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Health workforce policies in the WHO European Region

Equitable access to health workers is a critical determinant of health system performance and therefore central to full realization of the right to health. At its fifty-seventh session in September 2007, the WHO Regional Committee for Europe adopted resolution EUR/RC57/R1 on health workforce policies in the European Region, highlighting the consensus that exists on the prevailing crisis in human resources for health, the responsibility of Member States to develop their national health workforce plans and strategies, and the need for collective efforts to tackle international migration of health personnel. The resolution gave high priority to the process of developing policy options for managing migration and requested the Regional Director to facilitate the development of a framework for ethical international recruitment of health personnel.

In compliance with the mandate received from the Regional Committee and the values and principles set out in the Tallinn Charter, and in tandem with the global efforts led by WHO in line with resolutions WHA57.19 and WHA 58.17, which requested the Director-General to lead the development and implementation of a global code of practice for ethical international recruitment of health personnel, the Regional Office has improved its evidence base on the trends and patterns of migration of health professionals into and within Europe, has stepped up its activities for advocacy of ethical international recruitment and is continuing its efforts to build and strengthen networks and partnership for sustainable human resources for health. This document, together with background document EUR/RC59/BD/1, *A World Health Organization code of practice on the international recruitment of health personnel*, summarizes the progress made since 2007 at both global and regional levels in drawing up a code of practice for ethical and equitable recruitment of health professionals and their migration, discusses pros and cons of the main policy options and outlines the activities that will be continued into the biennium 2010–2011.

The Regional Committee discussion on health workforce policies is expected to focus on strengthening national capacities for sustainable human resource development for health in general, and on the roles and responsibilities of the Member States and the Regional Office for ethical international recruitment of health personnel in particular.

A draft resolution setting out key policy directions is submitted for the Regional Committee's consideration.

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Background

1. The ability of any health system to perform well in meeting the new health challenges of an ageing population, adopting innovative technologies and responding to both new and (re)emerging communicable diseases and ever-increasing morbidity and disability due to noncommunicable diseases, and to remain financially sustainable depends on the availability, skills, knowledge and motivation of health workers *(1)*. Strengthening the workforce is thus essential to ensuring that health systems achieve the goal of improved and equitable distribution of health outcomes.

2. An analysis by the Organisation for Economic Co-operation and Development (OECD) shows that financing requirements for health are expected to rise by an additional 6% of gross domestic product (GDP) by 2050 if health systems prove unable to adapt themselves to the new realities and improve their performance *(2)*. Part of the larger increase in the forecast health care expenditures relative to the overall rise in socioeconomic development would be attributed to the changes in health care needs such as long-term care as a result of epidemiological and demographic transition *(3)*. However, supply-side factors, such as increased reliance on technology and improved working conditions, will equally play a major role, depending on the extent to which health systems are able to cope with the transition and its consequences effectively *(1)*.

3. Having a competent, productive and high-performing health workforce is also important for the economy in general and thus for generating wealth. In Europe, it accounts for about 10% of the total labour force. In the European Union (EU), about 70% of health care budgets are set aside for staff- and employment-related expenditures *(4)*. While the ongoing technological innovations in health care are likely to change the nature of service delivery *(5)*, the business model in the health sector is expected to remain labour-intensive.

4. It is critically important that states develop policies that will ensure the availability of enough health workers with the relevant skills, adequately deployed by type, level and location of services, and working in environments that motivate them to perform well. This is particularly so because redressing imbalances between the supply of and demand for health workforce takes much longer, up to 10 years for some specialties, than redressing imbalances in physical or financial resource needs *(6)*. Traditional approaches to health workforce planning, production, deployment and management are no longer adequate to meet human resource needs *(7)*, given the dynamics of the internal and international health labour markets, which are characterized by factors such as an increasing public/private mix, foreign direct investment, medical tourism and mobility of patients, to name just a few. Indeed, the familiar pattern by which a government directly recruits, trains and deploys all health workers no longer reflects the reality of many countries, where both supply and demand are constantly on the move.

5. What is needed is continuous assessment of the changing health care needs of the population and service standards, calculation of the human resources required to meet those needs and standards, and the introduction of policies that will bring the current staffing patterns, skills mix, geographical distribution and productivity to the desired level *(8)*. This, in turn, requires an understanding of the changing dynamics of supply and demand of workers, both internally and at regional/international levels, in an ever-globalizing world with freer flows of capital, goods, services and labour. There are numerous challenges to be faced.

6. The first challenge is to find the right mix in the composition of the health workforce, especially in times when health care services are becoming increasingly patient-centred, and are provided and coordinated by an array of health professionals. Various ratios used as international standards for this purpose may not apply equally to all countries because of

variations in demographics, morbidity or the organizational modes of practice. Regardless, countries with a low health personnel-population ratio, often have skewed ratios of doctors to nurses, which further exacerbate low performance and inefficiency, as health workers with higher qualifications may perform activities that could easily and safely be delegated to auxiliary personnel *(9)*. There may also be a problem with equity of access if some needs are not met because some types of skills are not available or because existing ones are not adequately used.

7. A second challenge is to ensure equitable geographical distribution of the health workforce. In almost all countries, developed or developing, there are difficulties in bringing health workers to remote, rural and poor areas. Various strategies, from coercion to incentives, have been tried, some with success, but according to the report of a recent WHO expert consultation, "Success in one country, municipality or community will not necessarily translate to the same success in a different place or time" *(10)*. In other words, strategies to correct geographical imbalances need to be time- and context-specific *(11)*.

8. A third and most likely the biggest challenge is to have a full understanding of the dynamics of the national stock of health workers, which includes all workers active on the market, whether employed or not, and varies according to the flows of health workers entering and leaving the market *(12)*. The majority of entrants are graduates of national training institutions; the rest are migrants who either come on their own initiative or are contracted. There might also be some re-entrants, i.e. people who left the market at some point and have become active again. These may be people who exited temporarily for family, health or other reasons, who have retired but are willing to continue to work on a contractual basis, or who left the country and have returned. As regards outflows, these result from planned and predictable exits, such as retirement, and from unplanned ones, like attrition due to ill health or death before retirement age, or decisions to leave the health sector for another one or to leave the country (emigration).

9. It is therefore important to keep in mind the fact that migratory flows are just one dimension of the dynamics of the health labour market. This means that they should not be analysed out of context and that interventions in relation to them should consider the whole dynamics of the market. It is also important to understand what motivates the decision to emigrate, how it occurs, and what impacts emigration has on migrants and on source and destination countries *(12)*.

10. Effective policy-making to respond to these challenges requires timely and accurate data on the quantity, quality, distribution and skills mix of the health workforce and a good understanding of the factors that influence its mobility and performance *(13)*. The lack of reliable and timely data on human resources for health (HRH) in the WHO European Region (regarding age/sex distribution, participation in the labour market, working hours, productivity, remuneration, institutional and geographical deployment, and distribution by type and level of services, in both the public and the private sector) is a feature common to most countries and, as such, precludes any meaningful analysis and forecasting of HRH needs. There are also gaps in qualitative information on education and training capacity and processes, on working conditions, on management practices and on workers' expectations. Sound policy development at national and regional levels requires this type of data, to ensure adequacy with current and projected health service needs.

11. Equitable access to health workers is a critical determinant of health system performance and therefore central to full realization of the right to health. Migratory flows of health workers from lower- to higher-income countries are jeopardizing the right to health in the former and represent a major policy challenge for their governments. The right to health is also an

international commitment.[1] States must not only "respect, protect and fulfil" the right to health within their own borders, they are also required to "respect the enjoyment of the right to health in other countries and prevent third parties from violating the right in other countries".[2] This can be interpreted as an ethical commitment to, and responsibility for, "doing no harm" to other countries. This is of particular importance when analysing the complex issue of health worker migration, especially because of the need to strike the right balance between respecting and protecting the rights of migrant health workers, and alleviating the consequences faced by health systems in the developing countries from which they originate *(12)*.

12. Migration of health professionals has been high on WHO's agenda since 2004, when the World Health Assembly first noted with concern that highly trained and skilled health workers from the developing countries were continuing to emigrate at an increasing rate to certain countries, weakening health systems in the countries of origin; in resolution WHA57.19, it accordingly requested the Director-General, in consultation with Member States and all relevant partners, to lead the development and implementation of a code of practice on the international recruitment of health personnel *(16)*.

Progress to date towards a global code of practice

13. Following the adoption of that resolution, a report by the Secretariat was presented at the Fifty-eighth World Health Assembly in 2005 reviewing the progress made. The Health Assembly then adopted resolution WHA58.17, identifying additional areas related to the international migration of health personnel that required further attention. The Fifty-eighth World Health Assembly also requested the Director-General to intensify efforts to implement fully resolution WHA57.19 and to report on that implementation to the Fifty-ninth World Health Assembly in 2006. A progress report by the Secretariat was accordingly presented to the Health Assembly in 2006. That report *(17)* summarized the work done since 2004 to implement the recommendations contained in resolution WHA57.19, including the development of a code of practice on the international recruitment of health personnel.

14. The resolution adopted by the Regional Committee at its fifty-seventh session in September 2007 *(18)* urged Member States to develop their national health workforce strategies and plans. Highlighting the consensus on the prevailing crisis in human resources for health, the Regional Committee also gave high priority to the process of developing policy options for better management of international migration. The resolution specifically requested the Regional Director to facilitate the development of an ethical framework for, and contribute to the development of, a global code of practice for international recruitment of health personnel.

15. In January 2008, the Executive Board at its 122nd session noted the Secretariat's report *(19)* describing work on drafting a code and the global consultation process. The Secretariat also suggested that consultations with Member States on developing a global code of practice on the recruitment of health personnel should begin in early 2008 and that a draft code should be submitted to the Board at its 124th session in January 2009 and then, should the Board so decide, to the Sixty-second World Health Assembly in May 2009.

16. To support WHO in developing a code of practice, a multistakeholder process, the Health Worker Migration Policy Initiative (HWMI), was established. This initiative comprises (i) the Global Policy Advisory Council (GPAC), led by the Global Health Workforce Alliance and a nongovernmental organization (Realizing Rights: the Ethical Global Initiative); and (ii) a WHO-led technical working group (TWG). As for the WHO Regional Office for Europe, a regional

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[1] As specified in Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) *(14)*.
[2] See General comment no. 14 regarding interpretation of ICESCR Article 12 *(15)*.

technical expert group on health worker migration was established soon after the resolution was adopted, to generate evidence and provide technical guidance for policy decision-making. The technical expert group conducted a desk review of existing codes and other policy options for international recruitment of health workers involving European Member States, to assess all the various policy instruments in terms of the lessons that can be learned to support the development of a global code of practice.

17. In March 2008, the TWG prepared a draft outline of the code of practice, which was presented for the first time at the First Global Forum on Human Resources for Health (Kampala, Uganda, March 2008). The Kampala Declaration also emphasized the importance of developing a code of practice on the international recruitment of health personnel. Indeed, while acknowledging that migration of health workers is a reality and has both positive and negative impacts, the Kampala Declaration and Agenda for Global Action *(20)* called on countries to put appropriate mechanisms in place to shape the health workforce market in favour of retention and on WHO to accelerate negotiations for a code of practice on the international recruitment of health personnel. During the Forum, the WHO Regional Office for Europe initiated a dialogue between “source” and “destination” countries and conducted a round-table discussion to explore the latest ideas and evidence on policies related to health worker migration. The report of the discussion *(21)* was published and shared with Member States and partners for further discussions and consultations.

18. Subsequently, a virtual “global dialogue on health worker migration” was launched in March 2008 for a period of three weeks, in which more than 600 individuals and organizations from 70 countries participated. This dialogue provided a forum to introduce and receive feedback on the draft outline of the code of practice from many interested parties, including health workers, policy-makers, trade unionists and international agencies. Again concurrently with the global events, the Regional Office in March 2008, initiated and contributed to a multistakeholder dialogue on migration of health professionals and a global code of practice with representatives of diplomatic missions, civil society and international organizations, held in Brussels in collaboration with the European Policy Centre (EPC) in the framework of the Coalition for Health, Ethics and Society.

19. The WHO European Ministerial Conference on Health Systems: “Health Systems, Health and Wealth”, held in Tallinn in June 2008, was a major turning point in developing a new vision on the linkages between health systems, health and wealth. The Tallinn Charter *(22)*, adopted at the Conference and later endorsed by the WHO Regional Committee for Europe in Tbilisi in September 2008 *(23)*, provides guidance and a strategic framework for strengthening health systems in the Region. The Charter aims to reinforce the conviction that spending on health systems, when it is cost-effective and appropriate, is a good investment and can benefit the health, wealth and well-being of populations.

20. The Tallinn Charter is grounded in Member States’ commitment to the fundamental and universal human right to health, as expressed in the WHO Constitution and its Eleventh General Programme of Work. According to the ICESCR, and specifically the general comment on its Article 12 *(15)*, States have a core obligation to ensure the satisfaction of the right to essential primary health care, which consists of the duty to provide access to health facilities, minimum essential food, basic shelter and essential drugs, as well to ensure the equitable distribution of all health facilities and the adoption and implementation of a national public health strategy.

21. The Tallinn Charter recognizes that investment in the health workforce is critical, as it also affects other countries in the context of a globalized health labour market; it goes on to state that “the international recruitment of health workers should be guided by ethical considerations and cross-country solidarity, and ensured through a code of practice”. Three policy briefs on health workforce policies, including one on migration *(12)*, were prepared as

background material for discussions at the Tallinn Conference, namely in a separate satellite session on the issues of health worker retention, international recruitment and a global code of practice.

22. In August 2008, the Secretariat finalized a first draft of the WHO code of practice and, between 1 September and 3 October 2008, organized a global, web-based public hearing on that first draft *(24)*. Comments were received from a wide group of stakeholders, including Member States, national institutions, health professionals' organizations, intergovernmental and nongovernmental organizations, academic institutions and individuals. The Regional Office coordinated and submitted consolidated comments on the draft code during the web-based public hearing, based not only on its involvement in the work of the HWMI, the GPAC and the TWG and in the organization of their numerous meetings but also on its broad consultation with Member States.

23. In January 2009, a progress report, draft resolution and the revised draft code of practice *(25)* were presented to the Executive Board at its 124th session. The Executive Board noted the report and suggested that more consultations with Member States on the draft code were needed. The Executive Board also proposed that the topic should be included in the agenda of the sessions of the six WHO regional committees in 2009.

24. In April 2009, a high-level consultation on "Health in times of global economic crisis", convened jointly by the WHO Regional Office for Europe and the Norwegian Government, issued a set of recommendations. One related to stepping up the education of health professionals and ensuring ethical recruitment, even in times of economic crises, with a view to investing in the education of health professionals and local health workers for the future and of supporting the development of a code for ethical recruitment across sectors and borders *(26)*.

25. The relevance and importance of having a global code of practice has been on the agenda of other fora, including the group of eight industrialized countries (G8), which, at its summit in Hokkaido Toyako in Japan, issued a statement *(27)* encouraging WHO to finalize the voluntary code.

26. The G8 meeting held in L'Aquila, Italy, in July 2009 followed up on the recommendations made in Japan a year previously by identifying, in a background report, the following as potential areas for G8 action: "support countries in greatest need to develop and adopt national plans on human resource development, retention and utilization, including community and mid-level workers, towards the WHO threshold of 2.3 health workers per 1000 people and in line with the 2008 Kampala Declaration and Agenda for Global Action launched by the Global Health Workforce Alliance; encourage G8 countries' engagement to address both the push and pull factors related to the international migration of health workers; and *encourage the ongoing WHO process to finalize the Code of Practice on the International Recruitment of Health Personnel*" *(28)*.

27. More importantly, the G8 Leaders Declaration made on 8 July 2009 entitled *Responsible leadership for a sustainable future* stated that "in order to advance the goal of universal access to health services, especially primary health care, it is essential to strengthen health systems through health workforce improvements, encompassing both health professionals and community health workers, information and health financing systems including social health protection, paying particular attention to the most vulnerable. We reaffirm our commitment to address the scarcity of health workers in developing countries, especially in Africa, and we note the 2008 Kampala Declaration and the Agenda for Global Actions launched by the Global Health Workforce Alliance" *(29)*.

Unfinished agenda: outstanding issues and next steps

28. In a constantly globalizing world, and especially in these times of financial crisis and economic slowdown, the need for broad-based consultation and consensus on a WHO-led code of practice on international recruitment of health personnel is all the more pronounced and urgent as countries struggle to meet their long-term objectives of strengthening health systems in a context of renewed emphasis on primary health care and reducing inequities through action on the social and economic determinants of health.

29. What are the key issues that require further consultation and consensus, although it has long been agreed that the code, when ratified as a formal resolution by the World Health Assembly, will be a nonbinding instrument recommending some voluntary standards of behaviour by Member States and other agencies and stakeholders? The first is that, despite its nonbinding nature, an internationally adopted code is likely to lead to national laws, policies and regulations, and will constitute a framework for any bilateral, multilateral or regional codes between and among countries and their agencies (e.g., recruiters, employers), thus setting a strong moral and ethical reference. Nonetheless, many countries may find it difficult to abide by its recommendations or guiding principles, either because they are federated or highly decentralized, thus not having the jurisdiction to enforce its various elements, or simply because there will be reluctance by states where the emigrating health workforce is not only a very significant source of foreign exchange through remittances they send back, but also one way of managing the national oversupply of health workers. There may also be reluctance and therefore likely non-compliance in the destination countries because of the pressure to recruit, as well as some resistance from professional associations which may have disincentives to see the number of health personnel increase to such an extent that their negotiating power with financing agencies is reduced. All these point to the need to find the right balance between: (i) the individual rights of health workers and those of the people who have the right to enjoy the highest attainable standard of care by professionals, to whose training they have contributed through their taxes and other means; (ii) the source and destination countries, in the way they steward their human resources policies in line with their long-term objectives of health system strengthening; and (iii) international and national conventions, treaties and other agreements governing the flow of labour across borders and protection of workers' rights in the destination countries.

30. Secondly, a code of practice of a nonbinding nature also needs to find a balance between what is ideal and what is optimal or feasible. For instance, while few Member States and stakeholders would object to the principle of the mutuality of benefits between source and destination countries, its effective implementation is likely to be very difficult, if not impossible, unless what is meant by mutuality and benefits are clearly identified, negotiated and agreed upon *(30)*. All other things being equal, voluntary donations or increased development assistance to source countries and/or twinning arrangements between their training institutions are more likely to be agreed and acted upon than mandatory, "one-size fits-all" financial compensation *(31)*.

31. A third and perhaps more crucial issue is the need to ensure health workforce sustainability, especially in source countries where shortages and/or distribution of health workers are particularly severe, thus further complicating the issue of having an ethical international stance vis-à-vis recruitment from these countries, and to show solidarity and global commitment to assisting them with retention and deployment of their health workers. After all, migration from African to OECD countries constitutes about 12% of the total health workforce that is needed for the former to meet their Millennium Development Goals; this points to the need to focus on human resources production, retention and overall management *(2)*. On the other hand, the increasing awareness of stakeholders, especially professional associations, in the

destination countries of the severe health workforce shortages that international migration brings about is likely to be an effective advocacy tool.

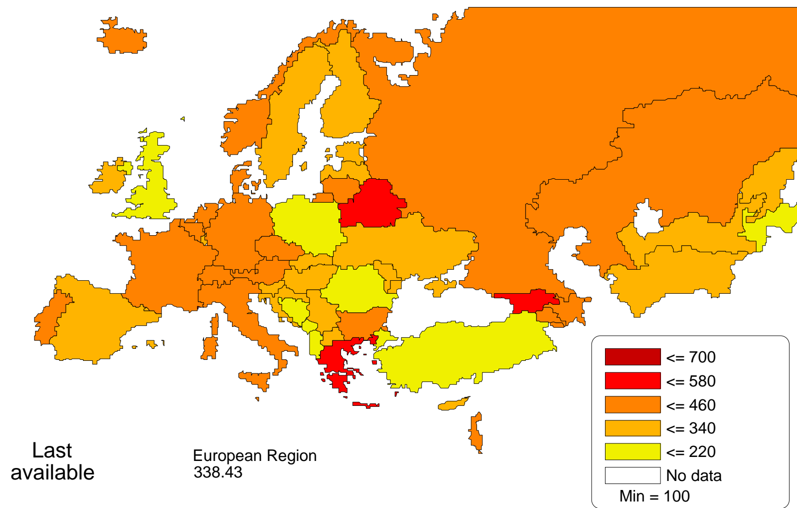
32. Last but not least, the tasks of monitoring and assessing the implementation of the code and gathering and exchanging data and information to that end, another sensitive issue, need to be tackled to the satisfaction of all parties if we are to move towards health workforce sustainability in all Member States.

European specificity

33. The issues raised above are equally applicable to the WHO European Region. However, there also are important features specific to the Region, not least the rapid ageing of the population, which thus requires more long-term care, and that of health professionals; these together with more stringent limits on the total number of work hours and compensatory rest, especially in the EU, make the current and future shortages in health workforce all the more pressing. Between 1995 and 2000 alone, the number of physicians in the EU who were 45 years or above increased by more than 50%. Similarly, in many EU member states, half of the nurses are aged over 45 *(4)*.

34. In addition, there are huge variations across Europe in the availability (Fig. 1) and distribution (Table 1) of health workers, especially doctors and nurses, making intraregional migration an equally relevant and important issue in Europe, although many European Member States have traditionally been on the receiving end of emigration of health workers from the developing world, mainly Africa, but have also, to a lesser extent, lost some of their doctors and nurses to emigration from Europe to North America and elsewhere. Some countries, like the United Kingdom and Ireland, have until recently been major importers of health workers, principally from low-income African and Asian countries but also from the Caribbean, in the case of England, as well as from other European countries, mainly those in the EU (Fig. 2 and Table 2). These countries have also been exporters of health workers, on a smaller scale: Ireland to England, England to the United States. Other countries such as Italy, Portugal and Spain receive workers from other European countries (Italy from Romania, Portugal from Spain, Spain from Portugal) and from other regions of the world, mainly Latin America.

Fig. 1: Distribution of physicians in the WHO European Region
(per 100 000 population)



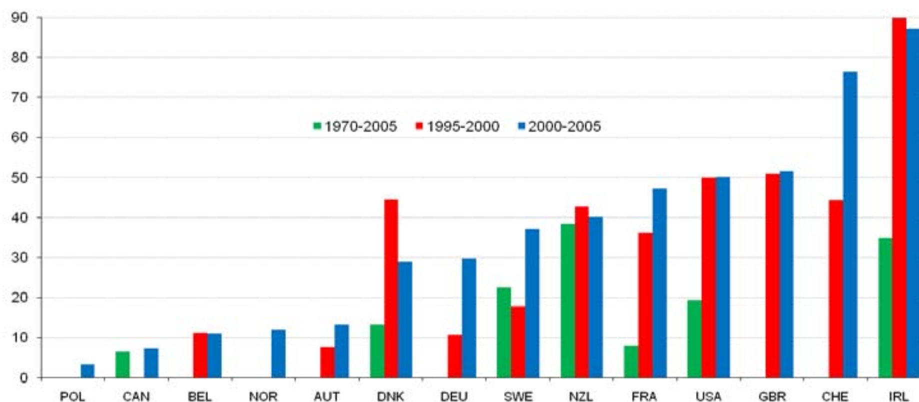
Source: WHO HFA database *(32)*

Table 1: Diversity in the WHO European Region: Health professionals
(per 100 000 population)

	Physicians	General practitioners	Nurses	Pharmacists
European Region	339.71	68.05	727.45	52.28
EU	322.38	96.71	745.64	71.43
CIS	376.78	28.78	794.73	20.55
Lowest	115.02 (Albania)	17.56 (Azerbaijan)	310.8 (Turkey)	3.35 (Uzbekistan)
Highest	534.59 (Greece)	177.3 (Belgium)	1549.78 (Ireland)	154.0 (Finland)

Source: WHO HFA database *(32)*

Fig. 2: Contribution of foreign-trained doctors to the net increase in the number of practising doctors in selected OECD countries, percentage 1970–2005



Source: OECD Health data 2007 *(33)* and OECD International Migration Outlook 2007 *(34)*

Table 2: Growing reliance on foreign and foreign-trained doctors and nurses in Europe and elsewhere

Doctors

		2000		2005	
		Number	**%**	**Number**	**%**
Foreign-trained	**Austria**	461	*1.8*	964	*3.3*
	Denmark	1 695	*7.7*	2 769	*11.0*
	England	25 360	*27.3*	38 727	*32.7*
	Finland	687	*3.6*	1 816	*7.2*
	France (1)	7 644	*3.9*	12 124	*5.8*
	Ireland	1 198	*10.3*	3 990	*27.2*
	Sweden (1)	3 633	*4.3*	5 061	*4.9*
	Switzerland	2 982	*11.8*	5 302	*18.8*
	Canada	13 342	*23.1*	13 715	*22.3*
	New Zealand	2 970	*34.5*	3 203	*35.6*
	Japan	95	-	146	-
	United States (1)	207 678	*25.5*	208 733	*25.0*
Foreigners	**Belgium**	1 341	*3.1*	1 633	*3.4*
	Germany	14 603	*4.0*	18 582	*4.6*
	Norway	2 327	*15.1*	2 833	*31.5*
	Slovak Rep. (1)	130	*0.7*	139	*0.8*

Nurses

		2000		2005	
		Number	**%**	**Number**	**%**
Foreign-trained	**Denmark**	4 618	*6.0*	5 109	*6.2*
	Finland	122	*0.2*	274	*0.3*
	Sweden (1)	2 517	*2.5*	2 878	*2.7*
	Canada	14 910	*6.4*	19 230	*7.6*
	New Zealand (1)	6 317	*19.3*	9 334	*24.3*
Foreigners	**Belgium**	1 009	*0.7*	1 448	*1.0*
	Germany	27 427	*4.2*	25 462	*3.8*
	Turkey	25	-	45	-

Notes: "-" indicate that percentages are below 0.1%.
(1) 2004 instead of 2005.

Source: International Migration Outlook (OECD) 2007 *(34)*

35. Another feature of the WHO European Region is that codes or guidelines of ethical international recruitment are already in existence in countries such as the United Kingdom and Ireland, or adopted by regional associations (e.g. the European Hospital and Healthcare Employers' Association (HOSPEEM)). While planners and recruiters have to take them into account in projecting the needs for health workers or recruiting from other countries, the effectiveness of these instruments has not yet been evaluated, however, mainly as a result of the absence of a system to track flows of health workers, especially those with lower skills typically used in long-term care *(3)*. Indeed, few countries have reliable and timely data on how many health workers they lose or recruit, especially when mobility is temporary, or when workers move to a different country for periods of time as short as weekends to do replacement work. This type of mobility is probably more prevalent within the EU, where freedom of movement is guaranteed. The phenomenon is difficult to measure and its impacts are not well known. Policy-makers need to be aware that it exists and try to assess its importance and consequences for the national health workforce.

36. In December 2008, the European Commission launched a green paper on the European workforce for health and initiated a debate on it with all stakeholders *(35)*. The green paper aims to increase the visibility of the issues facing the EU health workforce, to generate a clearer picture of the extent to which national health managers face the same challenges, and to provide a better basis for considering what could be done at EU level to address these problems effectively and in a manner that does not have a negative impact on health systems outside the EU. Along with other health workforce challenges, the green paper presents the migration of health professionals in and out of the EU; unequal mobility within the EU; and, in particular, the

movement of some health professionals from poorer to richer countries within the EU, as well as the health "brain drain" from developing countries.

Consequences of the financial crisis on labour markets

37. The current financial crisis will have an impact on the health sector in general and the health workforce in particular. Even though its full effects are yet to be experienced and documented, demand for some services is likely to rise at a time when the financial resources to produce them may not be fully available. Curtailed demand today as a result of supply shortages or inability to pay is also likely to generate more demand for health care in the future, which can be exacerbated as a result of trade-offs between investing in health workforce education and training for the future and spending the limited funds to deal with current budget constraints.

38. In many western European countries, the health sector experienced growth in employment as recently as in 2008, at the outset of the crisis. The Austrian region of Tyrol, for instance, reported a 10% increase in employment in the sector. Germany reported an overall increase of 33 000 new employees (+3.2%), whereas unemployment among physicians, dentists and other health professionals has shown an upward trend since November 2008 *(36)*. Overall, the supply of health personnel is likely to rise in the short term, as those who have been inactive start looking for employment and those already in the workforce increase the hours they wish to work. In the longer term, however, limitations in available funding would mean that there will be greater mismatches between supply and demand. In addition, cost containment pressures are likely to increase the workload of individual staff, which may lead to job-related stress. Although no statistics are available, the crisis may trigger shifts in mobility patterns as workers (and their families) from more severely affected countries will be increasingly attracted to countries where job prospects are better, or will leave countries to which they had moved because the job market has deteriorated.

39. Different measures are being taken with regard to health workers' levels of pay. Bulgaria and Hungary have frozen salary levels in state-owned hospitals. Hungary has eliminated payment of a thirteenth month of salary per year. Ireland and Lithuania are also considering pay reductions. On the other hand, countries such as Finland and Greece have increased pay levels and Romania is considering a raise of 7% *(37)*.

40. Fewer health workers are retiring early and hospitals have more of their core positions filled. Older nurses seem to be delaying retirement, and part-time nurses are working more shifts. Hospitals are delaying expansion work. Some hospital administrators report that more patients are postponing elective surgery, which translates into fewer nursing hours needed. The postponement of retirement could be a response to the desire of employers for older workers to continue working a few extra years to combat labour shortages. However, this behaviour may change rapidly if the economy improves.

41. Another consequence would be less than full employment of the new graduates who discover that entry-level jobs have become less accessible as hospitals scale back hiring, in sharp contrast to recent times when hospitals rapidly hired new graduates to address nursing shortages. Hospitals acknowledge that the job market has temporarily shifted as the economy prompts executives to scrutinize costs and staffing levels. There is no incentive to hire inexperienced nurses, in part because of the time and expense required to train them.

42. Finally, there is anecdotal evidence that, as a consequence of the financial crisis, combined with measures to augment domestic production and "discipline" international recruitment, the flow of immigrant health workers into Ireland and the United Kingdom may have been reduced, but documenting such trend changes is a major challenge, pointing, once again, to the need to gather data on patterns and trends of migration.

The way forward

43. The background paper *Health workforce policies in the European Region* prepared for the fifty-seventh session of the WHO Regional Committee for Europe *(38)* summarized the key challenges that Member States face today, in terms of moving from information to action, improving training for better performance and managing the health workforce, and emphasizes the importance of HRH regulation, including international coordination. These challenges are as relevant today as ever, if not more so in the current context of financial crisis. It is important that the Member States continue to put emphasis on developing long-range human resource policies and plans for sustainability, while realizing that self-sufficiency may be elusive in an increasingly global world with increased flows of good, services and indeed labour. This would require establishing and maintaining a database and using a comparable set of indicators on human resources and migration.

44. A broad-based consultation within the European Region and with international and regional entities is ongoing. Both a genuine debate around the EU green paper and implementation of the 2007 "European programme for action to tackle the critical shortage of health workers in developing countries" are being actively pursued. The WHO European Region, on the other hand, is actively engaged in the process of drafting the code of practice through its involvement in various political entities and technical groups such as the Global Health Worker Migration Initiative, collection of information on migration in Europe and other advocacy activities, especially with the professional associations. Yet the remaining challenge is to ensure that the global code on migration of health personnel, in its final form, reflects the European values of equity, solidarity and participation, and the principles of transparency, ethics, fairness and mutual benefits. This would mean finding the right balance between the rights of health personnel to migrate and the rights, expectations and obligations of states, recruiters and employers, so that the accrued benefits, for both individuals and states, are mutual and equitable, that employment conditions prevent exploitation and that there is an agreement for improving retention policies in the source countries, especially those with critical shortages of health workers.

45. The work of the Regional Office on generating evidence for technical assistance and conducting policy dialogue on HRH with Member States is ongoing through its biennial collaborative agreements with 15 Member States and their professional associations.[3] Similarly, the development of indicators on HRH is also ongoing in partnership with the Statistical Office of the European Communities (Eurostat) and OECD, and work on finding solutions to geographical imbalances in workforce deployment is being pursued together with WHO headquarters. The Regional Office will continue to consult all Member States with regard to cross-border HRH issues such as health workforce migration, and will continue its advocacy and coordination role with its partners in relation to the development and eventual adoption of the code of practice and the harmonization and standardization of health workforce indicators for monitoring migration into, within and from the European Region.

[3] Such as the symposium organized by the Regional Office, on the ethical international recruitment of health workers during the annual Forum of the European Federation of Medical Associations (Bratislava, Slovakia, April 2009).

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