# The Dutch Human Resources for Health (HRH) Alliance

## Rights

- The shortage of health personnel threatens the Right to Health of every individual. Governments are obliged to respect, protect and fulfill this right.

## Shortage

- 57 developing countries face the most severe deficits
- 4.3 million health workers are urgently needed for basic service provision[i]
- Africa loses about 28% of its doctors and 11% of its nurses to rich countries.

## Dimensions

- insufficient training of staff
- inequitable geographic distribution
- lack of management capacity
- uneven skills mix
- international migration

## Introduction

**The global shortage of health workers is one of the main reasons why progress in attaining the health related Millennium Development Goals is hampered. Many developing countries are facing a severe health workforce crisis. A large number of developed countries are also not self-sufficient and rely on foreign health workers.**

The global HRH crisis manifests itself in many dimensions. International migration for example, often referred to as moving to 'greener pastures,' contributes significantly to experienced health workforce deficits. Migration stands for better life and career opportunities for health workers and their families. However, health worker migration undermines adequate health service provision in source countries. We acknowledge freedom of movement - the right of an individual to migrate - as a principal human right. However, international migration of health workers undermines investments in the health sector by national governments and donor agencies, hence affects the realisation of the Right to Health (RtH).

Critical elements of Dutch government policies are: a) to avoid negative impacts of health worker immigration; b) to ensure policy coherence and c) have a sound workforce policy in health. Recently, the Dutch delegation at the September 2009 WHO EURO meeting emphasized the need for *'increased efforts to provide targeted assistance to low income countries with a human resources for health crisis and avoid further weakening of health systems'*. Yet, the Ministry of Justice has developed a new migration policy that promotes foreign skilled personnel to contribute to "Dutch economy and scientific growth" which also applies to the migration of health personnel[ii]. The implications of this migration policy for source countries where these health workers have been trained require careful evaluation. The concern of a possible 'brain drain' has also been acknowledged by the State Secretary of Justice in a recent letter to Parliament and requires specific attention[iii].

The sustainability of the global health workforce is a mutual responsibility: in a globalised world a personnel shortage in one part of the world is eventually having an effect in another part of the world as well. The Netherlands is part of the global solution. The HRH shortage threatens the RtH of every individual, and governments are obliged to respect, protect and guarantee/fulfil this right. Moreover, States are obliged to help each other with its implementation. The Dutch government therefore bears a responsibility for health in its own country and is also expected to assist other countries with the realisation of the RtH.

Several new - global and regional - initiatives and networks related to HRH and migration have been launched in response to the increased attention for the significant role of HRH in health systems, such as the Global Health Workforce Alliance (GHWA), WHO supported health workforce observatories, and the *EU Programme for Action to tackle the shortage of health workers in developing countries (2007-2013)[iv].* The EU program describes the need

for action at global, regional and national level both HERE (higher income countries) and THERE (in lower income countries). Only recently, the European Commission[v] concluded that so far not enough has been done by the Member States to implement the *Programme for Action*.

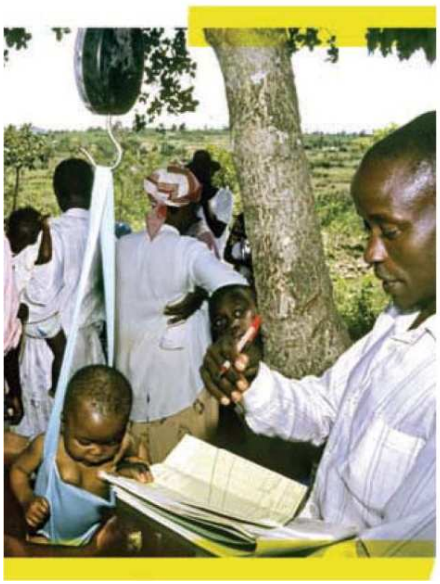
At the national level in developing countries several HRH initiatives, for instance related to increasing medical training capacity and the introduction of incentive schemes, are supported by donors (e.g. Sweden, Norway, the Netherlands, USA) or development organizations like Cordaid, Wemos, or USAID's Capacity*Plus* Project. However, presently there is no Netherlands based initiative that departs from and focuses on the Dutch situation, while aiming for links with (inter)national initiatives.

***Notes***

i http://www.who.int/whr/2006/en/ and http://www.rockfound.org/library/03hrh.pdf and
ii http://www.hup.harvard.edu/catalog/JOIHUM.html
iii Factsheet Wetsvoorstel Modern Migratiebeleid naar Tweede Kamer (September 2009)
iv http://parlis.nl/kst127852
v http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2006:0870:FIN:EN:PDF
vi http://ec.europa.eu/development/icenter/repository/health_progress_report_implementation_2008_en.pdf
vii Based on positive talks and meetings with several (inter)national organisations (a.o. WHO, GHWA) and individuals it was decided by Wemos and CBG in July 2009 to draft this written proposal in order to allow more people to become involved in taking its development further.
viii http://www.who.int/hrh/governance/en/
xi There is room for new actors and innovative approaches in the arena of HRH. The usual suspects active on issues related to the global HRH crisis belong to the development cooperation sector. It is recognized that organizations and individuals in the Dutch health sector can also become involved based on their knowledge and expertise on HR. When joining forces between sectors and actors, one can contribute to tackling the global HRH crisis and reaching the health related MDGs in developing countries.
x EFPC = European Forum for Primary Care, NPHF = Netherlands Public Health Federation, V&VN = Verpleegkundigen en Verzorgenden Nederland, KIT = Royal Tropical Institute, UvA = University of Amsterdam, IFHHRO = Int. Federation of Health and Human Rights Organisations, Nederlandse Vereniging voor Tropische Geneeskunde.
xi www.equinetafrica.org

## Objective

To identify, promote and implement policies and practices[ix] in and by the Netherlands (government as well as other actors) in order to contribute actively to addressing the global health workforce shortage.



# The Dutch HRH Alliance

On 7th April 2009, World Health Day, a number of Dutch organisations organised a breakfast session, a roundtable discussion and workshops on the global HRH crisis for MPs, policy makers and CSOs in The Hague[vi](see vii). Discussions between the many different actors present at this whole day event resulted in the initiative to establish an alliance for HRH to join forces across sectors and contribute in a Dutch manner to addressing the global HRH crisis[viii].

We envisage that this initiative that combines the expertise and efforts of different stakeholders will enable actions to be taken both HERE and THERE and promote action HERE that does not harm THERE. The Alliance will address both individual rights of health workers as well the rights of the population to health care. The Alliance is envisaged to develop in line with the WHO HRH Observatory network[x].
As this network is in early stages of development with only few examples of national observatories (mostly in developed countries), opportunities exist for the Dutch to take on a leadership role at the European and global observatory levels.

Based on initial talks with the above mentioned members, we foresee that this initiative will:

Support HRH policy decision making: Contribute to sound national workforce policy and practices not reliant on health workers from abroad; avoiding of unethical recruitment by rich countries and enhancing coherence between domestic and international policies/practices;

Share lessons learned: Contribute to development/exploration, application and exchange of best practices, innovative approaches and North-South cooperation in solving the health workforce crisis. This can include new ways of financing, HR mapping mechanisms, attracting and retaining HR (e.g. magnet concept), inter-sector strategies to scale up the workforce, circular migration initiatives with triple gain (instead of brain drain), intercultural aspects of health systems, etc.;

Monitor and evaluate: Develop and sustain the information knowledge base for human resources for health in the Netherlands.

***Membership***

The involvement of a mix of different actors and health workers is important to advocate for a strong health workforce based on long term sustainability, national self-reliance and quality care HERE and THERE. The alliance foresees that through cooperation and joint identification of opportunities and implementation of actions at (inter)national level the Dutch contribution to tackling the global HRH crisis will be reinforced.

Members may include a wide range of Dutch stakeholders[xi]: (inter-) governmental agencies, (policy makers from) ministries; civil society organisations (Wemos, Cordaid) and actors in the arena of health (EFPC, NPHF, CGB); migrant organizations (IOM); research institutions (KIT, University of Amsterdam); health and HR specialists/consultants (ETC Crystal), professional and consumer associations (V&VN); labour unions (Abvakabo/FNV, NU'91); Members of Parliament; and health professionals themselves (IFHHRO, NVTG members)[xii].

# Colophon

Dutch HRH Alliance

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The participating networks and organizations recognize the importance of being at the forefront of decision making in relation to critical aspects of high quality health care delivery. Members are given the opportunity to exchange ideas and opinions and will be able to give their voice/advice via the Alliance on issues at stake. This will facilitate taking a position on behalf of a group without purely (vested) interests.

***Way of working***

The HRH Alliance will facilitate information exchange via meetings, round tables, portals, exploratory sessions between members (and their constituents), encourage discussion on solutions, as well as undertake joint action by engaging many actors. The Alliance will take further already existing small-scale exchange and twinning between North and South. The dual track of Action HERE and Action THERE forms the baseline for activities. The Health Systems approach with a strong emphasis on equity and *People Centred Care* will form the rationale for any output. Examples of expected outputs of our joint action:

- Generate joint positions and recommendations on certain topics, for instance on circular migration initiatives, compensation measures from destination countries for source countries in the South, labour market policy based on self-sufficiency and aligned with the (domestic) code of practice on ethical recruitment.

-Exchange of experiences with one or more developing countries to enhance knowledge and capacity in HRH management and HRH interventions. For example, an expert with knowledge on workforce planning could travel with somebody from a diaspora organization to a source country; a labour union representative and a Dutch CSO visit a source country for 'linking and learning' with the unions.

- Further exploration of the impact of political, economic and demographical trends on the migration of doctors and nurses from certain African countries to more developed countries. For example, in cooperation with the African research network EQUINET[xiii] the effects of certain measures taken in Africa and the Netherlands to stimulate an effective growth of the African health workforce will be analyzed and translated into policy options and actions.

-Identify HRH information gaps and possible data linkages needed to improve health workforce monitoring.

***Envisaged duration and funding***

The Dutch HRH Alliance/Observatory kicked off by a meeting held in November 2009. The Alliance will start the different activities and allow more members to sign up/participate in 2010. In order to achieve a number of joint outputs it seems realistic to plan for the period 2010-2014 and use 2015 to evaluate the outputs, processes, etc. and determine future areas for cooperation.

A membership fee will be charged to member organizations (t.b.d.). Grants are needed for activities (meetings, research, etc.) as well as the financial compensation for the secretariat. A financial budget will be drafted in due course in line with a proposal (ToR) and funding exploration.