have highlighted the critical role of investments in health and the health workforce in sustainable development, pointing to the integrative power of strengthening the health sector by addressing simultaneously various Sustainable Development Goals (SDGs). [1] The SDGs recognize decent work as a central factor in ensuring inclusive economic growth and its contribution to social progress. Pursuing full and productive employment and decent work for all women and men is an integral part of SDG 8 that also underlines protection of labour rights. Regarding the health sector, SDG 8 links directly to the call for increasing the recruitment, development, training and retention of the health workforce as part of SDG 3 to ensure healthy lives for all.

3. The United Nations (UN) General Assembly, in 2012, endorsed the concept of Universal Health Coverage (UHC) and urged governments to invest in health with the aim to ensure universal access to basic health services while protecting from financial hardships. [2] The ILO Social Protection Floors Recommendation, 2012 (No. 202), provides a rights-based framework for achieving universal access to essential health care while ensuring basic income security by building comprehensive social security systems. [3]

4. The High-Level Commission on Health Employment and Economic Growth (HEEG Commission), established by the UN Secretary-General in March 2016, concluded in its report that investments in the health workforce are needed to make progress towards the SDGs. [4] The Commission recognized the health sector as a key economic sector and generator of jobs, supported by new evidence suggesting that investments are expected to yield returns in terms of improved population health, economic growth and health security. Taking action is an urgent matter in order to address current and projected future health workforce shortages. The cost of inaction can be high: the Ebola outbreak 2014–15 in West Africa demonstrated the harsh consequences that inadequate investments in public health systems and their workforce can have on societies, economic development and international health security.

5. Equal access to quality health care depends on the availability of sufficient numbers of adequately trained health workers where they are needed. Their vital role in protecting and improving population health has been recognized in various ILO documents over time. Yet, global health workforce shortages and imbalances in their distribution persist. Virtually all

[1] United Nations: Sustainable Development Goals, available at: http://www.un.org/sustainabledevelopment/sustainable-development-goals/.

[2] UN General Assembly: *Global health and foreign policy*, resolution adopted by the General Assembly on 12 December 2012, A/RES/67/81, available at: http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/67/81.

[3] All ILO international labour standards are available at: http://www.ilo.org/normlex.

[4] HEEG Commission: *Working for health and growth: Investing in the health workforce*, Report of the High-Level Commission on Health Employment and Economic Growth (Geneva, WHO, 2016).

countries face challenges in recruiting, deploying and retaining sufficient numbers of well-trained and motivated health workers where they are needed. Decent work deficits are among the key reasons for this situation.

6. To address health workforce shortages effectively, investments in the health workforce have to extend beyond increasing numbers of workers. More employment opportunities in the health sector are needed and those have to be accompanied by measures to provide decent employment and conditions of work in order to attract and retain competent health workers. It also means reviewing and improving the conditions of work of current health sector jobs. Decent work has to be part and parcel of effective strategies addressing the challenges in the health sector.

1. Global context: Developments, opportunities and challenges in the health sector

1.1. Global policy initiatives and their implications for the health sector

7. The global context of the health sector [5] has in recent years been marked by important initiatives for strengthening health systems and the health workforce. A common feature of these initiatives is the call for transformative action, changing mindsets, and partnerships at all levels to seize the opportunities at hand and address the immense challenges ahead.

1.1.1. Universal Health Coverage (UHC)

8. In 2012, the world community endorsed UHC as a key strategy towards achieving the goal of health for all. The UN resolution on global health and foreign policy (2012) reaffirmed the right to health, to a standard of living adequate for health and well-being and to social security, and noted with concern that for millions of people these rights remained out of reach. It urged governments to accelerate the transition towards universal access to basic health services as well as protection from financial hardships caused by impoverishing health-care costs with particular focus on those most in need, including poor and vulnerable population groups and those in rural and remote areas. [6]

9. The ILO Social Protection Floors Recommendation, 2012 (No. 202), also provides a rights-based framework for UHC while preventing or reducing poverty risks related to health and social conditions. Based on the principle of universality of protection, it requires that basic social security guarantees "ensure at a minimum that, over the life cycle, all in need have access to essential health care and to basic income security" and "be established by law". Essential health care comprises "a nationally defined set of goods and services … including maternity care that meets the criteria of availability, accessibility, acceptability and quality" (paragraphs 4, 5 and 7).

[5] For a description of the scope and characteristics of the health sector, see Chapter 2.

[6] UN Resolution A/RES/67/81, op. cit., see preamble and paras 2, 8, 9 and 10.

1.1.2. Sustainable Development Agenda

10. The 2030 Agenda for Sustainable Development has set an ambitious framework for action towards a life of dignity for everyone, striving for equality and social justice with the promise that "no one will be left behind". [7] It emphasizes an integrative approach with interdependent, indivisible Goals and interlinked targets that require extended collaboration across sectors, calling on stakeholders to overcome "silo-thinking" for achieving the transformative impact needed.

11. From a sectoral perspective, action on strengthening health services and health workforce development leads to powerful interactions with gains across various SDGs, including SDG 1 (poverty reduction), 3 (healthy lives and well-being), 4 (quality education), 5 (gender equality), 8 (inclusive economic growth and decent work for all) and 10 (reduction of inequalities). Further, SDG 12 (sustainable consumption and production) and 16 (peace, justice, strong institutions) benefit from effective health-sector initiatives.

12. In adopting the 2030 Agenda for Sustainable Development, UN member States committed to take the "bold and transformative steps which are urgently needed to shift the world on to a sustainable and resilient path". [8] Creating strong health systems and a sustainable health workforce also needs bold and transformative action. Such an approach is elicited by the recognition that, to achieve the Development Goals in health, profound change rather than just doing "more of the same" is required.

1.1.3. High-Level Commission on Health Employment and Economic Growth (HEEG Commission)

13. It is in this spirit, that the HEEG Commission made a strong case for a paradigm shift in thinking about the health sector and its economic significance. The task of the HEEG Commission was to consider and recommend ways to stimulate investments in health employment and the health workforce to enable SDG achievement. It challenges the traditional economic view that the health sector is a resource-draining burden for national economies, highlighting its role in economic growth and societal well-being: [9] first, through the greater productivity of a healthy population, and second, as an important source of employment with a potential for generating more decent jobs through increasing demand for its services and through its contribution to stimulating growth in other economic sectors, such as infrastructure, equipment, suppliers and technology production, administrative and other services.

14. The Commission's recommendations (box 1.1) emphasize the need for transformative change to create sustainable health systems with a workforce that has the capacity to respond effectively to population health needs. Such transformation involves changes in health service delivery models, labour market policies, and education and training, also taking account of technological advances. Further, it calls for investing in decent working conditions, ensuring gender equality, rights-based migration policies and improving capacity to respond to emergencies. Enabling these changes requires adequate health financing from multiple national sources, including extending social protection floors (SDG 1), as well as international sources in support of countries in need (SDG 10). This scope of change

[7] UN General Assembly: *Transforming our world: The 2030 Agenda for Sustainable Development*, resolution adopted by the General Assembly on 25 September 2015, A/Res/70/1, available at: http://www.un.org/ga/search/view_doc.asp?symbol=A/RES/70/1&Lang=E.

[8] ibid., Preamble.

[9] HEEG Commission: *Working for health and growth: Investing in the health workforce*, op. cit.

demands actions beyond traditional health policies towards integrating the goals of health for all (SDG 3), quality education (SDG 4), employment, decent work and inclusive economic growth (SDG 8), and gender equality (SDG 5), which in turn calls for multi-sectoral collaboration. Improved data is needed to inform action and strengthen accountability.

Box 1.1
HEEG Commission: Ten recommendations (summary)

1. Stimulate investments in creating decent health sector jobs.
2. Maximize women's economic participation and foster their empowerment.
3. Scale up transformative, high-quality education and lifelong learning.
4. Reform health service delivery and organization.
5. Harness the power of technologies.
6. Ensure core capacities for response in emergencies, and protection of health workers.
7. Raise adequate funding from domestic and international sources.
8. Promote inter-sectoral collaboration at national, regional and international levels.
9. Increase the benefits from, and reduce the negative effects of, health worker migration and safeguard migrants' rights.
10. Undertake robust research and analysis to strengthen evidence, accountability and action.

Source: HEEG Commission: *Working for health and growth: Investing in the health workforce*, op. cit.

15. The Commission's recommendations concur with the World Health Organization (WHO) *Global strategy on human resources for health: Workforce 2030*, [10] adopted by the World Health Assembly in 2016 that aims to enhance progress towards UHC and the SDGs by ensuring equitable access to health workers within strengthened health systems. The strategy sets forth guiding principles with reference to decent work, workers' rights, gender equality and fair migration policies.

1.2. Challenges for health-care systems

16. Health-care systems are continuously challenged to adapt to an ever-changing environment in order to achieve their set goals. Demographic transitions and epidemiological developments, knowledge gains in medical, pharmaceutical and health sciences and new technologies require constant adjustments in the delivery of health services with consequences for how work is carried out and, hence, on the demands made on the health workforce. While the specific issues to be addressed vary across countries and their socio-economic characteristics and the burdens of their disease patterns, policy-makers everywhere are faced with the challenge of meeting increasing demand for health services with limited resources.

1.2.1. Unequal access to health care and health workforce shortages

17. Despite progress on global health goals, major health inequities persist, significantly influenced by socio-economic inequalities. While the health sector alone cannot address

[10] WHO: *Global strategy on human resources for health: Workforce 2030*, 2016, available at: http://www.who.int/hrh/resources/pub_globstrathrh-2030/en/.

social determinants of health, it has a central role and responsibility in ensuring universal access to health services. The access deficits require urgent action: in 2012–13, almost 40 per cent of the world population had no legally-mandated health protection. These deficits were particularly striking in low-income countries where more than 90 per cent of the population remained without legally-mandated health coverage; the gap in necessary financing for health exceeded 90 per cent; and nearly half of health expenditures (47.8 per cent) were borne by out-of-pocket payments jeopardizing the affordability of health services and constituting a risk for poverty due to needed health care. [11]

18. Within countries, inequalities exist notably between rural and urban areas. According to estimates in 2015, 56 per cent of the population living in rural areas experienced legal health coverage gaps compared to 22 per cent in urban areas; 63 per cent of the rural population compared to 33 per cent of urban populations lacked access to health services due to inadequate health financing. [12] Consequently, the rates of avoidable infectious diseases, maternal and under-5 mortality are higher for rural than for urban populations.

19. While progress has been made in addressing the global health workforce crisis, significant shortages remain in many countries, which constrain their ability to provide essential health care. Projections suggest a shortfall of 18 million health workers by 2030, primarily in low- and lower-middle-income countries. [13] The unequal distribution of health workers globally and within countries constitutes a barrier to achieving health equity, as health worker gaps primarily affect the poorest populations. The share of the population without access to health services due to health workforce shortages in 2014 has been estimated at 84 per cent in low-income countries, and 55 per cent and 23 per cent in lower-middle-income and upper-middle-income countries, respectively (figure 1.1). In some African and Asian countries, over 90 per cent of the population had no access to health care due to extreme health workforce shortages (less than three health workers per 10,000 people). [14]

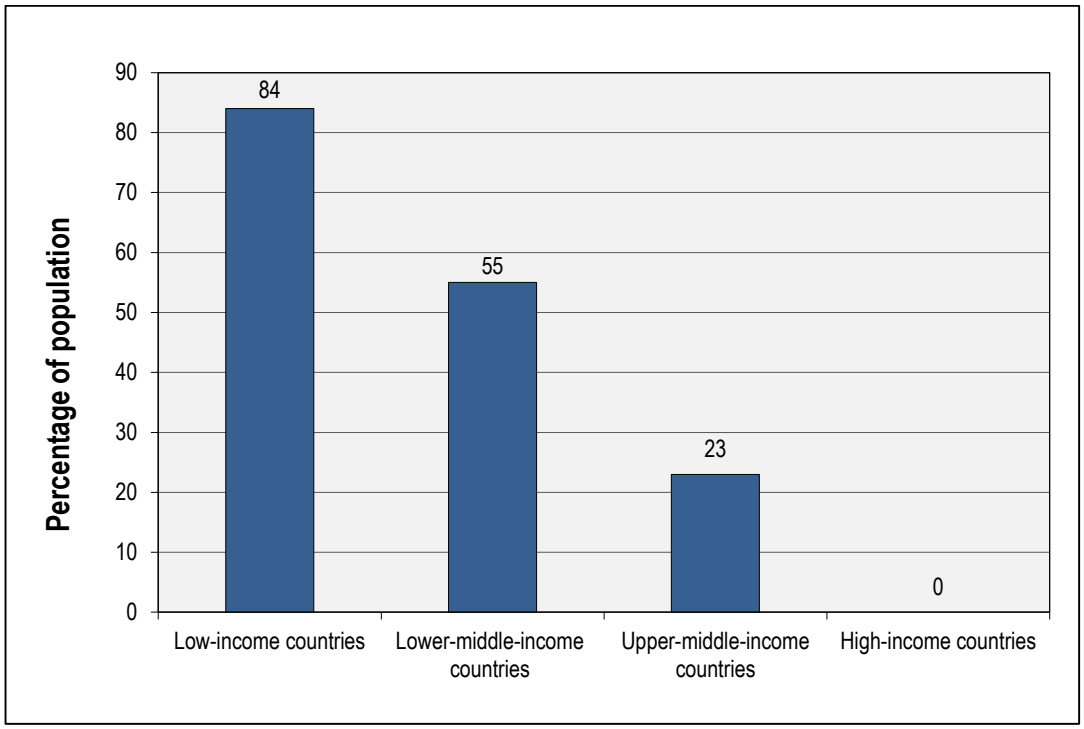
[11] ILO: *Addressing the global health crisis: Universal health protection policies* (Geneva, 2014).

[12] X. Scheil-Adlung (ed.): *Global evidence on inequities in rural health protection: New data on rural deficits in health coverage for 174 countries* (Geneva, ILO, 2015).

[13] HEEG Commission: *Working for health and growth: Investing in the health workforce*, op. cit.

[14] X. Scheil-Adlung et al.: "Health sector employment: A tracer indicator for universal health coverage in national social protection floors", in *Human Resources for Health* (2015, 13:66), available at: http://www.human-resources-health.com/content/13/1/66.

Figure 1.1. Share of population without access to health care due to health workforce shortages, 2014



Note: Estimates of coverage gaps (in percentage of population) due to health workforce shortages, by countries' income levels (ILO threshold 41.1 health workers per 10,000 population, 2014).

Source: X. Scheil-Adlung et al., op. cit.

1.2.2. Health financing and health system organization

20. Worldwide total health-care spending per capita is projected to increase by 2.4 per cent annually between 2013 and 2040, driven partially by long-term growth in national incomes and spending power, along with price increases and innovative, but more expensive, interventions, and increasing demand due to population growth and ageing. However, income-related gaps are large: annual average health expenditure per capita (2013) in low-income countries stood at US$84 (adjusted for purchasing power parity) compared to US$9,019 in high-income countries. These gaps are expected to persist. Projections suggest that private prepaid health spending will grow, which along with increasing government health expenditures promises progress towards better financial risk protection for people in need of health care. However, in some countries out-of-pocket payments are expected to grow and remain extremely high. [15]

21. In many countries, government health expenditures have not been adequate to create or sustain robust health systems. In 2001, African Union (AU) Heads of State and Government pledged to set a target of at least 15 per cent of their annual budgets to the health sector. Ten years later, while 26 countries had increased the proportion of total government expenditure allocated to health, only Tanzania had achieved the set target. During the same period, 11 countries had reduced their share of government expenditure allocated to health. Similarly, by 2009, only five countries from the international donor community had reached

[15] J.L. Dieleman et al.: "National spending on health by source for 184 countries between 2013 and 2040", in *The Lancet* (2016, Vol. 387), pp. 2521–2535, available at http://dx.doi.org/10.1016/S0140-6736(16)30167-2.

the agreed official development aid (ODA) target of 0.7 per cent of gross national income (GNI). In 2009, following the global financial crisis, ODA represented just 0.31 per cent of GNI on average for 11 of the 23 Organisation for Economic and Co-operation Development (OECD) countries, reflecting an actual decrease of overall ODA since 2001. [16]

22. Across Europe, government responses to the 2008–09 financial crisis varied, with public health spending decreasing or being frozen in a number of countries while others managed to ring-fence their health services expenditures. In some countries, cost efficiencies were achieved by reducing pharmaceutical costs and other supplies or hospital sector restructuring. [17] In Greece, Portugal and Spain, austerity measures resulted in significantly reduced access to health services. A combination of fiscal austerity, economic recession and weak social protection systems fuelled a health and social crisis in Europe. Strong social protection mechanisms could have mitigated the effects of economic crisis. [18]

23. Irrespective of the level of health financing, the inefficient use of resources is seen as contributing to weak health systems everywhere. Criticism here revolves around the health sector's high fragmentation, lack of coordination of service provision and an undue focus on hospital-centred and specialized care. There is growing demand to reorganize health systems to provide people-centred services, requiring an integrated multidisciplinary way of working. The push for greater focus on preventive health services to curb non-communicable diseases and on primary health care is not new but has regained momentum. Primary health care is seen as an effective strategy to address organizational inefficiencies and to contain costs through improved coordination of ambulatory with hospital services, preventive with curative care, and health services with social care to address needs of ageing populations.

24. Many health care reforms have focused on cost containment and greater competition for better cost efficiencies. While private sector involvement can improve service delivery, the notion of commercialization has also generated concerns by some stakeholders, notably with regard to considerations of inclusion of health services in trade treaties. [19] The 1998 conclusions on terms of employment and working conditions in health sector reforms provide that: "… health care for all must be in the public interest. This does not necessarily mean that health care must be organized and implemented by public services but that it can also be provided on a private basis. Health care is a not a commodity and thus not a tradable good." [20]

1.2.3. Changing demands

25. Population ageing is a major aspect of demographic transitions that will impact on all sectors. Despite increasing health-care needs in older population groups, many see ageing as a lesser

[16] WHO: *The Abuja Declaration: Ten years on*, 2011, available at: http://www.who.int/healthsystems/publications/abuja_declaration/en/.

[17] A. Maresso et al.: *Economic crisis, health systems and health in Europe* (Copenhagen, WHO, 2015).

[18] M. Karanikolos et al.: "Financial crisis, austerity, and health in Europe", in *The Lancet* (2013, Vol. 381), pp. 1323–1331, available at: http://dx.doi.org/10.1016/S0140-6736(13)60102-6.

[19] J. Lethbridge: *Health care reforms and the rise of global multinational health care companies* (London, Public Services International Research Unit, 2015).

[20] ILO: *Note on the proceedings*, Joint Meeting on Terms of Employment and Working Conditions in Health Sector Reforms (Geneva, 1999), conclusions, para. 2.

driver of increasing health expenditures than new technologies or changes in clinical practice. Health systems will have to adapt to the needs of ageing populations by shifting from curative towards integrated care and developing sustainable long-term care (LTC) systems. [21]

26. Recent years have seen increasing demand to respond to health needs in humanitarian and emergency settings arising from natural disasters, armed conflict and public health emergencies. The number of people displaced by conflict was estimated at 60 million in 2015, mostly in low- and middle-income countries. Natural disasters forced 184 million people to leave their homes between 2008 and 2014, and an estimated 1 billion people live in fragile settings. In a globalized world with fast mobility patterns, infectious diseases, such as severe acute respiratory syndrome (SARS), Middle East respiratory syndrome (MERS), and Ebola virus disease (EVD), spread across borders constituting international health threats.

27. Many countries' health systems are inadequately prepared to respond to emergencies. The unprecedented 2014–15 EVD outbreak in western Africa demonstrated the severe consequences of weakened health systems on populations, the economy and society. The poor conditions of health services at the moment of the outbreak, including lack of equipment, supplies, drugs and trained health personnel hampered its containment. It also put frontline health workers unduly at risk, as evidenced by the unprecedented high number of health worker infections and deaths.

1.3. Migration of health workers

28. Health worker migration is a feature of global health labour markets. In OECD countries, the number of migrant physicians and nurses increased by 60 per cent from 2000 to 2010. On average, the respective share of migrant doctors and migrant nurses constituted 22 and 14.5 per cent across 22 OECD countries. The main source countries included India for physicians and the Philippines for nurses, but other Asian countries, including China, Pakistan and Viet Nam, also experienced increasing emigration of health workers. [22] The dynamics of labour markets and immigration policies influence migration flows; where the domestic supply increases, for instance, the demand for foreign health workers declines.

29. Working conditions and incomes remain common drivers for individual health workers to emigrate. For example, the correlation between income levels in origin countries and intentions to emigrate were observed in 17 European countries, where health professionals were attracted to countries offering higher income, while outflows decreased in countries where salaries improved. [23] Other factors for health professionals to leave their countries of origin include an overall dissatisfaction with working conditions and the quest for professional development. [24]

[21] WHO: *World report on ageing and health* (Geneva, 2015).

[22] OECD: *International Migration Outlook 2015* (Paris, 2015).

[23] M. Wismar et al. (eds): *Health professional mobility and health systems: Evidence from 17 European countries* (Copenhagen, WHO/European Observatory on Health Systems and Policies, 2011).

[24] N. Humphries et al.: "'Emigration is a matter of self-preservation: The working conditions … are killing us slowly': Qualitative insights into health professional emigration from Ireland", in *Human Resources for Health* (2015, 13:35).

30. Policies to address adverse effects of migration require all countries to ensure a sustainable domestic workforce to reduce reliance on migrant health workers and to address decent work deficits for better recruitment and retention. The report on the implementation of *The WHO Global Code of Practice on the International Recruitment of Health Personnel* (2010) found that measures taken to meet health workforce needs domestically, such as employment creation and improved pay and working conditions, were reported by 70 countries. [25] Benefits of international experience, such as professional development and skills transfer require mechanisms for the recognition of qualifications and policies for reintegration of returnees into the domestic health system.

31. The protection of migrant health workers' rights along with the application of international labour migration standards is of utmost importance (box 1.2). The regulation of recruitment of migrant workers is critical to effective labour migration governance. The ILO *General principles and operational guidelines for fair recruitment* (2016) provide practical guidance to governments, enterprises and recruiters. [26]

Box 1.2
Key instruments relevant for health worker migration governance

- Migration for Employment Convention (Revised), 1949 (No. 97)
- Migrant Workers (Supplementary Provisions) Convention, 1975 (No. 143)
- Equality of Treatment (Social Security) Convention, 1962 (No. 118)
- Maintenance of Social Security Rights Convention, 1982 (No. 157)
- International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families, 1990 (United Nations)
- Private Employment Agencies Convention, 1997 (No. 181)
- *The WHO Global Code of Practice on the International Recruitment of Health Personnel* (2010)
- ILO *General principles and operational guidelines for fair recruitment* (2016)

1.4. International labour standards and decent work in the health sector

32. The ILO Decent Work Agenda is built on the four pillars of productive employment, rights at work, social protection and social dialogue. Similar to the SDGs, the four strategic objectives to achieve decent work are "equally important …, inseparable, interrelated and mutually supportive" and the "failure to promote any one of them would harm progress towards the others" as emphasized by the ILO *Declaration on Social Justice for a Fair Globalization* (2008). [27]

33. International labour standards and national labour law both provide guidance on what decent work implies in concrete terms. While international labour standards generally apply to all workers, some are of particular relevance for the health sector. The 1998 ILO Joint Meeting

[25] WHO: *WHO Global Code of Practice on the International Recruitment of Health Personnel: Second round of national reporting*, Report by the Secretariat, 69th World Health Assembly, A69/37 (2016).

[26] ILO: *Outcome of the Meeting of Experts on Fair Recruitment (Geneva, 5–7 September 2016)*, Report of the Director-General: Fourth Supplementary Report, GB.328/INS/17/4.

[27] ILO: *Declaration on Social Justice for a Fair Globalization* (2008), paras A and B.

on Terms of Employment and Working Conditions concluded that "in accordance with ILO Conventions Nos 87, 98, and 151, health workers have the same right to organize and to bargain collectively as workers in other sectors". It further recommended that special consideration be given to the standards provided for in the Nursing Personnel Convention, 1977 (No. 149), and Recommendation, 1977 (No. 157), and the Medical Care Recommendation, 1944 (No. 69), [28] Equal remuneration and the elimination of discrimination in employment and occupation are important with a view to realizing gender equality for the predominantly female health workforce and to protect migrant health workers. Standards providing safe working environments and social protection are critically important considering the occupational risks involved in health-care work. To address issues of specific concern to health sector workers, the ILO has developed a range of guidance and training materials, such as guidelines on HIV and health services, and training materials regarding violence at work, on workplace improvement and on social dialogue in health services.

Box 1.3
Key ILO Conventions and Recommendations relevant for the health sector

- Freedom of Association and Protection of the Right to Organise Convention, 1948 (No. 87)
- Right to Organise and Collective Bargaining Convention, 1949 (No. 98)
- Equal Remuneration Convention, 1951 (No. 100)
- Discrimination (Employment and Occupation) Convention, 1958 (No. 111)
- Nursing Personnel Convention, 1977 (No. 149)
- Nursing Personnel Recommendation, 1977 (No. 157)
- Labour Relations (Public Service) Convention, 1978 (No. 151)
- Social Security (Minimum Standards) Convention, 1952 (No. 102)
- Social Protection Floors Recommendation, 2012 (No. 202)
- Occupational Safety and Health Convention, 1981 (No. 155)
- Promotional Framework for Occupational Safety and Health Convention, 2006 (No. 187)

34. Workforce shortages, rising health worker migration and early exits from health professions are symptoms of decent work deficits that need to be addressed.

35. Health workers are the backbone of national health systems. To perform effectively, they need employment opportunities, adequate pay, safe and healthy working conditions, appropriate education, continuing professional development, career opportunities, equal treatment and social protection. Assuring them decent work first requires recognition of their essential contribution to the health and wealth of their societies.

36. Virtually all countries face challenges in recruiting, deploying and retaining sufficient numbers of well-trained health workers where they are needed. The reported causes for high turnover and attrition rates of health workers in many countries are mainly dissatisfaction with working conditions, including low salaries, work overload, long hours and weak career

[28] ILO: *Note on the proceedings*, Joint Meeting on Terms of Employment and Working Conditions in Health Sector Reforms, op. cit., conclusions, paras 10 and 14.

prospects. Despite differences across countries and occupational groups, health workers' job satisfaction and their intentions to leave the job are linked. [29, 30]

37. Working conditions influence the quality of care. Patient outcome indicators, such as morbidity and mortality, are closely associated with staffing levels, staffing stability and health workers' education levels. Research across nine European countries shows that an increase in a hospital nurse's workload by one patient increases the risk of in-patient mortality by 7 per cent; while, inversely, each 10 per cent increase in the proportion of nurses with a bachelor's degree is associated with a 7 per cent decrease of patient mortality. [31] Studies in South Korea similarly found an association between a low level of staffing and an increased risk of patient mortality. [32]

38. Thus, decent work in the health sector has a critically dual role in reinforcing positive outcomes: ensuring sustainable health workforces and the provision of quality care. Improving employment and working conditions both attracts and retains health workers, while also enabling them to perform more effectively.

2. Employment

2.1. Work in the health sector: Scope and characteristics

39. The health sector and its workforce can be defined either narrowly or broadly, depending on a variety of approaches to the definition of employment related to health. [33] To understand the full extent of work related to health care requires broadening the view to the full range from clinical work to those functions, including in other sectors, which support the delivery of health services and outcomes. Employment in this broad range includes:

- personnel trained in health occupations delivering clinical work in health facilities;
- all staff employed in the health sector, public and private, regardless of their occupation; and

[29] D. Blaauw et al.: "Comparing the job satisfaction and intention to leave of different categories of health workers in Tanzania, Malawi, and South Africa", in *Global Health Action* (2013, 6:19287), available at: http://dx.doi.org/10.3402/gha.v6i0.19287.

[30] L.H. Aiken et al.: "Patient safety, satisfaction, and quality of hospital care: Cross sectional surveys of nurses and patients in 12 countries in Europe and the United States", in *BMJ*, (2012; 344:e1717) (published 20 March 2012), available at: http://dx.doi.org/10.1136/bmj.e1717.

[31] L.H. Aiken, et al.: "Nurse staffing and education and hospital mortality in nine European countries: A retrospective observational study", in *The Lancet* (2014, Vol. 383) pp. 1824–1830, available at: http://dx.doi.org/10.1016/S0140-6736(13)62631-8.

[32] E. Cho et al.: "Effects of nurse staffing, work environment, and education on patient mortality: An observational study", in *International Journal of Nursing Studies* (2015, Vol. 52(2), Feb.), pp. 535–542.

[33] ILO: *Terms of employment and working conditions in health sector reforms*, Report for discussion at the Joint Meeting on Terms of Employment and Working Conditions in Health Sector Reforms (Geneva, 1998).

- those whose work supports the delivery of services even though they are employed by other sectors or industries, such as outsourcing service providers, e.g. cleaning, catering, security or agency staff.

40. Additionally, the sector's operations generate employment in other sectors and industries which provide a wide range of products and services to it, such as equipment producers and suppliers, pharmaceutical products, infrastructural support, health insurance and other financial services, training and research.

41. Moreover, much health-related work is carried out on an unpaid basis; for instance, elderly care provided by family member who give up their paid employment in the absence of care services, or volunteer health work. Taking account of the increasing integration of health care and social work, the boundaries between both types of services are becoming more blurred. Elderly care is especially carried out along a continuum of social support, personal care and health care.

42. These different notions of work and employment related to health make it difficult to generate comparable data across countries. Furthermore, organizational approaches vary in their definitions, data sources and calculation models leading to differing results, as discussed in the HEEG Commission report. [34] In order to improve the quality of data to better inform policy, the HEEG Commission has recommended developing a set of harmonized metrics to monitor health labour markets in a transparent way. [35] A challenge in this regard is the quality of data at source, particularly in developing countries. Investments are required to establish robust information systems and to build national level analytical capacity.

43. Because of the difficulty of segregating statistical data for the two, unless otherwise stated, data in this report refers to paid employment for the combined health and social work sectors [36] and provide a profile of the workforce by occupational groups. [37] Recent ILO estimates of health employment multiplier effects in these sectors are added, supplemented by information from other sources.

2.2. Trends and characteristics of health and social sector employment

2.2.1. Global health and social sector employment trends

44. The health sector is a major source of employment. In 2013, health and social work together accounted for more than 105 million jobs worldwide, constituting approximately 3.4 per cent

[34] HEEG Commission: *Working for health and growth: Investing in the health workforce*, op. cit., p. 24.

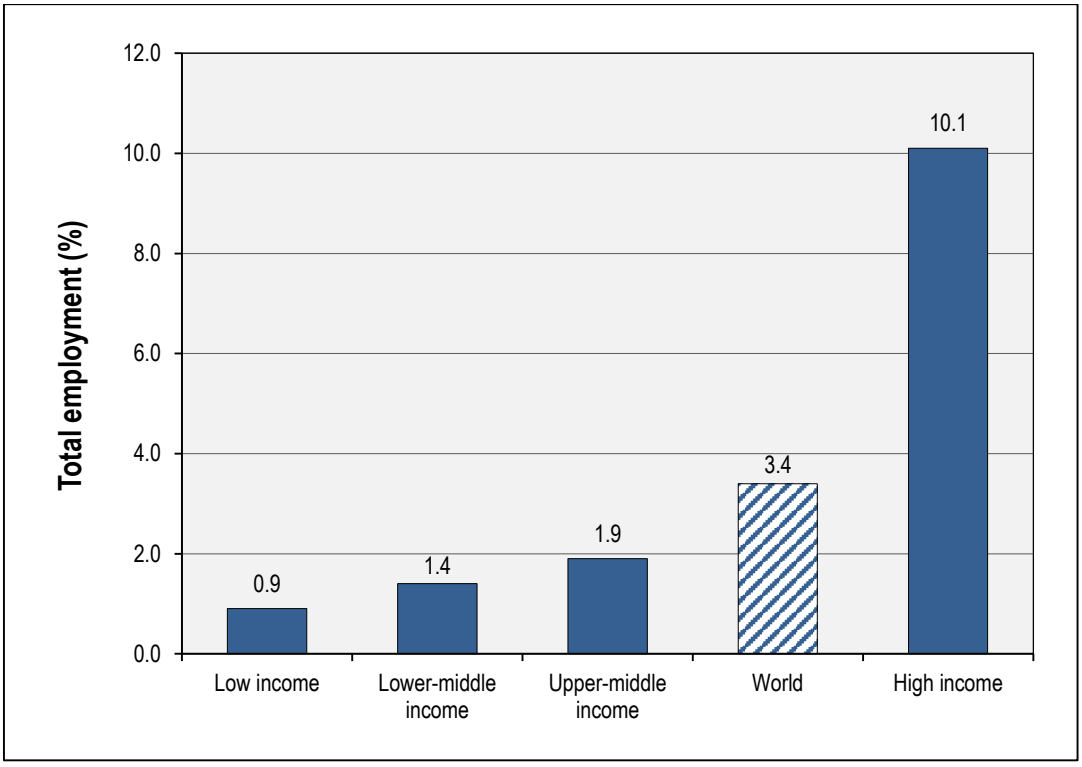
[35] ibid., p. 12.

[36] As defined by the International Standard Industrial Classification of All Economic Activities (ISIC), revision 4, section Q: Human health and social work activities, available at: http://unstats.un.org/unsd/cr/registry/regcst.asp?Cl=27.

[37] As defined by the International Standard Classification of Occupations (ISCO-08), available at: http://www.ilo.org/public/english/bureau/stat/isco/isco08/.

of total global employment, [38] rising to an estimated 107 million jobs a year later. Health employment is positively correlated with economic development; [39] it constitutes around 10 per cent of overall employment in high-income countries compared to less than one per cent in low-income countries (figure 2.1).

Figure 2.1. Share of employment in the health and social sector as a percentage of total employment, by country income group, 2013



Source: *World Employment and Social Outlook: Trends 2015,* ILO WESO database 2015.

45. Across regions, the proportion of employment in the health and social sectors as a share of total employment was lowest in Africa and Asia and the Pacific (1.6 per cent) and highest in Europe and Central Asia (8.8 per cent), while it respectively represented 3.7 and 7.4 per cent in the Arab States and the Americas.

46. In times of slowing economic growth, employment in the health and social care sectors has remained quite stable, with steady employment growth even through the global financial crisis. However, in the aftermath of the crisis the sector experienced a significant deceleration in employment growth (from 2.8 per cent growth in 2012 to 0.4 per cent in 2013). The impact of the financial crisis on total employment was most notably felt in developed economies. [40] While total employment in those countries dropped significantly in 2009 (by 2.2 per cent) globally, employment in health and social services maintained its

[38] *World Employment and Social Outlook: Trends 2015*, Data source, if not otherwise stated is the ILO WESO database, 2015, which includes 174 countries for which there is comparable data, available at: http://www.ilo.org/global/research/global-reports/weso/2015/lang--en/index.htm.

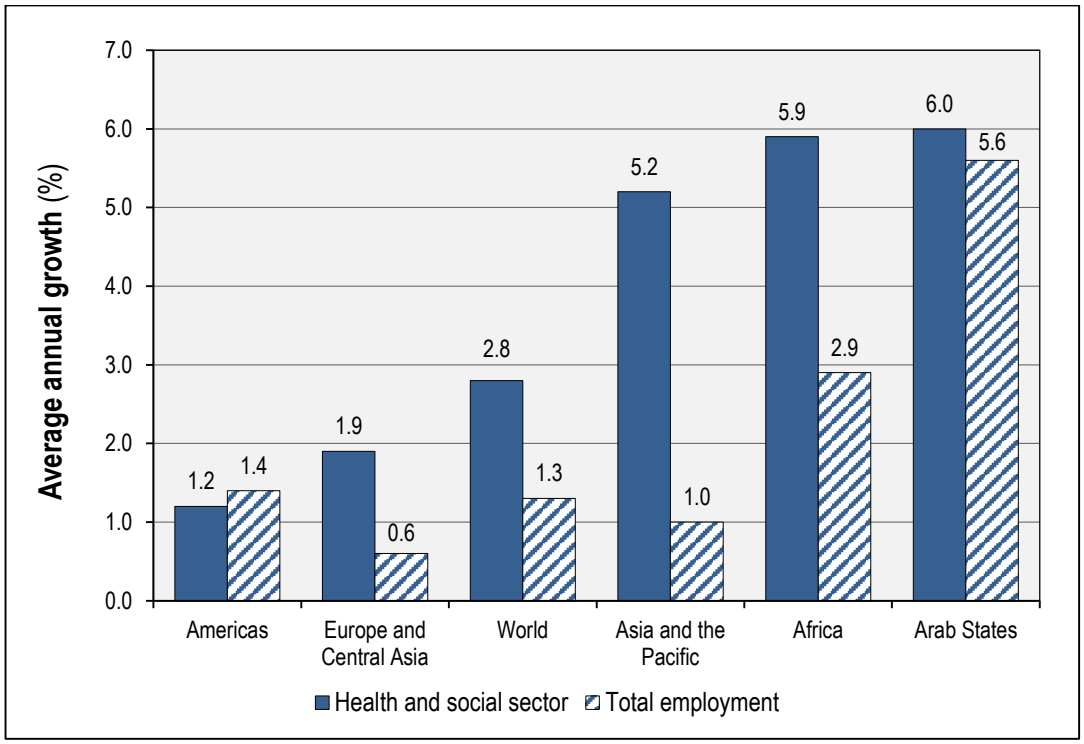
[39] Country income groups based on the World Bank classification of economies, 2014, available at: https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups.

[40] Developed economies according to ILO WESO grouping, including 37 countries, see ILO WESO database, op. cit.

upward trend. The drop in health and social services employment in 2013 could be associated with reforms as well as the effects of austerity measures in many countries affecting particularly the public sector, including health services.

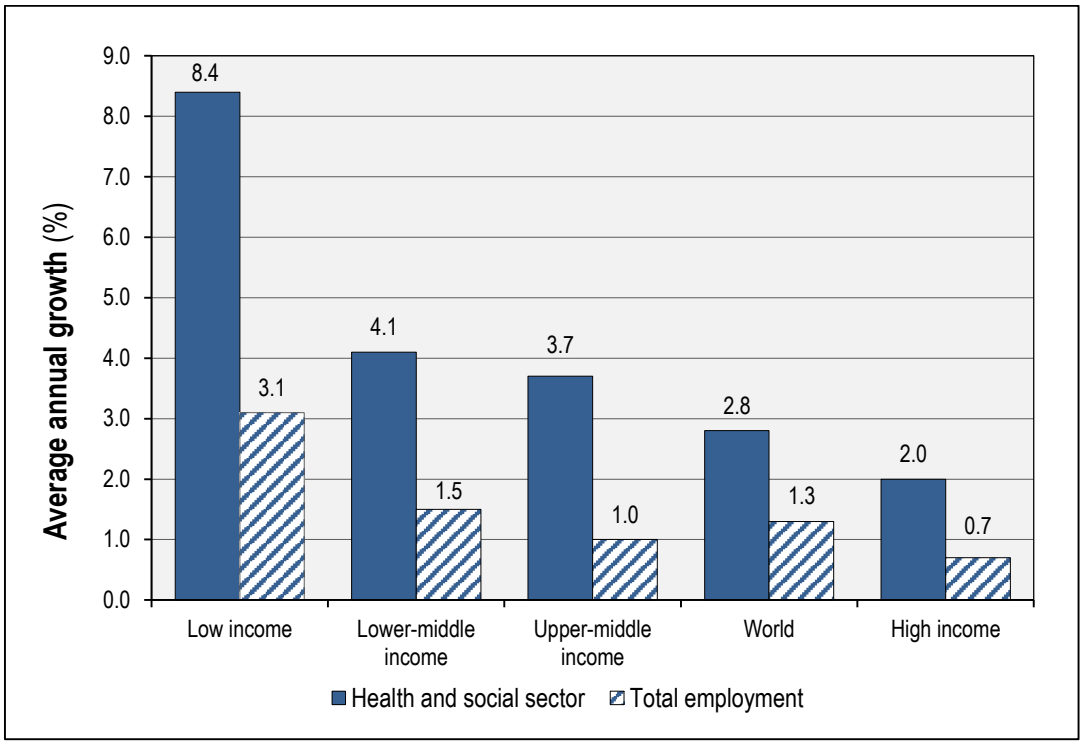
47. Globally, the average annual growth in health employment was as high as double that of total employment (2.8 per cent versus 1.3 per cent, respectively). Across regions, with the exception of the Americas, employment growth in health and social work outpaced total employment growth, particularly in Asia and the Pacific and in Africa. The slower growth in developed economies during and after the crisis is reflected in the low average annual growth in Europe and Central Asia (figure 2.2) and confirmed by the data concerning country income groups (figure 2.3), showing the lowest annual employment growth rates in high-income countries.

Figure 2.2. Average annual employment growth (as a percentage), by ILO region, 2005–13



Source: ILO WESO database, 2015.

Figure 2.3. Average annual employment growth (as a percentage), by country income groups, 2005–13

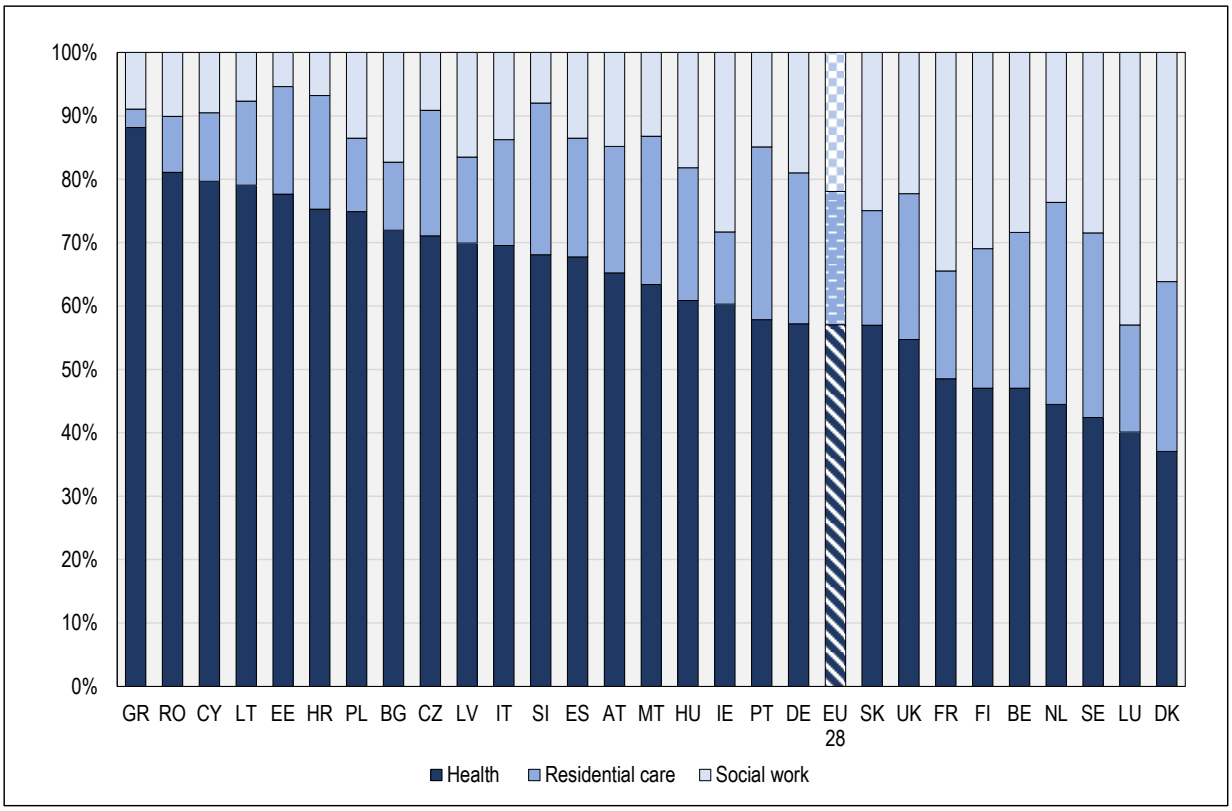


Source: ILO WESO database, 2015.

48. Regarding the different areas of work in health and social services, 2015 data from the European Union (EU) shows, on average, that more than half of employment is in the field of health (57.1 per cent), and the remaining share equally distributed between the fields of residential care (including nursing and elderly care facilities) and social work activities without accommodation (21 per cent and 21.9 per cent, respectively). [41] A significant variation across EU countries could be related to differences in health and social systems organization (figure 2.4).

[41] With reference to ISIC, revision 4, section Q, subdivisions 86, 87, 88.

Figure 2.4. Employment share of the three subdivisions of the health and social sector as a percentage of total health and social sector employment, EU-28 countries, 2015



Source: ILO calculations based on Eurostat Labour Force Survey data.

2.2.2. Health employment multiplier effects

49. Increasing demand for health services is expected to generate around 40 million new jobs for health workers by 2030, mainly in high- and middle-income countries. [42] Taking into account a broad range of workers and potential multiplier effects in industries providing goods and services for health, the potential for job creation is even higher, including for low-skilled workers. With regard to paid employment, ILO estimates suggest that globally, for each health occupation job (such as physician, nurse, physiotherapist), 1.5 additional jobs are generated for workers in non-health support occupations (administration, cleaning, manufacturing) both in the health sector and the broader health-related economy. Taking into consideration additional unpaid long-term elderly care work, this would raise this ratio to 2.3 non-health jobs per 1 health occupation job. This approach takes into account all workers producing health-related products and providing services regardless of their occupation, employment status or economic sectors. Accordingly, the workforce has been estimated to be 234 million workers in the entire health-related economies globally, consisting of 71 million workers in health occupations, 106 million paid workers in non-health occupations and 57 million unpaid non-health occupation workers, mostly persons who left paid employment to provide care to relatives. The aggregate employment creation

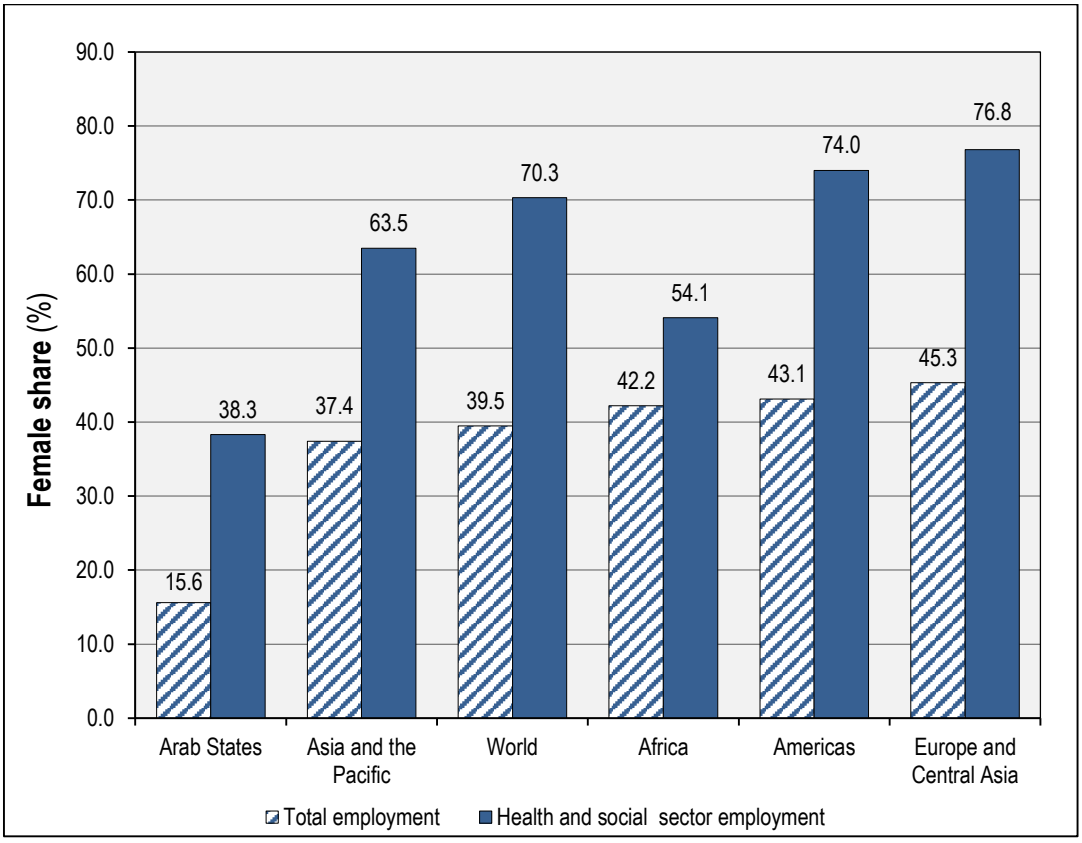
[42] J.X. Liu et al.: *Global health workforce labor market projections for 2030*, Policy Research Working Paper No. 7790 (Washington, DC, World Bank, 2016), available at: https://openknowledge.worldbank.org/handle/10986/25035. Note: Health workers data refers to physicians, nurses, midwives and a limited group of other health occupations, based on WHO databases.

potential associated with health services has been projected to be around 129 million jobs globally by 2030. [43]

2.2.3. Composition of the global health workforce

50. The health and social work sectors are an important employment source for women. Globally, more than 70 per cent of workers in these sectors are women – nearly one third greater than in total employment. It is noteworthy that, while it is the lowest across regions, even in the Arab States, women's share in health and social services employment is more than twice that of their share in total employment (figure 2.5). High-income countries have the highest share of women in the sector (76.7 per cent) while it is lowest in lower-middle and low-income countries (46.3 per cent and 47.2 per cent, respectively).

Figure 2.5. Proportion of women working in the health and social sector compared to share of women in total employment, by ILO region, 2013



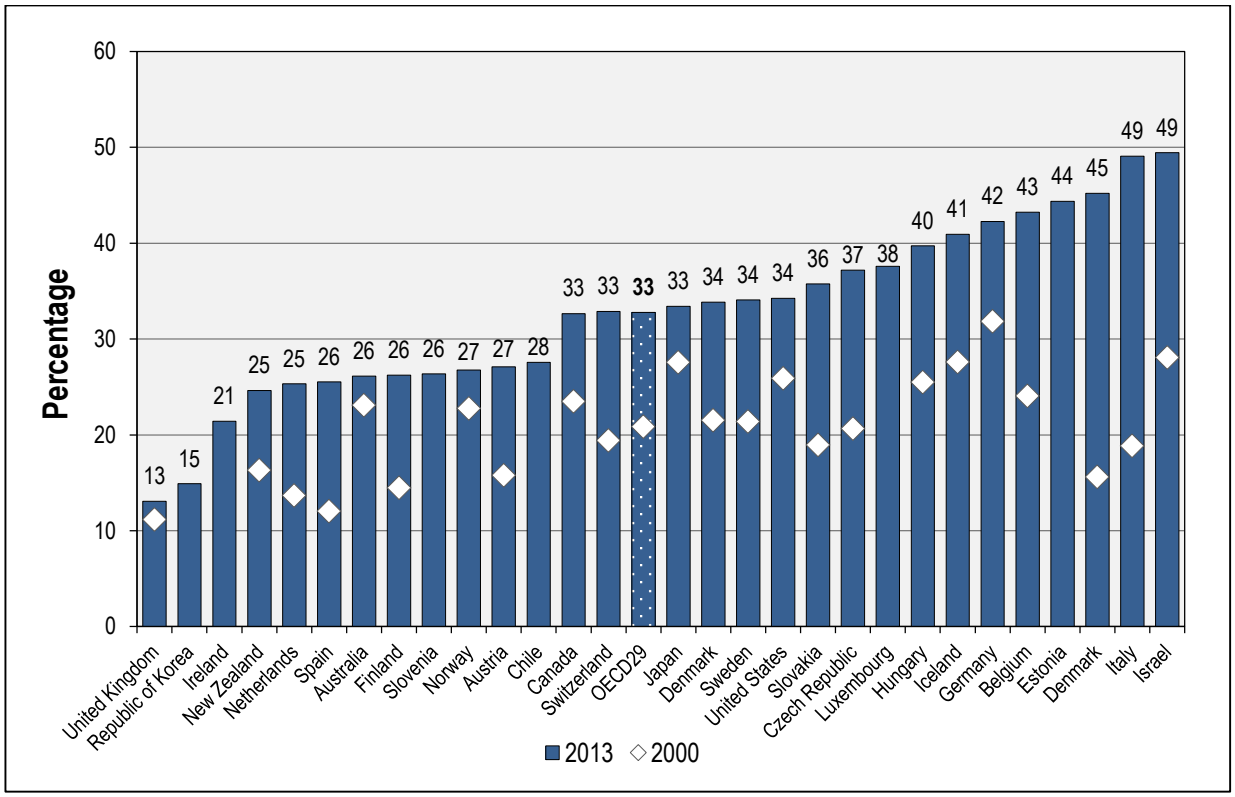
Source: ILO WESO database, 2015.

51. Along with population ageing, health workforce ageing has been observed. In EU countries, for instance, more than one third of physicians were aged 55 years or over (37 per cent) in 2014, [44] similar to the average age of physicians across OECD countries (figure 2.6). In 2015, in Australia, 40 per cent of nurses and midwives were aged 50 years or more, while in the United States half of the registered nurses were in that age group.

[43] X. Scheil-Adlung: *Health workforce: A global supply chain approach – New data on the employment effects of health economies in 185 countries* (Geneva, ILO, 2016).

[44] Eurostat: *Healthcare personnel statistics* (Luxembourg, 2016).

Figure 2.6. Share of doctors aged 55 years and over (percentage), 2000 and 2013 (or nearest year), OECD countries



Source: OECD Health Statistics, 2015, available at: http://dx.doi.org/10.1787/health-data-en.

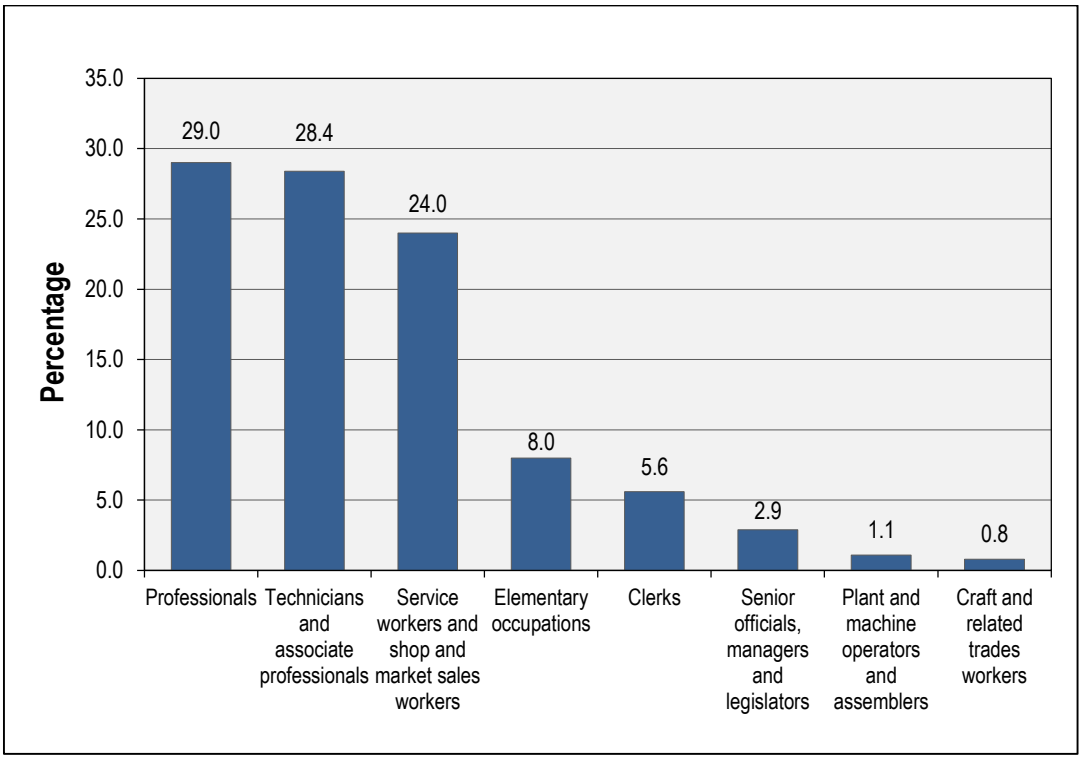
52. Data on the composition of the health workforce by occupation is limited, both by occupational groups and by countries. According to WHO, in 2013, there were globally 9.8 million physicians, 20.7 million nurses and midwives, and an estimated 13 million of other health workers. [45] The disparities between WHO regions are significant: the median density per 10,000 population was 2.4 doctors and 10.7 nurses and midwives in Africa compared to 32.3 doctors and 41.7 nurses and midwives in Europe. [46] Across regions, nurses and midwives constitute the biggest occupational group in health care.

53. The broad scope of occupational groups employed in the EU-28 health and social services sectors is illustrated in figure 2.7. Health professionals and associate professionals constitute nearly 60 per cent of the sectors' workforce, while 40 per cent consist of other occupations contributing to the functioning of health services.

[45] WHO: *Global strategy on human resources for health: Workforce 2030*, op. cit.

[46] WHO: *World health statistics 2016: Monitoring health for the SDGs* (Geneva, 2016).

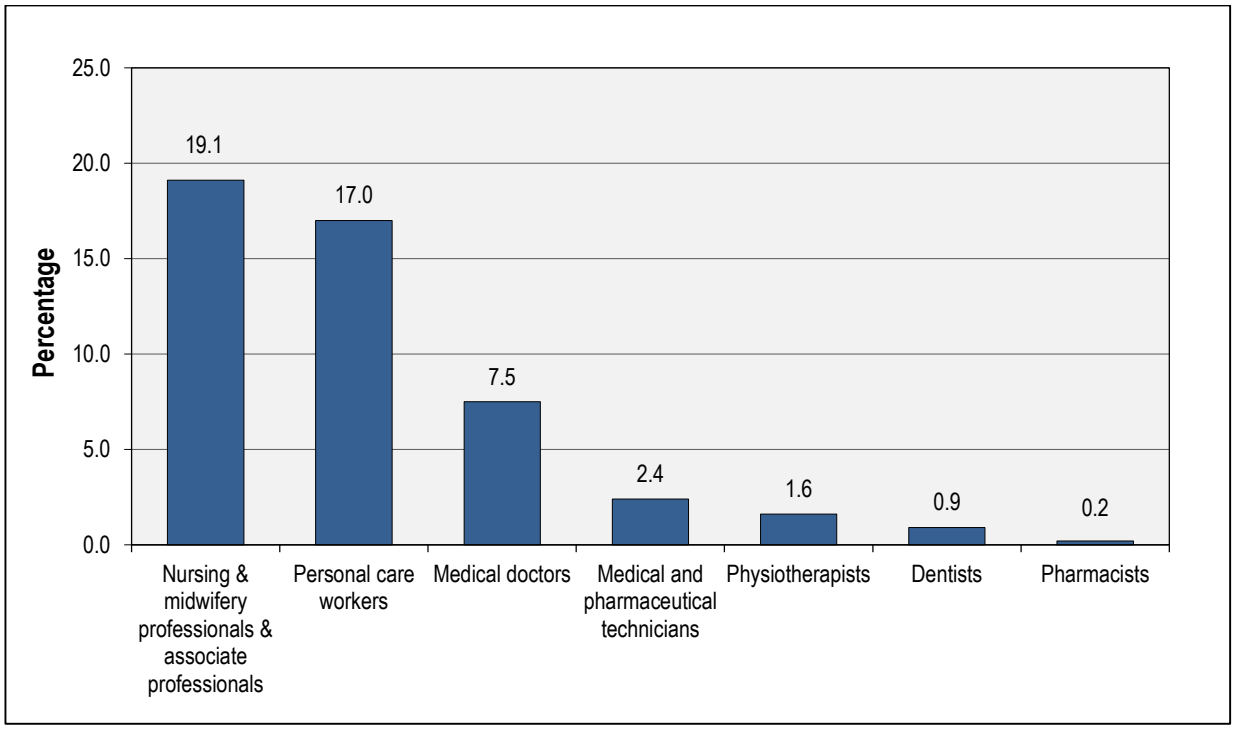
Figure 2.7. Scope and share of major occupational groups as a percentage of employment in the health and social sector, EU-28, 2015



Source: ILO calculations based on EUROSTAT Labour Force Survey data.

54. The composition of health occupations across EU countries varies in accordance with their health service organization. The share of medical doctors in health sector employment in 2015 varied from 22 per cent in Greece to 4 per cent in Finland. In line with the global trend, nursing personnel represent the biggest group in health sector employment (figure 2.8). The large share of personal-care workers reflects the needs of ageing populations.

Figure 2.8. Share of select health occupational groups as a percentage of employment in the health and social sector, EU-28, 2015



Source: ILO calculations based on EUROSTAT Labour Force Survey data.

55. For developing and transition countries in other regions, occupational data is limited. Across countries, marked variations in occupational groups reflect health systems and cultural differences. The female share in the health workforce was around three-quarters in the Dominican Republic and Ecuador (73 per cent and 72 per cent, respectively), and 57 per cent in the United Republic of Tanzania. In Bangladesh and Pakistan, women in health employment constituted 39 per cent and 24 per cent, respectively, reflecting the low share of women in paid employment. Nursing personnel accounted for around a quarter of the health workforce in the Dominican Republic, Ecuador and the United Republic of Tanzania (24.6, 22.7 and 23.2 per cent, respectively) and physicians for 17 per cent in Bangladesh and Ecuador, and in Pakistan and the United Republic of Tanzania, 10.6 per cent and 9 per cent, respectively.[47]

56. Data on employment status is available mainly for European countries. In 2015, the majority of the EU health services workforce were employees; self-employment accounted on average for 8.7 per cent, with significant variations across countries. [48] The share of self-employment was higher among the group of health professionals [49] (a 22.9 per cent EU average). For selected countries for which data is available, the rate of self-employed exceeded employees only in the case of physicians and dentists.

57. An average of 13.7 per cent of the total EU health workforce held temporary employment contracts in 2015, ranging from 27 per cent in Spain to 6.3 per cent in the United Kingdom. For all professional groups, personal-care workers had the highest share of temporary

[47] Based on ILOSTAT Labour Force Survey data, 2015, or latest available.

[48] Based on EUROSTAT Labour Force Survey data.

[49] Refers to ISCO code 22.

employment (16 per cent, EU average), ranging from 42 per cent in Poland to 2 per cent in Latvia.

58. On average one third of the EU health sector workforce worked part time (32.8 per cent) in 2015, ranging from 78.7 per cent in the Netherlands to 4.1 per cent in Slovakia. The majority of all those working part time in the health sector were women (89.1 per cent, EU average), while among all women employed in the sector one third worked part time (37.3 per cent, EU average).

2.3. Employment conditions

59. Employment conditions concern the nature of the relationship between the employer and the employee, the presence and nature of a contract, issues of contractual working time and contract duration, and the conditions of remuneration in salary and in benefits.

2.3.1. Employment relations

60. Health sector reforms, in response to cost and efficiency concerns, have resulted in a growing diversification in forms of employment. The sector uses non-standard forms of employment (NSFE) that include fixed term, temporary work, temporary agency work, dependent self-employment and part-time work. Well-designed and regulated NSFE can help organizations to respond in a timely manner to changing demands, and replacement of temporary absent workers. NSFE can also facilitate the engagement of workers in the labour market, such as freely chosen part-time work arrangements that allow workers to better reconcile work, life and family responsibilities. However, workers in these kinds of arrangements tend to be more exposed to decent work deficits, in terms of job insecurity, lower pay, gaps in access to social protection, higher risks of safety and health, and limited organizing and collective bargaining power. [50]

61. There is a trend in different countries to replace permanent public health services employment with fixed-term contracts, and to use outsourcing for certain types of work. Agency workers often have no employment security, are excluded from collective bargaining coverage and may not receive the same pay as their employee colleagues. [51] Further, the use of zero-hour-contracts, which are employment arrangements without guarantee of a minimum number of work hours, is on the rise; they expose workers to high levels of insecurity regarding the amount of work, income and working schedules. In 2013, an estimated 27 per cent of health-care employers in the United Kingdom were using zero-hour contracts. In England, 307,000 workers in the private care sector were on such terms of employment. [52]

62. In South Africa, the use of agency staff and similar contractual arrangements within the same institutions has been identified as a growing problem compromising service delivery, continuity of care, health and safety, and contributing to greater inequality. Outsourced

[50] ILO: *Conclusions of the Meeting of Experts on Non-Standard Forms of Employment*, GB.323/POL/3 (Geneva, 2015).

[51] S. Malcolm and H. Sutschet: *Non-standard working in public services in Germany and the United Kingdom* (Geneva, ILO, 2015).

[52] UNISON: *Zero hours contracts fact sheet*, updated January 2016, available at: https://www.unison.org.uk/content/uploads/2016/02/Zero-Hours-Factsheet.pdf.

ancillary services jobs are mostly temporary, part-time and insecure, with agencies supplying workers on demand to the public health service. [53]

63. Employment policies have to provide protection for workers in such vulnerable contractual arrangements. The case of the Brazilian health system, Sistema Único de Saúde (SUS) (National Health System), provides an example of how institutional openness to dialogue and negotiation can create a way to decrease the instability of outsourced work through guarantees of the rights of these workers or by the adoption of policies to replace outsourced workers with public servants through a public selection. [54]

Box 2.1
Brazil: Regulating employment relations in the SUS through social dialogue

In Brazil, in response to the concern of the "precarisation" of the workforce in the SUS, the Ministry of Health created the National Inter-institutional Committee on de-precarisation of Work in the SUS, composed of government representatives (federal, provincial and local) and trade union leaders. It aims to promote the creation of employment relationships that guarantee rights and job stability to workers as well as the quality of the health services. Today, due to these efforts, there is an institutional plan to regulate labour relations in the health sector and to substitute outsourced and informal temporary workers with permanent public servants.

Source: Verma & Gomes, 2014.

64. Examples from European countries illustrate the potential mutual benefits of NSFE for employers and workers. In the Slovakian public health sector, due to the lack of qualified professionals, various types of contracts have been offered to temporarily fill vacancies and to maintain proper service provision. Doctors use the opportunity to work in hospitals for a few hours a week to improve their skills and broaden their experience with specific patients and with equipment that might not be available to them in other health-care facilities. Case studies from the Netherlands and the United Kingdom highlight cases of public sector employers using NSFE to respond to recent budget cuts in such a way as to enable them to preserve at least part of their qualified staff and to provide them with some work and income. [55]

2.3.2. Remuneration

65. Pay is a major recruitment, retention and worker motivation factor. For health workers, remuneration reflects the level of recognition and value attached to their work. The level of pay should be comparative and competitive to occupational groups of similar levels in other economic sectors and reflect qualifications, responsibilities, duties and experience as, for example, specified for nursing personnel in Recommendation No. 157. Income is also important for the independence of health workers in exercising their functions according to their professional ethics.

66. Over the first decade of this century, the remuneration of salaried health workers as a proportion of gross domestic product (GDP) remained nearly unchanged globally, and decreased in terms of total health expenditure (figure 2.9). In some countries, workers in the

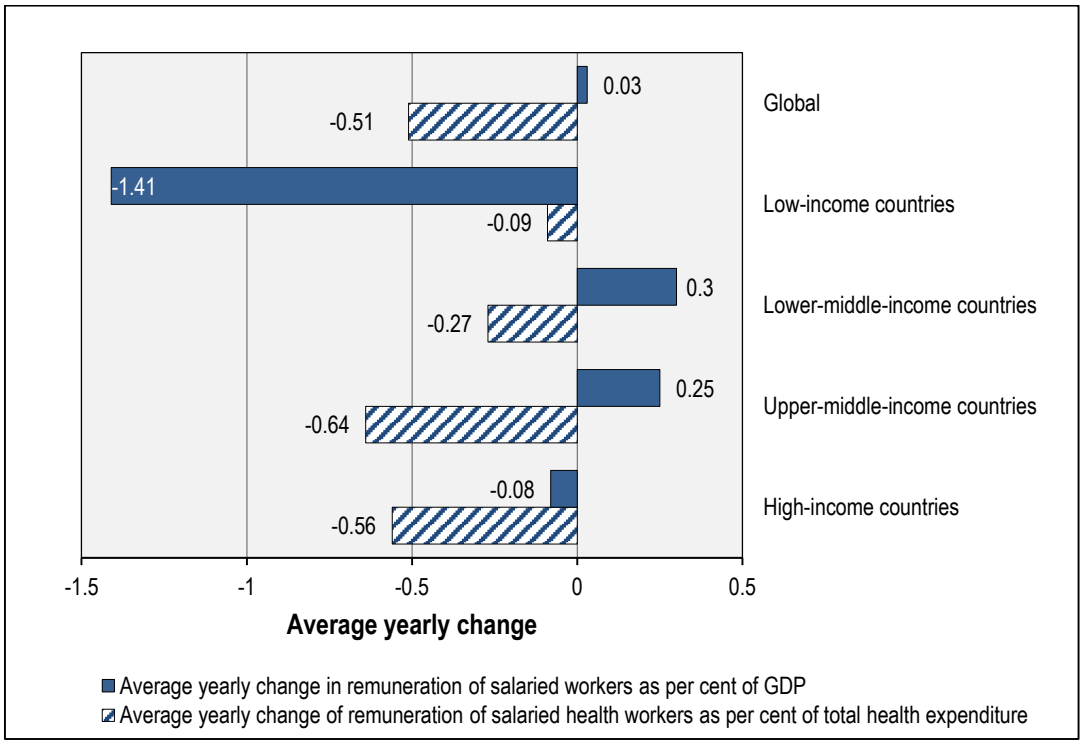
[53] S. Kisting, A. Dalvie and P. Lewis: *South Africa: Case study on working time organization and its effects in the health services sector* (Geneva, ILO, forthcoming).

[54] A. Verma and A. Gomes: *Non-standard employment in government: An overview from Canada and Brazil* (Geneva, ILO, 2014).

[55] European Foundation for the Improvement of Living and Working Conditions (Eurofound): *New forms of employment* (Luxembourg, Publications Office of the European Union, 2015).

lowest paid categories on average received wages that were 1 per cent above the poverty line. [56] To make up for low wages, health workers often resort to working multiple jobs or increasing shifts or overtime. [57, 58]

Figure 2.9. Yearly change of health workers' remuneration of total health expenditure and GDP by country income level, 2000–10 (percentage)



Source: ILO *World Social Protection Report 2014–15.*

67. In response to the economic crisis, some European countries reduced salaries drastically or froze them as well as benefits. These measures contributed to increasing wage imbalances, further stimulating health worker outflows. Austerity measures induced a radical transformation in the hierarchy of wage levels between the public and the private sectors, resulting in wage penalties for public service workers. [59, 60, 61] The effects on remuneration

[56] ILO: *World Social Protection Report 2014–15: Building economic recovery, inclusive development and social justice* (Geneva, 2014).

[57] Voluntary Service Overseas (VSO): *Valuing health workers: Cambodia report* (London, 2013).

[58] J. Messenger and P. Vidal: *The organization of working time and its effects in the health services sector: A comparative analysis of Brazil, South Africa and the Republic of Korea* (Geneva, ILO, 2015).

[59] S. Thompson et al.: *Economic crisis, health systems and health in Europe: Impact and implications for policy* (Copenhagen, WHO Regional Office for Europe and European Observatory on Health Systems and Policies, 2014).

[60] M. Karanikolos et al.: "Financial crisis, austerity, and health in Europe", in *The Lancet* (2013, Vol. 381), pp.1323–1331.

[61] D. Vaughan-Whitehead (ed.): *Public sector shock: The impact of policy retrenchment in Europe* (Geneva, ILO, 2013).

varied across the main occupational groups. The incomes of physicians and nurses in Hungary fell in 2009; in Belgium and France, the incomes of general practitioners dropped in 2010 and stagnated for nurses in 2010 and 2011, while it continued to grow for specialist physicians. In Denmark, income reductions for physicians and nurses started in 2011. [62]

68. The variation in wage levels among occupations is large: among 16 health occupational groups across 20 countries, medical doctors were paid the highest and personal-care workers the lowest, while the nursing and midwifery groups ranked in the middle. This reflects the different skill levels, education and qualifications required for the various occupations. Wage differentials between countries are also significant. [63]

2.4. Gender aspects

69. Paradoxically, while the global health workforce is predominantly female, women in the health and social work sectors tend to concentrate in lower-skilled jobs, with less pay and at the bottom end of the professional hierarchies. [64] In the United Kingdom, female employment in care services is mostly related to direct-care work, while managerial jobs tend to be held by men. LTC is, in particular, mainly performed by women (90 per cent in OECD countries), often in part-time arrangements, while the training and skills development of formal LTC workers is often at very low levels compared to other health workers. [65]

70. Because care work involves tasks that women have traditionally performed without pay, the skills required for care work – and care provision in general – are undervalued or overlooked in national measures of the economy. [66] It has been argued that the labour market devalues so-called "female" tasks and skills, as shown by the fact that where women's share in the workforce or in an occupation increases, wages often decline. [67] Women's contribution to healthcare has been estimated to account for nearly 5 per cent of global GDP, equivalent to over US$3,000 billion, but nearly half of this is unpaid and unrecognized. This informal and volunteer work in families and communities is considered a hidden subsidy to health systems and society that should be recognized and compensated. [68]

[62] J. Buchan et al: *Wage-setting in the hospital sector*, OECD Health Working Papers No. 77 (Paris, 2014), available at: http://dx.doi.org/10.1787/5jxx56b8hqhl-en.

[63] K. Tijdens et al.: "Health workforce remuneration: Comparing wage levels, ranking, and dispersion of 16 occupational groups in 20 countries", in *Human Resources for Health* (2013, 11:11).

[64] A. Langer et al.: "Women and health: The key for sustainable development", in *The Lancet* (2015, Vol. 386), pp. 1165–1210.

[65] F. Colombo et al.: *Help wanted? Providing and paying for long-term care*, OECD Health Policy Studies (Paris, OECD Publishing, 2011).

[66] ILO: *Women at work: Trends 2016* (Geneva, 2016).

[67] K. Tijdens et al.: "Health workforce remuneration: Comparing wage levels, ranking, and dispersion of 16 occupational groups in 20 countries", op. cit.

[68] A. Langer et al.: "Women and health: The key for sustainable development", op. cit.

71. The gender pay gap, globally estimated at an average of over 20 per cent in the overall economy, [69] appears even more marked in the human health and social work sectors; on average 26 per cent in high-income and 29 per cent in upper-middle-income countries. [70]

2.5. Care work

72. The care economy has been identified as a source of future job growth due to ageing populations, yet many existing needs for care go unmet because of financial constraints or because they are covered by resorting to underpaid or unpaid carers. [71]

73. In elderly care, the composition of the LTC workforce is heterogeneous regarding skills levels and occupations, albeit with a female majority. Besides LTC workers in formal employment there are informal LTC workers, often employed directly by households, plus those providing unpaid care to family members. The ILO estimates a global shortfall of 13.6 million workers in formal LTC jobs. [72] Informal or unregistered carers usually have less favourable working conditions, less social security and receive lower wages. [73] In general, LTC workers face low wages; for example, in Australia, the United Kingdom and the United States they earned around half (55–57 per cent) of the average earnings in all occupations in 2014. [74] In Shanghai, China, workers providing home care for the elderly are a marginalized group trapped at the bottom of the wage hierarchy. [75] Across various studies, the low status of care work has been underlined and also been associated with gender segregation. The lack of recognition, including low pay not reflecting the demanding aspects of the work, drives many to leave the profession, resulting in costly staff turnover. [76] With women in the majority among carers, the gender aspects influence their conditions of work.

74. It is important to ensure decent work which will also translate into better quality of care. In this regard, a sectoral collective agreement for home-care workers in the Argentine private

[69] ILO: *The future of work centenary initiative*, Report of the Director-General, Report I, International Labour Conference, 104th Session, Geneva, 2015.

[70] This refers to an unadjusted gender wage gap. Data available from 40 countries (27 high-income; eight upper-middle-income; four lower-middle-income; one low-income); latest available data: 2011–13. Source: ILOSTAT based on national labour force surveys and official estimates of each country.

[71] ILO: *The future of work centenary initiative*, op. cit.

[72] X. Scheil-Adlung: *Long-term care protection for older persons: A review of coverage deficits in 46 countries* (Geneva, ILO, 2015).

[73] European Agency for Safety and Health at Work (EU–OSHA): *Current and emerging issues in the healthcare sector, including home and community care*, European Risk Observatory Report (Luxembourg, 2014).

[74] International Trade Union Confederation (ITUC): *Investing in the care economy: A gender analysis of employment stimulus in seven OECD countries* (Brussels, 2016), available at: www.ituc-csi.org.

[75] X. Dong et al.: "Relative pay of domestic eldercare workers in Shanghai, China" in *Feminist Economics*, 2016, available at: http://dx.doi.org/10.1080/13545701.2016.1143108.

[76] S. Austen et al.: "Recognition: Applications in aged care work", in *Cambridge Journal of Economics* (2016, Vol. 40), pp. 1037–1054, available at: http://cje.oxfordjournals.org/ [doi:10.1093/cje/bev057].

sector shows innovative solutions in protecting care workers while integrating continued training to upgrade skills and allowing time for education of often low-skilled workers.

Box 2.2
Argentina: Collective agreement for home-care workers

In December 2016, a sectoral collective agreement entered into force in Argentina, between the Federation of Trade Unions of Health Workers of Argentina (FATSA) and the Business Chamber representing the Residential and Home Care Sector. The Ministry of Labour and Social Security established that the collective agreement is mandatory for all companies in the country. It applies to more than 40,000 private sector workers in home care. Up till now, workers are affected by a high informality in labour relations. The agreement determines: hours of work, overtime, and overtime pay in accordance with national legislation; it sets out a minimum level of remuneration in periods of inactivity between assignments that provide some income security; and states that the parties must comply with national health and safety regulations. A specific feature of the agreement is the provisions on vocational training and education, which are financed by employers' special contributions. In addition, home-care workers in secondary or tertiary education are entitled annually to a special leave of ten or 15 days, respectively. A joint commission has been established to monitor the implementation of the collective agreement and to manage dispute settlement arrangements.

(Argentina, Collective Labor Convention No. 743/16)

Source: UNICARE.

75. Further, cooperatives are emerging as a type of care provider, generating access to better terms and conditions of work largely for informal care workers. They foster integrative, participatory and people-centred care work by privileging equitable inclusion and democratic decision-making across the care delivery chain, enabling care workers, care beneficiaries and their families and other stakeholders to have a voice in the nature of the service provided and the operations of the care provision enterprise. [77] In Rwanda, for example, community health workers have been organized in cooperatives with the support of the Ministry of Health. [78]

3. Skills development, education and training

76. Education, vocational training and lifelong learning are central to employability and productive employment, and indispensable in ensuring decent work and inclusive economic growth. [79] Rapid technological change, demographic transitions, epidemiological developments and scientific advancement require continuous health workforce development to meet current and future health needs. Achieving SDG 3 on healthy lives and well-being for all is closely linked to SDG 4, which underlines the importance of inclusive and equitable quality education and the promotion of lifelong learning opportunities for all.

77. There is increasing recognition that current education models are inadequate in preparing health workers for their tasks. An independent expert review has highlighted a "mismatch of competencies to patient and population needs; poor teamwork; persistent gender

[77] ILO: *Global mapping of the provision of care through cooperatives: Survey and findings* (Geneva, 2016).

[78] J. Condo et al.: "Rwanda's evolving community health worker system: A qualitative assessment of client and provider perspectives", in *Human Resources for Health* (2014, 12:71), available at: http://www.human-resources-health.com/content/12/1/71.

[79] ILO: *A skilled workforce for strong, sustainable and balanced growth: A G20 training strategy* (Geneva, 2011).

stratification of professional status; narrow technical focus without broader contextual understanding; episodic encounters rather than continuous care; predominant hospital orientation at the expense of primary care; quantitative and qualitative imbalances in the professional labour market; and weak leadership to improve health-system performance". [80] It called for an integrative systems framework for health workers education, connecting to health labour markets and to population health needs.

78. The ILO Human Resources Development Recommendation, 2004 (No. 195), concerning human resources development, education, training and lifelong learning, similarly urges governments to "ensure that vocational education and training systems are developed and strengthened to provide appropriate opportunities for the development and certification of skills relevant to the labour market" (Paragraph 8(f)) to "recognize that education and training are a right for all", and, in cooperation with the social partners, to "work towards ensuring access for all to lifelong learning" (Paragraph 4(a)). Education, training and lifelong learning should be seen as both a right for all health workers and a responsibility of governments, employers and workers.

79. A good skills-development system should anticipate skills needs; engage employers and workers in decisions about how training is organized and delivered, including for specific sectors; maintain the quality and relevance of training; make training accessible to all sectors of society; ensure viable and equitable financing mechanisms; and continuously evaluate the economic and social outcomes of training. The involvement of employers and workers and their representative organizations is critical to keeping training relevant and ensuring that training costs and the gains of productivity improvement are shared equitably. [81]

80. Sector skills bodies can be effective mechanisms to keep education and training relevant for the labour market. They may include representatives of public authorities and the private sector, social partners, and education, vocational training and research institutes, and be tasked to identify or analyse skills needs or to otherwise contribute to education and training that adequately prepares the workforce for specific economic sectors. [82] While differing in their institutional composition they provide a platform for social dialogue on skills development and regulation involving social partners and the relevant education and health-sector stakeholders. In Australia, the Community Services and Health Industry Skills Council conducted an environmental scan to identify future skills demand in an environment of changing needs, such as more complex health requirements of ageing populations. The key trends identified included: increased scope of support worker roles; emerging demand for care coordination roles; continuing demand for skills development of workers, including more advanced roles; and a greater emphasis on technological skills and knowledge. [83] In South Africa, to improve access to primary health care, the Department of Health proposed training 45,000 community health workers (CHW) until 2019, and regulating, accrediting and integrating this mainly informal workforce with varying skill levels into the formally employed health workforce. The Health and Welfare Sector Education and Training

[80] J. Frenk et al.: "Health professionals for a new century: Transforming education to strengthen health systems in an interdependent world", in *The Lancet* (2010, Vol. 376, No. 9756), pp. 1923–1958.

[81] ILO: *A skilled workforce for strong, sustainable and balanced growth: A G20 training strategy*, op. cit., p. 2.

[82] P. Lempinen: *Sector Skills Councils: What? Why? How? Contributing to better VET relevance to the labour market needs* (Torino, European Training Foundation, 2013).

[83] Community Services and Health Industry Skills Council (CS&HISC): *2015 Environmental Scan – Building a healthy future: Skills, planning and enterprise* (Sydney, 2015).

Authority, composed of representatives of government, employers, unions, professional bodies and sector bargaining councils, has assisted the Department of Health in developing new CHW qualification levels. Challenges in this process included uncertainties of the CHW scope of work, roles and responsibilities and related, appropriate levels of education as well as their conditions of employment and work. [84]

81. The HEEG Commission has called for scaling up "transformative, high-quality education and lifelong learning so that all health workers have skills that match the health needs of populations and can work to their full potential". [85] Integrative collaboration and coherent workforce development strategies of education and health sectors are required to respond to the challenges. Education and training must focus on practice and adjust to health system needs.

82. Reorganizing scopes of practice to optimize the skills mix, often referred to as "task-shifting", can improve access to services. However, when extending scope of practice, it is important to concurrently redefine workers' and employers' upstream legal accountabilities, for instance, in cases of a medical error. Health workers require appropriate training in order to shift to new tasks. ILO Recommendation No. 157 provides that laws or regulations regarding the practice of the nursing personnel should "specify the requirements for the practice of the nursing profession as professional nurse or as auxiliary nurse". It also states that nursing personnel "should not be assigned to work which goes beyond their qualifications and competence" (Paragraphs 13(a) and 15(1)). Skills recognition systems are important for matching skills with tasks, particularly in case of occupational and geographical mobility, and where skills have been attained outside formal education systems, such as on-the job-training. [86] The private sector in many countries is now playing an increasing role in health workers' education. To ensure standards, quality and alignment with public goals, regulation of public and private education is a prerequisite. The ILO Nursing Personnel Convention, 1977 (No. 149), sets out that "the basic requirements regarding nursing education and training and the supervision of such education and training shall be laid down by national laws or regulations or by the competent authority or competent professional bodies, empowered by such laws or regulations to do so" (Article 3(1)).

83. There is widespread recognition of the importance of health workers' continuing education, lifelong learning and professional development. ILO Recommendation No. 195 defines lifelong learning as "all learning activities undertaken throughout life for the development of competencies and qualifications" (Paragraph 2(a)).

84. While some countries encourage regular periodic continuing medical education, particularly for practising physicians, most lack formal regulatory requirements. For instance, since 2005, Singapore has made compulsory continuing medical education for all physicians to maintain their licences. [87] The Abu Dhabi Health Authority requires physicians to attain at

[84] Health and Welfare Sector Education and Training Authority (HWSETA): *Sector skills plan update for the health and social development sector in South Africa: HWSETA SSP Update 2014–15 for the period 2015–20* (Johannesburg, 2014), available at: http://www.hwseta.org.za.

[85] HEEG Commission: *Working for health and growth: Investing in the health workforce*, op. cit., p. 11.

[86] J. Braňka: *Understanding the potential impact of skills recognition systems on labour markets: Research report* (Geneva, ILO, 2016).

[87] Singapore Medical Council: *Information for registered doctors: Continuing medical education*, 2011, available at: http://www.healthprofessionals.gov.sg/content/hprof/smc/en/leftnav/information_for_registereddoctors/continuing_medical_education.html.

least 50 hours of continuing medical education per year, 25 of which must be in the form of formal education from either an accredited medical school or a professional body, for licence renewal. [88] However, the evidence remains inconclusive whether in fact mandatory continuing education for relicensing leads to better health performance.

4. Working conditions

85. The regulation of working conditions in such areas as working time, occupational safety and health (OSH), and maternity protection is central to effective and inclusive labour protection. As the health sector increasingly finds itself having to compete for skilled workers with other economic sectors, an attractive work environment becomes a key competitive factor for health-care operators.

86. This chapter focuses on major aspects of working conditions, including working time, safety and health, social protection and the impact of technologies.

4.1. Working time organization and its effects in the health sector

87. The ILO advocates decent working time as one element to improving working conditions by reconciling workers' needs and organizational requirements. Decent working time is described as working time arrangements that: promote health and safety; foster gender equality; are family-friendly; advance the productivity and performance of organizations; and facilitate worker choice and influence over their hours of work. [89]

88. In the health sector, the working time arrangements impact on worker safety and health and their motivation, and on organizational performance in terms of patient outcomes. The complexity of a sector that has to ensure 24-hour-a-day services seven days a week poses enormous challenges for both workers' well-being and organizational performance.

89. Shift work, including night work, combined with long daily and weekly working hours are common practices within the health services sector around the world. Moreover, significant personnel shortages are often compensated for by overtime, putting further strain on existing staff as it extends shift lengths and reduces rest time between shifts ("quick returns"). There is abundant evidence of the negative effects of excessive working hours on the health of workers in the sector, on their family life, and on quality of care and workplace safety. [90]

90. Thus, reconciling workers' well-being, including their work–life balance, with organizational performance to achieve health objectives constitutes a complex but crucial challenge for the sector.

[88] Health Authority Abu Dhabi (HAAD): *Continuing medical education guide*, 2014, available at: https://www.haad.ae/cme/.

[89] ILO: *Decent working time: Balancing workers' needs with business requirements*, Conditions of Work and Employment Programme (TRAVAIL) (Geneva, 2007).

[90] P. Tucker and S. Folkard: *Working time, health and safety: A research synthesis paper* (Geneva, ILO, 2012).

4.1.1. Normative guidance

91. Working time has been a subject of central interest for the ILO since its creation in 1919. The very first standard adopted by the International Labour Conference – the Hours of Work (Industry) Convention, 1919 (No. 1) – established fundamental principles regarding the limitation of daily and weekly working hours. Since then, numerous standards have addressed different aspects of working time, including weekly rest and annual leave with pay. However, not all general standards on working time apply to health workers.

92. For nursing personnel, Convention No. 149 contains succinct provisions on working time. It requires ratifying States to ensure that nursing personnel enjoy conditions at least equivalent to those of other workers regarding: hours of work, convenient hours and shift work; weekly rest; and paid annual holidays. Recommendation No. 157 provides guidance on such issues as on-call duty, overtime or shift work. It sets out that: "Normal daily hours of work should be continuous and not exceed eight hours, except where arrangements are made by laws or regulations, collective agreements, works rules or arbitration awards for flexible hours or a compressed week." A normal working day should not exceed 12 hours, including overtime, and there should be a continuous rest of at least 12 hours between shifts. [91]

93. Some standards provide guidance on principles of working time organization relevant for the health sector, provided they apply at national level to all occupational groups and sectors. These include:

- Weekly Rest (Commerce and Offices) Convention, 1957 (No. 106);
- Holidays with Pay Convention (Revised), 1970 (No. 132);
- Night Work Convention, 1990 (No. 171); and
- Part-Time Work Convention, 1994 (No. 175).

94. Of further relevance to working time for a mainly female workforce is the Workers with Family Responsibilities Convention, 1981 (No. 156), providing for equal opportunities in accommodating workers' needs arising from family responsibilities.

4.1.2. Actual hours of work and shift systems

95. In many countries, the basic principles on working time are regulated in national labour legislation. In Brazil, Japan, South Africa, and South Korea, for example, normal daily working hours are limited to eight, with normal weekly hours ranging between 40 and 45. [92] In the EU, the 2003 Working Time Directive [93] sets limits at 48 hours per week, including overtime, averaged over a reference period not exceeding four months, which under certain conditions (e.g. in the case of a collective agreement), may be extended up to a maximum of

[91] Recommendation No. 157, Paragraphs 33, 37 and 38.

[92] J. Messenger and P. Vidal: *The organization of working time and its effects in the health services sector: A comparative analysis of Brazil, South Africa and the Republic of Korea*, op. cit.

[93] Directive 2003/88/EC of the European Parliament and of the Council of 4 November 2003 concerning certain aspects of the organisation of working time, European Commission, in *Official Journal* (L299, Vol. 46, 18 Nov. 2003), p. 9–19, available at: http://eur-lex.europa.eu/legal-content/EN/ALL/?uri=CELEX:32003L0088

one year. It provides for a minimum daily rest period of 11 hours. A weekly rest of 35 hours can be averaged over a two-week period. However, the EU Working Time Directive allows for certain specific derogations regarding health services, including doctors in training. [94]

96. There is evidence that a majority of health facilities operate with arrangements that often exceed the legal limits for working time in their specific countries. There is a link between long hours and workforce shortages where current staff have to fill in for the gaps to ensure continuity of services, leading to excessive overtime. This is particularly acute in rural and remote areas with scarce health workers. Furthermore, there is a link between long hours and low pay: across countries, many health workers resort to extra shifts or multiple jobs to supplement their incomes. [95]

97. Working time arrangements are diverse across and within countries and among different types of health services. They include, in different combinations: fixed day work (six or eight hours); rotating shifts; eight-hour three-shift system; 12-hour two-shift system; split shifts; and compressed workweeks. Moreover, shift work, including night work and weekend work, is usually accompanied by substantial on-call periods. [96] Trends point to the use of flexible working time arrangements, including: flexi-time schemes; time banking systems; differential hours over the year; annualized hours; staggered hours; job-sharing and part-time work. [97] Those arrangements aim to reconcile workers' needs to balance work and private life with health services needs for ensuring continuous service and responding to peak times. To be effective, flexible working time arrangements need to ensure that workers have influence and choice concerning their working schedules.

98. The ILO's 1998 report on the health sector already noted a trend from the three-shift (eight-hour shifts) towards the two-shift system (12-hour shifts) as one result of health sector reforms to gain higher efficiency. [98] The overall prevalence of 12-hour shifts in the sector has since increased. For instance, a 2014 review of nurses' shifts in Europe found that whereas they have become the norm in a few countries, they do occur in all the countries surveyed. [99] In South Africa, a study found that 12-hour shifts had become the norm in both the public and the private sectors in hospital nursing. [100] A survey of the Japan Federation of Medical Workers' Unions found an increase of the two-shift system from 7.7 per cent in 2000 to 32.1 per cent in 2015. Nearly half of respondents reported working 16-hour night

[94] Directive 2003/88/EC of the European Parliament and of the Council of 4 November 2003 concerning certain aspects of the organisation of working time, op. cit.

[95] J. Messenger and P. Vidal: *The organization of working time and its effects in the health services sector: A comparative analysis of Brazil, South Africa and the Republic of Korea*, op. cit.

[96] ibid.

[97] European Trade Union Confederation (ETUC): *Working time in the health sector in Europe: Fact Sheet* (undated).

[98] ILO: *Terms of employment and working conditions in health sector reforms*, op. cit., pp. 51–53.

[99] Peter Griffiths RN et al.: "Nurses' shift length and overtime working in 12 European countries: The association with perceived quality of care and patient safety", in *Medical Care* (2014, Vol. 52(11), Nov.), pp. 975–981.

[100] S. Kisting, A. Dalvie and P. Lewis: *South Africa: Case study on working time organization and its effects in the health services sector*, op. cit.

shifts in 2015. [101] A related problem are "quick returns", which fail to provide sufficient rest time between shifts. This may lead personnel to opt for long shifts and compressed weeks in order to save on commuting times.

4.1.3. Effects on workers and on organizational performance

99. Long hours, shift work and night work hours are targeted for normative reasons by international and national legislation because of their damage to workers' health. [102] Effects on workers' health include increased emotional and mental fatigue, disruption of the sleep rhythm due to shift work and various illnesses such as musculoskeletal disorders and depression. Moreover, these health effects are associated with higher incidences of sharps injuries, physical discomfort and accidents. [103] Research also suggests that shift work involving circadian disruption is probably carcinogenic to humans. [104] Related to fatigue, a diminished capacity to manage the workloads and chronic stress can lead to job dissatisfaction, burnout, absenteeism, increased staff turnover, and poor service delivery, including medical errors, which in turn can result in adverse patient outcomes. [105, 106]

100. The working times of health workers have a bearing on both their family life and leisure time. In addition to the difficulties of scheduling shifts to be compatible with family responsibilities, health workers often find the quality of their family and social life to be challenged by chronic fatigue. Also, long commuting distances to the workplace, inadequate transportation and a deficit of child-care facilities worsen employees' ability to balance paid work with family and social life. Women and single parents particularly find work schedules that clash with their family responsibilities to result in distancing them from their children, whose care is often handed over to extended family or to hired help. [107]

101. For organizations, an effect of their employees' difficulties in balancing work schedules with child-care needs can be increased part-time work particularly among women or the risk of absenteeism. In South Africa, absenteeism among nurses has been observed to increase during school holidays, when schools and child-care centres close, obviously related to their

[101] A. Shimizu: *Results of the 2015 Night Work Survey*, presentation at the Nihon-Iroren International Symposium on Achieving the Improvement of Night Shift Work of Nursing Personnel, Tokyo, 6 Sep. 2016.

[102] P. Tucker and S. Folkard: *Working time, health and safety: A research synthesis paper*, op. cit.

[103] J. Messenger and P. Vidal: *The organization of working time and its effects in the health services sector: A comparative analysis of Brazil, South Africa and the Republic of Korea*, op. cit.

[104] WHO–International Agency for Research on Cancer (IARC): *Painting, Firefighting, and Shiftwork,* IARC Monographs on the Evaluation of Carcinogenic Risks to Humans (2010, Vol. 98).

[105] C. Dall'Ora et al.: "Association of 12h shifts and nurses' job satisfaction, burnout and intention to leave: Findings from a cross-sectional study of 12 European countries", in *BMJ Open* 2015 (Vol. 5 (9 Mar. 2016)).

[106] A.L. Matos de Oliveira: *Brazil: Case study on working time organization and its effects in the health services sector*, Sectoral Policies Department Working Paper No. 308 (Geneva, ILO, 2015).

[107] S. Kisting, A. Dalvie and P. Lewis: *South Africa: Case study on working time organization and its effects in the health services sector*, op. cit.

hours of work. [108] In the United Kingdom, a study found that 42 per cent of women doctors worked less than full time, particularly those with children, while having children had no direct effect on male doctors' work patterns. [109]

4.2. Safety and health for health workers

4.2.1. Brief overview

102. Workers in the health sector face a range of occupational risks associated with biological, chemical, physical, ergonomic and psychosocial hazards. In the EU, health workers had the fourth highest rate of work-related health problems among all sectors. The sector ranked highest with regard to exposure to biological and chemical hazards, work-related stress, violence and harassment. [110]

103. Of particular concern to health workers are sharps injuries as sources of infections of hepatitis B and C and HIV. In 2003, the WHO estimated that 3 million health workers were exposed annually to sharps injuries at work, and 37 per cent of all new Hepatitis B cases, 39 per cent of new Hepatitis C cases and around 5.5 per cent of new HIV cases among health workers were attributed to accidental exposure at work. [111] The wide range of occupational hazards in health work calls for particular attention to the protection of expecting mothers and the reproductive health of both female and male workers. While infection prevention and control with a view to patient safety is well considered in most health services, the aspect of OSH for health workers tends to be neglected. Research across all regions shows lack of attention to OSH concerns negatively influence the retention of health-care professionals.

104. The following sections illustrate specific OSH concerns in the sector and their impact on both health personnel and patients.

4.2.2. The case of the Ebola outbreak of 2014

105. During the Ebola crisis in West Africa, the infection and mortality rates among the national health and emergency workforces were exceedingly high, WHO reporting 881 confirmed or probable cases of Ebola-infected health workers as of October 2015 of whom 513 had died. [112] An August 2014 Public Services International (PSI) survey in Guinea, Liberia, Sierra Leone and neighbouring Nigeria revealed that the region's health workers faced the successive EVD outbreaks with virtually none of the equipment and supplies that were

[108] S. Kisting, A. Dalvie and P. Lewis: *South Africa: Case study on working time organization and its effects in the health services sector*, op. cit.

[109] S. Lachish, et al.: "Factors associated with less-than-full-time working in medical practice: Results of surveys of five cohorts of UK doctors, 10 years after graduation", in *Human Resources for Health* (2016, 14:62), available at: https://human-resources-health.biomedcentral.com/articles/10.1186/s12960-016-0162-3.

[110] European Agency for Safety and Health at Work: *Current and emerging issues in the healthcare sector, including home and community care*, op. cit.

[111] WHO: *WHO guideline on the use of safety-engineered syringes for intramuscular, intradermal and subcutaneous injections in healthcare settings* (Geneva, 2016).

[112] WHO: *Ebola situation report*, 21 Oct. 2015, available at: http://apps.who.int/ebola/current-situation/ebola-situation-report-21-october-2015.

required to: prevent transmission, apply universal precautions or protect themselves from EVD. Responses also revealed that health-care workers experienced weak administration of their services as well as an overall lack of resources. [113] Confirming these findings, WHO reported that health workers' risk of infection was between 21 and 32 times higher than that of the general population at the beginning of the outbreak due to the lack of personal protective equipment, supplies for hygiene, infection prevention and control, and OSH management. Once those measures were in place, the infection rate among health workers dropped significantly. [114] Health workers on the frontlines especially were put at undue risk of infection due to the lack of OSH measures and protective equipment. As a result of prevailing fear and rumours, health service workers experienced mistrust, stigma and discrimination during and after the outbreak and violent attacks against them occurred on various occasions.

4.2.3. Violence at work and in emergency and humanitarian settings

106. Violence, including harassment, ranging from verbal abuse to physical aggression, is inflicted on health workers by colleagues, the health facility hierarchy, patients and relatives of patients. Its prevalence is persistently high in the sector in both developed and developing countries. [115] In the United States, for instance, the rate of violence from patients against health workers is 16 times higher than from clients in other service professions, the risk being even higher where care is provided outside of institutional settings. [116] A 2007 study in Rwanda found that 39 per cent of health workers had experienced workplace violence in the preceding year. [117] Previous studies reported that high proportions of health workers surveyed had experienced physical or psychological violence, notably in Bulgaria (75.8 per cent), Australia (67.2 per cent), South Africa (61 per cent), Portugal (37 per cent to 60 per cent), Thailand (54 per cent) and Brazil (46.7 per cent). [118]

107. Health workers are increasingly under attack in emergencies and conflict situations. The International Committee of the Red Cross (ICRC) reported 655 violent incidents between 2008 and 2010 in health-care settings across 16 countries, resulting in the death of 68 health workers and injury to 98 health workers, as well as the death of, or injury to, hundreds of

[113] O. Frank: "Les travailleurs du secteur public de la santé au coeur de la crise Ebola" [Public sector health workers at the heart of the Ebola crisis], in *Travail Décent* (Vol. 1, No. 3, Dec. 2015), available at: http://www.world-psi.org/sites/default/files/documents/research/travail_decent-ebola.pdf.

[114] WHO: *Health worker Ebola infections in Guinea, Liberia and Sierra Leone: A preliminary report* (Geneva, 2015), available at: http://www.who.int/hrh/documents/21may2015_web_final.pdf.

[115] I. Needham et al. (eds): *Violence in the health sector – Proceedings of the Fourth International Conference on Violence in the Health Sector: Towards safety, security and wellbeing for all*, Miami, 22–24 Oct. 2014 (Amsterdam, Kavanah, Dwingeloo & Oud Consultancy, 2014).

[116] ILO: *Background paper for discussion at the Meeting of Experts on Violence against Women and Men in the World of Work*, Geneva, 3–6 Oct. 2016.

[117] C.J. Newman et al.: "Workplace violence and gender discrimination in Rwanda's health workforce: Increasing safety and gender equality", in *Human Resources for Health* (2011, 9:19, doi:10.1186/1478-4491-9-19).

[118] V. di Martino: *Workplace violence in the health sector – Country case studies: Brazil, Bulgaria, Lebanon, Portugal, South Africa, Thailand and an additional Australian study*, Synthesis report (Geneva, ILO, ICN, WHO, PSI, 2002).

patients. [119] Between 2012 and 2014, 87 health workers had been killed and 202 wounded in 11 countries. Health workers were also kidnapped, threatened, arrested, robbed, denied passage, subjected to sexual violence and to torture, forced disappearance or general harassment. [120] The deliberate targeting of health facilities has drawn attention as it is a violation of international human rights and humanitarian laws. [121]

4.2.4. Effects of staffing levels on health workers and patient safety

108. Staffing levels refer to the ratio of patients to health workers. Their relation to safety and health at work derives from worker workloads; the more patients a health worker has to care for the higher is the work intensity, which can result in an increased risk of accidents and work-related stress and consequently, injuries and ill health of health workers including fatigue and burnout. Ultimately, inadequate staffing levels also have implications for patient safety and quality of care in terms of higher morbidity and mortality, mediated by such factors as care left unprovided, failures-to-rescue, medication errors or wound infections. [122, 123, 124]. Staffing levels also impact job satisfaction and thus balancing the cost of staffing and job satisfaction is a major challenge for managers; however, reducing staffing to an inadequate level can lead to high staff turnover costs and lower quality of care.

109. In hospitals, it has been shown that more appropriate ratios of patients to health-care workers, or patient quotas, improve working conditions and health outcomes for patients. [125] The emerging term "safe staffing" refers to both patient safety and workforce well-being. In Australia, positive results have been reported with the introduction of nurse to patient ratios since 1998. The ratios differ between wards according to patient acuity levels. They are reviewed every three years through collective bargaining. Key features of the ratios include their transparency and effective dispute settlement procedures. [126] Research suggests that local organizational solutions to staffing and skills mix needs are the most efficient. Safe and effective deployment of different cadres in a team can free up clinical time, contributing to

[119] ICRC: *Health care in danger: A sixteen-country study* (Geneva, 2011).

[120] ICRC: *Health care in danger – Violent incidents affecting the delivery of health care: January 2012 to December 2014*, third interim report (Geneva, 2015).

[121] Office of the United Nations High Commissioner for Human Rights (OHCHR): *Attacks on medical units in international humanitarian and human rights law* (Geneva, Sep. 2016).

[122] L. Poghosyan et al.: "Nurse burnout and quality of care: Cross-national investigation in six countries", in *Research in Nursing and Health* (2010, Vol. 33), pp. 288–298.

[123] X.W. Zhu et al.: "Nurse staffing levels make a difference on patient outcomes: A multisite study in Chinese hospitals", in *Journal of Nursing Scholarship* (2012, Vol. 44(3)), pp. 266–273.

[124] L.H. Aiken et al.: "Nurse staffing and education and hospital mortality in nine European countries: A retrospective observational study", op. cit.

[125] L.H. Aiken et al.: "Patient safety, satisfaction, and quality of hospital care: Cross sectional surveys of nurses and patients in 12 countries in Europe and the United States", op. cit.

[126] Australian Nursing and Midwifery Federation (ANMF): *Improvements after the implementation of nurse to patient ratio*, presentation at the Nihon-Iroren International Symposium on Achieving the Improvement of Night Shift Work of Nursing Personnel, Tokyo, 6 Sep. 2016.

improved patient outcomes, increased client access to services and improved staff retention. [127]

4.2.5. Occupational safety and health protection

110. The effective protection against OSH risks for health workers depends on applying OSH standards at global, national and workplace levels which, in turn, requires strong political will and good governance involving all stakeholders.

111. A number of ILO instruments set out general principles for OSH (box 4.1). Others address this in specific sectors or concerning particular hazards. For nursing personnel, Convention No. 149 sets out that: "Each Member shall, if necessary, endeavour to improve existing laws and regulations on occupational health and safety by adapting them to the special nature of nursing work and of the environment in which it is carried out" (Article 7).

Box 4.1
International labour standards on OSH

- Occupational Safety and Health Convention, 1981 (No. 155)
- Occupational Health Services Convention, 1985 (No. 161)
- Promotional Framework for Occupational Safety and Health Convention, 2006 (No. 187)

112. International tools to address particular risks to which health workers are exposed include:

- *Joint WHO–ILO–UNAIDS policy guidelines on improving health workers' access to HIV and TB prevention, treatment, care and support services* (and *Guidance note*), 2010;
- *Joint ILO/WHO guidelines on health services and HIV/AIDS*, 2005; and
- Joint ILO/ICN/WHO/PSI *Framework guidelines for addressing workplace violence in the health sector*, 2002.

113. There is little comparative information on the application of general OSH laws and regulations in the health sector at national level. A recent study of six developing countries on OSH laws (Dominican Republic, Kenya, Mali, Namibia, Senegal and Uganda), highlighted shortcomings in their application, and identified a range of contributing factors, including lack of training, the need for revising and updating the laws, or the overall need for a higher budgetary priority to monitor and enforce their application. [128] The strengthening of labour inspection capacity is critical to workplace compliance with national standards.

[127] Health Workforce Australia: *Nursing workforce sustainability: Improving nurse retention and productivity* (Canberra, Commonwealth of Australia, 2014), available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/nursing-workforce-sustainability-improving-nurse-retention-and-productivity.

[128] A. Fitzgerald: *Occupational safety & health survey: Results from six country programs* (Chapel Hill, IntraHealth, 2014).

114. Guidelines on OSH management systems have been developed by the ILO according to internationally agreed principles defined by the ILO's tripartite constituents. [129] Although these guidelines are not health sector-specific, they provide guidance on establishing comprehensive OSH management systems for sustainable prevention and protection. Other tools include training guides on risk assessment and an auditing tool designed to help identify strengths and weaknesses in an organization's OSH management system, and opportunities for improvement. [130]

115. An example of social dialogue in developing OSH standards is the European Framework Agreement on prevention from sharp injuries in the hospital and healthcare sector, Directive 2010/32/EU of 10 May 2010 implementing the Framework Agreement concluded by the European Hospital and Healthcare Employers' Association (HOSPEEM) and the European Public Service Union (EPSU) in 2009. [131]

116. Education and training are also critical to enhancing the capacities of health workers and managers in addressing safety and health risks at work. The ILO–WHO "HealthWISE – Work Improvement in Health Services" is a practical, participatory quality-improvement tool for health facilities that encourages workers and managers to work together to improve workplaces and practices using local, low-cost solutions, combining learning with action while promoting social dialogue. It focuses on OSH topics, personnel management and environmental health. [132]

4.3. Social protection

117. Labour protection and social security are complementary, and together provide the protection that workers and their families need. [133] Health workers, like other workers, have the right to social protection. In addition to protecting safety and health, income security in a range of situations has importance in the health sector. In the event of unemployment, workers should be accorded income security sufficient to guarantee a decent standard of living and health for both themselves and their families. Due to the range of OSH hazards in the sector, provisions for adequate financial compensation for the loss of income and the cost of treatment in the case of work-related fatalities, injuries and diseases are important. Pregnant and nursing health workers require effective maternity protection, including protection against employment termination or loss of earnings during maternity leave, as well as access to quality maternal health care and services. In line with a number of

[129] ILO: *Guidelines on occupational safety and health management systems, ILO–OSH 2001*, second edition (Geneva, 2009).

[130] ILO: *OSH Management System: A tool for continual improvement* (Geneva, 2011); ILO: *Audit Matrix for the ILO guidelines on occupational safety and health management systems (ILO–OSH 2001)* (Geneva, 2013) available at: http://www.ilo.org/safework/areasofwork/occupational-safety-and-health-management-systems/lang--en/index.htm.

[131] Council Directive 2010/32/EU of 10 May 2010 implementing the Framework Agreement on prevention from sharp injuries in the hospital and healthcare sector concluded by HOSPEEM and EPSU, available at: https://osha.europa.eu/en/legislation/directives/council-directive-2010-32-eu-prevention-from-sharp-injuries-in-the-hospital-and-healthcare-sector.

[132] ILO/WHO: *HealthWISE Action Manual: Work improvement in health services* and *HealthWISE Trainers Guide: Work improvement in health services* (Geneva, 2014).

[133] ILO: *Resolution concerning the recurrent discussion on social protection (labour protection)*, International Labour Conference, 104th Session, Geneva, 2015.

international Conventions, health workers should also be accorded adequate social security benefits that ensure income maintenance and income security in old age.

118. For nursing personnel, Recommendation No. 157 provides that they should have access to social security protection at least equal to the protection afforded to other public service personnel or private sector workers taking account of the particular nature of their work. National laws or regulations should make compensation possible for any illness contracted by nursing personnel as a result of their work. This requires the recognition of occupational diseases relevant for health services work.

4.4. Impact of new technologies

119. Technological innovations are profoundly changing the way work is organized and carried out in the sector; the related global net job losses are projected to exceed 5 million by 2020. [134] The number of health professions is predicted to remain stable. [135] New health-care technologies are reshaping work organization and impacting tasks and skills requirements. Innovation and technology can help tackle such challenges as growing demand, and improve quality of care, enabling patients to be better informed and more involved in their own care. The use of social media, for example, has been found to enhance patient empowerment through improved access to information and social support, leading to better communication between patients and professionals, to greater quality in decision-making, and more patient-centred care. [136]

120. New technologies are also extending quality care to remote areas. In Rwanda, a project was launched to deliver essential medical products in remote, hard-to-reach areas through a robot aircraft (drone). [137] In Ghana, an initiative will recruit, train and deploy 20,000 CHWs and 500 E-Health technical assistants across the country in the next two years. The programme will ensure that CHWs are fully equipped and deployed with mobile phones to improve communications, data collection, community-based disease surveillance and monitoring, as well as to overcome geographical barriers. [138]

121. New technologies can, in addition, increase job satisfaction, free up staff time and reduce stress and medical errors by avoiding repetitive tasks easing physical efforts through improved ergonomics. Communication technologies create collaborative work environments, allow more inter-professional collaboration facilitating information exchange

[134] World Economic Forum (WEF): *The future of jobs: Employment, skills and workforce strategy for the fourth industrial revolution* (Geneva, 2016).

[135] United Nations Development Programme (UNDP): *Human Development Report 2015: Work for human development* (New York, 2015).

[136] E. Smailhodzic et al.: "Social media use in healthcare: A systematic review of effects on patients and on their relationship with healthcare professionals", in *BMC Health Services Research* (2016, 16:442), available at: https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-016-1691-0.

[137] Al Jazeera: *Rwanda turns to drones to deliver vital blood supplies*, News Agencies, 14 Oct. 2016, available at: http://www.aljazeera.com/news/2016/10/rwanda-turns-drones-deliver-vital-blood-supplies-161014095632407.html.

[138] One Million Community Health Workers Campaign: *Ghana to launch new CHW programme*, press conference in Accra, Ghana, in January 2016 announcing the CHW Programme, available at: http://1millionhealthworkers.org/2016/03/23/ghana-to-launch-new-chw-programme/.

and sharing of experiences through electronic medical records or mobile technologies or video consultations between medical teams in urban and rural areas. New technologies may affect jobs by reducing the number of staff needed to perform tasks, but also enable less skilled workers to take up new more simplified tasks, freeing up skilled staff for deployment elsewhere. [139]

122. New technologies also have positive impacts on transforming education, and training with e-learning showing itself at least as efficient as traditional learning methods helping to address shortages in educators and reach a wider audience. [140] Innovative methods, including web-based network learning or simulation exercises can improve inter-professional and team-based learning. The main barriers to e-learning include lack of infrastructure, inadequate technology, connectivity costs, poorly designed packages, or lack of computer skills. To address barriers, adequate funding, integration of e-learning into existing curricula, blended teaching, user-friendly packages, access to technology, support, and dedicated work time for e-learning have to be considered. [141] The standardization of curricula and their regulation are critical for the quality of e-learning.

123. The impact of high technologies on the workload of health workers varies according to the context, influenced by working conditions, forms of work organization, management models, institutional structures and values. [142] The introduction of new technology can be associated with occupational stress and job dissatisfaction, work overload, feelings of uncertainty in the face of new technology, lack of direction from supervisors and lack of influence on work management. [143] Health workers need adequate training to handle the new equipment with confidence to adapt to new work processes without stress. However, if the primary goal of the introduction of technology is cost reduction, workloads may increase.

124. When planning and introducing new technologies, the involvement of health workers in the decision-making process is crucial, as their specific workplace experience makes them better placed to assess the relevance of the new technology for patients and staff, and the kind of training they would need to facilitate their adoption. [144] Conversely, perceived dysfunctional technology can severely affect staff motivation and the uptake of the new technologies. Technologies should therefore be pilot-tested before being fully rolled out, and a support system should be available in order to facilitate the adoption and use. Finally, it is important

[139] The Evidence Centre for Skills for Health: *How do new technologies impact on workforce organisation? Rapid review of international evidence*, Report developed by The Evidence Centre for Skills for Health (Bristol, Skills for Health, undated).

[140] N. Al-Shorbaji et al. (eds): *E-Learning for undergraduate health professional education: A systematic review informing a radical transformation of health workforce development* (Geneva, WHO, 2015).

[141] The Evidence Centre for Skills for Health: *How do new technologies impact on workforce organisation? Rapid review of international evidence*, op. cit.

[142] D.E. Pires de Pires et al.: *New technologies and workloads of health care professionals* (Berlin, Digital Repository of Technische Universität Berlin, 2013).

[143] A. Yassi and B. Miller: "Technological change and the medical technologist: A stress survey of four biomedical laboratories in a large tertiary care hospital", in *Canadian Journal of Medical Technology* (1990).

[144] A.J. De Veer et al.: "Successful implementation of new technologies in nursing care: A questionnaire survey of nurse-users", in *BMC Medical Informatics and Decision Making* (2011, 11:67), available at: http://bmcmedinformdecismak.biomedcentral.com/articles/10.1186/1472-6947-11-67.

to consider the ethical, societal and cultural implications that technology may impose in health care, both for patients and the workforce.

5. Social dialogue and labour relations

5.1. Social dialogue

125. The 2002 Joint Meeting on Social Dialogue in the Health Services concluded that social dialogue contributes positively to the development and reforms of health services and is particularly important in times of structural change. Such dialogue, which in the health services can involve public authorities or private service operators as well as employers' and workers' organizations as social partners, can take various forms, from exchange of information, consultation and negotiation to collective bargaining, and include mechanisms and processes for dispute settlement. It operates at various levels, through national institutions or the workplace, and takes into account what is suitable for the context and issues concerned. In the health services, it is based on certain values and principles, including patients' needs, professional ethics, and affordable and universal access to health care. Effective social dialogue requires strong, representative and independent social partners who recognize each other's legitimate roles. Through dialogue, the tripartite or bipartite partners can advance on interests they have in common and reach compromises about matters on which their views differ.

126. The social dialogue agenda in the sector can range from institutional reforms, financing, quality of services, working conditions, skills and lifelong learning, staff recruitment and retention, career development, pay systems and gender issues. [145] National level social dialogue is considered key in the development and implementation of social protection floors that are critical in financing health systems. [146]

5.2. Labour relations

127. Voice and participation are critical for enabling health workers to take active roles in enhancing positive work environments and quality of health services. The freedom to express their concerns, to organize and participate freely in dialogue are guaranteed in the fundamental rights to freedom of association and the effective recognition of the right to collective bargaining. The conclusions of the 1998 Joint Meeting on Terms of Employment and Working Conditions in Health Sector Reforms state that: "In accordance with ILO Conventions Nos 87, 98 and 151, health workers have the same right to organize and to bargain collectively as workers in other sectors. Pay determination and working conditions should be subject to bargaining procedures between health workers and employers." [147]

[145] ILO: *Note on the proceedings*, Joint Meeting on Social Dialogue in the Health Services: Institutions, Capacity and Effectiveness (Geneva, 2003).

[146] ILO: Social Protection Floors Recommendation, 2012 (No. 202).

[147] ILO: *Note on the proceedings*, Joint Meeting on Terms of Employment and Working Conditions in Health Sector Reforms, op. cit., conclusions, para. 10.

Box 5.1
Key instruments on social dialogue, freedom of association and collective bargaining

- Freedom of Association and Protection of the Right to Organise Convention, 1948 (No. 87)
- Right to Organise and Collective Bargaining Convention, 1949 (No. 98)
- Labour Relations (Public Service) Convention, 1978 (No. 151)
- ILO Declaration on Fundamental Principles and Rights at Work and its Follow-up, 1998

128. The notion of participation of workers' and employers' organizations in health policy-making has already been formulated in Convention No. 149, which sets out that: " … a policy concerning nursing services and nursing personnel designed, within the framework of a general health programme, … , shall be formulated in consultation with the employers' and workers' organizations concerned ... " (Article 2) and specifies that "participation of nursing personnel in the planning of nursing services and consultation with such personnel on decisions concerning them" should be promoted and "the determination of conditions of employment and work shall preferably be made by negotiation between employers' and workers' organizations concerned." (Article 5).

129. Mutual gain bargaining, focusing on the common public interest of quality health services, can create an environment that also helps in dispute prevention and settlement. The 2014 Global Dialogue Forum on Challenges to Collective Bargaining in the Public Service also concluded that: "Collective bargaining should be carried out in a wider context of fostering and maintaining quality public services." [148]

130. Globally, health services are considered essential services and, as such, subject to restrictions on the right to strike in many countries. ILO supervisory bodies have considered at various occasions the questions on essential services and related industrial action. National legislation usually governs the maintenance of an emergency level of service, which allows for limited strike action in the health sector provided vital or minimum services are kept functional. In Norway, for example, there are no specific restrictions to the right to strike for health sector workers; however, strikes have often been stopped by compulsory arbitration on the grounds of danger to health and life. In Cyprus, the restriction concerning the right to strike in essential services, including hospitals, was abolished through a 2004 agreement between the social partners. [149] In a few countries, such as Liberia, public servants are denied the right to organize, according to PSI. [150] A number of cases considered by the ILO supervisory system concern anti-union discrimination and the application of essential services regulations in various countries. In 2007, the Supreme Court of Canada ruled that the Canadian Charter of Rights and Freedoms protected the collective bargaining process,

[148] ILO: *Points of consensus: The contribution of collective bargaining in addressing challenges facing the public service, including the impact of the economic and financial crisis*, Global Dialogue Forum on Challenges to Collective Bargaining in the Public Service, GDFPS/2014/9, available at: http://www.ilo.org/sector/Resources/recommendations-conclusions-of-sectoral-meetings/WCMS_250902/lang--en/index.htm.

[149] Eurofound: *Employment and industrial relations in the health care sector* (Dublin, 2011), available at: www.eurofound.europa.eu.

[150] PSI: *Safe workers save lives: PSI health priorities and trade union response to the Ebola virus disease* (Ferney-Voltaire, 2016), available at: www.world-psi.org.

and that the sections of the 2002 Health and Social Services Delivery Improvement Act (Bill No. 29) restricting the bargaining rights of health care workers, were unconstitutional. [151]

131. The European Sectoral Social Dialogue Committee for the Hospital and Healthcare Sector, whose social partners are the EPSU and the HOSPEEM, was established in 2006. They agree on joint work programmes and have adopted a range of joint documents, including: Guidelines and examples of good practice to address the challenges of an ageing workforce (2013); the Framework of actions on recruitment and retention (2010); Multi-sectoral guidelines to tackle third-party violence and harassment related to work (2010); Framework agreement on prevention from sharp injuries in the hospital and healthcare sector (2009); and a Code of conduct and follow-up on ethical cross-border recruitment and retention in the hospital sector (2008). [152]

132. In South Africa, the 2012 Public Sector Bargaining Council's (PSBC) resolution on the rearrangement of working time calls for reviews of working time schemes to provide a better provision of health care. [153]

133. In November 2015, the Brazilian Ministry of Health and the social partners signed a protocol for the National Negotiation Table for the National Health System *(Mesa Nacional de Negociação Permanente do SUS)* to establish a Decent Work Agenda for health workers in the National Health System *(Agenda Nacional do Trabalho Decente para Trabalhadores e Trabalhadoras do Sistema Único de Saúde (ANTD–SUS), Protocolo – No. 009/2015).* The Agenda aims to generate more and better jobs in the SUS; strengthen health workforce management; strengthen dialogue and negotiation of working conditions and labour relations in the SUS; and combat all forms of discrimination at work, with special attention to gender, race and ethnicity. [154]

[151] ILO Normlex: Freedom of association cases (2016), available at: www.ilo.org/normlex.

[152] All documents available from www.epsu.org and www.hospeem.eu.

[153] J. Messenger and P. Vidal: *The organization of working time and its effects in the health services sector: A comparative analysis of Brazil, South Africa and the Republic of Korea*, op. cit.

[154] Ministério da Saúde, Secretaria de Gestão do Trabalho e da Educação na Saúde Mesa Nacional de Negociação Permanente do SUS, available at: http://u.saude.gov.br/images/pdf/2015/dezembro/02/protocolo-mesa009.pdf.