



HEALTH WORKFORCE SHORTAGES AND INTERNATIONAL MOBILITY IN THE EU

An overview of three cross-cutting trends from the perspective of the WHO Code of practice and its implementation in the region

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EU Disclaimer

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Foreword

THE INITIATIVE 'HEALTH WORKERS FOR ALL AND ALL FOR HEALTH WORKERS': TOWARDS A SUSTAINABLE HEALTH WORKFORCE

'Health workers for all and all for health workers' (HW4All) is a civil society-led advocacy initiative involving organizations in Belgium, the UK, Italy, Germany, Poland, Romania, Spain and the Netherlands. Through advocacy and campaigning, it contributes from within Europe to the development of a sustainable health workforce worldwide. With the support of health workers and citizens, it calls upon politicians and policymakers in Europe to implement the WHO Code of Practice on the International Recruitment of Health Personnel (WHO Code).¹

As the WHO states, *"the Code aims to establish and promote voluntary principles and practices for the ethical international recruitment of health personnel and to facilitate the strengthening of health systems."* In this sense, it:

- establishes principles and represents a point of reference for a legal framework for the ethical international recruitment of health personnel;
- provides guidance on bilateral and international legal instruments; and
- promotes international discussion and cooperation regarding ethical international recruitment with a focus on strengthening health systems in developing countries against the threat of a 'brain drain' from those countries.

From the perspective of WHO Code implementation from within Europe – and as a complement to work carried out at national level by HW4All partners – this report presents a review of three cross-cutting issues relevant to WHO Code implementation at regional level:

- *HRH planning capacity across the EU*: Article 5.4 of the WHO Code recommends that all states should forecast and plan their own health personnel needs and strive to meet them without resorting to international recruitment. Chapter 1 of this report provides an overview of how the European Union is working to achieve this aim and of the tools currently available for this purpose.
- *Fiscal space for health workforces in the context of the economic crisis*: Chapter 2 questions the possibility for EU member states to "take effective measures to educate, retain and sustain a health workforce that is appropriate for the specific conditions of each country" (Art 5.4 of the WHO Code) in the context of the austerity measures currently being imposed on many national governments. Fiscal tightening brings with it the risk of restrictions on the capacity to train and retain personnel for future HRH needs, creating a potential for large-scale future problems and an increase in the global shortfall.
- *HRH mobility and trade in services*: by adopting the perspective of "health in all policies", Chapter 3 forges the link between the provisions of the WHO Code and the EU's approach to trade in services, which constitute two different approaches to the international mobility of health workers.

¹ For the full text of the Code, see http://www.who.int/hrh/migration/code/code_en.pdf

The analysis presented in the following chapters recognizes the fact that the European Union's mandate on health is limited to supporting, coordinating or supplementing national health policies, while member states remain responsible for the definition of their health policy and the organization and delivery of health services.² Equally, however, the EU and its member states have a legal obligation to make their policies coherent with development objectives.³

The recommendations at the end of each chapter therefore set out strategies for future action leading to a sustainable health workforce. This action is to be taken by HW4All partners and other stakeholders.

² See The Treaty of Lisbon, Article 6 of the Treaty on the Functioning of the European Union, http://europa.eu/lisbon_treaty/full_text/index_en.htm.

³ See The Treaty of Lisbon. The official term is 'Policy Coherence for Development'. See more at: <http://www.concordeurope.org/4-coherent-policies#sthash.YEexvA8X.dpuf>

Introduction

THE PRESENT SITUATION IN THE REGION by Giulia De Ponte, AMREF Italy

The demand for health care will increase dramatically as a result of Europe's ageing population. The number of people aged 65 and over is projected to almost double over the next fifty years, and this will happen together with an expected reduction in the availability of informal carers, as a result of changing family structures.⁴ The increasing number of elderly people with multiple chronic conditions will require not only new care delivery models but also changes in skill mixes and new ways of working for health professionals.

Most EU member states are currently facing critical workforce shortages, affecting certain health professions and medical specializations or geographic areas. These could be exacerbated in the future if no action is taken. The retirement of a large cohort of health professionals is drastically shrinking the EU's health care workforce and, by 2020, the annual percentage of European doctors entering retirement is expected to reach 3.2%.⁵ A similar situation applies to the nursing workforce as, based on data collected by some member states, the average age of nurses employed today is between 41-45.⁶

Young health professionals coming through the training system are still not sufficient in numbers to replace those who are leaving the profession. In Italy, 13,400 nurses were due to retire in 2010, while only 8500 nurses graduated in 2008-2009. Germany is facing serious difficulties in training a sufficient number of graduates, Slovakia has insufficient nurses, midwives, physiotherapists, radiology assistants and paramedics, and Hungary faces serious bottlenecks in supply caused by cutbacks in the training of nurses. Unfilled specialist training positions are reported in Romania, France, Hungary and Austria.⁷ The health labour market is not sufficiently attractive to members of the younger generations choosing their professions.

Evidence from some countries shows an increasing turnover in the health professions, due partly to low rates of pay, but also to non-financial factors such as unsatisfactory working conditions.⁸ The nursing workforce study Nurse Forecasting in Europe⁹, confirms that all twelve European countries studied face problems of nurse burnout and dissatisfaction. The issue of work-life balance, in particular, is all the more relevant in the health care sector, where the participation of women in the workforce has historically been significant and is increasing.¹⁰

⁴ European Commission, Commission Staff Working Document on an Action Plan for the EU Health Workforce, 2012, http://ec.europa.eu/dgs/health_consumer/docs/swd_ap_eu_healthcare_workforce_en.pdf

⁵ *ibidem*.

⁶ Based on data collected from 6 MS: DE, DK, IE, FR, SE, UK. (<http://www.euro.who.int/en/what-we-do/health-topics/Health-systems/health-workforce/facts-and-figures>, http://www.icn.ch/images/stories/documents/pillars/sew/DATASHEET_SUMMARY_NURSING_PROFILE_2011.pdf)

⁷ M. Wismar, C. B. Maier, I. A. Glinos, G. Dussault and J. Figueras (eds., 2011), Health professional mobility and health systems. Evidence from 17 European countries, Observatory Study Series No. 23, European Observatory on Health Systems and Policies, WHO Regional Office for Europe, Copenhagen. (http://www.euro.who.int/__data/assets/pdf_file/0017/152324/e95812.pdf)

⁸ For a more detailed analysis, see the Second Biennial Report on social services of general interest, 2011, <http://ec.europa.eu/social/main.jsp?catId=794&langId=en&pubId=5940&type=2&furtherPubs=yes>.

⁹ Nurse forecasting: Human resources planning in nursing, <http://www.rn4cast.eu/>

¹⁰ European Commission, 2012.

Moreover, although skill levels are relatively high and working conditions are often demanding, overall wage levels in the health and social services sectors tend to be lower than in other sectors of the economy across the continent,¹¹ a factor which is of course related to the gender pay gap.

The European Commission, in its Staff Working Document on an Action Plan for the EU Health Workforce, estimates that without further measures to meet these challenges, a potential shortfall of around 1 million health care workers will take place by 2020, rising up to 2 million if long-term care and ancillary professions are taken into account. This means that around 15% of total care will not be covered¹² compared to 2010.

Table 2: ESTIMATED SHORTAGE IN HEALTH CARE SECTOR BY 2020

Health Professionals or other health workers	Estimated shortage by 2020	Estimated percentage of care not covered
Physicians	230.000	13,5%
Dentists, pharmacists and physiotherapists	150.000	13,5%
Nurse	590.000	14,0%
Total	970.000	13,8%

Source: European Commission

Many member states also face the challenge of an unequal distribution of health professionals: the research project PROMeTHEUS¹³ provides evidence from 17 European countries, confirming that there is an undersupply of health professionals in rural areas, for example in Denmark, Finland, France, Germany, Romania, and an oversupply of doctors in some urban areas, particularly in Germany, and an oversupply of nurses in Belgium.

In terms of the international mobility of health professionals within the EU, the PROMeTHEUS study concludes that all 27 member states are experiencing migration of health professionals, with outflows rarely exceeding 3% of the domestic workforce. There are, however, significant differences in cross-border movements with a clear east-west asymmetry for doctors, nurses and dentists. In particular, although the overall EU enlargement in 2004 did not lead to massive outflows of health professionals from the newer member states to the EU15, the accession of Bulgaria and Romania to the EU in 2007 led to critical shortages in these countries due to out-migration, particularly among medical doctors.

¹¹ ibidem

¹² An Agenda for new skills and jobs: A European contribution towards full employment, COM (2010) 682 final.

¹³ M. Wismar, C. B. Maier, I. A. Glinos, G. Dussault and J. Figueras (eds., 2011), Health professional mobility and health systems. Evidence from 17 European countries, Observatory Study Series No. 23, European Observatory on Health Systems and Policies, WHO Regional Office for Europe, Copenhagen. (http://www.euro.who.int/__data/assets/pdf_file/0017/152324/e95812.pdf)

Health workforce shortages in some member states have also increased the reliance on the recruitment of health care professionals from outside the EU. National patterns of migration flows of doctors coming from outside the EU vary widely, with mobility especially prevalent from the major former colonial countries that are linguistically and historically connected to source countries. A survey of ten member states found that nearly 30% of all migrant doctors come from outside the EU in Austria, Belgium, Denmark, Germany, the Netherlands and Poland. This figure rises to 60% in France and Italy and to 80% in Ireland and the UK.¹⁴

Currently, recruitment of non-EU health professionals appears to be decreasing, however, due to both stricter implementation of EU legislation and the changing economic context: the EU may, in fact, be by-passed by third country nationals who not only face problems in entering the EU, but who also prefer the US or Canada. In particular, there may be an upsurge in active recruitment by the US in EU member states, which could in turn exacerbate existing shortages in the EU.¹⁵

¹⁴ Gilles Dussault, Inês Fronteira and Jorge Cabral (2009) Instituto de Higiene e Medicina Tropical, Lisbon, Migration of health personnel in the WHO European Region.

¹⁵ M. Wismar, C. B. Maier, I. A. Glinos, G. Dussault and J. Figueras (eds., 2011), Health professional mobility and health systems. Evidence from 17 European countries, Observatory Study Series No. 23, European Observatory on Health Systems and Policies, WHO Regional Office for Europe, Copenhagen. (http://www.euro.who.int/__data/assets/pdf_file/0017/152324/e95812.pdf)

CHAPTER 1

HEALTH WORKFORCE PLANNING CAPACITY ACROSS THE EUROPEAN UNION by Linda Mans, Wemos Foundation

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

Art. 5.4, WHO Code of Practice on International Recruitment of Health Personnel

One of the main purposes of health workforce planning is to respond to challenges in terms of balancing the demand for and the supply of human resources for health.¹⁶ Given the rigorous nature of current budget constraints, health systems are under strong pressure to pull off this balancing act in a cost-effective way, while also making fundamental reforms to the way in which they deliver health care. Innovative solutions are, however, always dependent on a high quality motivated health workforce of sufficient capacity and with the right skills to meet growing health care demands.¹⁷

European countries are facing similar challenges when it comes to the sustainability and affordability of their health systems. Many European countries still lack the tools to enable them to estimate present and future health workforce supply and demand. The limited availability of relevant indicators, the poor comparability of data at the national and international level and the scarce use of planning tools prevent many countries from developing adequate health workforce planning strategies and systems. While definite estimates of possible shortages of health professionals have been developed in only a handful of countries, it would nevertheless appear that, across Europe, the current supply and skills mix of human resources for health might not be adequate to meet future health needs. In addition, intensifying mobility flows (within countries and across countries) affect the structure and skills mix of the health workforce across Europe and need to be taken into consideration when ensuring the sustainability of the system. European enlargements, for example, have resulted in a substantial expansion of the pool of health professionals within the EU labour market and have increased economic diversity. Larger salary differentials and increased differences in infrastructures and in the use and availability of modern medical technology have further intensified health professional mobility.

¹⁶ In 2012 Matrix Insight and the Centre for Workforce Intelligence conducted a feasibility study on EU-level collaboration on forecasting health workforce needs, workforce planning and health workforce trends. The study is available at http://ec.europa.eu/health/workforce/docs/health_workforce_study_2012_report_en.pdf
This chapter is based on this study.

¹⁷ Commission Staff Working Document on an Action Plan for the EU Health Workforce. Strasbourg 18.04.2012

These challenges and trends have a clear European dimension, as they are widespread and shared across countries. European collaboration can help in addressing some of these common challenges, tackling interdependencies across countries. Recognizing the international dimension of the health workforce crisis and recognizing the key role of health workforce planning, the European Commission, together with other international institutions (e.g. WHO, OECD), has proposed policies and tools that aim to support national governments.¹⁸

While there are important interdependencies across countries, which should be addressed through broad and comprehensive action, it is also important to recognize the complexity of health workforce planning. Not only does it involve multiple areas at the national level (such as labour market, education, health), but it also encompasses multiple levels of governance (international, European, national, regional and local). Each of the separate dimensions of health workforce planning is present at different governance levels and can draw on multiple aspects, such as the education system, for instance. Moreover, the governance mechanisms can differ across professional occupations and entities. For this reason, cooperation should take place at multiple levels and encompass multiple areas.¹⁹ As a consequence, action needs to be cross-cutting, taking into account the development of human resources, education and training strategies, EU employment, social affairs, the internal market and cohesion policies. Policy initiatives should be aligned at the European and the national level (e.g. Social Agenda, Qualifications Directive, Working Time Directive, Roadmap for equality between women and men).

While it may be difficult to identify the perceived purpose of health workforce planning and evaluate the availability of technical and financial resources, it is possible to assess whether sufficient data are available in a country in order to carry out model-based health workforce planning. From a data availability perspective, it is possible to conclude that there is significant scope for more countries to engage in model-based health workforce planning than is currently the case, and for countries already engaging in such planning to extend the reach of their current models.

The extent to which the workforce planning process is institutionalized and integrated varies substantially across countries. With the exception of the Centre for Workforce Intelligence in the UK, there are few institutions in Europe dealing exclusively with health workforce planning. In most countries, the national Ministry of Health (or specific agencies therein) is responsible for health workforce planning. However, a range of institutions are usually involved in the planning process, including other public institutions such as Education and Finance Ministries, National Health Services, professional associations, health and social security insurers, and independent planning institutions.

¹⁸ Matrix Insight, p. 139

¹⁹ *ibidem*

Many countries lack a comprehensive health strategy and corresponding health workforce strategy, aimed at achieving predetermined health targets. Several factors explain the limited success of planning and implementation of health workforce strategies.

1. Lack of comprehensive national health strategies to clarify the long-term development of the health system. These include research allocation, system characteristics and workforce policies, which in turn can be influenced or informed by health workforce planning.
2. Low levels of stakeholder involvement. In many countries, workforce planning is not yet structured in an integrated manner, i.e. without the involvement of multiple stakeholders and multiple institutions, such as professional associations and education and training institutions.
3. Lack of strategic engagement of workforce planning institutions. In many countries, workforce planning is detached from decision making in the health system and in the education system.
4. No evaluation of workforce planning outcomes. In most settings, the outcomes of workforce planning and its impact on decision making at the national, regional or local level are not clear.

EU Joint Action on Health Workforce Planning and Forecasting

The European Union recognizes that collaboration can help countries face both the common challenges and the shortcomings of health workforce planning systems. European collaboration could help address what is sometimes referred to as the EU-wide health workforce crisis by providing support for national authorities, and by creating tools, methodologies, common definitions and indicators to carry out monitoring and analysis at the European level. The *Action Plan for the EU Health Workforce*, in particular, sets out actions to foster European cooperation and share good practices to improve health workforce planning and forecasting, to anticipate future skills needs, and to improve the recruitment and retention of health professionals, while mitigating the negative effects of migration on health systems.

In April 2013 the EU Joint Action on Health Workforce Planning and Forecasting (Joint Action) was launched within the framework of the Action Plan. It has established “a platform for cooperation between member states on forecasting health workforce needs and health workforce planning in close cooperation with Eurostat, OECD and WHO”. The Joint Action addresses a range of different topics, such as data for improved health workforce planning and the exchange of good practices in health workforce planning methodologies. The high outflow of health professionals has provoked policy debates on the impact on health care systems in some member states, reinforcing the need for accurate and comparable data on mobility and migration flows in the EU to develop policy responses based on evidence. The Joint Action has therefore included a discussion on the applicability of the WHO Global Code of Practice in the International Recruitment of Health Personnel in the EU context.²⁰

In January 2014 the Joint Action organized a conference where policymakers active in the field of health workforce planning could meet and participate in the development of a European platform for networking initiatives and sharing expertise. In this context, HW4All

²⁰ Partners of the ‘Health Workers for All and All for Health Workers’ are actively engaged in this discussion.

was invited to organize a workshop on the global mobility of health workers. One of the workshop's objectives was to link the debate on health workforce mobility and WHO Code implementation with the debate on austerity measures in Europe: the WHO Code of Practice, in fact, promotes the creation of self-sustainable production of health professionals in order to avoid a heavy reliance on foreign health workers, thereby avoiding a brain drain. Drastic health budget cuts in European countries, however, are currently pulling in the opposite direction, jeopardizing the long-term sustainability of the health workforce in these countries, where the ageing of the population poses long-term challenges. HW4All introduced this topic by mirroring the experiences of African countries that have had austerity measures imposed on them by the World Bank and the International Monetary Fund (IMF) for decades and by reflecting on the link between budget cuts, an increase in health workforce mobility and the prospect of brain drain.

Recommendations

Data collection to monitor stock and flows of human resources for health is urgently needed. This needs to be done under EU leadership, as health workforce issues are interconnected and extend beyond national borders. The Joint Action discusses possibilities and responsibilities regarding data collection and information sharing. EU-wide information and data collection mechanisms should focus on:

- Developing common key indicators and comparable definitions;
- Collecting, analysing and reporting clear data on stock, flows, internal flows and different types of mobility;
- Collecting, analysing and reporting information on education and training capacity;
- Facilitating data and information exchanges with countries outside the EU;
- Publishing and disseminating good practices on health workforce planning methodologies; and
- Analysing the effectiveness of specific workforce management strategies.

To rise above short-term policies on health workforce planning, longer-term strategic planning is needed:

- European member states as well as third countries should be encouraged to articulate policy targets for the self-sustainability of their health workforce. In this sense, countries that still rely on foreign-trained health workers should strictly implement principles of ethical recruitment as identified in the WHO Global Code of Practice.
- Member states should also apply appropriate strategies to integrate foreign-trained health workers. Such strategies could include (further) collaboration with organizations such as labour unions and representatives from migrant health workers to ensure that the rights of migrant health workers are equal to those of locally trained health workers. They could also include the development of an EU-wide portal, fed by national data collection institutions, to compare non-EU qualifications and to enable registrars to verify foreign qualifications.
- Member states should be encouraged to adapt education and training to the current and forthcoming needs of the health care labour market. For this reason, a strategic rethinking of the health systems and of education and training for human resources for health might be needed.

CHAPTER 2

FISCAL SPACE FOR HEALTH WORKFORCES IN THE CONTEXT OF THE ECONOMIC CRISIS by Giulia De Ponte, AMREF Italy

The current financial and economic crisis is having – and will continue to have – an impact on the way in which EU member states implement the WHO Code of Practice.

Since 2008, public debt in many European countries has reached levels perceived as unsustainable, fiscal deficit has become excessive and there has been a snowballing of debt, with a consequent rise in the risk premium on borrowing, principally in southern European countries.²¹ Although countries in Europe have responded to this situation in various ways, most of them have adopted austerity policies, including large-scale cuts and public sector reforms. These policies were imposed on countries in need of financial rescue packages (i.e. Greece, Ireland and Portugal²²) as a pre-condition by the so-called ‘troika’ (the European Commission, the International Monetary Fund, and the European Central Bank), but they have also been taken as a point of reference by other EU countries.

In the context of the austerity packages implemented in 2009–2011, public spending on health fell both in absolute terms and as a share of total government spending in many countries, in spite of efforts to protect the health budget.²³ At the same time, sweeping government spending cuts have also been made in the areas of community services, education and social protection,²⁴ while Official Development Assistance budgets decreased in 2011 by approximately 3% in OECD countries.²⁵

These developments are impacting directly on the relationship between health workforce mobility and investments in health workforce development, which are at the heart of the Code of Practice. Employee wages, salaries and allowances account for 42.3% of public 42.3% of public spending on health in the 18 countries of the WHO European Region for which data are available²⁶ and policy in many countries has therefore focused on cutting salaries.²⁷

²¹ WHO Regional Office for Europe, Report of the Oslo conference Health systems in times of global economic crisis: an update of the situation in the WHO European Region, 17-18 April, 2013, http://www.euro.who.int/__data/assets/pdf_file/0007/190456/Health-systems-in-times-of-global-economic-crisis,-an-update-of-the-situation-in-the-WHO-European-Region.pdf

²² Marina Karanikolos et al., “Financial crisis, austerity, and health in Europe”, *The Lancet*, 27 March 2013.

²³ WHO Regional Office for Europe, Health, health systems and economic crisis in Europe. Impact and policy implications. Summary, World Health Organization, 2013.

²⁴ WHO Regional Office for Europe, Report of the Oslo conference Health systems in times of global economic crisis: an update of the situation in the WHO European Region, 17-18 April, 2013, http://www.euro.who.int/__data/assets/pdf_file/0007/190456/Health-systems-in-times-of-global-economic-crisis,-an-update-of-the-situation-in-the-WHO-European-Region.pdf

²⁵ OECD (Organization for Economic Cooperation and Development) National Accounts online Database, 2012.

²⁶ Patricia Hernandez et al., Measuring expenditure for the health workforce: evidence and challenges, World Health Organization, 2006, http://www.who.int/hrh/documents/measuring_expenditure.pdf

²⁷ Mladovsky P, Srivastava D, Cylus J, et al., Policy summary 5. Health policy responses to the financial crisis in Europe, World Health Organization (on behalf of the European Observatory on Health Systems and Policies), 2012. http://www.euro.who.int/__data/assets/pdf_file/0009/170865/e96643.pdf

There are indications that some European countries did indeed reduce (e.g. Cyprus, Ireland, Lithuania, Portugal, Romania) or freeze (e.g. United Kingdom, Slovenia) the salaries of health professionals, or reduce the rate of salary increase (e.g. Denmark).²⁸ Greece faced particularly significant reductions in its health workforce.²⁹ Other approaches to lowering salaries included substantial increases in public sector pension contributions and reductions in benefits, leading to a de facto pay cut (United Kingdom); cutting overtime and night shifts, and lengthening shifts that involve fewer staff and costs (Iceland); and making workers accept lower wages in order to keep their contracts (privately contracted housekeeping and IT support staff in Serbia). In the Czech Republic, physicians managed to resist cuts to their salaries through negotiation or protest. Meanwhile, Albania, which was largely insulated from the crisis, and Belarus and Ukraine continued to increase health worker salaries.³⁰

To achieve short-term savings by lowering overhead costs, some countries also reported closing, merging, centralizing or cutting staff in non-provider organizations such as the health ministry, public health agencies and, less frequently, health insurance funds (Bulgaria, Croatia, Czech Republic, Denmark, Greece, Iceland, Kyrgyzstan, Latvia, Lithuania, Moldova, Portugal, Romania, Scotland, Serbia, Slovakia, Spain, Tajikistan, Ukraine, United Kingdom). In a few countries, quite radical changes were implemented.³¹

Wage imbalances between countries (depending on changes in wages in immigration countries compared to emigration countries) or within countries (if the private and public sector have different rates of pay) are therefore likely to change considerably and have the potential to increase health-worker brain drain.³² Initial indications are already flowing in, from Italy for example, which has gone from being a country of arrival for foreign trained nurses in the early 2000s, to a country of departure for both Italian nurses and doctors seeking jobs abroad.³³ Similarly, almost 1000 doctors, most of them specialists, leave Hungary every year to live and work in another European country.³⁴

A range of non-financial tools can be put in place by Ministries of Health to provide a limited degree of assistance in retaining health workers who are facing salary reductions and wage freezes. These tools include clear job descriptions, professional standards and codes of conduct, the proper matching of skills to the tasks in hand, supervision, information and communication, infrastructure including equipment and supplies, life-long learning, team management and team working, and responsibility with accountability.³⁵

²⁸ Marina Karanikolos et al., "Financial crisis, austerity, and health in Europe", *The Lancet*, 27 March 2013.

²⁹ These included a 25% reduction in doctors contracted by the central social security fund, and a 25% reduction in physicians' wages and fees by the end of 2012.

³⁰ Mladovsky P, Srivastava D, Cylus J, et al., Policy summary 5. Health policy responses to the financial crisis in Europe, World Health Organization (on behalf of the European Observatory on Health Systems and Policies), 2012. http://www.euro.who.int/__data/assets/pdf_file/0009/170865/e96643.pdf

³¹ WHO Regional Office for Europe, Health, health systems and economic crisis in Europe. Impact and policy implications. Summary, World Health Organization, 2013.

³² Marina Karanikolos et al., "Financial crisis, austerity, and health in Europe", *The Lancet*, 27 March 2013.

³³ Manuela Perrone, "Medici con la valigia: fuga dall'Italia. Raccontateci la vostra storia", *Il sole 24 ore*, 17 July 2013, http://www.sanita.ilssole24ore.com/art/lavoro-e-professione/2013-07-17/medici-italiani-valigia-fuga-180449_PRN.php

³⁴ <http://www.presseurop.eu/it/content/news-brief/4004541-nel-paese-restano-sempre-meno-medici>

³⁵ Mladovsky P, Srivastava D, Cylus J, et al., Policy summary 5. Health policy responses to the financial crisis in Europe, World Health Organization (on behalf of the European Observatory on Health Systems and Policies), 2012. http://www.euro.who.int/__data/assets/pdf_file/0009/170865/e96643.pdf

A broader range of strategies – in particular changing the skills mix and task shifting arrangements³⁶ to reduce the unit cost of labour – are also under consideration in many crisis-hit countries as an alternative or as a complement to salary cuts.³⁷

Due to the lack of evidence and analysis, however, it is difficult to assess the full range and effects of cost reduction strategies on health systems and health workforces imposed to date in response to the economic crisis.

Nevertheless, research carried out by the European Observatory on Health Systems and Policies has found that the pressure to achieve short-term savings was apparently greater than the desire to attain long-term equity and efficiency. “Despite the fact that the crisis offers the opportunity to address waste in the health system, to cut wisely, to invest carefully, and to engage in structural reform in countries where this is needed, the survey indicates that cuts had been made in many cases ‘across the board’: clearly, it was often easier to increase user charges than to streamline the benefits package, and to cut health workers’ salaries rather than service prices.”³⁸

This approach can be seen in cuts to health worker salaries: in countries such as Greece and Romania, where health worker salaries were already low, there is a genuine risk of further reductions impacting severely on the workers concerned, who may consider migration abroad, and on patients, who may end up paying informally to supplement low wages.³⁹

However, access to a sufficient and competent health workforce, and through it to vital services, is determined not only by the response to the crisis within the health system, but also by a country’s broader fiscal policy response, i.e. the extent to which it follows a path of austerity as opposed to a path of counter-cyclical spending.

Greece, Spain and Portugal – and Italy to a certain extent – adopted strict fiscal austerity; their economies continue to recede and the strain on their health care systems is growing, with cuts restricting access to health care. By contrast, Iceland rejected austerity through a popular vote, and the financial crisis seems to have had few or no discernible effects on health.⁴⁰

³⁶ This typically involved nurses and GPs taking on some of the work of specialists or nurses taking on some of the work of GPs.

³⁷ Mladovsky P, Srivastava D, Cylus J, et al., Policy summary 5. Health policy responses to the financial crisis in Europe, World Health Organization (on behalf of the European Observatory on Health Systems and Policies), 2012. http://www.euro.who.int/__data/assets/pdf_file/0009/170865/e96643.pdf

³⁸ WHO Regional Office for Europe, Report of the Oslo conference Health systems in times of global economic crisis: an update of the situation in the WHO European Region, 17-18 April, 2013, http://www.euro.who.int/__data/assets/pdf_file/0007/190456/Health-systems-in-times-of-global-economic-crisis,-an-update-of-the-situation-in-the-WHO-European-Region.pdf

³⁹ WHO Regional Office for Europe, Health, health systems and economic crisis in Europe. Impact and policy implications. Summary, World Health Organization, 2013.

⁴⁰ Marina Karanikolos et al., “Financial crisis, austerity, and health in Europe”, *The Lancet*, 27 March 2013.

The WHO affirms that countries, which implemented counter-cyclical fiscal policy tend to be in a stronger position to deal with the impact of the financial crisis.⁴¹ Research even indicates that investments in health can accelerate economic recovery.⁴² If fiscal balance has to be restored in the medium term, this does not necessarily require cuts in health and social spending during the crisis, when the need for these services rises and when the need for solidarity and equity may grow.⁴³

On the contrary, any fiscal policy should explicitly take account of the impact on health: for this reason it would be wise to make health ministers an accountable part of the negotiations on macroeconomic policies and even on austerity measures at the national as well as the continental level.

This is even more advisable if we consider that the likely scenario is one of increasing international scrutiny of health budgets and a risk of restriction of fiscal space for health: countries bailed out by the 'troika' in 2010 and 2011 are facing "the kind of detailed international involvement in their health systems that has more normally been seen only in developing countries".⁴⁴ In addition, the EU is moving towards a new treaty that will further reinforce European monitoring of national budgets,⁴⁵ together with a new package of legal rules that provides for financial sanctions on countries that do not keep their budget deficits below 3% of GDP and government debt below 60% of GDP.⁴⁶ This will affect not just countries seeking bailouts; nearly the whole European Union will be compelled to further reduce public expenditure, as only four countries currently meet those overall criteria.⁴⁷

Health and the health workforce will therefore inevitably become central to discussions about public expenditure, since health systems and workforces account for so much spending that they cannot be ignored. Across the EU, health is typically the largest area of government expenditure after social protection.⁴⁸

In addition, health is under particular pressure because it is the area of public expenditure that is seen as having the greatest potential for improved productivity: the wide variations that exist within and between European countries in terms of cost and outcomes of health systems suggest a scope for substantial efficiency gains. This is less the case with social protection issues such as pensions, for which entitlements are defined.⁴⁹

⁴¹ World Health Organization, Regional Committee for Europe, <http://www.euro.who.int/en/what-we-do/health-topics/Health-systems/health-systems-financing/activities/impact-of-the-financial-crisis-on-health-and-health-systems>

⁴² David Stuckler, Sanjay Basu, *The Body Economic. Why Austerity Kills*, Basic Books, 2013.

⁴³ WHO Regional Office for Europe, Report of the Oslo conference Health systems in times of global economic crisis: an update of the situation in the WHO European Region, 17-18 April, 2013, http://www.euro.who.int/__data/assets/pdf_file/0007/190456/Health-systems-in-times-of-global-economic-crisis,-an-update-of-the-situation-in-the-WHO-European-Region.pdf

⁴⁴ Fahy N. Who is shaping the future of European health systems?. *BMJ* 2012; 344: e1712. In Greece, for example, the 'troika' has capped public spending on health, demanding that it should not exceed 6% of GDP, setting a precedent of control by the European Union over national health systems in individual countries.

⁴⁵ European Council. Treaty on stability, coordination and governance in the economic and monetary union, 2012. http://european-council.europa.eu/media/639235/st00tscg26_en12.pdf.

⁴⁶ European Commission. EU economic governance "six-pack" enters into force. MEMO/11/898, 12 Dec 2011. <http://europa.eu/rapid/pressReleasesAction.do?reference=MEMO/11/898>

⁴⁷ Fahy N. Who is shaping the future of European health systems?. *BMJ*, 2012; 344: e1712.

⁴⁸ *ibidem*

⁴⁹ *ibidem*

Overall, therefore, the capacity for Europe and its individual member states to provide a sustainable health workforce in times of crisis is closely linked to the much more political issue of their capacity to claim fiscal space for health both in national and in regional negotiations, as a condition of advancement along the path of Universal Health Coverage.

Resources are, of course, limited and tough political choices on priorities therefore need to be made. The tools available to enlarge this fiscal space must also be sharpened: more progressive national taxation and the means to combat capital flight⁵⁰ and tax evasion (in Italy, for example, the problem of tax evasion is thought to equate to 17.4 % of the country's GDP), together with reduced defence budgets, can all free up considerable resources to fund health services across the continent and provide the resources to train and pay for sustainable health workforces. These same imbalances undermined the development of health systems and social services in low income countries: between 1970 and 2004 capital worth 600 billion US dollars was withdrawn from forty Sub-Saharan African countries, almost three times the level of public debt of the same countries.⁵¹ The discussion about fiscal space and social justice must therefore be integrated in the public discourse on the right to health, to a sustainable workforce, and the brain drain from the European continent and at a global level.

Recommendations

- Countries that have implemented counter-cyclical fiscal policy tend to be in a stronger position to deal with the impact of the financial crisis both from an economic and from a public health perspective. Austerity policies implying cuts in health and social spending during the crisis may therefore be counterproductive at a point when the need for these services rises and the need for solidarity and equity may grow.⁵²
- Any fiscal policy should explicitly take account of health impact. Health ministers should be made an accountable part of negotiations on macroeconomic policies and austerity measures. As such, they should acquire the authority to claim fiscal space for health both in national and in regional level negotiations.
- The crisis may offer the opportunity to engage in structural health system reform in countries where this is needed. However, cost-effective public health and primary health care services need always to be protected in the event of budget cuts.
- The discussion about fiscal space and social justice must be integrated in the public discourse on the right to health, to a sustainable workforce and on the brain drain from the European continent and at a global level.

⁵⁰ Tax havens are home to between 21 to 32 trillion US dollars, which are therefore subtracted to national taxation, see http://www.tax-justice.net/cms/upload/pdf/Price_of_Offshore_Revisited_120722.pdf

⁵¹ Tax Justice Network, Magnitudes: Dirty Money, Lost Taxes and offshore, 2012, http://www.taxjustice.net/cms/front_content.php?idcat=103

⁵² WHO Regional Office for Europe, Report of the Oslo conference Health systems in times of global economic crisis: an update of the situation in the WHO European Region, 17-18 April, 2013, http://www.euro.who.int/__data/assets/pdf_file/0007/190456/Health-systems-in-times-of-global-economic-crisis,-an-update-of-the-situation-in-the-WHO-European-Region.pdf

CHAPTER 3

IS THE HEALTH WORKFORCE A TRADABLE COMMODITY?

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There is a direct link between the international trading regime and the enjoyment of human rights. As the United Nations High Commission for Human Rights states, economic growth does not automatically lead to greater promotion and protection of human rights.⁵³ Speaking at the 2010 WTO Public Policy Forum, Ms Navanethem Pillay, the UN High Commissioner for Human Rights, stressed that “it is true that human rights are predicated on the equality of all human beings, while the imperative of comparative advantage in trade inevitably creates winners and losers. And it is true that human rights’ priorities lie in the protection and empowerment of the vulnerable and the marginalized, while success in trade rewards those who possess a competitive edge in navigating the global markets. Further, human rights law insists on State obligations, while the liberalization of trade may make the role of States progressively shrink.” Trade rules established within and outside the framework of the World Trade Organization (WTO) Agreement and the macroeconomic policies of international financial institutions do in fact have a particularly strong influence on shaping global society.

Health care deserves special attention in trade policies, not only because it is a basic human right and has an important role in development but also because it is prone to market failure.⁵⁴ In theory, markets produce the goods and services we want in the right quantities and at the lowest possible cost. This is why markets are so powerful. But in the real world markets do not always work in the way theory predicts. This requires a stringent set of conditions – perfect information, an abundance of buyers and sellers, a uniform product and freedom of entry and exit – all of which ensure that firms are price takers, producing for the lowest possible cost in the long run and only earning normal profits. If producers do not operate in this way and, in particular, if they have a significant power to influence price or the total quantity being produced, then the market will fail. Suppliers of health care often have this power. If reliable evidence confirms that a particular trade policy has a negative impact on the enjoyment of the right to health of those living in poverty or of other disadvantaged groups, then the State has an obligation under international human rights law to revise the relevant policy. It is thus imperative that, at the very least, trade and economic policies should do no harm to health.

When negotiating trade agreements, special attention must therefore be paid to their potential impact on health, particularly on population health, on the risks to health, on the resources available for health and on universal access to health services. All trade agreements should

⁵³ Statement by Ms Navanethem Pillay, United Nations High Commissioner for Human Rights to the WTO Public Policy Forum, “Doing it Differently: Reshaping the Global Economy”, Geneva, 16 September 2010.

⁵⁴ Ronald Labonté et al, Globalization and Health Equity: Innovation for an Interconnected World, 2007. Based upon: Towards Health-Equitable Globalization: Rights, Regulation and Redistribution. Final Report to the Commission on Social Determinants of Health. Available at: <http://www.globalhealthequity.ca/electronic%20library/Globalization%20and%20Health%20Equity%20Labonte%20GFHR%2011.pdf>

be subject to an assessment of health impacts, and should be publicly debated before signing. In this chapter, we intend to discuss some of the more contentious aspects of the debate on trade in services as it relates to the movements of health personnel.

Are services tradable?

'Trade in services' was included as an issue for multilateral trade negotiations in the Punta Del Este Ministerial Declaration, which launched the Uruguay Round Negotiations under the WTO umbrella in September 1986. These negotiations were preceded by a long and controversial debate on the tradability of services and hence on its relevance as a subject for multilateral trade negotiations. The General Agreement on Trade in Services (GATS), which came into force in 1995 between the members of the World Trade Organization, is the first agreement on principles and rules for trade in services. The GATS negotiations are therefore ongoing as a part of the Doha Development Round. In 2008, negotiations had once again been suspended and it was unclear if and when the outcome in this round would be reached. Following the release of results in the recent WTO ministerial conference in Bali in 2013, it is expected that negotiations will resume as soon as possible in Geneva. It is this prospect that has motivated us to take the trade in services at the centre of our analysis.

The international trade in services

International trade in services is defined by the Four Modes of Supply of the General Agreement on Trade in Services (GATS) negotiated within the framework of the WTO. If we follow the WHO's⁵⁵ suggestions in declining the commercial aspects of health services, we will find that:

- (Mode 1) Cross-border trade - is defined as health services provided from the territory of one member state in the territory of another member state. This usually takes place via interactive audio, visual and data communication. Typical examples include Internet consultation, diagnosis, treatment and medical education.
- (Mode 2) Consumption abroad - this mode covers supply of a service from one country to the service consumer of any other country. It usually covers incidents when patients seek treatment abroad or when people abroad find themselves in need of treatment. It can generate foreign exchange, but it can equally crowd out local patients and act as a drain on resources when their treatment is subsidized by the sending government.
- (Mode 3) Commercial presence – which covers health services supplied in one member state, through a commercial presence in the territory of another member state. This covers the opening up of the health sector to foreign companies, allowing them to invest in health operations, health management and health insurance.
- (Mode 4) Presence of natural persons – this is the temporary movement of a commercial provider of services (for example, a doctor or a nurse) from their own country to another country to provide his or her services under contract or as a member of staff transferred to a different country. This is one of the most contentious areas for health, as there is concern that it will increase the brain drain of health personnel from poor to rich countries. However, GATS is concerned only with health professionals working in other countries on a temporary basis.

⁵⁵ <http://www.who.int/trade/glossary/story033/en/>

The EU25 is by far the world's largest exporter and importer of services.⁵⁶ The share of services in cross-border trade has been increasing faster than the trade in goods. This trend has been driven by a number of factors, including technological change, commercialization and liberalization, and accelerated by the increased reliance on China and other low-wage countries to supply the need for manufactured goods. Tertiariation (development of the service sector) has given rise to a wide range of controversial issues, from job quality to the appropriateness of existing structures of social regulation, social insurance and also collective interest representation.

GATS guarantees foreign service providers access to markets under stable conditions; in theory, the countries will gain in terms of output and employment, growth in services and cheaper and better quality services, thereby generating positive welfare effects on the economy as a whole. On the other hand, critics – consisting of parts of the labour movement, civil society organizations, some academics and some national governments – emphasize the threats to national sovereignty and negative consequences for equity and social development. Critics also fear that the new rounds of services negotiations will force WTO members to open all services sectors to foreign competition, including public services. The threats from GATS are seen as particularly serious since GATS commitments are irreversible. GATS threatens to seriously undermine any public health care service that has not been privatized, based on the claim that the government should not offer subsidized services that the market also offers.⁵⁷ An opt-out alternative exists in theory, but developing countries, lacking market power and the resources to hire highly skilled negotiators and experts to defend their national interests in multilateral negotiations, are unlikely to be in a strong enough bargaining position to hold firm to such an alternative through successive rounds of negotiation.

Movement of natural persons

Under GATS, the fourth mode of service supply or 'presence of natural persons' does not apply to persons seeking access to the employment market in the host country, nor does it affect measures regarding citizenship, residence or employment on a permanent basis. The Agreement does not prevent a member from taking measures to regulate the entry of natural persons into, or their temporary stay in, its territory, including those measures necessary to protect the integrity of, and to ensure the orderly movement of natural persons across its borders. Mode 4 of GATS, in relation to the trade in health services, focuses particularly on the provision of health services by individuals from another country on a temporary basis. The possible impact of GATS on health care is controversial. In terms of migration, some countries may benefit from the fact that agreeing to send their health workers abroad will reduce unemployment at home, but GATS, like all WTO agreements, requires reciprocity. All countries have the opportunity to negotiate agreements, so this measure does not automatically translate into a unique advantage for the proposer. For example, other WTO members are entitled to ask the same country for equal access to health services for their own professionals, in effect cancelling out the impact of the original measure.

Early indications suggest that countries are more likely to enter into agreements for the modes that govern the supply of services and commercial presence (Modes 1–3), such as private hospitals and clinics and a range of other commercial health-related facilities, than they are to

⁵⁶ The EU25 accounts for 27% of global exports and 24.4% of imports, almost double the respective figures for the USA (14.7% and 12%). Japan and China follow at a considerable distance. Gintare Kemekliene and Andrew Watt, GATS and the EU: impacts on labour markets and regulatory capacity, European trade union institute, 2010.

⁵⁷ Missoni E. Understanding the impact of global trade liberalization on health systems pursuing universal health coverage. *Value Health*, 2013 Jan-Feb;16(1 Suppl):S14-8. doi: 10.1016/j.jval.2012.10.002. Epub 2012 Nov 16.

make commitments under Mode 4.⁵⁸ One other anticipated difficulty with GATS is that it does not define what is meant by 'temporary movement'. This might serve as an advantage to source countries by restricting the amount of time for which health workers can obtain a visa, thus favouring return and circular migration. However, GATS will reinforce the move towards the international harmonization of qualifications, which has already gained some momentum in nursing.⁵⁹ In recent years there has been a proliferation of educational courses that target international clients. This has led to concerns about quality and consistency, and has highlighted the need for international standards of education.⁶⁰

As the WTO admits, quantifying the impact of Mode 4 flows poses formidable challenges. No clear statistical framework is currently in place to assess the size of Mode 4 trade.⁶¹ We lack any comparable data on the number of workers crossing international borders to work under GATS as temporary service providers in EU countries and outside.

Another problem is posed by the asymmetry in bargaining powers between the various WTO members in the ongoing negotiations, and their capacity to impose their interests on others. For example, the EU has a 'defensive' interest in the inclusion of unskilled workers in Mode 4, and an 'offensive' interest in third countries opening up their markets for Mode 3 trade.

Developing countries, on the other hand, see scope for generating revenue by 'exporting' some of their lower-skilled workers under Mode 4 and, although keen to attract foreign investment, they are concerned about abandoning their own regulatory capacity with regard to opening up market access under Mode 3. The link between Mode 4 commitments and temporary permits is especially apparent in health and business services, and in transport services. For instance, estimates in the UK based on work permits granted to non-EU workers show that services imports in the form of non-EU temporary workforce movements amounted to nearly USD 2.5 billion, equivalent to 0.2 % of the UK's GDP.⁶² However, the reliability of this data as a measure of Mode 4 trade is undermined by the fact that it also includes temporary movements of workers under bilateral schemes, while self-employed temporary workers are not included in this category of work permits.⁶³

While the available statistics are not sufficient to draw firm conclusions, the existing data suggest that temporary labour migration is increasing. Labour mobility for skilled workers, often facilitated by special programmes, is also increasing and seems to be concentrated in the services sectors. A key point to be emphasized is that, to date, the GATS negotiations have not led to large-scale commitments by WTO member countries, including the EU member states, in terms of opening up their labour markets to workers under GATS Mode 4. None of the high-recipient countries for foreign-trained health workers (Canada, the US, the UK – as part of the EU – and Australia) have made commitments that would directly facilitate the movement of physicians, nurses or other health professionals.

⁵⁸ Nielson J. Movement of People and the WTO, 2002. Available from: <http://www.oecd.org/dataoecd/48/41/1960878.pdf>

⁵⁹ Stilwell, Barbara et al. Migration of health-care workers from developing countries: strategic approaches to its management. Bull World Health Organ, Geneva, 2004; vol. 82, no. 8, August. Available from <http://www.scielosp.org/scielo.php?script=sci_arttext&pid=S0042-96862004000800009&lng=en&nrm=iso>. Accessed on 7 January 2014. <http://dx.doi.org/10.1590/S0042-96862004000800009>

⁶⁰ Baumann, A., Blythe, J., "Globalization of Higher Education in Nursing" OJIN: The Online Journal of Issues in Nursing, 2008; Vol. 13 No. 2 Manuscript 4.

⁶¹ Secretariat, World Trade Organization. Health and social services: background note. Geneva: World Trade Organization, 1998.

⁶² Gintare Kemekliene, Magnitude and possible consequences of labour migration under GATS, ETUI-REHS, European Trade Union Institute, 2007.

⁶³ Gintare Kemekliene and Andrew Watt, GATS and the EU: impacts on labour markets and regulatory capacity, European trade union institute, 2010.

Going bilateral

The long-running lack of progress that has dogged the WTO negotiations has generated the diffuse perception that the multilateral system is not functioning effectively. Bilateral and/or regional cooperation is increasingly being seen by actors as a good substitute for the WTO. An increasing number of countries are pursuing or have signed bilateral or regional trade agreements that include service-sector supply commitments for all modes of services. These are structured as WTO+ agreements. Actual levels of liberalization that run deeper than GATS commitments are occurring through bilateral and regional agreements. To date, however, there are no trade agreements in place between the major players in the WTO – the EU, the US, Brazil, China, and India – but negotiations are ongoing for the creation of the two largest free trade areas ever established. On the one hand, negotiations have been taking place to form a Trans-Pacific Partnership (TPP) involving Australia, Brunei, Chile, Canada, Japan, Malaysia, Mexico, New Zealand, Peru, Singapore, the United States and Vietnam. On the other side of the world, the US and the EU are negotiating the Transatlantic Trade and Investment Partnership (TTIP), which will create a free trade area between the two biggest commercial players (and internal markets) on the planet. At present, most of the regional agreements in force are between industrialized countries – especially the US and EU countries – and developing economies. The most controversial mode of service supply – Mode 4 – has also been the subject of a number of bilateral agreements, for example agreements between the UK and South Africa and Ghana. Regarding the health workforce, a voluntary Code of Practice for international recruitment for NHS employers was launched in 2001 to mitigate the impacts of this liberalized service supply and the increased number of health workers migrating to the UK. The Code had only a limited effect, a major drawback being the fact that it excludes the private sector. Over half of Ghana's health workers have migrated. Using salary estimates, in 2004 the annual value of Ghanaian health workers to UK health service users was estimated at £39 million.⁶⁴ Many Ghanaian health workers are now remigrating due to improved working conditions in their homeland.

In general, countries seem to prefer to address Mode 4 movement of service suppliers on a country-by-country basis, rather than through the multilateral approach in GATS. To a great extent, this reflects a need to keep regulatory autonomy under control, to manage the movement of service providers and to withdraw commitments if and when necessary.

The EU, for instance, is liberalizing the movement of natural persons and trade in health services at a slower pace within the GATS regime than in its internal regulations or other non-WTO bilateral or regional trading agreements. It is worth noting that although the EU has undertaken ambitious commitments on opening hospital services up to the market in its 1993/94 GATS schedule, it has reduced the coverage of these commitments under its Economic Partnership Agreement with the CARIFORUM⁶⁵ to 'privately funded services', reflecting the sensitivity surrounding the commitment of publicly funded services in a trade agreement. Statements by the European Services Forum (ESF), which represents the interests of private sector services entities in the EU, similarly reflect the recognition of health and education services as special sectors where government plays an important role and acknowledge

⁶⁴ Health Poverty Action. Aid in reverse: The UK's responsibility to address the health workforce crisis. Healthworkers4all briefing. October 2013. Available from: <http://www.healthpovertyaction.org/wp-content/uploads/downloads/2013/11/Aid-in-Reverse-briefing-web.pdf>

⁶⁵ The Forum of the Caribbean Group of African, Caribbean and Pacific (ACP) States (CARIFORUM) is the body that comprises Caribbean ACP States for the purpose of promoting and coordinating policy dialogue, cooperation and regional integration, mainly within the framework of the Cotonou Agreement between the ACP and the European Union and also the CARIFORUM-European Community Economic Partnership Agreement (EPA).

that public health services must not be challenged by trade negotiations. According to the ESF, countries should be free to determine whether they wish to open up their health sector to foreign providers.⁶⁶

It is a fact that the newest generation of bilateral and plurilateral free trade agreements (FTAs) have little to do with tariffs. The core objective of those agreements is not to lower customs and tariffs, but to break down barriers to trade consisting of quality standards for services, national legislation and specific requirements that in fact hinder the free movement of commercial offers made by service providers capable of operating on a global or at least regional scale. With regard to the newly proposed plurilateral Trade In Services Agreement (TISA), negotiated in secret between a small group of WTO members, Public Services International (PSI)⁶⁷ is asking that it “should not expand the deregulatory requirements that already exist in GATS, but instead roll them back”.⁶⁸ The trend towards creating corporate rights that supersede the rights of citizens and nations, particularly those enforceable in private courts, is being called into question. The new generation of trade agreements effectively stops democratically elected governments from safeguarding environmental, labour and social standards that may inhibit the actions of corporations. These deals seek fewer protections for migrant workers, treating them like other commodities to be bought and sold through free markets.⁶⁹

Alarmingly, the negotiators involved in these agreements have not heeded the warnings of the financial crisis and are seeking to prohibit precisely the type of financial regulation that is required to ensure that capital markets never again cripple the economy. But, as PSI reminds us, workers are not commodities and should not have their movements regulated by trade agreements. Unlike goods and services, people require institutions to protect their human rights. Only the normative standard-setting process of the tripartite International Labour Organization is competent to regulate labour migration.

Recommendations

Sixty years ago, the international community agreed, within the framework of the Universal Declaration of Human Rights, that “everyone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized”.⁷⁰ Health is a basic human right, as is freedom of movement, and trade interests cannot be allowed to interfere with their promotion and protection. A rights-based approach to trade is a conceptual framework for the processes of trade reform; it must be affirmed and made more evident to all relevant stakeholders because it is normatively based on international human rights standards.

The trade in health services, and specifically the movement of health personnel, does not always operate as ideally as we might hope, yet it is not our intention to suggest that all trade activities in health should be prohibited. Nor do we think that we could or should restrict doctors and nurses from moving, as it would simply foster a black market, or encourage these professionals to move to other more lucrative occupations. However:

⁶⁶ Rupa Chanda, India-EU relations in health services: prospects and challenges *Globalization and Health* 2011, 7:1 <http://www.globalizationandhealth.com/content/7/1/1>

⁶⁷ PSI is a trade union federation of over 500 public sector unions in over 140 countries.

⁶⁸ Public Services International statement to the 9th WTO Ministerial Conference Bali, Indonesia, 3-6 December, 2013

⁶⁹ Cole Stangler, 30 December 2013. The Next Corporate-Friendly Trade Pact. In *These Times*. Retrieved 4 January 2014. Available from: http://inthesetimes.com/article/16044/ttp_the_next_corporate_friendly_trade_deal/
See also: http://action.sierraclub.org/site/DocServer/TTIP_Investment_Letter_Final.pdf

⁷⁰ Universal Human Rights Declaration, Art. 28

- 1) Measures still need to be taken to alleviate the adverse impact of the brain drain, and the adverse impact of commodification of the right to health driven by trade in services liberalization. Article XX (General Exceptions) of GATT 1994, still in force as the 'golden rule' for trade, recognizes that governments may need to apply and enforce measures for purposes such as the protection of public morals, the protection of human, animal or plant life and health, and the protection of national treasures.

GATT 1994 does not prevent governments from adopting and enforcing such measures. However, any measure adopted under the general exceptions provisions must not constitute a means of arbitrary or unjustifiable discrimination nor should it be a disguised restriction on international trade. Article XIV of GATS recognizes that members need to maintain a balance between trade measures and other legitimate policies and interests, such as the protection of the health of its citizens. This is a legal provision and one that needs to be emphasized and defended in the near future. In the long term, 'localization' is the key: all efforts should be localized into enhancing health system capacity. No health investment can be sustainable without concomitant improvements to the underlying health system.

- 2) Human rights law is neutral with regard to trade liberalization or trade protectionism. Instead, a human rights approach to trade focuses on processes and outcomes, on how trade affects the enjoyment of human rights. Such an approach places the promotion and protection of human rights among the objectives of trade reform. In 2004 Paul Hunt, the first UN Special Rapporteur on the right to health, wrote in his report on a mission to the WTO that "trade impacts on the right to health in numerous ways" and that "states have to ensure that the trade rules and policies they select are consistent with their legal obligations in relation to the right to health." Hunt explains that "international human rights law takes a position neither for nor against any particular trade rule or policy, subject to two conditions: first, the rule or policy in question must, in practice, actually enhance enjoyment of human rights, including for the disadvantaged and marginal; second, the process by which the rule or policy is formulated, implemented and monitored must be consistent with all human rights and democratic principles."⁷¹

⁷¹ Report on Mission to the World Trade Organization (E/CN.4/2004/49/Add.1) submitted to the Commission on Human Rights on 1 March 2004.

CONCLUSIONS

In the context of health personnel shortages and maldistribution, it is interesting to note that the European Union adopts a perspective on health workforce development which originates from considerations based on the employment potential of the health sector.

The Action Plan for the EU Health Workforce is in fact an annex to the Commission's Communication Towards a job-rich recovery, which sets out a range of measures to encourage employment within the Europe 2020 framework for smart, sustainable and inclusive growth. Health care is identified in the *Action Plan* as a highly labour-intensive sector and one of the largest sectors in the EU.⁷² As such, health workforce development is rightfully given a prominent focus in EU policies, both in terms of shortages and of the skills needed.

The perspective on health workforce development for the region, however, appears to be less well-defined if read from the point of view of policy coherence, as it needs to be viewed within the context of the restriction of public health spending in the region⁷³ due to the austerity measures promoted by the Commission itself. From this angle, the development of self-sustainable health workforces would appear to be less achievable, as public health systems may not have the resources needed to employ them. Rather, the resulting scenario appears to be one of the development of workforces for the benefit of a growing private health sector in many EU member states.

Shifting our focus within health workforce development from shortages to international mobility, we once again find that policy coherence and public health considerations take second place to market development approaches. Free mobility of workers and services within the EU internal market is an economic imperative and a civil right enshrined in the Lisbon Treaty,⁷⁴ supported by a wealth of secondary legislation.⁷⁵ The EU arena can therefore increasingly be seen as a single market for health workers.⁷⁶ It should also be seen as a protected market, given that Directive 2005/36/EC on Recognition of Professional Qualifications gives health workers from the European Economic Area (EEA) easier access to employment than their non-EEA counterparts.

As formal EU documentation suggests, this approach is based on the assumption that the EU internal market functions as a mechanism to distribute health workers to where they are most needed. The evidence points to a different conclusion, however, showing that the free movement of health workers leads them to seek better opportunities abroad, creating a conflict in which personal and professional ethics sometimes collide.⁷⁷ As such, it may be counterproductive in terms of improving the distribution of health workers across areas and countries.

⁷² Despite the economic downturn, the sector will produce an estimated 8 million job openings between 2010-2020. Action Plan for the EU Health Workforce.

⁷³ WHO Regional Office for Europe, Health, health systems and economic crisis in Europe. Impact and policy implications. Summary, World Health Organization, 2013.

⁷⁴ Title IV, Chapters 1 and 3, <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2008:115:0001:0012:EN:PDF>

⁷⁵ Freedom of movement applies to the European Economic Area (EEA), which includes the EU28 member states and Iceland, Liechtenstein and Norway.

⁷⁶ Gilles Dussault, James Buchan et al. The economic crisis in the EU: impact on health workforce mobility, PROMeTHEUS study 2014, forthcoming.

⁷⁷ Frits Tjadens, Weilandt Caren, Eckert Josef, Mobility of Health Professionals, Springer, 2012.

It is important to remember, however, that the risk of international competition to attract health personnel occurring at the expense of weaker health systems exists not only within the EEA zone, but also beyond. EU policies, again, indicate an interest in competing to the full in order to attract health workers at a global level, for example through the Blue Card Directive.⁷⁸ This scheme provides preferential access to employment for highly qualified migrant workers, including doctors, nurses, midwives and other technical health professionals, trained in non-European countries. It is worth noting that, while being implemented in the national legislation of member states, this tool is in some cases losing its original frame of reference: the need to avoid a brain drain from countries of origin facing a critical shortage of health workers.

Lastly, in the name of competition, negotiations for a free trade area between the US and the EU (TTIP) may expose Europe not only to the lowering of tariffs, but also to the lowering of non-tariff rules and standards for trade in health services and for health service delivery, unless the non-tradability of the latter is acknowledged.

Overall, in the context of austerity policies which tend to increase health professional migrations in the region⁷⁹ and widen health inequalities⁸⁰, the EU is adopting a competitive approach to the international mobility of health workers which further rewards more attractive health systems and empties resources from the less attractive, both within Europe and beyond its borders. This approach is in conflict with the principles of the EU's own Health Strategy and with the Health Programme 2014-2020, which assigns an important role to the reduction of inequalities in the region; it is equally in conflict with the role that the EU intends to play in global health⁸¹ in terms of ensuring that migration policies do not undermine the availability of health professionals in third countries.

The WHO Code is therefore to be seen as a tool that can serve as a guide in solving this incoherence, as it brings a public health perspective back into the debate on the mobility of health workers, by looking at the impact of international mobility and of brain drain on health systems of origin. By pointing to solutions such as self-sustainability in health workforce planning, migration management, incentives capable of orienting this mobility, and international cooperation at global level, the Code is a valid tool for tackling brain drain challenges both within and outside the region.

If Europe does not have the option of restricting the free movement of skilled health professionals, how can it support health systems of origin that are losing mobile health professionals? Which cross-border policy instruments are available to enable Europe to control and to manage health professional mobility?

⁷⁸ Available at: http://europa.eu/legislation_summaries/internal_market/living_and_working_in_the_internal_market/l14573_en.htm

⁷⁹ Gilles Dussault, *ibid.*

⁸⁰ David Stuckler, Sanjay Basu, *The Body Economic. Why Austerity Kills*, Basic Books, 2013.

⁸¹ European Commission, *The EU Role in Global Health*, available at http://ec.europa.eu/development/icenter/repository/COMM_PDF_COM_2010_0128_EN.PDF

Initial discussions indicate that a range of policy tools is available, including twinning, staff exchanges, education support, compensation or training for international recruitment.⁸² Taking a wider perspective, however, the EU must look at its cohesion policy, which shapes the programming and deployment of structural funds, with a view to increasing support for the development and the equitable internal distribution of a well-educated and skilled health workforce.

Given that planning for the self-sustainability of domestic health workforces is a key response to the challenge of health worker mobility, and given that this requires important investments in member states' health systems, the EU should also revisit its austerity-driven approach to the current economic crisis, by allowing more fiscal space for health system development especially in member states which are losing trained health workers to other countries. This should be done not only from the perspective of economic recovery from the crisis, but also with a view to increasing health equity and achieving greater regional cohesion.

Finally, the EU should review its development aid policy, with particular regard to countries of origin of health personnel. In this case, aid may take the form of compensation – although not presented as such – for the sending countries' loss of investment, in the context of wider agreements. The EU should therefore reverse the current trend of aid stagnation or reduction in the majority of EU27 countries.⁸³ At the same time, it should ensure that 50% of new funding for health is directed towards strengthening the health system, with 25% impacting directly on the training and retention of the health workforce, as recommended by the WHO, channelling funds through national health plans and related health workforce strategies.

If such a policy coherence approach is adopted, the EU will then have sufficient policy instruments (including regulations, directives, and decisions) to allow it to respond to health professional mobility issues and to implement the WHO Code in a way that goes beyond the voluntary nature of its provisions.⁸⁴

⁸² Buchan J (2008) "Health Systems and Policy Analysis: How can the migration of health service professionals be managed so as to reduce any negative effects on supply?", WHO European Ministries Conference on Health Systems, 25–27 June 2008. Available at: http://www.intl-nursemigration.org/assets/pdfs/7_hsc08_epb_10.pdf

⁸³ See more at: <http://www.concordeurope.org/276-aidwatch-2013-press-release>

⁸⁴ M. Wismar, C. B. Maier, I. A. Glinos, G. Dussault and J. Figueras (eds., 2011), Health professional mobility and health systems. Evidence from 17 European countries, Observatory Study Series No. 23, European Observatory on Health Systems and Policies, WHO Regional Office for Europe, Copenhagen. (http://www.euro.who.int/__data/assets/pdf_file/0017/152324/e95812.pdf)