HealthWorkers 4all

Health workers for all - CASE STUDY

ITALY

The FNOMCeO commission on development cooperation

AMREF

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Pictures
Title page: Trainee doctors' strike, Rome 2012

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Contents

WHO Code correspondence:*

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

Article 8.2. **All stakeholders referred to in Article 2.2 should strive to work individually and collectively to achieve the objectives of this Code. All stakeholders should observe this Code, irrespective of the capacity of others to observe the Code.**

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

Introduction

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

While over the past decade public health expenditure increased[2] faster than economic growth, it remains extremely limited in Italy. The increase in life expectancy of the population, which in Italy is among the highest in Europe, has generated the need for better targeted strategic intervention. We need to advance a political vision that accords primary importance to innovative health services for elderly and fragile patients, who are not necessarily outcasts and marginalised members of society but very often middle-class workers with poor or intermittent salaries or pensions, exposed to social determinants of illness and with no capacity for private health expenditure.

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

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

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

[1] It was equal to EUR 412,255 million in 2010. The 'Social Security/Pensions' element, which represents the most significant component, accounts for 66.4% of total expenditure, followed by 'Social assistance' at 8% (Italian Health Policy Brief, 2013).
[2] Public health expenditure increased overall by EUR 61.8 billion, rising from EUR 51.7 billion to EUR 113.5 billion (with the out-of-pocket

The context

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

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

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

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

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

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

Description of the practice

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

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

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

In this framework, physicians 'must also strive for policy creation and consolidation of a fiduciary relationship between local communities and health care systems, favouring interventions for prevention and the treatment of diseases responsible for the greater burden of disease and mortality'.
This opening of perspectives and the approach to the role of health professionals has facilitated renewed discussion on international cooperation, global health and the protection of health in developing countries by NGOs, universities, medical doctors, nurses, other health professionals and concerned institutions. This debate has been formalised through the creation of an internal Committee on Global Health and Development Cooperation in which various stakeholders, in collaboration with institutional representatives from the Federation, share common positions and engage in common activities.

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

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

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

[4] It can be found here http://www.manifestopersonalesanitario.it/manifesto
[5] http://www.manifestopersonalesanitario.it/amref-partecipa-alla-due-giorni-fnomceo-su-salute-e-cooperazione-internazionale
[6] http://www.fnomceo.it/fnomceo/Codice+di+Deontologia+Medica+2014.html?t=a&id=115184

Art. 5
Promozione della salute, ambiente e salute globale
Il medico, nel considerare l'ambiente di vita e di lavoro e i livelli di istruzione e di equità sociale quali determinanti fondamentali della salute individuale e collettiva, collabora all'attuazione di idonee politiche educative, di prevenzione e di contrasto alle disuguaglianze alla salute e promuove l'adozione di stili di vita salubri, informando sui principali fattori di rischio.
Il medico, sulla base delle conoscenze disponibili, si adopera per una pertinente comunicazione sull'esposizione e sulla vulnerabilità a fattori di rischio ambientale e favorisce un utilizzo appropriato delle risorse naturali, per un ecosistema equilibrato e vivibile anche dalle future generazioni.

The original text of Codice di Deontologia medica 2014

What is to be learned?

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

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

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