HealthWorkers 4all

Health workers for all - CASE STUDY

ITALY

The Contact Point for migrant health workers organised by IPASVI Florence

AMREF

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Contents

WHO Code correspondence:*

Article 4.1. **Member States and other stakeholders should take measures to ensure that migrant health personnel enjoy opportunities and incentives to strengthen their professional education, qualifications and career progression, on the basis of equal treatment with the domestically trained health workforce subject to applicable laws. All migrant health personnel should be offered appropriate induction and orientation programmes that enable them to operate safely and effectively within the health system of the destination country".**

** 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 private expenditure at EUR 144 billion).

The context

The low level of public health financing in times of crisis is also reflected in the low numbers of health workers. Skilled health workers are the backbone of any health system (Global Health Workforce Alliance and WHO, 2014); however, health workers are currently experiencing a global crisis. Their numbers are much too small to deliver the services needed, they are unequally distributed and they often lack decent working conditions. As a result, in many countries, health workers are stretched beyond their limits and seek jobs elsewhere. This, in turn, often further reduces the availability of health services, especially in rural areas, and contributes to a 'drain' of skills and of public investment in education in these skills.

Public expenditure for health personnel in Italy went from an annual average increase of 2.4 percent in 2006-2010 to a reduction of 1.4 percent in the period 2010-2013, reducing its average share of total health expenditure from 33.2 percent in 2010 to 32.2 percent in 2013. A blocking of turnover for the regions under a national debt repayment plan, the blocking of contractual procedures for the 2010-2012 period, and the freezing of salary levels to those in force in 2010 were the major measures implemented to deal with public debt.
This created a harsh rebound effect in employment levels. In six years, 25 percent of health professionals lost their jobs. The report by the Consortium Almalaurea in Bologna highlighted a further worsening of the employment trend in the last year: the survey involved 64 universities and nearly 450,000 graduates and stated that the 'occupational performance' of the health professions for the period 2007-2012 is in crisis in all four areas, albeit to different degrees: dropping from 88 to 78 percent (-10%) in rehabilitation; from 74 to 50 percent (-23%) in the area of prevention; from 90 to 60 percent (-30%) in nursing-midwifery; and from 81 to 50 percent (-31%) in technical areas (Almalaurea, 2014).

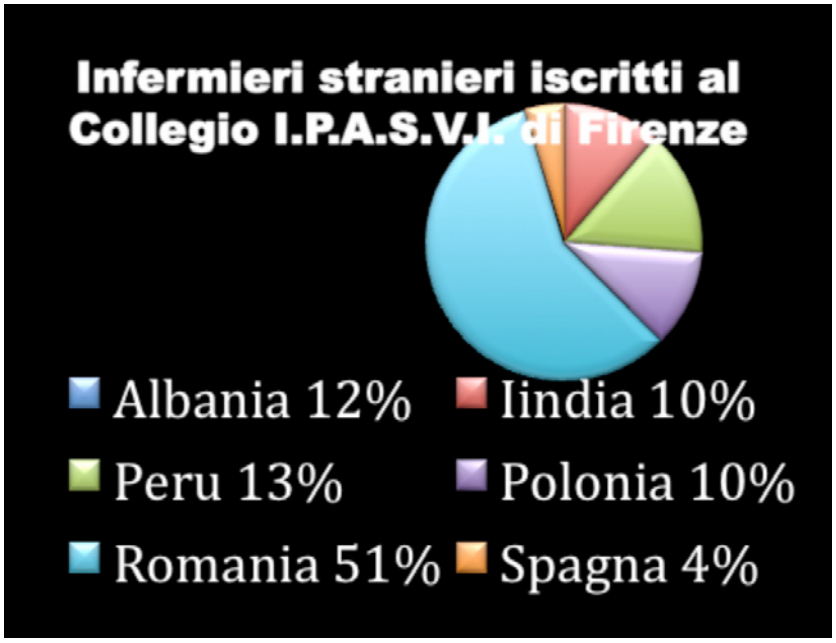
This crisis is wide and deep: delays in payment are frequent, the consequences include absenteeism, requests for informal payments and a brain drain of workers seeking better wages outside the country. In addition, job and wage cuts for health workers due to fiscal adjustments in the framework of austerity measures has significantly reduced access to health services, and is transforming Italy into a country of departure as health workers look for more attractive job locations (ILO, 2014).

Description of the practice

Italy used to be a desirable place to live and operate for health workers from many countries in the world. The nursing shortage in the country changed the recruitment of personnel in the health care sector, and from the end of the 1990s the legislation at the national and EU levels also opened the way to the health professions. However, strict regulations introduced by the Bossi-Fini law on migration, and by its proceedings in more recent years, have pushed professional organisations to put in place focused measures to support international colleagues, many of whom saw their presence in Italy jeopardised by the changes in the rules for obtaining their work and residence permits in 2007. In the province of Florence, the IPASVI (the national professional federation of nurses) put in place the first Contact Point for international health workers at the national level to address their concerns and concrete problems.

The Contact Point is accessible via email and phone, and it is possible to book an appointment with an expert or an IPASVI representative to obtain concrete assistance on issues such as the recognition of professional qualifications, contract and working conditions, as well as other general living and employment issues. The four pillars of the Contact Point are: 'Welcoming/Listening/Directing/Tutoring'. According to research undertaken at the School of Nursing Education, University of Florence (Codella, V. 2012), in 2010-2011, 789 international nurses in the province of Florence were assisted by the Contact Point and almost two-thirds of the requests received positive support. The principal needs which were addressed were the recognition of national degrees; renewal of residence permits; access to post-basic training courses; searches for work; but also salary not received for 4-5 months; and 'atypical' employment contracts.

The Contact Point has also supported IPASVI in achieving a clearer vision of the nature and needs of international health workers operating in the province of Florence.



Nationality of international nurses affiliated with IPASVI (2012)

IPASVI also used the information collected through the Contact Point as a test of the needs of health workers generally, including the most vulnerable, that is, their affiliated members arriving from abroad. The broader picture described in the national report released by IPASVI at the national level at the end of 2013 confirms the evidence which had already emerged at the local level.

The report confirms that in the nursing profession there has been a sharp drop in the number of international nurses, with a substantial and progressive decrease from 35.3 percent in 2007 to 15.3 percent in 2012. Significant, however, is the data related to the place where international nurses gain their professional qualification, with only 50.3 percent having graduated abroad (the number was 70.4% five years earlier).

In 2012, 2,152 new registrations concerned international health workers, equivalent to 15.3 percent of new IPASVI members. With regard to the international presence, Italy is divided into three distinct areas: the northwest, where they account for a very significant component of new students (28.3%, with a peak of 36% in Liguria); the centre-northeast, where the international presence is important, but does not reach the levels recorded in the northwest (16-19%); and the south, where the international component is almost negligible (4.5-5.0%).

The most significant evidence remains the major decrease in the registration of international nurses in recent years. As mentioned above, since 2007, the international share of new IPASVI members has decreased from 35.3 to 15.3 percent. Apart from a few isolated and episodic exceptions, the decreasing trend characterises all locations, where the weight of international nurses among new members has essentially halved. Slightly less than half of all newly registered international health workers (46.4%) are from outside the EU (IPASVI 2013–data from 2012).

What is to be learned?

The IPASVI Contact Point proved to be a valuable tool in providing concrete support to international health workers in Florence, but also confirmed that in the context of a general crisis, the promotion of health personnel is a strategic element in the defence of the health system as a whole. AMREF Italy, as part of the 'Health workers for all' coalition, and in collaboration with IPASVI, has also promoted a seminar in Florence to exchange information and views with and among health worker representatives and relevant local stakeholders, on the issue of the more sustainable management of international health worker recruitment, in line with the proposal made by the WHO Code of Conduct.[3] In this context, the Contact Point of IPASVI Florence emerged as a good practice, offering professional support to international health workers, as proposed by the Code. However, it also clearly emerged that there was a lack of policy coherence between employment provisions and measures related to security and migration, at both the national and European levels.

[3] http://www.amref.it/locator.cfm?PageID=9189

Today, the experience of the Contact Point reveals some difficulties, as reported by IPASVI Florence, which is in contact with the authors of this study. Fewer people are accessing the Contact Point, and it seems that this is because international nurses are reluctant, if not frightened to do so, too often because of the precarious and difficult working conditions in which they operate.

According to ILO, collective bargaining is the best way to negotiate workplace arrangements that attract the necessary number and quality of health care workers. Furthermore, public authorities need to be exemplary employers. Thus, the expenditure of public funds and any contract for health care provision must include clauses ensuring decent wages. Key instruments to achieve the necessary conditions include laws and regulations, collective agreements and other mechanisms for negotiation between employers' and workers' representatives, and arbitration awards. Finally, with respect to the migration of health workers, bilateral and multilateral arrangements are needed with a view to compensate for training costs and avoiding brain drain (ILO 2014).

All of these elements are included in the Call to Action launched by the 'Health workers for all' coalition to address growing concerns regarding health worker recruitment and working conditions in Europe in times of crisis. Specifically, the Call to Action demands respect for the rights of migrant health workers (3rd Recommendation), pointing out that the voices of migrant health care workers, their organisations and the trade unions must be heard by institutions and stakeholders at both the national and EU levels. This is required to shape effective action and plans that avoid exploitation and the violation of their rights. The experience and work of organisations such as the Florence Contact Point must be supported and replicated to ensure this happens. In this way we can learn from those who are at the forefront of the health services and thus better respond to the need for equity that is growing all around the world.