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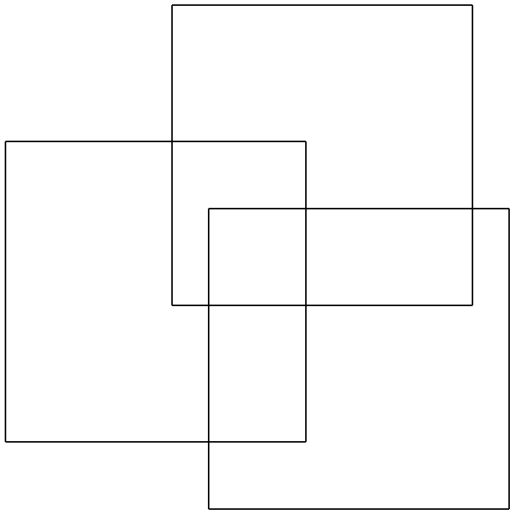
International
Labour
Office

Geneva

Notes on the proceedings

Tripartite Meeting on Improving Employment and Working Conditions in Health Services
(Geneva, 24–28 April 2017)



Geneva, 2017

Sectoral
Policies
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Contents

I. Introduction

1. The Tripartite Meeting on Improving Employment and Working Conditions in Health Services was held at the ILO in Geneva from 24 to 28 April 2017.

2. The Office had prepared a report [1] to serve as a basis for the Meeting's deliberations. It provided a general overview of the trends in health services and discussed the employment and working conditions as well as the role of social dialogue in addressing the challenges of the sector.

3. The Governing Body had designated Ms S. Cappuccio, Worker member of the Governing Body, to represent it and to chair the Meeting. The three Vice-Chairpersons of the Meeting were: Ms H. Kherrour (Algeria) from the Government group; Mr D. Long from the Employers' group; and Mr H. Beck from the Workers' group. Mr A.J. Vicente Pérez and Ms R. Pavanelli were respectively Employers' and Workers' group spokespersons.

4. The Meeting was attended by Government representatives from: Algeria, Brazil, Chile, Colombia, Dominican Republic, France, Germany, Ghana, India, Indonesia, Italy, the Islamic Republic of Iran, Jordan, Kazakhstan, the Republic of Korea, Lao People's Democratic Republic, Latvia, Lesotho, Madagascar, Malaysia, Malta, Myanmar, Namibia, Norway, Panama, the Philippines, Poland, Portugal, the Russian Federation, Slovenia, South Africa, Spain, Sri Lanka, Sudan, Swaziland, Switzerland, Republic of Tanzania, Thailand, the Netherlands, Togo, Tunisia, Turkey, Uganda, Uruguay, Zambia, and Zimbabwe, as well as seven Employer and eight Worker representatives accompanied by 16 Worker advisers.

5. Observers also attended from the following international governmental and non-governmental organizations: the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Population Fund (UNFPA), the International Organization for Migration (IOM), the Organisation for Economic Co-operation and Development (OECD), the World Health Organization (WHO), the World Bank, the European Federation of Public Service Unions (EPSU), the International Commission on Occupational Health (ICOH), the International Council of Nurses (ICN), the International Hospital Federation (IHF), the International Pharmaceutical Federation (FIP), the NGO Forum for Health, the World Federation of Public Health Associations (WFPHA), the World Medical Association (WMA), the International Organisation of Employers (IOE), the International Trade Union Confederation (ITUC) and the World Federation of Trade Unions (WFTU).

6. The three groups elected their Officers as follows:

Government group	
Chairperson:	Ms H. Kherrour (Algeria)
Employers' group	
Chairperson and spokesperson:	Mr A.J. Vicente Pérez
Secretary:	Mr J. Dejardin (IOE)
Workers' group	
Chairperson and spokesperson:	Ms R. Pavanelli

[1] ILO: *Improving employment and working conditions in health services*, Tripartite Meeting on Improving Employment and Working Conditions in Health Services, Geneva, 2017.

	Secretaries:	Mr J. Beirnaert (ITUC)
		Mr B. Aye (PSI)
		Ms S. Vermuyten (PSI)
		Mr A. Durtschi (UNI Global Union)
7.	*Secretary-General of*: *of the Meeting*	Ms A. van Leur, Director, Sectoral Policies Department (SECTOR)
	Deputy Secretary-General:	Mr A. Isawa
	Executive Secretary:	Ms C. Wiskow
	Experts:	Ms A. Barth
		Mr J. Sendanyoye
		Mr O. Liang
		Mr C. Carrion-Crespo
		Ms N. Postic
		and several other specialists from different ILO departments
	Meeting Coordinator:	Ms M.M. Than Tun

8. The Meeting held six plenary sittings, including four devoted to the discussion of the points for discussion that were approved during the first plenary sitting following these themes:

(i) challenges and opportunities that governments and the social partners experience in promoting decent work in the health services sector – particularly regarding employment creation, employment conditions, gender equality, skills development, and safe, healthy working conditions and how these affect access to health services and provision of quality care;

(ii) guidance, policies, strategies, programmes and tools that are required to ensure decent work in the health services sector;

(iii) how social dialogue could be enhanced to better contribute to addressing the challenges regarding decent work in health services; and

(iv) recommendations for future action by the International Labour Organization, governments, employers' and workers' organizations regarding the promotion of decent work and employment in the health services sector.

II. Opening speeches

9. The Chairperson, Ms Cappuccio, opened the Meeting, noting that effective universal health services were both a prerequisite for the well-being of societies and human development as the sector was, globally, a major generator of jobs and driver of inclusive economic and social growth. The aim of the Meeting should be to discuss strategies that enhanced decent work in health services, as an essential basis for addressing current and projected health workforce shortages, paying special attention to the gender implications and concerns. Equal access to quality health services for all people in need required the availability of sufficient numbers of health workers who were well-trained, whose rights at work were assured, including those on occupational health and safety (OSH) and who were paid adequate wages.

Furthermore, working conditions influenced the quality of care, since disregarding workers' health and safety could lead to reduced public health outcomes.

10. The Secretary-General of the Meeting, Ms van Leur, observed that the 2030 Agenda for Sustainable Development (2030 Agenda) had set an ambitious framework for action towards a life of dignity for all. It was an agenda that pursued equality and social justice, with the promise that "no one be left behind". Yet, ILO estimates noted that, because of workforce shortages in the sector, too many people in the world lacked access to health services, with as many as 84 per cent of populations in low-income countries having no access to health services at all. For the rural population, that figure was around 50 per cent globally. Were it to continue business as usual, the world faced the likelihood of an estimated gap of 18 million health workers by 2030, mainly in low-income countries, making it all but impossible to achieve the goal of universal health coverage. Major global policy initiatives had underlined the wide range of benefits from investing in the health workforce. The UN High-level Commission on Health Employment and Economic Growth (UN HEEG Commission) identified, for instance, health as a key employment sector and provided solid evidence on the gains that investment in the health workforce would generate for national economies. The Commission recommended bold and transformative action, with employment creation and decent work as a core priority. An information session of the Commission's recommendations and follow-up action was scheduled as a side event the following day. She looked forward to hearing participants' views, and working with them to build consensus on conclusions that would be both aspirational and inspire collective efforts that adequately promote decent work in the health services sector. She closed her remarks with a presentation of the various members of the Meeting's secretariat, inviting participants to not hesitate to request for any assistance they might require.

III. Presentation of the report and general discussion

11. The report that had been prepared for the Meeting was introduced by the Executive Secretary. She noted that rather than providing an exhaustive picture of the situation of such a complex and diverse sector, it aimed to present a sufficient overview to stimulate discussion and develop consensus on the way forward to enhance employment and decent work in the sector. The Introduction drew attention to the essential role of decent work in the current global context, underlining the need to build on its core pillars of employment, labour standards, social protection and social dialogue, as integral elements of effective strategies to address the challenges in the sector. Such a role was twofold: ensuring sustainable health workforces and enabling them to provide quality care. Chapter 1 set out the global context, characterized by multiple challenges as well as opportunities, major policy initiatives, such as the 2030 Agenda, the Universal Health Coverage strategy and the High-level Commission on Health Employment and Economic Growth and their common call for transformative action to address the challenges which health systems faced. Chapter 2 outlined major aspects related to health employment and attempted to delineate the scope of work related to health. It highlighted trends which showed the sector as a major source of employment even in times of economic crises and its multiplier employment effects in other sectors. It provided an overview of a diverse workforce in terms of occupations and skills levels which, although mainly female, still faced challenges of gender equality. While care work was an area of future job growth, it required attention because of significant decent work deficits, including for those providing unpaid care services; again mainly women substituting for gaps in formal care jobs. Employment relations had also become increasingly diverse with varying results in terms of job quality and organization performance. Chapter 3 underlined the role of education and lifelong learning for a competent and effective health workforce. The current education models had been

recognized as inadequate in preparing health workers for their tasks; education systems needed to better connect to health labour markets and population health needs.

12. Using examples, chapter 4 illustrated select aspects of working conditions, including working time, occupational safety and health, social protection and the impact of increased use of technology. Working time organization was tricky in the context of a sector having to ensure 24-hour services seven days a week, and impacting on worker safety and health as well as on patient outcomes. The sector ranked high in terms of occupational risks relating to biological, chemical, ergonomic and psycho-social hazards. Weak occupational safety and health protection could have dramatic consequences as demonstrated by the 2014–15 Ebola outbreak in western Africa where infection and mortality rates among health and response workers had been exceedingly high. Effective responses were equally required to address violence against health workers that occurred in daily work and increasingly in the form of targeted attacks on health workers and facilities in emergencies and conflict situations. The closing chapter covered the role of social dialogue in the development of the sector and the importance of health worker participation in shaping quality health services. It considered specific characteristics of labour relations in a sector that featured essential services.

13. The spokesperson for the Workers' group underlined the timeliness of the Meeting, noting that recent global policy initiatives, particularly the Sustainable Development Goals (SDGs) and the UN HEEG Commission had drawn attention to the importance of quantitative and qualitative adequacy of the health workforce for realizing the human right to health. Achieving equal access to health for all and ensuring the required trained workforce needed for that goal faced huge challenges, particularly in low- and middle-income countries, which would bear a disproportionate burden of an envisaged shortage of 18 million health workers by 2030, if determined actions were not taken. Privatization, commercialization, cuts in public health funding, liberalization of health services delivery, driven by free trade agreements; rising corruption; increasing labour market flexibilization and deregulation, including outsourcing of non-clinical and clinical services; climate change, violent conflicts and humanitarian disasters and demographic transitions were all having an alarming impact on employment creation and conditions, gender equality, skills development, and safe, healthy working conditions in the sector. Cuts in funding were putting huge strains on the health workforce and affecting the quality of health services, while austerity measures were also leading to freezing in collective bargaining and pay caps which amounted to effective pay cuts. The situation was exacerbated by general attacks on income and job security which had worsened during the economic crisis. Investment in primary and preventive health care was crucial to decreasing health costs, while primary and preventive health care were often carried out by community-based health care workers (CHWs) who faced underpayment, insufficient training and exploitation, and lack of sustainable funding in several countries. Work in the sector appeared increasingly unattractive to youth and numerous professionals were making premature job exits. In many low-income countries, health workers chose to migrate looking for better conditions, while those who continued, were under-paid and overworked, often suffering burnouts. In already fragile health systems, crisis preparedness was undermined, while the rising need for long-term care in upper and middle-income countries was inadequately met and increasing precarization of work numbed commitment. Rather than aiming at reducing workforce levels, technology should be used to improve occupations and working conditions.

14. The universal principle of health as a fundamental human right, enshrined in several international and regional instruments and reflected in the constitutions of about 150 countries, should inform strategies at the international, regional and national levels. Additionally, such other fundamental initiatives and instruments as the Five-Year Implementation Plan for Health Employment and Economic Growth, and International Labour Standards remained veritable means for promoting joint commitment of all social partners to decent work. The background report captured 11 key ILO Conventions and Recommendations most relevant for the health sector, as well as pertinent guidance and

training materials. Lack of ratification and satisfactory implementation of the Freedom of Association and Protection of the Right to Organise Convention, 1948 (No. 87) and the Right to Organise and Collective Bargaining Convention, 1949 (No. 98), and the limited number of countries which had ratified Nursing Personnel Convention, 1977 (No. 149), were some of the gaps limiting their effectiveness, while the increase in non-standard forms of employment and precarization arising from health and/or labour reforms undermined job security and compromised service delivery and care continuity. The growing trend from eight-hour to 12-hour shifts violated decent work principles and risked severe consequences for service quality and safety of both workers and patients; guidelines on employment and working conditions in the sector were required to reverse this trend. Safe and effective staffing for health was both critical for decent work and quality service delivery. The Australian practice that blended legislation and collective bargaining, where states legislated a basis reviewed periodically with the instrumentality of collective bargaining was a desirable model. Migration of health workers remained an important global developmental issue of concern, and, in this regard, promoting respect for *The WHO Global Code of Practice on the International Recruitment of Health Personnel (2010)* was imperative, as was, in line with the Private Employment Agencies Convention, 1997 (No. 181) and Migration for Employment Convention (Revised), 1949 (No. 97), taking a stand against workers having to pay recruitment fees. Violence at health workplaces, particularly third-party violence, had reached alarming proportions requiring special measures to address the problem. Standardization of guidelines on the use of staff, especially on CHWs who were categorized as "volunteers" in several countries even though they served regular working hours, was a contentious issue and a major disincentive for provision of quality services. The ongoing development of CHWs guidelines by the WHO should be supported. Multinational health-care and insurance companies were pushing the commercialization of public health and social care services, including through international trade treaties, opening these services to competition. It was important that as a public good, health not be traded as if it were a commodity.

15. She underlined the pivotal role of trade unions in ensuring decent work, and expressed concern that health workers' rights to organize and collectively bargain remained constricted, highlighting Liberia as a particularly worrisome case and calling on the Meeting to reaffirm the relevance of Conventions Nos 151, 87 and 98. Social dialogue, for example through regional tripartite forums to promote the outcome, would be crucial in taking the Meeting's conclusions forward; while, at the national and workplace levels, it was imperative for trade union rights to be respected and for collective bargaining to be carried out in good faith by all social partners. It was disconcerting that in recent times more and more unions around the globe were having to undertake industrial action to demand respect for provisions of collective agreements or over non-payment of salaries when due. She noted positive examples in the background report of social dialogue's contribution to decent work and in curtailing workplace violence. The 2002 Joint ILO, ICN, WHO and PSI *Framework Guidelines for Addressing Workplace Violence in the Health Sector* would be a good starting point. In concluding, she recommended three future actions from her group: first, the formulation of guidelines for the improvement of employment and working conditions in the health sector; second, a request for a general survey on Convention No. 149, which had thus far been ratified by only 41 countries; and third, that particular attention be paid to health workers in the revision of Employment (Transition from War to Peace) Recommendation, 1944 (No. 71). Her group looked forward to a fruitful discussion committing ILO constituents to the goal of achieving health for all, as a healthy world was a more equal and wealthier world and, in the end, a better world.

16. The spokesperson of the Employers' group stated that health care was crucial and should be linked to economic development. A huge issue in the fast-growing health-care sector was that of providing and maintaining access to its employment benefits for young people, who faced increasingly high unemployment. Admission to higher levels of education and training was becoming more difficult and restricted even though these were crucial to all citizens to

facilitate access to all labour market sectors, including for doctors, nurses, physiotherapists, and others who were employed in other capacities in the health sector. There was a general lack of resources, but it was important to facilitate access to training and study in the health sector by providing any necessary support, including, but not limited to, financial support. This applied to both private and public funding, in all developing as well as developed countries. Health was important for all companies working across sectors, as had been emphasized by the WHO, and it was an objective worthy of pursuit by all companies to ensure and guarantee the health of all their workers. It was essential to avoid fatalities, injuries, and illnesses due to workplace conditions, and to put in place the necessary measures to encourage workers to have a healthier lifestyle in the interests of a healthier population with a greater life expectancy. He noted a general insufficiency in trained health-care workers and doctors, as well as gaps among countries, with some having an oversupply of certain kinds of qualified individuals (e.g. doctors) where others had a shortage. Although this created a basis for a cycle of exchange, there was still an overall scarcity. He agreed with his Worker counterpart regarding the need for limits to daily and weekly working hours, while noting that certain situations, such as workload peaks due to absences which could compromise the universal objective of the 48-hour week, required to be addressed to ensure a balance between the needs of both employers and workers. Therefore, in order to ensure health coverage globally, the promotion of access to and financing of education and training in any sector, including health services, was important. It was in the employers' interest to promote this objective and to work towards a joint solution.

17. The Vice-Chairperson of the Government group thanked the Office for the comprehensive report provided as a basis for discussion. Reliable data, statistics, and monitoring were crucial in order to better address and improve the situation. Regarding job creation, the UN HEEG Commission's ten recommendations should be taken into consideration, particularly as, by 2030, the gap in the global health-care workforce was projected to reach 18 million. There was a need to align the discussion with the 2030 Agenda, and to extend the discussion to include organizations such as the WHO. Migration was a key issue and one of great concern for many governments. In some cases, a shortage of health specialists in some countries could be mitigated through migration. There was thus a need for cooperation on both bilateral and multilateral levels, including through the ILO. Migrants also needed to be integrated into the health systems of their host countries, and returning migrants into the health systems of their home countries. Access to health care by migrants and those residing in rural areas was also of key importance. Low- and middle-income countries had emphasized the need of training and improvement of skills of health-care workers. Increased cooperation and ILO-facilitated technical assistance was required, as were more linkages between the private and public health sectors, ethical recruitment, and health-care workers protection from such hazardous diseases as Ebola. Protection should include safety from violence in the workplace as had been highlighted by the Workers' group. There was a need to recognize all components of health care, taking into account paramedical, administrative, and medical workers, including those in the field of prevention. In their group discussion, the representative of the Government of India had underlined particularly the need to promote prevention. Finally, the inclusion of new technologies, as noted in the report, was important for the future development of decent work in the sector.

18. The representative of the Government of Chile fully endorsed the statement by the Vice-Chairperson of the Government group, underscoring the importance of linking decent work objectives with those of the 2030 Agenda, particularly regarding access to health, and gender issues, and that of migration, especially in terms of ethical recruitment. Countries varied in their needs, and it was vital to consider the reasons for the future shortage of health-care workers, particularly with aging populations around the world. Appropriate measures were required to address this issue and prevent its exacerbation. Chilean workers were accustomed to a certain amount of flexibility in their working hours, and trade unions were well

positioned to maintain a working balance without excessive overtime, which was common in the health-care services and was detrimental to health-care workers and patients alike.

19. The representative of the Government of Malta noted that his country had a sound national health service, though it was subject to labour shortages which were addressed through communication and liaison with other countries where there were oversupplies of health-care workers. In his capacity as Chief Nursing Manager, he had been involved in discussions in one of his country's leading hospitals with 12-hour shift rosters. These discussions had highlighted the fact that some nurses preferred to work such longer 12-hour shifts in order to have a day's break, rather than shorten the length and increase the total number of shifts. Doctors in training had similarly voiced a preference to maintain the extra hours they worked beyond the stipulated 48-hour week because of the resulting increase in their total salary. He noted that governments paid wages even when doctors were not on duty. It was therefore important to take these preferences into account as long as there was no compromise with the safety of patients or the health of the workers, and while ensuring the efficient use of resources.

20. The Government Vice-Chairperson, speaking as the representative of the Government of Algeria, noted that despite a projected increase of 40 million global health sector jobs by 2030, there was also an expected shortage of 18 million health workers, particularly in countries with an aging population. The 2001 commitment of the African Union Heads of States to increase their annual health sector budgets by 15 per cent had proved difficult to keep due to various financial crises affecting many countries. Nevertheless, employment and working conditions needed to be improved. The UN HEEG Commission, established by the UN Secretary-General in 2016, had made ten recommendations that were both transformative and cross-cutting with the SDGs. Recommendations 1, 2, and 4 in particular, regarding job creation, gender and women's rights, and health service delivery and organization respectively, should be taken into consideration by the Meeting. The health sector had been ring-fenced from the sharp cuts in her country's overall public budget, in fact benefiting instead from an increase of approximately 19 billion Algerian dinars (DZD) in its 2017 budget, from DZD379.40 in 2016 to DZD398.07 billion. In 2015, the numbers of some key health sector professionals in the country were: 81,162 doctors, 149,075 paramedics, 11,874 dentists, and 11,108 pharmacists. There were nevertheless gaps in terms of specialist doctors and regional coverage, particularly in the south and south-east of the country, notably the region of central Hauts Plateaux, with a ratio of a doctor per 3,874 people, south-east region with a doctor per 2,934 people, and the south-west region with one doctor per 2,965 people. Since 2013, adjustments had been made to alleviate the disparities, with new university hospitals being established in conjunction with the Ministry of Education, and new medical and pharmaceutical faculties in the southern regions. A second set of guidelines had been established to run until 2035. These emphasized public–private, public–parapublic, and public–public sector cooperation on human capacity building, fair territorial distribution, initial training and health-adapted curricula, as well as a civil service framework for specialist doctors as a cooperation project. Negotiations on health issues would be maintained.

21. The representative of the Government of Togo thanked the Office for a highly informative report and the WHO, together with the ILO, for supporting the establishment of his country's OSH programme six months earlier. He reiterated the importance of health worker protection, which had been integrated into the National Health Plan (2017–22), and in particular a strategic focus on monitoring the WHO global plan of action on workers' health 2008–2017 and a health personnel protection programme through the ILO–WHO HealthWISE tool. His Government was also concerned with ensuring the protection of health workers in emergencies, especially in such instances as outbreaks of Ebola and Lassa fever. His Government had trained at least 100 health workers nationwide, with WHO support. These were now also being instructed on how to protect themselves in both emergency and non-emergency situations, using the ILO–WHO HealthWISE tool. It was

important for the health of workers in the sector not to be compromised in the process of their functions.

22. The Representative of the Government of the Islamic Republic of Iran underscored the priority that his Government attached to providing quality health services and generating sufficient jobs in the health sector. There was a need for global reinforcement and extension of social protection in order to generate more sustainable outcomes. Various steps had been taken to improve the health and education systems in the Islamic Republic of Iran, including through the extension of universal health coverage and providing social insurance to vulnerable persons, women, nomads, rural and urban residents, and many others previously not covered. Such advancements were accomplished through a multi-sectoral approach and in close cooperation with several government ministries. Expanding opportunities for education and training to improve health services could be advanced by the Office, in particular through the Turin Centre – International Training Centre of the ILO. New technologies were also needed to help improve service delivery and thus, should be linked to the Future of Work Initiative of the Office.

23. The representative of the Government of the Russian Federation emphasized that many countries suffered from insufficient access to health care due to health workforce shortages. Aging populations raised demand for health care and thus for health personnel. Her Government was proactively pursuing efforts to train an increased number of health-care professionals. With the adoption of legislation in 1993 related to compulsory medical insurance, the Russian Federation established that everyone had a right to health care. Temporary or permanent residents were insured and those seeking asylum also had a right to coverage under the Federal Law on Refugees. Training of health-care personnel was carried out in 86 federal technical colleges, with an average quota of 57 per cent of budgetary allocations. Such efforts had proven effective as the share of newly trained pharmaceutical and medical workers had reached 87.7 per cent health-care graduates last year. Special training centres were established to promote skills development. Preparatory work through the Ministry of Health was under way to promote continuous workplace training, including in the area of pharmaceuticals. In 2016, the Ministry had established a portal for continued training of health personnel, including various programmes and formal education through which 349 individual medical cabinets had already been registered with a listing of doctors and 11,000 programmes to improve health-care professionals' skills. In the Russian Federation, there were currently about 45.9 doctors and 105.8 nurses for every 10,000 people. The total health sector employment remained a constant 4.4 million people, representing 6.6 per cent of the economy-wide workforce. Approximately 79 per cent of health personnel were deemed highly qualified professionals, such as doctors as well as medium-level medical workers. Under the government programme, by 1 January 2018, wages of medical doctors would represent 200 per cent of the national average wage, while wages among medium-level health personnel would be 100 per cent of the national average. The national labour code established that working time in the health sector should not exceed 39 hours per week, adjusted according to specific jobs or roles of health professionals. Accordingly, the total number of hours worked may range from 36, 33, 30 or 24 hours per week. Over the past ten years, life expectancy had increased by five years and continued to be on the rise. From 2003, the national mortality rate had consistently decreased, reaching a historic low in 2016 among mothers, children, and infants.

24. The representative of the Government of South Africa acknowledged the linkages between the themes presented in the Office report and the outcomes of the UN HEEG Commission, highlighting a ministerial meeting convened in Geneva on 14–15 December 2016 to approve a five-year action plan to implement the Commission's ten recommendations. That action plan could also serve as a roadmap for addressing some of the issues raised in the report and in the ensuing outcomes from the meeting such as those related to stimulating investments towards the creation of decent health sector jobs, maximizing women's economic participation in the health labour market, reforming service models, and promoting inter-

sectorial collaboration at national, regional and international levels. Decent employment creation was a challenge that was affecting all people at a global level, especially in developing countries and, therefore, collaborative efforts were needed to identify programmes to reduce unemployment as a matter of priority. Proactive social dialogue was a prerequisite for addressing the unemployment challenge. Public–private partnership (PPP) provided an important opportunity for collaboration, which was essential since financing remained a challenge for all countries. Collaboration in policy development between organizations such as the ILO and WHO was also important. The financial and technical commitments pledged by the G20 and other international forums should be followed up and implemented, while fully respecting governments' national ownership. The unemployment rate was at its highest due to slow-moving global economic growth and other factors that impeded employment creation. Therefore, foreign direct investment (FDI), women's labour force participation, and youth employment in the health sector were some measures that could contribute towards greater creation of decent jobs. Youth unemployment remained a huge challenge globally. For example, 50 per cent of the unemployed in South Africa were young people. Migration of health practitioners represented another pressing challenge which was driven by low remuneration, poor living and working conditions, and the lack of opportunities for career development. The ILO had a role to play in identifying the challenges at national levels as well as promoting programmes that encouraged the ratification and compliance with relevant instruments in all countries.

25. The representative of the Government of Tunisia stressed her Government's well-structured national health system supported by the Ministry of Social Affairs which included engagement with insurance companies, civil protection defence organizations and others. Companies were however required to establish their own independent health services to cover safety and health in their workplaces and to improve occupational medicine and develop health teams. There was also a plan to establish health units in large industrial areas, extend training of occupational doctors and other specialists in OSH and to conduct OSH-related information activities at the regional and national levels. A social contract defining national policies on OSH had recently been signed between the Government and the social partners.

26. The representative of the WHO noted similar tripartite collaboration in terms of collaboration between the WHO, ILO and OECD last year in the UN HEEG Commission framework, which provided an opportunity not only to link health and labour issues, but also to make the macroeconomic and investment case for investing in the health workforce. He highlighted the health workforce as including, among others not only those clinically trained but also those engaged in prevention and promotion, palliative care, social care as well as workers in the health sector actively supporting the provision of health-care services, such as professional bodies, regulatory bodies, managerial bodies, those in catering and hotel services, facilities management, engineering services and others. The workforce operated in both public and private sectors as well as in the informal and formal economies. The UN HEEG Commission had clearly established that investments in the health sector were an investment, not a cost. Unfortunately, during times of austerity, governments and employers often sought to lower the conditions of employment or to reduce the number of staff or to change the sector's essential skills mix. Such measures negatively impacted the attainment of universal health coverage and sustainable development. Moreover, it was now commonly agreed that one of the fastest means for inclusive and sustainable growth was through the promotion of women's economic empowerment. Recent ILO data indicated that two-thirds of the health workforce were women, pointing to its vast potential to unleash economic and social progress through gender-sensitive policies. The Workers' group proposal to encourage tripartite agreement on the five-year action plan for implementing the UN HEEG Commission's recommendations was welcomed. He noted that the action plan would also be submitted for discussion to the next session of the World Health Assembly the following month. Some of the technical areas the action plan covered included migration, ethical recruitment, education and lifelong learning, the global mismatch between supply, demand

and the need for labour, investment in future education, and protection of health-care workers – not only when faced with public health outbreaks, but in all circumstances. This Meeting provided an opportunity for additional alignment between health and labour ministries to ensure strong and coordinated action across both portfolios.

27. The representative of FIP noted that his organization represented some 3 million pharmacists through 139 national associations. He noted that the SDGs, in particular target 3c, referred directly to the health workforce and was associated with a single indicator for measuring progress that related to the health worker density and distribution. Adoption of that indicator represented a major advance as its dataset measured the density of five professions including physicians, nursing and midwifery personnel, dentists, and pharmacists and would progressively expand to cover all other health cadres. It was therefore, appropriate that the report and the discussion equally considered all five professions, including pharmacists. The work by such professional bodies as FIP should be considered as a set of best practices. The FIP had organized the first global conference on pharmacy and pharmaceutical sciences education in 2016, which had adopted a global vision for pharmaceutical education and workforce, 13 pharmaceutical workforce development goals and 67 statements on international expectations relating to effective pharmaceutical education systems to meet local needs. Such recommendations were aligned with those of the UN HEEG Commission and could be translated to support further conclusions and actions. The current Meeting should consider two additional items related to working conditions, during experiential training such as under internships or residency programmes, as well as the consequences of ageing of health-care workers on their working conditions.

28. The representative of the International Council of Nurses (ICN, explained that it was a federation comprising more than 130 national nursing associations. He congratulated the Office on an excellent report which highlighted key issues affecting the health workforce. Good health care was a result of teamwork. With some 20 million nurses and midwives worldwide, their reach was enormous, and impacted daily on the lives of individuals, patients, communities and populations. The ICN had recently published a report based on case studies of nursing practices from around the world which demonstrated that the impact of nurses' daily work extended far beyond contributing to the achievement of SDG 3 (health). Nurses were key to improving access to health services not just because of their absolute numbers, but also because of the innovations that they brought to their work. Increased investment in education and continuing professional development was important as it enabled innovation in how services were provided to patients. The persistent global shortage of nurses remained a key driver of their migration. While labour mobility brought benefits, many countries were not doing enough to achieve self-sufficiency in the domestic supply of their health workforce. More transparent reporting, clearer metrics and data were required to determine the share of local and internationally-recruited workers. While better recruitment measures were essential, efforts must also focus on the retention of health workers. He welcomed the reference in the Office report to the issue of safe staffing levels, which continued to be one of the pressing challenges that affected patient outcomes and the health and well-being of nurses. Renewed efforts were also needed to encourage the ratification and implementation of Convention No. 149.

29. The representative of the International Commission on Occupational Health (ICOH/CIST), congratulated the Office on the report and looked forward to collaboration with the ILO and the WHO, in particular to ameliorate the global shortage of health workers.

IV. Composition of the Working Party

30. At its fifth sitting, and in accordance with the provisions of article 13(2) of the Standing Orders for sectoral meetings, the Meeting set up a Working Party to prepare draft conclusions taking into account the various views, proposals and suggestions made during the discussion in the Meeting.

31. The Working Party was chaired by the Government Vice-Chairperson, Ms H. Kherrour (Algeria), and was composed of the following members:

Government group

Brazil	Mr P. Sanges Ghetti
Chile	Mr P. Lazo Grandi
India	Mr S. Singh
Malta	Mr A. Xuereb
Philippines	Mr D. Cruz
South Africa	Mr K. Letoaba
Netherlands	Mr W. Kruijsen
Togo	Mr S. Kokou Kevi

Employers' group

Poland	Mr G. Juszczyk
Kenya	Ms A. Kamau
Australia	Mr D. Long
Zambia	Ms M. Mubita
Suriname	Mr J. Van Charante
Spain	Mr A. Vicente Pérez
Jamaica	Mr D. Wan

Workers' group

Germany	Mr H. Beck
Republic of Korea	Ms J. Yoo
Australia	Ms J. Kiejda
France	Ms R. Pavanelli
South Africa	Ms R. Thandeka Msibi
United States	Ms A. Twomey
Argentina	Mr C. West Ocampo
Argentina	Mr J. Yabkowski

The Working Party on Conclusions held two sittings and submitted its draft conclusions to the Meeting at the latter's sixth sitting.

V. Point-by-point discussion

Challenges and opportunities in promoting decent work in the sector

32. The Executive Secretary, introducing the first proposed point for discussion, noted that deliberations on point 1 were intended to stimulate the exchange of experience, with respect to the challenges and opportunities in promoting decent work in the health sector and how those affected access to health services and the quality of care. The issues listed in the point for discussion were not meant to limit the discussion, but rather to provide ample opportunity to exchange on country-specific or group examples.

33. The Employers' group spokesperson emphasized that all who worked in the health sector were aware of the challenges they faced including long working hours, exposure to complicated situations such as those related to safety and health risks as well as to biohazards. Working conditions required to be flexible in order to meet societies' medical needs and to be based on national circumstances with respect to fundamental rights at work, freedom of association, collective bargaining, the elimination of forced labour and child labour, and discrimination at work. The Office report was rather negative towards employers on those issues. It was not realistic to focus on examples of extreme working conditions. Rather, the problem was rooted in the insufficient numbers of health-care professionals. Governments needed to be more open to pharmacists collaborating in both private and public health service delivery, since they were often more easily accessible in rural areas. Regarding skills development, doctors, nurses or pharmacists should receive better training. Employers were keen to provide and develop additional training programmes focusing on future needs of the sector and on the use of new technologies. However, governments needed to provide incentives in the form of tax breaks and other inducements to encourage more people to work in rural areas. Governments should also consider creating national funds reserved for those who may need medical assistance later in life. Auxiliary workers or regular health workers had the same rights and obligations and should therefore be regulated equally by governments. Nothing was more dangerous than when some workers were regulated and others were not.

34. An Employer member from Poland illustrated the problem of shortages in health-care workers with the findings of a study by a university in Warsaw which determined that only 45 per cent of graduates in the last year had applied for formal registration with the Polish nursing chamber, meaning that less than half of all trainees actually ended up working in the health sector in Poland or the European Union. There were ample employment opportunities in the health sector, but there was a need for tax or other incentives to attract workers to the sector.

35. An Employer member from Suriname added that over the past 40 years, a substantial amount of money had flowed from workers, employers, and governments to the medical supply chain but with only a few people benefiting from it. Young people were paying high premiums for health insurance with nearly no claims. National governments should consider establishing tax-free funds to make reserves for older and aging persons who would be most in need of health services in the future.

36. The Workers' group spokesperson underlined the fact that major injustice around the world was caused by broken taxation systems. Tax evasion and loopholes were creating scarcity of resources needed to fund health systems and other public services. Taxation must be addressed as it was closely linked to the achievement of universal health coverage. Tax adjustments were acknowledged as a mechanism that facilitated employment growth in the health sector, but it was not through tax incentives that employment could be expanded or

working conditions improved. Health workforce shortages were caused by cuts in funding for health systems as a result of austerity or structural adjustment programmes. Furthermore, the health sector was no longer appealing to young or potential workers. Other factors such as occupational risks, morbidity, mortality of patients and the growing number of malpractice lawsuits meant that workers were not keen to pursue careers in the health sector without adequate compensation. At the global level, such factors led to growing absenteeism, premature worker exits from the sector and acute and chronic diseases among health professionals.

37. The Ebola outbreak displayed the critical importance of well-trained, prepared and equipped health-care workers to face an outbreak of such magnitude. A survey of working conditions of about 220,000 health-care workers in Guinea, Liberia, Sierra Leone and Nigeria had revealed health workers in the region had to manage the Ebola outbreak with virtually no equipment and essential supplies to prevent transmission. The consequence was the death of 1,000 medical workers. She drew attention to a 2016 survey on working conditions conducted by the Korean Health and Medical Workers Union (KHMU) which showed that the country's average weekly working time was 45.6 hours; while the average resting and mealtimes for hospital workers was 39.2 minutes. Despite legal prohibition, many female staff members were forced to follow the so-called "forced pregnancy schedule" due to health workforce shortfalls. Violence against nurses had led to an increasing number of suicides as well as nurses wanting to resign from their jobs. The survey further indicated that 76 per cent of nurses wanted to leave hospital work while 76.6 per cent of respondents believed their working conditions did not allow them to deliver health services properly. There was at the same time growing evidence of trade union suppression in the country, with documented cases of health-care enterprises attempts to close when the KHMU tried to unionize their workplaces.

38. The speaker noted that public health systems continued to be under attack in most countries due to austerity and structural adjustments, giving Brazil and Australia as examples. The Brazilian Government had approved reduction in public spending for the next 20 years, simultaneously outsourcing all services, which violated both international and national agreements and negatively impacted Brazilians' social rights. In New South Wales, Australia, a major concern related to a 99-year lease awarded to a private provider to design, build and operate health services in two major Sydney hospitals; a practice that had proved a major burden for taxpayers when the public had to buy back those newly privatized services.

39. Globally, the workforce was becoming increasingly precarious, with jobs usually based on short-term contracts. That was, inter alia, the case in Ireland, where zero-hour-contracts had become prevalent and unions were organizing to ensure secure, stable incomes and to safeguard and promote the collective bargaining rights for health workers.

40. Governments, employers and workers needed to find a balanced approach to provide patient care. The focus could not be on cutting costs or budget, as various research had shown that investing in health-care services was economically beneficial for all workers, employers and the overall society and the economy. It was important to consider issues of long-term care as well as childcare, including home-care work as that related to various forms of precarious working conditions such as zero-hour-contracts, extensive working hours, unpaid travel time and wages. Successes in the United States, Uruguay, and Argentina had shown that it was possible to improve working conditions through social dialogue and collective bargaining. There was ample scope for the ILO to offer increased support in that regard. Corruption in the global supply chains was a major challenge in health care – either at the macro level with regard to technology and pharmaceuticals, or at the micro level, such as petty crimes in hospitals. All such corruption tarnished the image of health-care workers and therefore needed to be addressed holistically, including through whistle-blower protection. Migration similarly remained a crucial issue in the sector. It was not advisable to encourage countries

to produce and export health professionals, but there was a need to stimulate the education and training of needed health professionals in each country. Full implementation and enforcement of Convention No. 97, the Migrant Workers Convention, 1975 (No. 143), and the 1951 United Nations Refugee Convention, as well as the provision of social protection and access to health and other public services was urgently needed. Gender-sensitive policies were also required to overcome inequality and to make the health sector a more desirable sector for the employment of women, girls and young people.

41. A Worker member from Argentina stressed the importance of responding to technological change and trends shaping the future of work. Workers were concerned about how governments and employers were dealing with such change, particularly since all forecasts predicted the health sector to grow due to demographic changes and increasing life expectancy. More than ever, trade unions and the ILO should have a vision for responding to the rapid changes facing the health sector in order to meet the demands of workers, to promote formal sector growth and to ensure that the rules of the game were upheld, including the right to strike and the right to training and lifelong learning. Collective agreements were needed to uphold the rights of all workers. It was a social responsibility to pay workers a fair wage and give them the necessary breaks and holidays to rest in order to ultimately improve the quality of care. Governments were responsible for ensuring that health services existed for the whole population regardless of whether the health care was provided by the public or private sector.

42. A Worker member from Australia observed that working conditions for nurses and midwives had changed significantly over the past few decades. Previously plentiful staffing, appropriate skills sets, and rare overtime shifts had since been on a steady decline, with nurses and midwives required to work overtime without adequate compensation. Working conditions made it infeasible for health workers to provide the best patient care possible. Public services were being eroded by governments who were moving towards privatization. Access to services should be universal, and not depend on either geographical location (rural or urban) or an individual's financial means. Despite a major campaign by her association against the privatization of five major hospitals outside the Sydney area, the Government had pushed ahead with the move. Australia's health-care system was becoming increasingly similar to the private insurance-based American model. One of the major issues of concern related to this was that the acquired rights and working conditions of workers transiting from public to private sector jobs were not being preserved. Research showed that mandated staffing provided the best possible outcome for all actors involved, but private sector organizations were reluctant to maintain those standards out of fear of compromising flexibility and management prerogatives. The result was that workers were increasingly overworked as the financial bottom-line became the defining factor as opposed to patient needs. Elderly care, categorized as "aged care" in Australia, was facing significant obstacles due to increased privatization and the distribution of care duties to large, often multinational companies whose operations were profit-driven. A recent survey by the National Midwives' Union showed that patients required nearly twice the hours of care than what was provided, with only 15 per cent of staff serving as registered nurses and only 10 per cent with diplomas. Many caregivers were unregistered and their remuneration remained inadequate. Moreover, an aging population resulted in an upward trend in health services demand. More and better cooperation on regional and international levels could more adequately address such challenges. Governments had a responsibility to ensure proper health-care services under conditions of decent work.

43. The Vice-Chairperson of the Government group noted the challenge of financing health care given budgetary constraints in all countries, particularly as result of the recent years' economic crises. The sector was also unable to attract sufficient numbers of workers, given the long working hours and lack of adequate compensation. To many, the sector was thought to be more of a vocation than a wage-incentivized form of employment. The shortage of health-care workers was exacerbated by the challenge of an aging population which was

increasingly prevalent across countries. There was insufficient training and opportunities for skills development, particularly on new and challenging epidemics and diseases. Many governments were confronted with reluctance from medical professionals to work in rural areas because of lack of amenities and schools, among other deficiencies. However, there were also several opportunities for redressing some of the imbalances, with strong political will on the part of governments at local, national, regional, and international levels to enhance decent working conditions in the sector. Migration represented both a challenge and an opportunity; on one hand, large numbers of migrants requiring health care could exacerbate the already existing problem of health-care worker shortages, while, on the other, gaps in particular fields of health care could be addressed by specialized migration. Trade unions were an informed partner that could help to highlight specific gaps and challenges in the sector. Telemedication and traditional medicine, which were already prevalent in many countries also had great potential for addressing health-care gaps.

44. A representative of the Government of the Russian Federation reported on a "rural doctors" programme adopted by her Government, under which health-care professionals in urban areas were incentivized to work in rural areas under labour contracts for five years, receiving a 1 million rubles salary. After the initial test period, more than 80 per cent of participants had expressed the wish to extend their involvement in the scheme in the rural areas where they had served. As a result of the scheme, more than 20,000 doctors had over the past five years been enticed to opt for work in rural areas.

45. The representative of the Government of Malta suggested that challenges in the health sector could be transformed into opportunities. In the past, his Government and trade unions had had opposing positions, which had resulted in unwanted patient care consequences. Such experience underlined the importance of finding a right balance through good industrial relations in order to mitigate and solve the problem of health worker shortages.

46. The representative of the Government of Brazil underlined the priority his Government attached to the challenges of health workforce shortages, especially in rural and remote areas, and recognized the importance of improving the sector's working conditions and aligning its reforms with the SDGs. Of particular concern was the current unequal global distribution of health workers, as highlighted in paragraph 19 of the Office report. There was interest in discussing ways to redress inequalities in the sector through training, skills development and other related policies. In response to comments by a Workers' representative and noting the pressures on the Brazilian economy from the recent recession, he pointed out that the Government was pressed to make difficult expenditure decisions placing a general cap on the national budget. A subsequent constitutional budget cap amendment decreed that any budgetary increases be based on the rate of inflation rather than on that of real growth. As such, there was a possibility of real health budgetary increases through budget reallocations from other ministries and sources. Meanwhile, the Government was aware that the new outsourcing legislation remained a cause of concern for some groups, but believed that the country's well-developed labour and legal systems provided adequate forums in which concerns and challenges regarding legislation could be addressed and resolved. In that regard, the Government was amenable to further discussion on that subject in more appropriate forums, including at the ILO.

47. The Employers' group spokesperson reiterated the importance of training to improve workers' professional knowledge. In an interconnected world, flexibility in working relations, training and working conditions would open the market to other professionals such as pharmacists, and attract them to work in rural areas.

48. The Workers' group spokesperson emphasized the need for joint commitments and efforts to address the issues outlined in the Office report and in the ensuing discussion. The problems encountered in the health sector were diverse and needed to be addressed at the national level, perhaps facilitated by the ILO through national dialogues.

49. The Governments' group Vice-Chairperson reiterated the need to find practical and constructive solutions given the lack of adequate funds and resources. It was important to consider how best to attract funding, and to build bridges between the private and public sectors.

Guidance, policies, strategies, programmes and tools for decent work in the sector

50. The Executive Secretary of the Meeting introduced suggested point 2 for discussion, noting that it focused on the types of guidance, policies, strategies, programmes and tools necessary to ensure decent work in the health services sector. The discussion also aimed at identifying any specific gaps in policies and tools.

51. The Workers' group spokesperson stated that ensuring decent work in the health and social services sector required international, regional and national capacity to enforce guidelines, strategies, programmes and instruments. All factors that helped improve the situation of all workers, not just health professionals but all cadres involved in the provision of quality health services, had to be considered. Due consideration was also needed to promote gender equality and women's rights, migrants rights, OSH, including under humanitarian settings and public health emergencies. Because international labour standards were crucial in setting the overarching guidance for the sector globally, efforts were needed to promote the ratification and implementation of key ILO Conventions and Recommendations, namely Conventions Nos 87, 98, 151 and the Collective Bargaining Convention, 1981 (No. 154). Despite a formal commitment to implement labour standards, major gaps remained in many countries with regard to implementation. Social dialogue, including collective bargaining, was equally crucial to address systemic challenges in the health sector. Yet, collective bargaining was not always accessible to all health workers, with many of them, especially in the public sector, not permitted to unionize in many countries. Austerity measures had led to the slashing of public funding and freezing of wages which had, de facto, reduced the capacity of collective bargaining for millions of workers. Many health workers, such as in Nigeria, had to work without being paid for months, which constituted a new form of forced labour.

52. There was also a need for a General Survey on promotion of Convention No. 149. A common definition of National Health Workforce Accounts (NHWA) was also needed since it was a useful tool for evidence-based policy and planning of the health workforce including educational requirements. Education should be free and accessible for all. In particular, girls should be encouraged to attain education. Various forms of training and education were needed, including for medical and health professionals but also for all workers who contributed to the delivery of public services. Unnecessary barriers to education should be removed as it hindered possibilities for additional health workers to be trained. A special provision for continuing professional development had to be provided for all workers in the sector, as well as possibilities for lifelong learning, including in such areas as social dialogue and collective bargaining. The promotion of gender equality and women's rights was crucial and a prerequisite for ending the gender pay gap. Low wages in the sector were due to the feminization of the health workforce. The protection of maternity and childcare provisions were important to ensure equal career possibilities for women and also to ensure equal pay for work of equal value in the workplace. The Equal Remuneration Convention, 1951 (No. 100), should be ratified and implemented.

53. The speaker underlined the need to curb workplace violence in order to reinforce the confidence of health workers. Legislation on OSH risks was also needed to address the many hazards prevalent in the sector. This should include regular assessment of working conditions and working time with a view to prevent accidents, and ensure health workers are routinely vaccinated against infections that could be contracted at work. The nature of work

in the sector also required that OSH policies take adequate note of musculoskeletal problems. All this required proper implementation of the Occupational Safety and Health Convention, 1981 (No. 155). While health workers' migration was important, it could not be considered the remedy to the sector's underlying challenges. Employers must ensure the ethical recruitment and retention of migrant workers, including by taking a stance against recruitment fees. The WHO Global Code of Practice on the International Recruitment of Health Personnel and the ILO's Multilateral Framework on Labour Migration provided the necessary normative guidelines for mitigating the downsides of health workers' migration and increasing the benefits. All relevant ILO and UN instruments should also be applied to protect the rights of migrant workers.

54. The challenge of generating adequate public resources and financing was difficult but needed to be addressed in order to achieve decent work in the health sector. Investing in the health sector should not be considered a cost whose budget could be cut as if it was an industrial factory where the profit-motive drove the service delivery. Governments had an obligation to ensure public health and therefore a duty to provide adequate public funding for health services. It was necessary to support universal health coverage with public funding, whether its delivery was through public or private service providers. Her group considered it necessary to end PPPs in the sector as such arrangements were not delivering satisfactory outcomes. An area as socially sensitive as the health sector, required strong public ownership and strong regulation of public financing. Governments also needed to harmonize the working conditions of workers in public and private health-care service providers address such problems as social dumping at the global, regional and local levels, with such issues addressed through future regional tripartite workshops.

55. A Worker member from Argentina explained his country had a long-standing tradition of collective bargaining in public and private health care. An agreement with private health-care providers had been reached for them to contribute a percentage of salaries to training of health workers. That contribution was to be paid directly to trade unions for them to provide the training. More than 40 training institutions across the country had been involved in training thousands of public and private health workers. In the Buenos Aires province, an experiment conducted in 2008 to provide grants to young secondary school-leavers to study nursing had resulted in over 10,000 young people becoming nurses, helping to fill the country's shortage of nurses. Such examples showed the potential of collaboration, social dialogue and collective bargaining to optimize benefits for the sector.

56. The Employers' group spokesperson stated that there were several issues that demanded attention, including the downward pressure on public financing as a result of past economic and financial crises, an increasing demand for health services, demographic change and new lifestyle trends around the world. Both public and private health-care budgets should be utilized to optimize service and spur improvements in health care. Due to the pressing needs of the health sector, effective innovations and funding models needed to be devised including through tax incentives, innovative economic and human resource management, in clinical and medical services and advances in technologies. Such examples would bolster quality health-care services. The growing disparity in the European Union's supply and demand of health-care workers meant that many health-care workers there had to take on multiple responsibilities and to work in different establishments. There was a need to foster greater collaboration between the public and private sector to effectively address health sector challenges. While many countries faced similar supply and demand disparities, one key difference among them was the financial means at their disposal to respond to such challenges. Therefore, individualized health-care strategies were needed with potentially higher public investments in some cases, and greater public–private collaboration in others. Legislation must also become less reactive in order to anticipate and address problems in a proactive manner. Governments, employers and workers needed to cooperate to promote healthy lifestyles since 46 per cent of deaths and chronic illnesses were caused by lifestyle factors. Awareness campaigns were needed to sensitize people about the importance of

healthy lifestyles. Despite demographic change in recent decades, governments had not succeeded in addressing primary health-care needs. There were shortages of hospitals, doctors and nurses. Pharmacists had an important role in improving access to care as they were more easily accessible to patients. As opposed to other sectors, health was more likely to face worker shortages rather than unemployment. It was thus important to consider stepping up training and improving and upgrading health workers' skills. Governments should provide assistance and incentives to improve the skills and working conditions of workers already employed in the sector and to attract young workers. There was an increasing generation gap among workers in the sector; for example, the average age of health workers in Spain was increasing while fewer younger people were available to replace older workers. It was therefore important to make the sector more attractive not just for nurses and doctors, but also for auxiliary workers.

57. A pressing issue concerning health workers' international mobility was the universal recognition of their degrees and qualifications across countries. The highly skilled Cuban doctors, who were required to work as generalists before they could exercise their specialization in Spain, was an excellent example of this problem where qualifications were not immediately recognized, making it difficult to attract highly skilled specialists from outside the country. A better system for recognizing professional medical qualifications was needed and the ILO should provide leadership in that regard. Technological innovation was bringing rapid change to the health sector. A transparent PPP framework, requiring enhanced financing and facilitating international cooperation was needed to improve technological systems for delivering quality health care. On the issue of equal pay for work of equal value raised by the Workers' group, the speaker was of the view their wages were no lower for women than they were for men, citing Spain as an example where male and female nurses had the same salary scale. Employers agreed, however, it was fundamental that women received the same access to jobs and equal pay as men when they did the work of equal value not just within the health sector but beyond.

58. The Governments' group Vice-Chairperson stressed the need for coherent policies and strategies at local, national and international levels through cooperation and consultation. Engagement with civil society and the social partners through effective social dialogue could improve the situation of workers and, in turn, improve service delivery. A holistic approach was essential to overcome the challenges in the health sector, including through the involvement of various departments beyond ministries of health, to put in place effective policies, to identify education and training requirements and to address other needs and gaps. Anticipation and prevention were key in creating a dynamic health sector. The ability to anticipate and prepare for the needed skills based on demographics required access to education and training facilities. There was also a need to anticipate and prevent emergencies such as contaminations due to epidemics or nuclear accidents which required proper planning. Country specificities, such as obesity or malnutrition should be tackled through the implementation of targeted strategies. Policies were needed to ensure managed migration by revising wages and developing bilateral cooperation agreements between countries of origin and those of destination in order to avoid brain drain and retain health workers in remote areas. Agreements might also be signed with health workers wishing to undertake training abroad whereby they committed to return to their country of origin upon completion of their studies. PPPs, inspection and control mechanisms were emphasized as a key element to ensure the rights of workers were protected. It was important to encourage coherence between laws and international standards such as those of the ILO and the WHO, as well as technical assistance in helping countries implement those standards.

59. The representative of the Government of Switzerland noted that his Government had recently approved a health-care strategy to ensure a sufficient number of health personnel equipped with the right skills. As part of the national health strategy, additional funding was provided in 2016 to increase the number of doctors trained in the country. Parliament had acted to standardize the law at the national level. An initiative was also launched in 2011 to

address shortages of skilled staff in the health sector, to increase productivity and to reduce dependency on health-care workers trained abroad. The first pillar of that strategy centred on training and skills development to meet health-care needs and to improve the work–life balance of health personnel. Two other pillars jointly aimed to create proper conditions for employment beyond retirement and improve productivity. The Swiss Federal Council had adopted two new programmes to support family care. Positive results had already been achieved, including increases in the number of professionals who have received university training and higher vocational training. However, many of the measures had long-term objectives.

60. The representative of the Government of India stated that the retirement age in his country had recently been raised, among other goals, with a view to reduce the shortage of health workers. A corporate social responsibility framework had also been adopted and the implementation of a rural health programme had started. An additional health-care programme was also launched that included pre-school activities as preventive measures, for example to prevent malnutrition. Specific preventive systems had been developed to utilize existing traditional medicinal systems as well as telemedicine to expand services to rural areas. In addition, maternity leave had been increased from 12 to 26 weeks to help ensure gender equality. Methods like yoga and other practices were also supported as preventive measures.

61. The representative of the Government of Togo stated that his country was currently implementing new measures as part of the national health development plan. OSH-related aspects were integrated into the nationwide health-care plan. Health security bodies will be trained in social dialogue and OSH, which will promote dialogue between personnel and management. Health security bodies were a means to identify biological risks such as Ebola, human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS) and types of hepatitis, psychosocial risks and other hazards to which health-care workers might be exposed. In the long term, several new aspects could be introduced at no additional cost, which would benefit both personnel and management. Togo was also in the process of implementing a nationwide OSH programme for health professionals, focusing largely on training. For the first time, OSH provision was integrated into the national health development plan, which should lead to its inclusion in the national budget in future years. Additional funding was needed, however, to support workplace OSH. Guidance was necessary on emergency and crisis management and the proper protection of health-care personnel.

62. The representative of the Government of the Islamic Republic of Iran stated that the social security organizations in his country covered 41 million insured people. A successful programme on decent work in the health sector had been established. Eighteen additional hospitals had been constructed across the country, with a total of 10,500 beds, as had 286 outpatient clinics staffed with 46,000 health workers. Those facilities provided health care for about a million patients annually. Working conditions were a central concern, including the need to decrease working hours of health professionals and to ensure fair compensation. Health-care staff were often exposed to harmful and dangerous conditions. Over an eight-year period from 2007 to 2016, the National Institute of Occupational Safety and Health (NIOSH) had achieved substantial improvements in OSH-related areas.

63. The representative of the Government of Malta stated that strategies may be utilized for the re-employment of retired officials in public services to fill workforce gaps, without compromising the employment of young people. Given budgetary constraints, resources needed to be used efficiently. A proactive dialogue with other stakeholders was necessary, including with unions, educators and training providers. Education facilities had to respond to country-specific trends and help guide labour market forecasting and planning. Governments had a responsibility to ensure workers were not being mistreated in the

workplace. In that regard, PPPs provided an effective means of cooperation between governments and the private sector to promote decent working conditions.

64. The Governments' group Vice-Chairperson, speaking as the representative of the Government of Algeria, emphasized anticipation of future labour market needs as a key priority for her Government. The national pension fund of Algeria would soon contend with the massive retirement of doctors as foreseen to take place in 2019 and 2020. The Government was working to address that challenge without changing the labour code. Gender-equality, including equal pay for work of equal value, was another priority issue. Algeria had an equal payments mechanism in place to protect against pay discrimination. Yet, the challenge remained for many women who had both formal jobs and also unpaid care work at home.

65. The Employers' group Vice-Chairperson, presiding over the afternoon plenary sitting, opened the floor for further discussion on point 2.

66. The representative of the Government of Italy emphasized lifelong learning not just for health professionals but also other workers in the sector, including auxiliary health workers. The health sector in his country had for example 1 million health professionals as well as an additional 1 million auxiliary health workers, with the latter more often in closer interaction with patients; hence the importance of extending lifelong learning programmes to workers in the latter category. Secondly, while university entry barriers might be seen as a problem from students' perspective, they also could in reality be a tool to prevent future unemployment in the sector. It was for that purpose that Italy set annual student intake limits, based on sectoral workforce supply and demand projections. An example of the negative consequences of not setting such limits was the case of pharmacists whose unemployment was currently approximately 5,000, especially among young graduate pharmacists, with that number forecast to rise to 50,000 by 2030. Improving workforce planning and management capacity at national and local levels was a prerequisite to ensuring having the right numbers of the health workforce in the right place with the right skills, and who were motivated and enjoyed decent working conditions. This was critical, as the High-level Commission on Health Employment and Economic Growth had proposed an ambitious target calling for more investment in the health workforce. Yet, without the right management support and planning capacity, the risk was that such an investment would just result in rising costs. Further, in order to build and manage the right future workforce and ensure decent work conditions, the current conditions and features of the workforce needed to be understood. Therefore, one of the priorities was to ensure that every country collected, updated and detailed data on its workforce. He underscored that the involvement of stakeholders, both at national and local level, including patient representatives, was a key factor at any stage of the health workforce planning and management process to ensure as far as possible equity among the health workforce. At the international level, one of the priorities was to invest in the management of health workforce migration, which meant first understanding the magnitude of flows, with the collaboration of all governments.

67. The representative of the Government of Spain stressed the need for intersectoral coordination mechanisms. Close cooperation between health and education authorities was considered crucial in his country. Looking ahead to the 2030 Agenda, it was vital to include health and disease prevention in education curricula at the earliest age as today's children were the patients and health-care professionals of tomorrow. Appropriate coordination was imperative in order to better match labour market demand for skills with those supplied by universities and other institutions of higher learning. Coordination was similarly essential at the international level to monitor and evaluate education and qualifications in the interest of providing high-quality health care that benefits patients worldwide.

68. The representative of the Government of Brazil highlighted his Government's attachment to coherence in global policies and strategies for the sector. The WHO, at its World Health Assembly (WHA), had already discussed and adopted resolutions and instruments for many of the issues under consideration, including WHA resolution 63.16 regarding a global code of practice on recruitment; resolution 64.6 on health workforce strengthening referring to the retention of rural health workforce, which was an issue of critical importance to many governments; resolution 66.23 regarding the transformation of health workforce education as part of ensuring universal health coverage with a view to strengthening capacity where the health workforce was most needed, such as in rural areas; and resolution 69.19 regarding a global strategy on human resources for health, which includes the need for a systemic view of health-care requirements. In the interest of greater international policy coherence, it was vital that all these decisions and instruments be taken into account in developing the Meeting's conclusions. It was equally essential for the ILO to listen to the actors on the ground regarding the reality of the issues they faced and their actual needs, in order to assist constituents to develop labour market institutions best able to support their national health systems, workforce development and management to achieve decent work in the sector.

69. The representative of the Government of the Philippines underlined the high value his country attached to education and training, especially for work in the sector. The Philippines produced a large number of nursing graduates annually, the challenge being how to find them employment locally. Many of those graduates ended up looking for jobs abroad, preceded by moving from rural to urban areas to seek training for those overseas jobs, which resulted in shortages in rural health-care workers. Several options to increase local employment such as PPPs, medical tourism or collaboration between sending and receiving countries on training and education were being discussed. He also noted that migrant domestic workers were often still uncovered by several host countries' labour laws which, in turn, tended to deprive them of health insurance. It was important to ensure that such workers were protected, and that, at a minimum, even undocumented migrant workers should have access to health care.

70. The Workers' group spokesperson supported the view expressed by the governments on the need for better coordinated and more holistic approaches to the issues that had been raised in discussions on this point. Overspecialization in the health sector raised costs and was not always effective in responding to patient needs in their integrity. Social dialogue was essential as a means to strengthen many of the health-care issues that had been discussed. She concurred with the representative of the Government of the Philippines that migrants should have access to social protection and health care as it was a fundamental right and a matter of safety for communities in the receiving countries. Education was another area where work needed to be done collectively to ensure harmonization. Training and education curricula should also take account of the need for integrating migrants. Gender pay gaps across the world remained a concern; even in Europe this amounted to an average of 22 per cent, arising mainly from differential career development tracks for men and women and a high incidence of women's absence due to maternity and childcare. Unhealthy long shifts or long working hours to which health workers were increasingly subjected inflicted high costs for both the sector and society at large. It was critical to reduce staff attrition rates and to improve their retention by improving working conditions and ensuring decent work. Pension systems based on prolonging working lives were not good for individuals whose work required exposure to workplace hazards and intense working conditions. Finally, corruption in health-care systems was an increasingly structural problem that needed to be addressed and this, in turn, required protecting whistle-blowers. Responding to an earlier comment from a government delegate, she stressed her group's view of PPPs in health services as a drain of funds from the public to private interests and, as such, a cause of long-term government indebtedness, and hence not advisable.

71. The Employers' group spokesperson reiterated the view that there was an ongoing conflict between two priorities: society's health needs and the high costs of providing for such needs. Working days in the sector were indeed long, but this was due to staff shortages. Besides addressing these issues, proper marketing of health service jobs was key to attracting young people. The responsibility to improve access to quality health care was shared by all three constituents. Governments needed to ensure adequate training opportunities were available. The role of the private sector in the sector was increasing, accounting for greater generation of jobs, even as public funding was becoming more constrained. All parties agreed on the importance of migration, recognition of qualifications and the issues related to them. There were obstacles to the international recognition of health-care qualifications, and a growing number of rural health-care workers sometimes crossed borders as the remuneration was better. Governments needed to lead in devising solutions to these challenges. The gender issues discussed, particularly relating to the wage gap, were often rooted in social values. Such values needed to be addressed as early as possible, including in elementary schools. Female nurses in Spain did not face a wage gap thanks to the legislation on gender equality.

Enhancing social dialogue to address decent work challenges in health services

72. The Executive Secretary introduced point 3 which concerned the role of social dialogue.

73. The Employers' group spokesperson recognized the importance of enhancing social dialogue. It was up to the countries individually to do this in accordance with their national legislation.

74. The Workers' group spokesperson underlined social dialogue as a central mechanism for building social cohesion and improving employment and working conditions in the health and social services sector. Experience proved the effectiveness of both bipartite and tripartite models of social dialogue. Over the last decade, however, unilateralism by governments and employers had too often become the norm. Lack of ratification and, more importantly, implementation of Conventions Nos 87, 98, 149, 151 and 154, had had an undeniably deleterious impact on the quality of social dialogue in the sector. Many health workers had neither the right to organize nor to strike, with governments expanding the list of essential services so that in effect large numbers of health workers could not strike at all. This issue deserved particular ILO attention. She illustrated these points with examples from Algeria, Australia, Colombia, Kenya, Liberia, Nigeria and the United States where workers faced challenges caused by disrespect for trade union rights. On the other hand, positive experiences were noted in New Zealand, Germany and within the EU where, in the latter framework, social dialogue had led to a directive on needle stick injuries, a cross-sectoral agreement on working time and employers' support for continuing professional development. The commitment of social partners within the national sphere to social dialogue was necessary as was the need for trade union rights to be respected and for collective bargaining to be carried out in good faith by all social partners, including at the national and workplace levels, for it to be functional and effective. Regional tripartite meetings would help to increase commitment. Social dialogue was also an instrument for curtailing workplace violence in the sector. Reviewing the 2002 Joint ILO, ICN, WHO and PSI *Framework Guidelines for Addressing Workplace Violence in the Health Sector* would be a good starting point. The formulation of guidelines for the improvement of employment and working conditions in the sector was recommended. Finally, she requested for a General Survey of Convention No. 149, ratified by 41 countries, and for particular attention to health-care workers in the revising of Recommendation No. 71.

75. A Worker member from the Republic of Korea stressed the importance of social dialogue for her country, where unions and employers had jointly agreed on the need to build a sectoral tripartite commission on the health-care industry, though in the face of the

Government's attitude there had as yet been no real progress over the previous nine years. However, in a recent forum, where the employers' associations, NGOs, unions and government officials had met to discuss the problem of the health-care workforce shortage, all had unanimously agreed that there was a need for a sectoral tripartite dialogue to address the problem and for the National Assembly to pass the Healthcare Workforce Act. The meeting had called on the Government to conduct a survey on the sector's workforce demand and supply as a basis for developing new education and training policies. She called on countries to set up sectoral tripartite commissions to propose ways to create new jobs and for governments to recognize industrial unions and to promote the expansion of sectoral bargaining through supporting regulatory mechanisms.

76. A Worker member from the United States reported on a growing trend in her country for large health-care systems to merge into mega-systems within single states and sometimes even across state lines. These systems, driven purely by profit-seeking, were increasingly eliminating small, community hospitals and stand-alone hospitals in rural areas where there was a higher level of uninsured people. Rather than viewing nursing as a valuable contribution to saving costs through effective and safe care, some hospital systems viewed them only as a short-term cost centre. Unionized health-care facilities were also being merged into large non-union facilities – diluting their strength and impact. Corporate leaders and for-profit owners invested in union-busting firms to challenge and eliminate workers' rights. This was placing the quality of care and the safety of both caregivers and patients at increasing risk.

77. An Employer member from Kenya pointed out that although the public sector was responsible for the provision of the bulk of health care in most countries, the contribution of the private sector could not be ignored. In her own country, the private sector was considered complementary to what the Government was able to provide. Faith-based organizations in particular were able to operate in remote places where government clinics and staff were unable to reach. Although some not-for-profit organizations were not able to bring the level of investment that similar government organizations could, they nevertheless were providing services that would otherwise have been absent or which would be reliant on the use of scarce foreign exchange. Moreover, these organizations helped to supply necessary training, as well as important employment opportunities for health-care workers. Private investment was therefore key to ensuring access to health care in some of the countries concerned.

78. Another Employer member from Poland underlined the positive role of PPPs in his own country, including needed investment to fill gaps in the health-care system. In his country, for instance, there were long waiting lists at public hospitals for certain procedures (e.g. orthopaedic or cataract surgeries). Private hospitals could help patients access the services they needed in a shorter time, with the national health service contributing to the funding of these procedures, including at private hospitals. The responsibility for providing services was collective. PPPs were only one possible way of addressing potential gaps, and could help with regards to training as well.

79. The Workers' group spokesperson acknowledged that there could indeed be a positive role for private health-care service providers, reminding the Meeting that she herself was, without any contradiction, a representative of workers from both the public and private sectors, who shared the same agenda as their workplace problems were similar. It was important to discuss how to fund the system, perhaps by putting in place fair tax reforms for example, but this was not the appropriate forum for such a discussion. She was encouraged by the collective commitment to social dialogue and collective bargaining and was convinced that this would lead to a constructive and cooperative effort to promote decent work in the health-care sector.

80. The Vice-Chairperson of the Government group acknowledged that all the points made by the various groups and governments had been pertinent and well-noted.

Recommendations for future action

81. The Executive Secretary, introducing point 4 of the discussion, explained that its main purpose was to invite recommendations for future action by the ILO, governments, employers' and workers' organizations regarding the promotion of decent work and employment in the health services sector.

82. The Workers' group spokesperson, stressed the importance of social dialogue and collective bargaining in building consensus on a sustainable approach to improving employment and working conditions in the sector. It was essential to protect workers by promoting decent working conditions, including on pay, working time, safety and health, equal pay, maternity protection, gender equality and non-discrimination, prevention of violence at home and in the workplace and ensuring access to public services. OSH standards were crucial to these goals and should be discussed and adopted within the ILO. Social partners should address the issue through the establishment of bipartite OSH committees as an integral element for the effective implementation of Convention No. 155. Labour migration must not be an obligation but a choice. Access to social protection and equal labour rights should be guaranteed to all migrants. Cross-border labour migration from developing countries should be undergirded by bilateral agreements concluded with the participation of social partners, in line with Convention No. 143, and the ILO Multilateral Framework on Labour Migration. The WHO Global Code of Practice on International Recruitment and Health Personnel (2010) should be adopted and implemented at the national level. Recruitment fees should be eliminated, bearing in mind the Private Employment Agencies Convention, 1997 (No. 181), and the ILO General Principles and Operational Guidelines for Fair Recruitment. Social dialogue was an essential tool in developing curricula and competencies – involving national and global trade union organizations as well as the ILO, the WHO and other stakeholders. Unnecessary barriers that prohibit entry into education systems for health professions should be removed and professional training systems should be tuition-free, supported by employer investments and contributions. The speaker emphasized the need for the ILO to remain deeply engaged in the implementation of the UN HEEG Commission's recommendations and the related five-year action plan, ensuring the inclusion of the social partners in associated processes at the national level. A tripartite commitment to implement the recommendations of the Commission was welcomed.

83. The outcomes of the current Meeting should advance decent work in the health sector by actions in several areas, including: regional tripartite meetings over the coming five years; the 2002 Framework Guidelines for Addressing Workplace Violence in the Health Sector should be reviewed in addition to the ongoing work on violence against women and men in the world of work; a tripartite expert meeting should be convened to formulate guidelines for the improvement of employment and working conditions in the health sector; comprehensive research should be conducted on community health workers, long-term care workers and homecare workers including opportunities to strengthen collective bargaining and improve labour and trade union rights; a General Survey of Convention No. 149, should be conducted; and revision of Recommendation No. 71, should give due attention to health-care workers.

84. The Employers' group spokesperson, underlined the need to devise appropriate recommendations and policies to address the shortage of skilled health workers. Studies were required on the various types of contracts within the sector to better understand delineations between local and international trends. A study was also needed on the impact of public and private sector investments in the sector, to better determine the number and impact of private hospitals, and the repercussions for health workers. The private sector should be called upon to provide increased data in order to help shape the future of the health sector. Migration was inherent in a globalized world; it was important therefore that the ILO undertake research on how to ensure worldwide recognition of health workers' skills and qualifications. Studies were also needed on the access of young people to the health labour

market, including, inter alia, national differences, the types of health workforce shortages at the national level, types of policies various governments were adopting to address shortages, including in terms of access to (higher) education. Similar studies should aim at determining the main factors deterring young people from pursuing health careers, as well as gender equality in the sector. Social dialogue remained a key tool for devising effective policies to strengthen the health sector. However, governments had the competency and responsibility to implement policies deemed most appropriate, including on social dialogue. Similarly, an ILO study should seek to expand understanding of the rural health sector, including the challenges and types of tools needed to make work in rural areas more attractive. There was also a need to understand how better cooperation with all health-care professionals such as doctors, nurses and pharmacists, could generate improvements in the sector, including access to health care.

85. The Governments' group Vice-Chairperson, emphasized that health sector financing should be considered an investment rather than a cost. Training was an essential tool to expand the health workforce but adjustments were needed to reflect demographic and epidemiologic changes. Moreover, all health-care workers, including administrative personnel and nurses should have access to training. Investments targeting many of the SDGs could render positive outcomes for the health sector. Policies to promote job creation should be prioritized, while gender equality and the abolishment of sexual harassment and violence at work required further attention. Policy-makers should bear in mind that decent work was both a means and an end, as it served as an overarching development objective as well as a tool for achieving development progress. ILO support was needed to help build health workers' capacity. Collaboration with all stakeholders at local, national and international levels was similarly needed and should be guided through tripartite engagement and dialogue. Research and efforts to enhance data quality would be necessary to help guide effective policies and further drive policy coherence at national and international levels. Patients should also be engaged in decision-making processes so as to give a voice to those directly affected by health policies. Further regulation was needed to address conditions of workers in non-regular employment and the ILO was well placed to provide assistance in that regard. Policies should not only target treatment as a component of health care but should also focus on prevention. Improvements in the management of the sector at the local level was needed, including the anticipation of skills requirements based on demographics and the use of new technologies. Health workforce migration presented many challenges and opportunities but further investments were needed to ensure balanced migration. Regional decent work programmes could help generate positive outcomes for strengthening health workforces. The challenges facing rural areas were acute and required special attention to attract and retain health workers as well as provide adequate health services to rural populations. Policies were also needed to engage women and youth in the health sector. The private sector had an important role in providing health services worldwide and therefore, should continue to be involved in efforts to strengthen the sector.

86. The representative of the Government of Norway congratulated the ILO, the WHO and the OECD for their joint work on the UN HEEG Commission, a model partnership needed to achieve the SDGs. There were a number of priorities that should be reflected in the conclusions of the Meeting. The case for investing in the health workforce should be acknowledged as it also presented possible gains across other SDGs. Job creation through the development of labour market policies that stimulated decent health sector jobs represented a clear priority, including the prioritization of education and employment opportunities for women. The quality of jobs created was equally critical in order to attract and retain a qualified and motivated health workforce. That required due consideration of working conditions, good training and career prospects, fair remuneration, adequate social protection, occupational safety, and social dialogue. Policy responses must be highly gender sensitive and directed at women and youth since many women were the main providers of care and continued to face high incidences of physical violence and sexual harassment in the workplace. Efforts must be made to create the necessary competencies to ensure that health

and social workers were in the right jobs, with the right skills and in the right functions. A balanced approach was needed towards international migration of health personnel. On the one hand, it was necessary to provide citizens with high-quality health services. On the other, it was important to ensure that national health sectors were operating in a globally responsible manner that did not put undue pressure on the health systems of developing countries. In that regard, the WHO Global Code of Practice on the International Recruitment of Health Personnel was a useful tool. There was also need for measurability, transparency and accountability which could be understood as strengthened policy coherence, which could be encouraged by governments that adopted a whole-of-government approach at the national level and by international organizations that undertook joint work across sectors.

87. The representative of the Government of Spain stressed that in terms of mobility and migration of health workers, it was important to come up with international measures, coordination and cooperation principles to facilitate mobility and to provide guarantees to health professionals. Tools were needed to encourage the recognition of degrees at the international level to ensure ongoing training for all health-care professionals throughout their careers. Those tools could help ensure the security and safety of health workers but also to ensure quality health-care for patients.

88. The representative of the Government of the Russian Federation, said that through the national labour code, her Government had established recommendations on wage levels, including for the health sector. Such efforts were designed to provide a unified approach on wages throughout the 86 regions of the country. That plan included guarantees that employers could not offer less than the recommended wage levels, which was monitored by the central government and regional authorities. Additionally, tripartite bodies were established in each of the regions to ensure proper implementation and follow up.

89. The representative of the Government of Togo stated that governments should consider resources for the health sector to be an investment as opposed to a cost. OSH plans tailored to the needs of health workers needed to be implemented at health workplaces, and then integrated into national strategic plans with the support of, inter alia, the health and finance authorities. Capacity building on the implementation of OSH plans in vulnerable countries was equally critical, since the recent Ebola epidemic highlighted the grave human and economic consequences that could result from lack of capacity and planning. The ILO and other partners must assist in ensuring the safety of health workers and in developing the capacity of health personnel. Such efforts would increase productivity, improve the quality of health care and generate a substantial return on investment through economic growth. Social dialogue was a key element to ensure that staff had the necessary tools to properly assess the risks to which they were exposed and to come up with coordinated action plans on solutions that could be applied rapidly to address such pressing challenges as violence in the workplace, infections and budget constraints.

90. The representative of the Government of the Philippines underscored the importance of protecting the health and well-being of trainees and interns in the sector. Far too often hospitals engaged the services of trainees or interns for long periods of time, as a means to save on labour costs. Those workers must be guaranteed adequate compensation and their rights protected.

91. The representative of the Government of Brazil stressed the importance of policy coherence, bearing in mind that other instruments had already been adopted by other organizations and bodies such as the WHO. Also, the various SDGs should be taken into account as many of their objectives were also correlated to many of the recommendations made during the current Meeting. In particular, SDG 17 which focused on effective partnerships, could be beneficial in identifying ways in which development cooperation could enhance health sector policies and the provision of decent work for all in the health sector. The ILO's Future of Work Initiative was well placed to address such issues as the smart use of technology and

its impact on job creation. He supported the Workers' proposal to consider elements of health care in the revision of Recommendation No. 71, during the 106th Session of the International Labour Conference in June 2017, noting, however, that the process was well advanced and that there could be difficulties inserting new concerns. While his Government had not ratified Convention No. 149, it had no objection to the proposal for a General Survey though the broad scope of such an undertaking should be considered. The ten UN HEEG Commission recommendations provided useful guidance to overcome health workforce challenges. The tripartite partners could therefore support those recommendations, including the needed paradigm shift on investments that the Commission had identified. It was however premature for the partners to support the proposed five-year action plan since it had yet to be published, though it might be submitted to the ILO Governing Body at a later date.

92. The representative of the Government of the Russian Federation recounted her Government's efforts to provide compensation for professionals working in high-risk employment. The Law on Special Working Conditions identified four specific risk categories which translated into different levels of compensation in the form of wages and holiday entitlements. A special risk assessment committee was established for transparency and monitoring purposes. The committee included trade union representatives working in the relevant sectors.

93. The Workers' group spokesperson thanked the previous speakers since many of the points raised represented a common commitment for future action. There was a need to strengthen the number and role of OSH professions in the sector. It was also important to uphold the rights of trainees and interns involved in service delivery in the sector, including fair compensation. While it may not yet be possible for the ILO Governing Body to endorse the UN HEEG Commission's five-year action plan, it was still important for the Meeting to endorse the overall package including the critical issues of financing, training, and the contribution of public and private sectors to the sustainability of health-care systems.

94. The Employers' group spokesperson stated that many employers were already bearing the cost of training and workplace OSH but felt that governments should assume responsibility for certain other needed provisions in the form of tax breaks. While welcoming the fact that many in the room accepted health care as an investment rather than a cost, the situation in the real world showed otherwise. In times of economic crises, health budgets were typically cut. The use of interns and trainees in the sector was directly related to health workforce shortages. More information was needed on the impact of technology on working conditions as well as how technology might add value to the sector. Policy coherence was critical in promoting health worker mobility, particularly as it related to university qualifications. Considerations were also required to ensure mobility did not lead to the deterioration of working conditions. Efforts were needed to make the health sector more attractive to young people.

95. The Governments' group Vice Chairperson expressed satisfaction with the high degree of convergence among participants on the issues raised and looked forward to collaboration on the conclusions.

VI. Consideration and adoption of the draft conclusions by the Meeting

96. The Working Party on Conclusions submitted its draft conclusions to the Meeting at the latter's sixth sitting.

97. Chairperson of the Working Party, presenting the draft conclusions, reported they were the result of a hard work and constructive social dialogue. She thanked the members of the working party for their inputs, discussions and compromises, which had allowed them to successfully complete their work.

98. The representative from the Government of Jordan stated that, as it was a public holiday back home, he had been unable to share the draft document with the relevant authorities in his country, requesting therefore that he have the right to provide observations at a later stage, particularly relating to paragraph 6, as he considered the reference to "migration" to solely refer to migration in his country subject to national laws and ratified Conventions.

99. The Governments' group Vice-Chairperson stressed that discussion on migration should not prejudge the outcome of other ongoing processes.

100. The representative of the Government of Jordan underlined his view that the Governments' group Vice-Chairperson should not base the group's conclusions on her understanding of the issues related to migration. His objection related only to the reference to illegal migration and not to migration as a whole.

101. At the same sitting, the Meeting unanimously adopted the draft conclusions, with a small number of amendments.

VII. Closing speeches

102. The Employers' group spokesperson, noting that the Meeting had presented a first opportunity for many participants to engage in an ILO tripartite meeting, stressed that the exchanges had revealed that many members of his group faced similar challenges. The rapid changes in the world of work implied that employers, workers and governments all had an obligation to keep up with the fast and extraordinary changes that were taking place in the health sector. The conclusions provided important guidance for the tripartite members but also for the ILO, which would also need to adapt its work to the issues of concern highlighted during the Meeting. The cooperation displayed during the Meeting represented positive and constructive dialogue.

103. The Workers' group spokesperson underlined her group's satisfaction with the conclusions of the Meeting. The health sector was of great importance for societies and communities as well as for economic growth and social inclusion. The present conclusions represented a major contribution to the achievement of the SDGs. Her group looked forward to continued cooperation in advancing the recommendations.

104. The Governments' group Vice-Chairperson thanked the social partners for their constructive efforts and flexibility in reaching an ambitious set of tangible conclusions. It was important to recall that decent work and social dialogue remained key components of strategies to improve employment and working conditions in the health sector.

105. The representative of the Government of Brazil thanked their group's Vice-Chairperson for her tireless efforts and leadership in coordinating the Government group.

106. The representative of the Government of Chile thanked the spokespersons of each of the regional groups who managed to successfully align the sometimes divergent positions within the Government group.

107. The representative of the Government of Togo stated that the conclusions of the Meeting represented a victory for all, particularly since the health sector impacted everyone. The policy recommendations reflected in the conclusions would provide useful guidance in the years to come and would need to be integrated into national action plans. He congratulated all the participants for their collaborative efforts.

108. The representative of the Government of India congratulated the participants for their positive contributions and for reaching a successful outcome. The conclusions displayed the power of social dialogue.

109. The representative of the WHO congratulated participants on the adoption of the conclusions which had an enormous potential for advancing policies, investments and actions to expand the health workforce. They represented an important reflection point for improving employment and working conditions in the sector; the task now was to turn the commitments and conclusions into action and the WHO, for whom it had been an honour to work with the ILO, particularly on the UN HEEG Commission, looked forward to continued collaboration to ensure that these commitments became a reality.

110. The Secretary-General reiterated the earlier point expressed by the representative of the Government of Togo that the Meeting represented a victory for all. It also represented an excellent example of social dialogue at work. She congratulated all of the tripartite participants for their dedicated efforts in arriving at a positive outcome and set of conclusions. She also thanked the members of the secretariat for providing effective support prior to and throughout the Meeting.

111. The Chairperson expressed satisfaction with the efficient working methods of the Meeting and congratulated the three groups for reaching a constructive consensus. She thanked the Office for its efforts in providing the Meeting's background material and the excellent support throughout the course of the last five days. The Chairperson declared the Tripartite Meeting on Improving Employment and Working Conditions in Health Services closed.

Conclusions on improving employment and working conditions in health services [1]

The Tripartite Meeting on Improving Employment and Working Conditions in Health Services,

Having met in Geneva from 24 to 28 April 2017,

Adopts this twenty-eighth day of April 2017 the following conclusions:

Introduction

112. Decent work in the health sector is fundamental to ensuring effective and resilient health systems and is a prerequisite to equality in access to health services, good quality health care, and productivity in societies. The sector provides growing opportunities for employment, particularly for women and young people. Decent work in health services is critical for achieving various Sustainable Development Goals (SDGs), particularly SDG 3 on ensuring healthy lives and promoting well-being for all at all ages, SDG 4 on quality education, SDG 5 on gender equality and SDG 8 on decent work and inclusive economic growth. The ten recommendations of the High-Level Commission on Health Employment and Economic Growth (HEEG Commission) on investing in the health workforce have been adopted by the General Assembly of the United Nations in Resolution A/RES/71/159, which calls on member States to develop intersectoral plans and investment in education and creation of decent jobs in the health and social sectors.

Challenges and opportunities in promoting decent work in the health services sector and their effects on access to health services and provision of quality care

113. The health sector faces numerous challenges. The already limited public funding for health care systems has been further reduced in many countries in current times of economic downturn. Health workers are faced with the challenge to adapt to greater demands for flexibility and productivity without compromising on the delivery of quality care. In many countries young people are not attracted to certain health-care jobs due to low wages, long working hours and occupational safety and health (OSH) risks, particularly in preparing for and responding to public health emergencies, whether they be due to new epidemics, evolving diseases, and natural disasters, as well as armed conflicts. Concerns about lack of social protection can also constitute a challenge in certain parts of this sector. As a result, there are severe shortages of health workers in some countries constraining the achievement of universal access to health care. It is especially challenging to attract skilled health workers to rural and remote areas. Health care work is for the most part carried out by women, and the prevailing decent work deficits in the sector often reflect overall gender inequalities and prejudices in societies. Health worker migration has been one of the means of addressing health worker shortages in many countries, yet it poses further challenges, including integration of migrant health workers, ensuring decent work and access to health services, and preventing the drain of skilled workers. This drain puts undue pressure on source countries which may have already spent the scarce financial resources available on their

[1] These conclusions were adopted by the Tripartite Meeting on 28 April 2017. In accordance with established procedures, they will be submitted to the 331st Session of the Governing Body of the ILO (October–November 2017) for its consideration.

training and may have a shortage of trained skilled workers themselves. Auxiliary and volunteer workers can also be used to fill the health worker gaps, but regulations are needed to ensure decent work. Privatization and outsourcing of health services have further diversified the sector, which could in some cases lead to challenges in effective social dialogue if not properly monitored and regulated.

114. There are also promising opportunities and measures for developing decent work in the health sector. Incentives and other financial reward schemes have been used to attract health workers to the sector in many countries, especially in rural and remote areas. Health worker migration, in line with international standards, can be a means of facilitating access of health workers to labour markets under decent work conditions, as well as filling gaps in the workforce of destination countries. Social dialogue with governments and representative employers' and workers' organizations enhances decent work for health workers in a sustainable and productive manner; it prevents costly labour conflict which can have a negative effect on services. Social protection systems which adequately provide for health financing and long-term care, such as old-age, disability, and chronic diseases care and support, are critical both for beneficiaries and the working conditions of health workers. International bodies can have a role in facilitating national social dialogue to explore solutions for improving working conditions for health workers.

115. Decent work for health workers needs to be considered in the context of the future of work, in particular the demographic trends that are driving the high demand for health workers, rapid developments in population health needs, including in preparation for and in response to public health emergencies, science and technology, evolving migration and gender dynamics, and changing employment relationships in the sector. More and reliable data are needed on trends in health-care work and also on the application of health workforce planning and forecasting tools. Skills development and training, continued education coupled with evaluation, enforcement of OSH standards, and better working conditions, including remuneration, can lead to greater attractiveness of careers in health services and more motivated and qualified health workers, and thus improve productivity. Technology can supplement and contribute to the delivery of health care to rural and remote areas and open up new employment paths, for instance in telemedicine and mobile clinics.

Guidance, policies, strategies, programmes and tools needed to ensure decent work in the health services sector

116. Inclusive and quality education for all is one of the key strategies for ensuring adequate numbers of appropriately qualified health workers. Education and training for the health sector should be designed in anticipation of and be sensitive to changes in health-care demands and emerging health needs, as well as emergency situations. It should be accessible and, where possible, free. Appropriate contributions from governments, employers, workers and relevant stakeholders to such training can increase its reach and accessibility. Education and training of health workers should extend to all occupational groups within the health sector, including auxiliary workers. These programmes should include OSH as part of basic and ongoing training. In addition, health education for the general public contributes to prevention of diseases and thus to a reduction of demands on the health system and costs. Professional development and lifelong learning approaches are essential and should be promoted and made accessible to all workers in health services. Creating education and skills development infrastructure in rural and remote areas can also be a means to attract and retain a local health sector workforce.

117. Without prejudice to ensuring the sustainability of the health workforce in source countries, health worker migration can help to address gaps in the health workforce, but requires clear processes for the international recognition of skills and occupational qualifications,

protection from unethical and unfair recruitment practices, and adequate social protection of migrant health workers, including those employed in home-based care. Recruitment practices should be in line with the ILO general principles and operational guidelines for fair recruitment and the *WHO Global Code of Practice on the International Recruitment of Health Personnel* (2010) and seek to benefit all parties.

118. Specific programmes to protect health workers from occupational hazards and risks in accordance with national legislation and backed by effective enforcement mechanisms in line with the relevant international labour standards, as well as the ILO/WHO Joint Global Framework for National Occupational Health Programmes for Health Workers, are indispensable in the health sector. In addition to dealing with the prevention of the transmission of diseases and sharps injuries, OSH measures and access to occupational health services should address the full range of hazards, including violence at work, musculoskeletal problems and communicable diseases, and provide for periodic medical examinations of health workers.

119. Gender equality needs to be mainstreamed in strategies and approaches to the health sector workforce. Strong maternity and parental protection that promotes work–life balance can augment the attractiveness of the sector.

120. The sector should be engaged in promoting policies that seek to eliminate any form of discrimination in the workplace and ensure protection to vulnerable groups.

121. Universal health care, with a focus on primary and preventative care, should be ensured through adequate public funding. Private investment can supplement public funding and health service delivery. In the public interest, health service delivery should be adequately regulated to ensure universal access to health care. Effective coordination of the health sector requires an intersectoral approach across government ministries which puts emphasis on dialogue with the social partners and other stakeholders.

122. Policy coherence and coordination at all levels is essential to ensure effective and quality health systems and services, taking into account relevant international labour standards and guidance and tools developed by the World Health Organization (WHO) and other international and regional organizations.

The role of social dialogue in addressing the challenges regarding decent work in health services

123. Social dialogue is a key strategy for developing sustainable health sector policies and practices in general, and for improving the working conditions of health workers in particular. Freedom of association and the right to collective bargaining for all health workers need to be promoted in line with the 1998 ILO Declaration on Fundamental Principles and Rights at Work and its Follow-up.

124. Social partners and governments have vital roles in promoting and using social dialogue to advance health goals and providing quality health care as a common public good. National and local social dialogue mechanisms, involving social partners and, where appropriate, other stakeholders, can be useful institutions for governing health-care reform efforts and providing input on legislation, education plans and financing schemes for health. Working conditions in the health sector, in so far as they are not otherwise made effective by collective agreements, arbitrational awards, or in such other manner consistent with national practice, should be set out in national laws and regulations.

Recommendations for future action by the International Labour Organization, governments, employers' and workers' organizations

125. Constituents in the health sector should:

(a) actively engage in effective social dialogue in its various forms in order to advance areas of common interest and to promote decent work and productive employment as well as continued professional development and lifelong learning for all health workers;

(b) define, invest in, and implement national health workforce strategies in accordance with the recommendations of the HEEG Commission with the active involvement of relevant stakeholders, and encourage the ILO Governing Body to consider the Five-Year Action Plan for Health Employment and Economic Growth (2017–21);

(c) ensure policy coherence in international initiatives and related partnerships in line with existing international labour standards and WHO guidance tools.

126. The Office should:

(a) promote ratification and effective implementation of international labour standards relevant to the health services sector, as well as respect for the fundamental principles and rights at work (FPRW) and build the capacity of constituents to realize these rights including through development cooperation, emerging partnerships, and the ILO International Training Centre (ITC–Turin) and regional centres;

(b) undertake a comprehensive study on member States' national laws and practices and assess if existing ILO programmes, activities and instruments and those from the WHO provide a sufficient framework for ILO constituents to promote decent work for all health workers and what additional guidance is needed, with particular attention to home care and community-based health workers. The study could be the basis for discussion for an ILO Tripartite Experts Meeting;

(c) actively contribute to the implementation of the HEEG Commission's recommendations and immediate actions with a particular focus on: the recommendations on the promotion of decent health sector job creation; maximizing women's economic participation and empowerment; and strengthening fair and rights-based health worker migration governance;

(d) provide policy advice and technical assistance in the development of national health workforce policies with a focus on employment creation and decent work, inter alia, through the decent work country programmes and regional decent work programmes; enhance capacity building on work improvement programmes in health services, such as HealthWISE; and foster implementation of national programmes on OSH for health workers in cooperation with the WHO;

(e) develop, together with constituents, the WHO, the Organisation for Economic Cooperation and Development (OECD) and other specialized international and regional agencies, a health workforce research agenda, and undertake comparative analyses to strengthen evidence, accountability and action to promote decent work and productive employment in the health sector. The research agenda should also consider the development of international recognition and acceptance of health workers' qualifications and certification; and

(f) to organize regional tripartite sectoral meetings over the next five years.

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