WHO Code of Practice on the International Recruitment of Health Personnel: lessons learned from the Italian case

By Giulia De Ponte, Advocacy Coordinator, AMREF Italy

Areas of committment in the frame of the WHO Code of Practice

The WHO Code of Practice establishes a relationship between the mobility of health personnel and the investments which each health system needs to put in place in order to train and retain health workers in the course of the years.

By signing up to the WHO Code of Practice, therefore, Italy committed not only to ethically manage health workforce migrations, but also to invest larger resources to train a sufficient number of health workers, enough to allow the country to respond autonomously to its own needs of health personnel; it finally committed to ensure, despite recent and future health budget cuts, an adequate absorption capacity of its trained health workforce.

An additional committment taken by Italy - both as a global player and in the frame of the WHO Code of Practice - is to contribute strenghtening health systems in low income countries through international development cooperation programmes. The latter can usefully become a part of bilateral agreements forseeing a compensation for the loss of investment deriving from qualified health personnel out-migration.

An under-financed health system

In this frame, which are the resources available to Italian National Health System (Sistema Sanitario Nazionale, SSN), in order to respond to these challanges?

According to international comparisons health expenditure in Italy is 21% lower than the UE-15 average. This is the result of its growth rate – in the last thirty years – of 1,4% lower compared to the UE-15 average.[1] In addition, by the end of 2015 the resources available to SSN, already so limited, will have to be reduced by 30 billion, as an effect of recent budget cuts. These cuts, eventually, risk to considerably reduce the offer of health services to the population. [2]

How and in which measure the economic crisis and health budget cuts interfere with health personnel development in Italy and with international mobility of health workers?

A scarce health workforce, increasingly insecure and prone to international mobility

Italy is among countries having the highest density of practicing doctors,[3] even if shortages are forseen in the next 5 years, as a result of the retirement of a large cohort of now practicing doctors. Italy, on the contrary, is among the countries having the lowest density of professional nurses: nurses are 375.000, with a nurse-doctor ratio close to parity, compared to an OCSE average of 2,5. IPASVI, the professional organization of nurses, estimates that, to make the

---

[1] Cergas Bocconi, Oasi Report, 2012.

[2] Cergas Bocconi, Oasi Report, 2012.

[3] 600 per 100.000 population, as affirmed by OCSE in its 34° report on migration in the Italian health sector.

situation acceptable, 71.000 additional nurses are presently required. And the gap will widen: each year only 8.000 nurses are recruited, while 17.000 retire.[4]

Few nurses, and very demotivated: according to Next[5] research carried out in nine European countries, over 20% of Italian nurses declare their interest in taking a different career. "*Health budget cuts are triggering job insecurity and brain drain. It is sufficient to think of the fact that this year we released about sixty "Certificates of Good Standing", a document we produce for those willing to work abroad. Last year we released only about ten*." states Giovanni Muttillo, President of the IPASVI provincial section of Milano and Lodi. [6]

The international mobility of Italian health workers, therefore, is a result of job insecurity at home, for nurses as well as for doctors: recurrent managerial reorganizations led to an increasing use of "atypical" contracts; this adds up to the stop of regular turn-over related recruitments in the public sector launched in 2008, as a response to budget deficits. "*Today - explains Daniele Carbocci, national Secretary of Nursind, a nurse trade union - we have about 80.000 nurses working with short term contracts, out of around 300.000 prefessionals working in the public health system*."

In this context of lack of financial and human resources and of widespread job insecurity, foreign trained health workers who entered into service in Italy in the last decade are now an irreplaceable element: in their absence the health system would not stand. Foreign nurses members of IPASVI increased of over 8.000 units (+25,1%). They were 38.315 at the end of 2010, ie. 10,2% of the total number of professional nurses in Italy. In some regions, the presence of foreign nurses is over 15% of the total number of nurses.[7] They contribute in a crucial way in covering the training gap mentioned above, and in ensuring service delivery. Data presented show, however, that there are substantive differences between Italian and foreign trained nurses: the latter tend to leave the profession earlier, have a shorter professional experience, while most of them obtained their professional licence in their own country.[8]

More informal care givers in the homes than personnel in health facilities: towards a "do-it-yourself welfare"?

International mobility supports also the area of social services in Italy, the more so in periods of financial restrictions, as the present one. There are today more informal care-givers in the homes (*badanti*, 774.000, most of whom are foreigners) than health personnel in the public sector (646.000).[9] The number of *badanti* increased by 42% since 2001, informs Censis research institute. Increasingly, they compensate the gap in assistance created by the health system which, strangled by the economic crisis, has the lowest expenditure in Europe for the assistance of non self-sufficient persons. The impression is that Italy is fast moving towards a "do-it-yourself

---

[4] European Migration Network, Politiche migratorie, Lavoratori qualificati e Settore sanitario, Idos 2009.

[5] Nurse's Early Exit Study , http://www.next.uni-wuppertal.de/EN/index.php

[6] http://milano.repubblica.it/cronaca/2012/11/27/news/londra_rimasta_senza_infermieri_l_agenzia_inglese_li_cerca_a_milano-47546633/

[7] IPASVI, Albo 2010: Rapporto stranieri, January 2012.

[8] E. Fortunato, "Gli infermieri stranieri in Italia: quanti sono, da dove vengono e come sono distribuiti", Rivista L'Infermiere N°1 – 2012.

[9] Cergas Bocconi, Oasi Report, 2012.

welfare system", indicated also by the fact that 55% of patients pay out-of-pocket for specialised visits and diagnostic investigations.[10]
One third of *badanti* declare that they provide primary health care in the homes. Only a few of them, however, have a training to do that.[11] Public health facilities, therefore, increasingly feel the need to create basic trining courses for *badanti*, which are in some cases promoted by those facilities themselves. The "*broader priority, however, is of better integrating health care in the homes with formal social services, to avoid dumping on families the burden of caring for non self-sufficient persons; in a period of economic crisis, this would carry the additional risk of translating into a loss of employment for family members*."[12]

The health workforce between international mobility and investments: the interventions tested

In this context, how Italian health authorities are managing the challange posed by the WHO Code of Practice, ie. finding a sustainable balance between international health workforce mobility and the investments needed to train and retain domestic health workers?

Ministries of Health and of University, in agreement with regional governments an with representatives of health professions, increased in the recent past the numbers of posts available for pre-service education of nurses; more recently, also the posts available for pre-service training of doctors did slightly increase. In 2013, however, a worring inverse trend has been registered for the first time, possibly linked to the reduced absorption capacity of the public health system and to the resulting growing unemployment in the sector.[13]

In addition, management innovations and new deployment models for existing health personnel are being increasingly tested by health facilities and hospitals, with the aim of managing active health workers in a more efficient way, and of increasing cost effectiveness: among them are disease-specific clinical networks which enhance the level of specialization of professionals; the reorganization of hospitals by care intensity; the association of General Practictionners to ensure 24 hours coverage; the integration of hospital and community care; or the creation of new professional profiles like auxiliary personnel who free up time of nurses by releaving them from non specialised tasks.

In the recent past, finally, health personnel has been actively attracted from abroad, mainly from eastern European countries: Romania, Albania, Polonia, Ucraina. Considerations about the sustainability of these operations for health systems of origin seem to have been marginal in many cases. The reference is in particular to active recruitment in those countries, but partially also to bilateral agreements between foreign training institutions and some Italian regional

[10] Cergas Bocconi, Oasi Report 2012.

[11] Half of them has a degree, but only a few of them has a degree in the health sector.

[12] As stated by Fiaso President Valerio Fabio Alberti, at the occasion of the presentation of the Bocconi Oasi Report 2012.

[13] A. Mastrillo, see March 27th 2013:
http://www.aitn.it/index.php?option=com_docman&task=doc_download&gid=354&Itemid=69 e http://www.aitn.it/index.php?option=com_docman&task=doc_download&gid=353&Itemid=69

governments or local authorities.[14] Active recruitment from abroad, however, does not seem to be happening any more in a significant way.

More recently, with the introduction in Italy of the European Blue Card in 2012[15] a preferential way of access to employment has been created for highly qualified workers, including doctors, nurses, midwives and other technical health professions, trained in non European countries: this new tool, however, has been introduced into Italian domestic legislation, without a reference to the need to avoid brain drain from countries of origin facing a critical shortage of health workers, and it will need therefore to be closely monitored.

Lessons learnt from the Italian case

The Italian case clearly shows how the economic crisis is rapidly changing the landscape of health workforce mobility. At the moment two possible scenarios are possible:

- Italy will need more foreign health workers in the frame of a private health sector expansion, following the reduction of the public health system;
- Private health sector will not expand because Italians will have no money for out-of-pocket health expenditure; at the same time public sector will be reduced by budget cuts. As a consequence, the need for foreign trained health workers will shrink, while Italian health personnel will start working abroad.

In both scenarios the WHO Code of Practice will remain a valid framework for international dialogue on health workforce related issues.

Budget cuts on social protection may push for more care to be conducted at home. This is a trend which goes beyond Italy, and interests many European countries. There is therefore a need for increased international information sharing on informal care givers mobility, in order to avoid brain waste.

Finally, there is a need for stronger political dialogue and closer monitoring around the Blue Card implementation at European level, to avoid that it becomes a tool for attracting health personnel from abroad without taking in due consideration the brain drain impact in health systems of origin.

[14] Veneto Region, for example, has an agreement with Bucarest and Pitesti; Parma Province with Cluji-Napoca. Italian Ministry of Employment has a bilateral agreement with Tunisia.

[15] Blue Card entered into force in Italy on August 8th, 2012 (DL n. 108/2012, see http://www.lavoro.gov.it/NR/rdonlyres/ACF747FA-3672-45BC-900E-5FCBC8D81392/0/20120628_Dlgs_108.pdf).

HealthWorkers 4all

This document has been produced in the framework of the project "Health Workers for all and all for Health Workers" DCI-NSAED/2011/106 with the financial assistance of the European Union. The contents of this document are the sole responsability of the project' partners and can under no circumstances be regarded as reflecting the position of the European Union

AMREF