CHANCES FOR CHANGE

Dutch measures to improve the global distribution of health personnel

wemos

Health for All

Preface

The Dutch Alliance for Human Resources for Health is concerned about the global maldistribution of human resources for health (HRH), which particularly affects the health of people in developing countries. This publication presents measures, composed by the Alliance, to be taken by Dutch actors to improve the distribution of health staff across countries.

The Dutch Alliance brings together a wide range of actors of the health and development cooperation sectors in the Netherlands: non-governmental organizations (NGOs), health professional organizations, labour unions, research institutions, HRH consultants, and other actors involved in the global shortage and international recruitment of health personnel. The Alliance joins forces and expertise, and aims to explore and promote policies and actions that are required for sufficient health staff and for strengthening health systems worldwide.

This publication is to inspire Dutch stakeholders involved in training, recruitment, retention, and employment of health personnel to collaborate and undertake tailor-made actions, which jointly constitute a substantial Dutch contribution to global health.

Human resources for health (HRH) are all personnel whose primary role is to improve health, including staff in health enterprises and employees in non-health organizations, such as nurses staffing a company or school clinic, and health service providers as well as health management and support workers.

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Distribution of human resources for health: a joint responsibility

Shortages of health personnel are experienced worldwide. They exist in developing countries as well as in developed countries. When one country's demand exceeds its supply of health personnel, a 'pull' is exerted for migration flows from other countries. This pull is not shaped by the burden of disease in a country, but by unequally distributed financial resources for health systems. Consequently, migration flows are directed towards more affluent countries and regions. This increases the global maldistribution of health personnel and inequities in health.

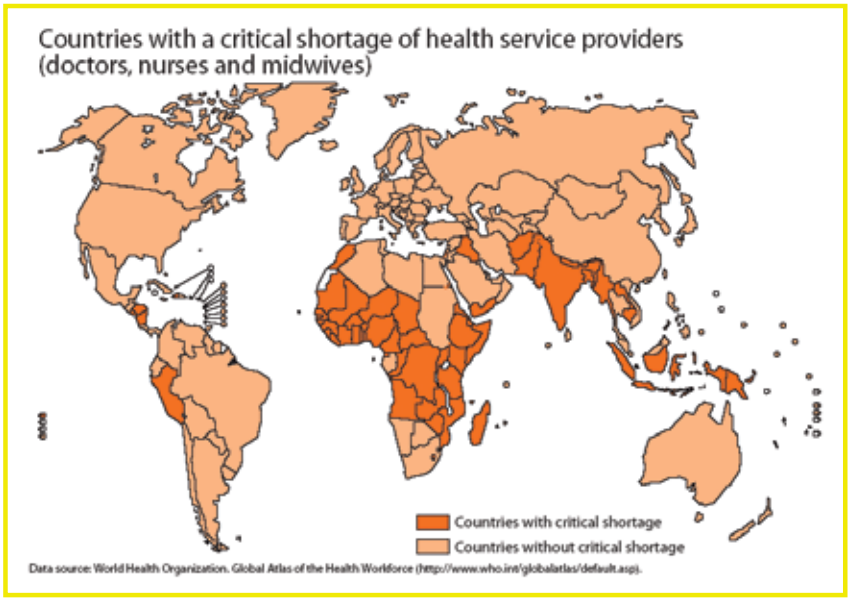
Migration flows of health personnel are directed towards more affluent countries and regions.

Health workers are distributed unevenly. Europe contains only 10% of the global burden of disease, yet almost 28% of the world's health workers live and work in this region. In contrast, the African region suffers more than 24% of the global burden of disease, but has access to only 3% of health workers and commands less than 1% of world health expenditure. Migration increases these inequalities and poses a challenge to all nations, including the Netherlands. The Netherlands relies on national recruitment, training, retention and innovative measures to meet the growing demand of health personnel. As a member state of the European Union's Internal Market the Netherlands can benefit from the free movement of services and people within the 27 member states of the European Union (EU). Other EU member states face the same HRH shortages as a result of their ageing populations, which makes the EU internal market of limited relevance for addressing national shortages of HRH. Recruitment of health personnel from countries outside the EU (third countries) is seen as a measure of last resort by the Dutch Ministry of Health, Welfare and Sport (MoH). However, Dutch hospitals have used this measure in 2009 and 2010, when a shortage of operating theatre nurses became evident. In India, they actively recruited more than 60 nurses.

Growing shortages in the health sector are to be expected, especially among nurses and caretakers for the elderly. According to recent predictions, the Dutch health sector will face a shortage of 450.000 employees, in 2025 (Zorginnovatieplatform, 2009).

Dutch responsibility

The Netherlands has a responsibility to contribute to solutions for the global maldistribution of health personnel, by preventing the exertion of a pull for HRH from third countries and by mitigating the negative impacts of international recruitment of health personnel on these countries. There are three important reasons. The Netherlands has a responsibility, because, first of all, it is committed to the **Universal Right to Health**, which is part of the Universal Declaration of Human Rights of the United Nations. The Right to Health implies the obligation of states to respect, protect and fulfil access to health care for its citizens. At the same time, there is the obligation of states to respect the integrity of the health systems of other states.



The Universal Right to Health

Shortage of health personnel impinges on the Right to Health, especially when weak health systems in source countries are undermined by an efflux of health personnel.

"The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."
Article 12 of the International Covenant on Economic, Social and Cultural Rights (entered into force on 3 January 1976)

" … State parties have to respect the enjoyment of the right to health in other countries, and to prevent third parties from violating the right in other countries."
§ 39 of General Comment no. 14 to the International Covenant on Economic, Social and Cultural Rights on the right to the highest attainable standard of health (adopted on 11 May 2000)

State intervention is required to ensure sufficient production and equitable distribution of health personnel at a national and global level. In a globalised world, challenges arise because nationally trained HRH have the opportunity to work across borders. As a result, patients and employers of foreign health personnel benefit from HRH trained by and for other states. The complex and global nature of the HRH crisis and the absence of a global authority make it tempting for countries to take insufficient domestic measures that address HRH shortages and regulate recruitment across borders. Individual countries, however, have opportunities to make a substantial contribution to improve global public health.

The second reason for the Netherlands' responsibility is a moral one. It is **unjust** for a rich country like the Netherlands to actively recruit health personnel trained by countries with severely constrained financial and human resources for health. This is inconsistent with bilateral and multilateral cooperation efforts to strengthening health systems in developing countries. The Netherlands has always been an important donor for international development cooperation.

The third reason is that the Member States of the World Health Organization (WHO), including the Netherlands, reiterated the necessity for action by adopting the **WHO Code of Practice on International Recruitment of Health Personnel**, in May 2010.

Global governance for health

Global governance for health is based on non-obligatory interaction between sovereign states. Governments are not held accountable by a supranational authority for their negative effects on the right to health in other countries, or for taking profit of HRH trained by and for other countries. It is now up to the WHO Member States to start the implementation process of the WHO Code of Practice on International Recruitment of Health Personnel (Code) in their respective countries.

By adopting the Code, Member States agreed

- to be self-sufficient in the domestic health workforce deployment;
- to guarantee the rights of migrant health workers, including their freedom to move;
- to make sure that health systems in source countries are not undermined by international migration of health personnel, since both source and destination countries should derive benefits from the international migration of health personnel; and
- to enhance gathering of data on health personnel and health personnel migration.

The Dutch government adopted the Code. Together with other Dutch stakeholders it is responsible for its implementation. Many stakeholders are involved in training, recruitment, deployment and retention of HRH in and for the Dutch health sector, including the Dutch Ministry of Health, Welfare and Sport, the Dutch Minister for Immigration and Asylum Policy, the Dutch Ministry of Education, Culture and Science, the Dutch Ministry of Social Affairs and Employment, the Dutch Directorate-General for Development Cooperation (of the Ministry of Foreign Affairs) as well as health care institutions (employers), recruiters, labour unions, health professional organizations, experts, researchers, and Dutch NGOs. The implementation of the recently adopted Code provides an excellent test-case for an intersectoral approach, in line with the Dutch tradition of interdepartmental cooperation.

An **intersectoral approach** is an important theme in the current discourse on governance for global health and development, as is reflected by strategy concepts like *Health In All Policies and Coherence for Development*. In 2010, the Dutch Scientific Council for Government Policy stated: 'The basic idea [of coherence for development] is, on the one hand, to prevent the positive effects of development aid from being undermined by the negative effects of policy on other areas such as trade, migration or environmental policy and, on the other hand, to ensure that policy in other areas has positive spillovers for developing countries.'

Dutch policies and activities

Dutch policies on health, workforce planning, education, migration, and development cooperation are substantially coherent. Currently, the Netherlands takes many initiatives to keep the domestic health sector labour market sustainable, anticipate on future shortages and avoid active cross-border recruitment of HRH.

The **Dutch Ministry of Health, Welfare and Sport** is responsible for the *Labour Market Policy Letter* on the health sector in close cooperation with the social partners (health sector labour unions and employers' representatives). The aim is to train and retain sufficient health personnel for national needs. The MoH expects health care institutions to start the recruitment process in the Netherlands, followed by recruitment in the European Economic Area (EEA), in accordance with the regulations for assignment of work permits. Recruitment of health personnel outside the EU is perceived as a measure of last resort. So far, data on the health workforce and foreign-educated health personnel is not being stored in a uniform format or by a central authority.

Health care institutions in the Netherlands are private actors and, therefore, solely responsible for their recruitment practices. They resort to recruitment of foreign health personnel when a required professional is not available on the Dutch and European health labour markets. Following a request from the MoH, the Dutch association of health care organizations (*Brancheorganisaties Zorg, BoZ*) established a voluntary Quality Mark for Foreign Workers Recruitment Agencies (*Keurmerk Bemiddelingsbureaus Buitenlandse Werknemers*), in 2008. This Quality Mark does not apply to foreign **recruitment agencies** that recently recruited health personnel from India. The Quality Mark has not yet been assigned to Dutch agencies. Currently, health employers are being requested to implement the recently adopted WHO Code.

Dutch health professional organizations and labour unions acknowledge and respect the freedom of each individual to move. However, concerns exist regarding the international recruitment of health personnel, as it might have a negative impact on the quality of care in the Netherlands. The Dutch language might cause communication problems, while the required additional training may increase workloads. At the same time, the organizations are apprehensive of the effects of foreign recruitment on health systems and HRH in the country of origin, as well as of the interests and rights of foreign health personnel. Other concerns are related to the social and professional status of the profession and opportunities for employment.

The **Dutch Minister for Immigration and Asylum Policy** (working within the Ministry of the Interior and Kingdom Relations) and the **Dutch Ministry for Social Affairs and Employment** allow migrant workers from outside the EU, including health personnel, to enter the Netherlands with a work permit or via special regulations for highly-skilled migrants. A work permit for migrant workers from third countries is granted only when the employer can demonstrate unsuccessful recruitment efforts in the Netherlands, followed by the European Economic Area (EEA). The work permit provides access to the Dutch labour market for the duration of the employment contract and up to three years. Highly-skilled migrants can be assigned a legal residence permit, which automatically gives access to the Dutch labour market for the duration of the employment contract and up to five years. After five years, they might receive a permanent legal residence permit. The regulations for highly-skilled migrants exclude employers from the requirements regarding proven attempts to recruit in the Netherlands and EEA before recruiting in third countries.

The Dutch labour union Abvakabo FNV believes that *"the shortages of HRH in the Dutch health care sector should be tackled primarily by and within the Netherlands. Recruitment of foreign health personnel can provide only a minor contribution to addressing the shortage in the Netherlands and only when migration takes place under strict conditions"*.

The **Dutch Ministry of Education, Culture and Science** is responsible for the education of medical staff and the central planning of HRH training capacity.

The **Directorate-General for International Cooperation (DGIS)** of the Dutch Ministry of Foreign Affairs actively invests in human rights and health system strengthening through bilateral and multilateral cooperation. DGIS also conducts several pilot studies on circular migration. Migration and development are seen as interlinked. So far, the health sector is not involved in these pilots. The Coherence Unit of the Ministry of Foreign Affairs has proven to be an effective instrument for implementing an intersectoral approach.

Several **Dutch NGOs** are actively involved in projects and (advocacy) programmes that focus on health systems strengthening and HRH in and for developing countries.

Dutch measures to improve the global distribution of health personnel

Recommendations for an intersectoral approach

Various Dutch stakeholders are involved in the training, recruitment, employment, and retention of health personnel. Substantial coherence between different policies exists in the Netherlands. A coordinated intersectoral approach that directs all relevant policies and practices towards the same objective could enhance synergies, both in preventing the exertion of a pull for health personnel from third countries and in mitigating the negative impacts of international recruitment of health personnel.

Dutch Ministry of Health, Welfare and Sport

The task of the Dutch Ministry of Health, Welfare and Sport is to anticipate that future shortages of health personnel in the Netherlands – and business incentives for recruitment agencies – will increasingly push employers in the health sector to recruit health personnel in countries outside the EU. Being responsible for the health care labour market policy, the Ministry has the legitimacy to provide leadership and incentives for the alignment of policies and practices of all national stakeholders towards a comprehensive plan of action to prevent and mitigate the negative effects of international recruitment of health personnel.

Recommendations

- Join forces with DGIS and raise awareness among the Minister for Immigration and Asylum Policy, the Ministry of Social Affairs and Employment, and the Ministry of Education, Culture and Science of the need to keep the national market sustainable and to prevent negative effects of shortages in the Netherlands on third countries.
- Assemble a Taskforce jointly with DGIS, and involve the Minister for Immigration and Asylum Policy, the Ministry of Social Affairs and Employment, the Ministry of Education, Culture and Science, the social partners (employers and employees), health professional organizations, the cooperative development sector, researchers, recruiters and other stakeholders. Use the Taskforce to:
  - translate and disseminate the Code to Dutch health actors;
  - formulate a joint understanding of HRH issues and principles for ethical recruitment
  - establish clear mechanisms for implementation of the Code; and
  - design an effective, intersectoral human resource information system to serve as a basis for strategic planning, monitoring and evaluating the health workforce, with relevant indicators on HRH, international recruitment and immigration of health personnel. Appoint a national authority for collection of information on international recruitment of health personnel, in accordance with the requirements of the Code.

- Define a position on mechanisms by which countries of origin can benefit from migration of HRH (for instance, exchange programmes of health personnel and institutional twinning) and coordinate this position with positions of other stakeholders and experts.
- Collaborate with the other Dutch ministries to define and address inconsistencies in Dutch policies and practices relating to HRH.
- Provide technical assistance and leadership on HRH within international platforms such as the EU, WHO and the Organization for Economic Co-operation and Development (OECD), and join forces with like-minded countries, including Sweden, Norway and Japan.

Dutch health care institutions

Dutch health care institutions decide whom and how they recruit. This depends on the situation of the labour market and the government's policy framework. Dutch health care institutions are employers and thus have the power to transform indiscriminate recruitment – leading to growing global inequities in health – into ethical recruitment.

Recommendations

- Define an institutional position on the active recruitment of foreign health personnel, which recognizes the negative impact of foreign recruitment on health systems and HRH in developing countries. Taking into account, domestic training and retention efforts, the rights of migrant workers, deskilling of health personnel, and institutional mechanisms by which countries of origin can benefit from HRH migration.
- Integrate the content of the Quality Mark for Foreign Workers Recruitment Agencies and the Health Sector Governance Code with the WHO Code and the EPSU-HOSPEEM code. The latter only applies to the hospital sector, while the conduct can be extended to non-hospital health institutions.
- Limit the voluntary nature of the Dutch Quality Mark for Foreign Workers Recruitment Agencies in order to make better use of the system to stimulate recruiters to work in an ethical manner. Define a position on the use of foreign recruitment agencies that are not within the scope of the Dutch Quality Mark system.
- Keep the implementation of the WHO Code on the agendas of the social dialogues with the MoH and labour unions.
- Cooperate with other stakeholders and proactively provide expertise on workforce planning, principles for ethical recruitment, mechanisms for implementation of the Code and mechanisms by which countries of origin can benefit from migration of health personnel.
- Contribute to setting up a national HRH information system for planning, monitoring and evaluating of the health workforce and migration of HRH.

The EPSU-HOSPEEM code of conduct on Ethical Cross-Border Recruitment and Retention in the Hospital Sector is an outcome of the European Social Dialogue in the Hospital Sector. This agreement between the European Federation of Public Service Unions (EPSU) and the European Hospital and Healthcare Employer's Association (HOSPEEM) promotes ethical and stops unethical practices in cross-border recruitment of health workers within the EU.

In November 2010, Dutch labour unions and the association of hospital sector employers (Vereniging van Ziekenhuizen, NVZ) signed an agreement on the implementation of the EPSU-HOSPEEM code in the Netherlands. The implementation, monitoring and follow-up procedure of this code can serve as an example for the implementation of the WHO Code of Practice in the Netherlands.

Dutch recruitment agencies

Together with the MoH and Dutch health care institutions, recruitment agencies have the power to implement ethical recruitment practices.

Recommendations

- Request the Quality Mark for Foreign Workers Recruitment Agencies and be committed to a corporate social responsibility strategy that is in accordance with the WHO Code of Practice.
- Proactively provide input for a central information system with relevant indicators on HRH, international recruitment figures and immigration of health personnel.

Dutch labour unions and health professional organizations

The shortages of HRH in the Netherlands affect the working conditions and health care delivery in the Netherlands and in developing countries, at the same time. Labour unions and health professional organizations have a role to play in the enhancement of working conditions and social and professional recognition of health personnel, either recruited in the Netherlands or abroad.

Recommendations

- Continue to advocate for ethical international recruitment of health personnel, for instance, in the social dialogues with the MoH and employers.
- Continue to have a dialogue with employers on the implementation of the EPSU-HOSPEEM code of conduct and support the extension of this code to non-hospital health institutions.
- Support members in addressing the international recruitment of health personnel, within their organizations, for instance, via the work or advice councils.
- Cooperate with other stakeholders on HRH and proactively provide expertise on the understanding of HRH issues, principles for ethical recruitment, mechanisms for implementation of the WHO Code, mechanisms by which countries of origin can benefit from migration of HRH (for instance, circular migration, exchange programmes of health personnel, and institutional twinning), and an HRH information system for planning, monitoring and evaluating the health workforce.

Dutch health insurance and investment companies

Health insurance and investment companies monitor the quality of management and health care provision as part of their purchase and investment policies.

Recommendations

- Monitor the quality, education, retention and foreign recruitment of health personnel in meetings with and reviews of health care institutions.

Shortages of HRH in the Netherlands affect the working conditions and health care delivery in the Netherlands and in developing countries at the same time.

Dutch Minister for Immigration and Asylum Policy and the Dutch Ministry of Social Affairs and Employment

The Dutch Minister for Immigration and Asylum Policy (working within the Ministry of the Interior and Kingdom Relations) and the Ministry of Social Affairs and Employment are jointly responsible for access of foreign health personnel to the Dutch labour market.

Recommendations

- Enhance alignment of the domestic labour market policy with the labour market policy for the health sector.
- Align the use of regulations for highly-skilled migrant health personnel with the MoH policy on international recruitment of HRH.
- Align the issuing of work permits and permits for highly-skilled migrants with policies on migration and development, circular migration and learning trajectories for foreign HRH.
- Provide the MoH with input regarding mechanisms for enforcement of ethical recruitment practices.

Dutch Ministry of Education, Culture and Science

The Dutch Ministry of Education, Culture and Science is responsible for the education and central planning of training capacity for HRH.

Recommendations

- Expand the capacity of health care education in the Netherlands, especially in areas where shortages are most severe.
- Facilitate the enrollment of students in health care education, for instance, by reducing the costs of medical education or through fiscal measures.
- Continue and expand the cooperation with the MoH on the fund for intern courses in the health sector, in 2011 and after this year.

The Dutch health care sector will face a shortage of 45.000 employees in 2025.

Dutch Directorate-General for International Cooperation

The Dutch Directorate-General for International Cooperation (DGIS, which is part of the Ministry of Foreign Affairs) subscribes to the importance of health systems strengthening in achieving its goals for HIV/AIDS and sexual and reproductive health and rights, via both bilateral and multilateral development cooperation efforts. The negative effects of international recruitment of HRH undermine DGIS' health systems strengthening efforts in developing countries, and lead to growing global inequities in access to health care.

Recommended national actions

- Join forces with the MoH and advocate for the need to keep the national market sustainable, and to prevent negative impacts of shortages in the Netherlands on third countries.
- Make use of the Coherence Unit to liaise with the Minister for Immigration and Asylum Policy, the Ministry of Social Affairs and Employment, and the Ministry of Education, Culture and Science.
- Collaborate with the MoH to establish a multisectoral Taskforce for joint action on HRH, including ethical recruitment of foreign HRH and mechanisms by which countries of origin can benefit from migration of HRH.
- Consider developing a list of countries from which recruitment cannot take place, in line with, for instance, bilateral agreements, Dutch health sector budget support and/or the WHO list of countries facing critical shortages of health personnel.
- Explore (criteria for) mechanisms by which countries of origin can benefit from migration of HRH (for instance, circular migration, working with diaspora, exchange programmes of health personnel, and institutional twinning).
- Join forces with the MoH and broaden the scope of Dutch foreign policy to include global health interests, in line with the United Nations' General Assembly Resolution on Global Health and Foreign Policy (February 2010).

Recommended bilateral actions

- Ensure HRH expertise with health advisors at the relevant Royal Dutch Embassies.
- Provide funding and technical support for HRH strategy development, personnel incentive packages, research, and information systems on HRH.
- Expand the training capacities of both the public and the private health sector (for instance, through the Netherlands Initiative for Capacity Building in Higher Education, NUFFIC, and the Netherlands Fellowships Programme, NFP).
- Support the role of women in the health workforce.

- Support civil society in the strengthening of HRH in source countries.
- Facilitate alignment and harmonization of health system strengthening and HRH, through collaboration with like-minded donors and global health initiatives (for instance, Japan, the United Kingdom, the United States President's Emergency Plan for AIDS Relief, the Global Fund to Fight AIDS, TB and Malaria, EU, Norway, and Sweden).

Recommended multilateral actions

- Make use of the Netherlands' influence to stimulate global health initiatives as well as AIDS donors and other disease-specific donors to fund health systems strengthening and the national public health workforce as part of their activities.
- Work via the Dutch Ministry of Finance and with the EU to influence the International Monetary Fund (IMF) and the World Bank to expand fiscal space for low-income countries to invest in public health and social sectors in order to address the critical shortage of HRH. Ensure the input of a broader range of stakeholders, including Ministries of Health, during macro-economic policy debates.
- Promote best practices on adherence to and implementation of the WHO Code of Practice, actively involving (inter)national civil society organizations.

"Experience in Tanzania demonstrates that the national HRH strategy can only be realized if the training capacities of both the public and private sector are fully utilized. Such implies that private not-for-profit Health Training Institutions should be eligible for long-term institutional grants for expanding their training capacity". *Consortium of ETC Crystal, Hanze Allied University Groningen, and University of Groningen.*

Dutch NGOs

Dutch NGOs can focus their work directly on health systems strengthening and HRH in countries affected by shortages of health personnel. The Dutch NGO community can join forces and expertise to promote policies and actions needed for HRH in the Netherlands, while ensuring that these are not undermining, at times even benefitting, HRH in developing countries.

Recommendations for Dutch NGOs that work with partner organizations in developing countries

- Support governance for HRH by government institutions and by community leaders. This can be achieved through the strengthening of capacity for HRH policy development and implementation, HRH planning (for instance, with accurate workload and productivity indicators) and monitoring and evaluation.
- Support participation of civil society organizations in HRH development and support advocacy for effective HRH plans with the authorities.
- Support development of health financing initiatives and analyse the cost-effectiveness of retention strategies, in order to ensure their sustainability.
- Insist that partner health organizations establish accurate norms and standards for determining the deficits in the public and private health care sector. This could also motivate the national MoH to improve its HRH forecasting models.
- Adhere to the NGO Code of Conduct on Health Systems Strengthening and join forces with other civil society organizations that work on HRH.

Recommended actions for members of the Dutch Alliance for HRH

- Continue to jointly raise public awareness and to hold Dutch stakeholders accountable for ethical recruitment, by engaging in multi-stakeholder discussions on HRH and the implementation of the WHO Code of Practice, and by proactively presenting joint NGO viewpoints on HRH via relevant fora and media.
- Commit to the NGO Code of Conduct for Health Systems Strengthening.
- Facilitate the development of training modules and research projects that support the evidence base on (governance for) HRH worldwide, including the implementation of the WHO Code of Practice on International Recruitment of Health Personnel.
- Link up with other stakeholders in Europe and at the global level (for instance, the Health Workforce Advocacy Initiative) to boost the momentum for HRH.

Dutch parliamentarians

Parliamentarians are primarily responsible for holding the government accountable. They monitor compliance with existing commitments and sound policy-making.

Recommendations

- Collaborate with the Dutch Alliance for HRH to hold the Dutch stakeholders accountable for preventing the exertion of a Dutch pull for HRH from third countries and for mitigating negative impacts of international migration of health personnel in source countries.
- Hold the Dutch government accountable for sound and coherent (health) policies, with special regard to recruitment of foreign health personnel.

Wemos advocates for the right to health of people in developing countries. *"We call upon all governments and other actors in health to take full responsibility for their contribution to improve the global distribution of health personnel. We promote sound policies and joint action for improved training, recruitment, retention and employment of personnel. This will greatly support the attainment of the right to health everywhere in the world".*

Conclusion

In this publication, the Dutch Alliance for Human Resources for Health presents recommendations to inspire Dutch stakeholders to jointly undertake action and improve the global distribution of health personnel. The Alliance believes in the added value of strong intersectoral cooperation, in particular with the different Dutch Ministries involved. Together stakeholders can turn 2011 into the year of implementation of the WHO Code of Practice on the International Recruitment of HRH in the Netherlands. The Dutch Alliance for HRH invites stakeholders to take the chances for change.

Photo by Christel Jansen

Bibliography

Brancheorganisaties Zorg (2005) *Zorgbrede Governance Code.* Brancheorganisatie Zorg, Utrecht.

Brancheorganisaties Zorg (2008) *Certificatieschema Keurmerk Bemiddelingsbureaus Buitenlandse Werknemers.* Brancheorganisatie Zorg, Utrecht.

Brinkerhoff D, Bossert T (2008) *Health Governance: Concepts, experience and programming options.* United States Agency for International Development, Washington.

Bressers H (2004) 'Implementing Sustainable Development: How to Know What Works, Where, When and How'. In: *Governance for Sustainable Development: The Challenge of Adapting Form to Function*, edited by William M. Lafferty and Edward Eldgar. Cheltenham. p. 284-318.

Buchan J (2008) *How can the migration of health service professionals be managed so as to reduce any negative effects on supply.* World Health Organization on behalf of the European Observatory on Health Systems and Policies, Copenhagen.

Center for Global Development (2010) *Zeroing in: AIDS Donors and Africa's Health Workforce.* Center for Global Development, Washington.

Center for Global Development (2007) *Does the IMF constrain health spending in poor countries? Evidence and an agenda for action.* Center for Global Development, Washington.

European Federation of Public Service Unions (EPSU) & European Hospital and Health Care Employers Association (HOSPEEM) (2008) *EPSU-HOSPEEM code of conduct and follow up on Ethical Cross-Border Recruitment and Retention in the Hospital Sector.* EPSU-HOSPEEM, Brussels.

European Commission (2006) *A European Programme for Action to tackle the critical shortage of health workers in developing countries (2007-2013).* European Commission COM (2006) 870 final, Brussels.

Gostin L, Heywood M, Ooms G, Grover A, Røttingen J, Chenguang W (2010) 'National and Global Responsibilities for Health'. In: *Bulletin of the World Health Organization* 88; p.719.

Health Alliance International (2008) *NGO Code of Conduct on Health Systems Strengthening.* Health Alliance International, Washington.

International Labour Organization (2006) *ILO multilateral framework on labour migration; Non-binding principles and guidelines for a rights-based approach to labour migration.* International Labour Organization, Geneva.

Kickbusch I et al. (2010) 'Addressing global health governance challenges through a new mechanism: the proposal for a Committee C of the World Health Assembly'. In: *Journal of Law, Medicine and Ethics on global health governance,* 38(3), p. 550-563.

Scientific Council for Government Policy (2010) *Less Pretension, more ambition. Development policy in times of globalization.* Amsterdam University Press, Amsterdam.

Sociaal Cultureel Planbureau (2010) *Zorgen voor zorg. Ramingen van personeel in de verpleging en verzorging tot 2030.* Sociaal Cultureel Planbureau, The Hague.

Norwegian Centre for International Cooperation in Higher Education (2010) *Norad's Programme for Master Studies (NOMA). Annual Report 2009.* Senter for internasjonalisering av høgre utdanning, Bergen.

UKAID/ DFID/HDRC (2010) *Results and value for money: A performance review of the human development portfolio in Mozambique.* DFID Human Development Resource Centre, London.

UK Consortium on AIDS & International Development and Action for Global Health (2010) *The IMF, the Global Crisis and Human Resources for Health*, United Kingdom.

United Nations General Assembly (2010) *Resolution 64/108: Global health and foreign policy.* United Nations, New York.
United Nations Secretary General (2010) *Background Paper for the Global Strategy for Women's and Children's Health: Access for All to Skilled, Motivated and Supported Health Workers.* The Partnership for Maternal, Newborn and Child Health, Geneva.
Went R (2010) *Internationale Publieke Goederen: Karakteristieken en Typologie.* Wetenschappelijke Raad voor het Regeringsbeleid, The Hague.
World Health Assembly (2010) *Global Code of Practice on the International Recruitment of Health Personnel.* WHO, Geneva.
World Health Organization Regional Office for Europe (2010) *Health in foreign policy and development cooperation: public health is global health.* WHO Regional Office for Europe, Copenhagen.
World Health Organization (2009) *Maximizing Positive Synergies between Health Systems and Global Health Initiatives.* WHO, Geneva.
World Health Organization (2006) *Working Together for Health. The World Health Report 2006.* WHO, Geneva.
World Health Organization and Global Health Workforce Alliance (2008) *The Kampala Declaration and Agenda for Global Action.* WHO, Geneva.
Willets A, Martineau T (2004) *Ethical international recruitment of health personnel: will codes of practice protect developing country health systems?* Liverpool School of Tropical Medicine, Liverpool.
United Nations High Commissioner for Human Rights (1966) *International Covenant on Economic, Social and Cultural Rights.* United Nations High Commissioner for Human Rights, Geneva.
VVD-CDA (2010). *Vrijheid en verantwoordelijkheid. Regeerakkoord VVD-CDA.* VVD en CDA, The Hague.
Zorginnovatieplatform (2009) *Zorg voor mensen, mensen voor de zorg. Arbeidsmarktbeleid voor de zorgsector richting 2025.* Zorginnovatieplatform, The Hague.

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