Basel / Attleboro / Amsterdam, 17 November 2014

# How to address health workers migration in the "Global Strategy on Human Resources for Health?"

Since early 2014, the Global Health Workforce Alliance (GHWA) has been coordinating a broad-based global consultation, through the development of 8 thematic papers, to collate evidence in support of a next global strategy on HRH[1]: "GHWA will utilize these papers to provide recommendations to WHO, as a foundation for the development of the global strategy. WHO will use the recommendations from GHWA to inform the deliberations by its Member States."

In a public consultation GHWA is currently inviting feedback on the 8 thematic papers "to ensure that the views and contributions of all interested stakeholders are considered in the development of the global strategy on HRH".

In view of the lack of a paper focusing on health workers migration, Medicus Mundi International – Network Health for All (MMI), the Health Workforce Advocacy Initiative (HWAI) and the European Project "Health Workers for all and all for health workers" (HW4All) herewith submit a joint feedback on the draft working group paper 1 on "Economic, Demographic, and Epidemiological Transitions and the Future of Health Labour Markets" which has at least a proper chapter on "Health Workforce Migration".

## The working group paper "Economic, Demographic, and Epidemiological Transitions and the Future of Health Labour Markets"

This working group paper[2] was drafted by a team chaired by the World Bank and including mainly World Bank staff and representatives of academic institutions. The paper intends to "summarize the analysis of available data and studies on health sector employment, taking into consideration the macroeconomic, demographic and epidemiological factors, and the greater mobility of health workforce in a globalizing labor market."

The paper, a synthesis of three not yet published background studies, "highlights the trends in health sector employment from a broader labour market perspective, and is intended to stimulate debate and further research on the underlying factors and policies that influence the health workforce, and to contribute to the broader global HRH strategy to help countries achieve a more equitable and sustainable health system." (p. 2)

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[1] WHO/GHWA website and information flyer on the development of a Global HRH Strategy: http://www.who.int/workforcealliance/media/news/2014/consultation_globstrat_hrh/en

[2] Economic, Demographic, and Epidemiological Transitions and the Future of Health Labor Markets. Draft GHWA Working Group Paper, September 28, 2014 http://www.who.int/workforcealliance/media/news/2014/WG1_SynthesisSept282014.pdf?ua=1

In the introduction, health workers migration is positioned as follows: "Health workers – like all workers – are sensitive to differences in remuneration, working conditions and career prospects. Substantive disparities in these factors both within and across countries create powerful market forces for migration, both within and outside of national borders, often with negative impact on the availability of health services for the under-served communities. Understanding the underlying market forces, and developing greater awareness and competency in managing health workforce labor markets and devising effective policies, will be an essential feature of an effective UHC strategy." (p. 2f.)

Otherwise, regarding migration, the document refers to a "forthcoming" review of the trends and impact of globalization and mobility of health workers on national policies on health workforce (Buchan). It is unfortunate that this key reference for the working group paper is not yet available.

## Migration out of radar?

***We are worried by the fact that migration of health personnel has disappeared from the top level of the HRH strategy development and must be "searched for" in the current working group papers.***

This might be the result of an assessment that migration is just a side-effect (symptom) of labor market dynamics and as such not an issue / problem that needs particular attention. This is wrong. Health workforce migration intersects between migration, health, development cooperation, fiscal and employment policies and must be addressed in a consistent manner.

***We are concerned by the mainly 'instrumentalist', rational economic lens on health workforce as a (free) labour market that needs to / can be better "managed" in order to achieve better results and more cost-effective policies.***

This is obviously due to the fact that the document is produced by a World Bank and health economists' team. We desperately miss a public health, human rights, health equity and health workers perspective.

***We are worried by the lack of references to key concerns regarding migration and international recruitment of health personnel that were expressed in previous WHO documents.***

Quoting the WHO Code of Practice on the International Recruitment of Health Personnel, we refer to:

- the responsibility of governments for the health of their people, which can be fulfilled only by the provision of adequate health and social measures;
- the need to mitigate the negative effects and maximize the positive effects of migration on the health systems of source countries;
- the need to conduct international recruitment of health personnel in accordance with the principles of transparency and fairness and the promotion of sustainability of health systems;
- the need to promote international cooperation and coordination on international recruitment of health personnel;
- the need to promote and respect fair labour practices for all health personnel and to avoid unlawful distinction of any kind in all aspects of the employment and treatment of migrant health personnel.

## Leave it all up to the market?

***Investing in a well-trained health workforce is absolutely vital to ensure the future sustainability of health systems, and we agree that a political-economy lens to health workforce development is crucial, both at national and international levels. But what would this imply? Can the "labour market" simply be "managed"?***

- We think that a (labour) market approach to health systems development requires a social contract framework in which governments acknowledge that their citizens have basic rights regarding social protection. One of the elements of this social protection mechanism is that citizens have a basic right to education and essential health care. The latter implies that there should be an essential number of skilled health professionals available, and that there is just distribution for both privileged and underprivileged parts of the population.

- We think that the capacity for individual states to provide a sustainable health workforce (especially in times of crisis) is closely linked to the much more political issue of their capacity to claim and define fiscal space for health both in national and in regional negotiations, as a condition of advancement along the path of Universal Health Coverage.

- We think that there is still a need and role for international solidarity: The funding balance of development aid needs to be adjusted to concentrate more on building general health systems in poor countries so they can withstand health crises like Ebola.

- Finally we think that there is a need for supranational regulation to have countries agree and implement the health obligations they have (regarding one another).

## The chapter on Health Workers Migration in the Working Paper

***Having stated these concerns, we admit that we agree with part of the content of the chapter dedicated to health workers migration (p.7-10), mainly with the following:***

- the need for better data;

- the assessment that "a narrow focus only on international flows, but ignoring flows within the national labour market, risks missing the complete picture, may overstate the significance of international migration, and may lead to policy misalignment";

- the need to include broader set of actors in the analysis, including employers, education and regulation authorities, recruitment agencies, professional associations, and government agencies in immigration and employment" (add unions and organizations of migrant and informal health workers!);

- the assessment that a narrow focus on health professionals, mainly doctors and nurses, runs the risk of missing important aspects of the impact of health workforce migration (add informal health workers and care givers to your list!);

- the need to deepen the analysis of the influence of demographic change and regional free markets for health workforce on migration patterns;

- the need to "continue the business" of the WHO Code of Practice in a renewed effort at examining its application in a broader policy context, in order to enhance its recognition and uptake as an instrument for setting broad based principles and practices.

## The value of health workers beyond economic figures

After these reflections focusing on the migration issue, we conclude with some remarks on the intrinsic value of health workers as a professional and dignified workforce at the core of providing comprehensive health services, and on the related obligations of states. Again, we miss such deeper considerations – on the right to health, on health and equity, on policy coherence – in this working group paper.

Health workers are (or could be) part of a societal cement in which social care and responsibilities, participation and action for an improved wellbeing are at the core of its functioning. Health workers could be actors of change that not only cure, care and prevent disease, but facilitate people with illnesses to participate, and fellow citizens to engage in health promotion programs that move beyond the health sector per se. There are numerous examples of health workers being core to (community) health programs, education and promotion.

***This is not so much 'demanded' for from a labour market analysis, but the professional ethics and dimension of this professional, autonomous group of workers should be stimulated rather than being reduced to a narrow cost-effective analysis.***

(Inter)national examples on policies, political and fiscal space to develop such a "transformative" workforce should be mapped and encouraged.

From this intrinsic value, we can also deduct the rights of health workers themselves (regarding fair remuneration, social protection etc.) as well as the core obligations by states to fulfil the right to health of its citizens, to "ensure minimum essential level of primary health care" and "to provide appropriate training for health personnel, including education on health and human rights"[3].

Therefore, the Covenant on Economic, Social and Cultural Rights, ratified by 162 UN member states, obliges all states "to take steps, individually and through international assistance and cooperation, especially economic and technical, towards the full realization" of the right to health.

***The Covenant and its legal implications are completely neglected in the working group paper. It would merit the working group to analyse this human rights framework and see how it matches the macro-economic and demographic projections.***

This could be the start of a much-needed debate about the essential level of health workforce that 'people' are entitled to, and about what should be done from domestic and national perspective to reach this core capacity. It is the light of the current Ebola outbreak that we raise this fundamental, normative question. It is not only from a rights perspective, but also from a security and protection perspective that the following was noted:

"The 2006 World Health Report identified 57 countries where shortages are so dire that they are very unlikely in the near future to be able to provide high coverage of essential interventions. These shortages are equivalent to a global deficit of 2.4 million doctors, nurses and midwives. These 57 countries, most of them in sub-Saharan Africa and South-East Asia, are struggling to provide even basic health security to their populations. How, then, can they be expected to become a part of an unbroken line of defence, employing the most up-to-date technologies, upon which global public health security depends?" [4]

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[3] Committee on Economic, Social and Cultural Rights. General Comment 14, The right to the highest attainable standard of health (Twenty-second session, 2000). U.N. Doc. E/C.12/2000/4 (2000). http://www1.umn.edu/humanrts/gencomm/escgencom14.htm

[4] The world health report 2007: A safer future: global public health security in the 21st century. Geneva: World Health Organization, 2007. http://www.who.int/whr/2007/whr07_en.pdf

The World Health Report 2007 stated that the development and capacity of health workforce is key to the provision of the International Health Regulations. Would the international community have taken the IHR seriously, we could have, perhaps, prevented the Ebola outbreak in West Africa.[5]

***The health labour market dynamics alone cannot solve these international governance and regulation requirements regarding both the right to health and the international commitment to protect outbreaks of emerging infectious diseases. We strongly recommend WHO/GHWA to include this analysis and related recommendations in its global strategy for HRH 2030.***

The health equity lens is another element not sufficiently elaborated in this working paper.

The paper mentions on page 8 that "a growth in mobility of health workers within the EU free market has taken place". It however does not mention other key factors of professional mobility in a "changing Europe". We refer to a recent report by the European Observatory on Health Systems Policies:

"With disparities in the EU on the rise, ethical and policy questions emerge on what are the responsibilities of both source and destination countries in planning, training and retaining health workforces. Crisis-hit, resource-strained countries will have less policy capacity to act, and less means to invest, but there is mounting evidence to show that cutting the means allocated to the health system and its workforce is short-sighted and can have dramatic unwanted effects. (...) There is good reason to believe that the economic crisis and the austerity measures imposed are leading to widening disparities in Europe (…). As the gap between wealthier and poorer EU Member States is widening, a new map of Europe and of its mobility flows may be emerging based on the relative strength of countries' economies and their ability to train, attract and retain health professionals. For the EU as a political entity, built to foster prosperity and reduce asymmetries between its members, a changing map raises new ethical and policy questions in terms of the relationship between Member States and whether there is, or should be, any scope for intra-EU solidarity." [6]

***The Global HRH strategy should adopt likewise a similar global solidarity scope when it comes to imbalances at a global level. There is no moral argument why an intra-EU solidarity should be adopted, and not to apply it a global level.***

Then there is still the aspect of Policy Coherence for Development and the debate around free trade agreements and their effects on the mobility of the workforce.

On the Trade in Services Agreement (TISA), currently prepared by a selected group of countries, Public Services International makes the following statement:

"This agreement will treat migrant workers as commodities and limit the ability of governments to ensure their rights. Labour standards should be set by the tripartite International Labour Organization (ILO) and not be covered by trade agreements. (...) The TISA will prevent governments from returning public services to public hands when privatisations fail, restrict domestic regulations on worker safety, limit regulatory authority in areas such as licensing of health care facilities. (...) If the political will existed, it would be a reasonably straightforward matter for trade and investment treaties to exclude those services which a party considers to be provided within the exercise of its governmental authority. Such a provision, and the universal public services it could facilitate, would

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[5] Horton R. Offline: 2015—the year to rebuild WHO. The Lancet 2014, 384(9952): 1412

[6] Health professional mobility in a changing Europe. New dynamics, mobile individuals and diverse responses. Edited by James Buchan, Matthias Wismar, Irene A. Glinos and Jeni Bremner. Observatory Studies Series No 32. European Observatory on Health Systems Policies. 2014. http://www.euro.who.int/en/about-us/partners/observatory/studies/health-professional-mobility-in-a-changing-europe.-new-dynamics,-mobile-individuals-and-diverse-responses

be desirable and beneficial to the majority of citizens who are too often left behind in the pitiless arena of global competition."[7]

There is no reference in the working paper on the possible negative (or positive) effects of free trade agreements that are currently under negotiation.

***We recommend GHWA/WHO to clearly state, in the Global HRH strategy, that health workforce and their services are excluded from trade agreements as they provide a public service, a common good that should be in the realm of policy space by states to guarantee basic services to their citizens.***

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[7] PSI Special Report: TISA versus Public Services. Public Services International. 2014. http://www.world-psi.org/en/psi-special-report-tisa-versus-public-services