A proposal for measures under Norwegian foreign and international development policy to address the global health workforce crisis

Report from the working group chaired by the Ministry of Foreign Affairs, with participation by the Ministry of Labour and Social Inclusion, the Ministry of Health and Social Affairs, the Ministry of Education and Research, the Norwegian Directorate of Health and Norad

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Contents

ABBREVIATIONS

AU	African Union
CHAM	Christian Health Association of Malawi
COP	Code of Practice for international recruitment of health workers
DHIS	District Health Information System
EFTA	European Free Trade Association
ESTHER	Ensemble pour une Solidarité Thérapeutique Hospitalière En Réseau
EU	European Union
EEA	European Economic Area
UN	United Nations
G8	The Group of Eight leading industrialised nations
GATS	General Agreement on Trade in Services
GAVI	Global Alliance for Vaccine and Immunisation
GFATM	Global Fund for Aids, Tuberculosis and Malaria
GFMD	Global Forum for Migration and Development
GHWA	Global Health Workforce Alliance
HISP	Health Information Systems Programme
HRH	Human Resources for Health
HSS	Health Systems Strengthening
IHP	International Health Partnership
ILO	International Labour Organization
INGO	International Non-Governmental Organisation
IOM	International Organisation for Migration
LDC	Least Developed Countries
NGO	Non-Governmental Organisation
NOMA	Norad's Programme for Master Studies
NUFU	The Norwegian Programme for development, research and education
OECD	Organisation for Economic Co-operation and Development
PRIO	International Peace Research Institute, Oslo
RBF	Results-based financing
SADC	Southern African Development Community
SAFH	Norwegian Registration Authority for Health Personnel
SWAp	Sector-Wide Approach
MDGs	Millennium Development Goals
UNAIDS	The Joint United Nation Programme on HIV/AIDS
WHO	World Health Organisation
WTO	World Trade Organisation

Summary

The shortage of health workers is a serious obstacle to the ability of many countries to provide public health care and promote economic development, and the poorest countries are the hardest hit. There are considerable inequities at the global level between the need for qualified health personnel and the number of health workers available. Generally speaking the crisis is caused by several factors: too few health workers are being trained, many of those who are qualified take jobs outside the health sector, demographic trends are making new demands on health care and advances in medicine require increasingly specialised personnel (Chapters 1 and 2).

Another factor contributing to this situation is that the numbers of health workers are unevenly distributed and in many cases their skills are not being utilised appropriately. Market forces and international migration are creating a situation where countries with the least developed health services, the lowest pay and the poorest working conditions are facing a health workforce crisis, while those that can offer better conditions are making use of their competitive advantage to import foreign workers to meet their own needs. The crisis is reducing health security for the entire world community and increasing its vulnerability. International cooperation as well as efforts by individual countries are needed to address the crisis and ensure access to basic services for all. Without this it will not be possible to achieve the health-related Millennium Development Goals, to which all UN member states have committed themselves (Chapter 3).

Norway is also a party to the global health workforce crisis, and the Government wishes to promote a coherent and comprehensive health workforce policy at the national and international levels. In March 2008 two workgroups were therefore appointed to provide recommendations. The present report was compiled by the workgroup that addressed the issue of human resources for health (HRH) in Norway's foreign policy and development cooperation. After considering the relationship between national and international challenges in this area, the group considered a range of appropriate instruments for Norwegian foreign and development policy (Chapters 4 and 5).

In accordance with its terms of reference, the workgroup has given weight to measures that will increase HRH coverage and promote functioning health care services in low-income countries. The group has paid particular attention to measures for supporting education and research cooperation, support for the global consultation process to develop a Code of Practice for international recruitment of health workers and devising agreements and schemes for mitigating negative effects on sending countries when qualified health workers are recruited across national borders (Chapter 6).

The group found that in low-income countries with a critical shortage of health workers, a weak health care system with poor financial resources, equipment and low capacity for government stewardship are deciding factors. Migration is also a contributory factor, and is in many cases a prominent symptom of the crisis. Training of health workers has been given insufficient priority, both by the countries themselves and by their development partners. Health workers have been regarded as an expense instead of an investment.

The workgroup was headed by the Ministry of Foreign Affairs and contained representatives from the Ministry of Health and Social Affairs, the Ministry of Education, the Ministry of

Labour and Inclusion, the Directorate of Health and Norad. The group confirmed the importance of the measures already being implemented in Norwegian foreign and development policy, but it also pointed out that these measures may be placed in a wider context and intensified, supplemented and given a more strategic focus.

Finally, the workgroup proposed that the responsibility for follow-up, coordination and reporting should be assigned to the Ministry of Foreign Affairs in order to ensure that further efforts are based on a coherent strategy.

Recommendations

The workgroup stressed that although the health workforce crisis is a global phenomenon, its causes are complex and are made up of a number of different factors that interact in different ways in the various countries. This means that solutions must be tailored to the situation in the individual country, and must be based on an analysis of the labour market, the health system and disease status, educational capacity, the relationship between public and private services, and the organisation, financing and regulation of the health system and its stakeholders.

In its foreign and international development policy, Norway should seek to:

- **raise awareness of the fact** that qualified health personnel are vital to a country's health security and to its efforts to achieve the health-related Millennium Development Goals,
- **contribute to international framework conditions** for enabling every country to secure sufficient human resources for health (HRH) to provide basic health care services for all its inhabitants,
- **ensure institutional cooperation and partnership between countries** based on reciprocal commitments and agreements relating to education and training, exchanges and research, and encourage Norwegian institutions to take an active part in these efforts,
- **make use of its development assistance to strengthen the capacity of individual countries** to train, recruit, allocate, administer and retain the necessary health personnel**.**

The workgroup pointed out that Norwegian foreign and development policy would obtain better results in its HRH efforts by combining the various instruments and measures and applying them in a strategic and consistent way.

The recommendations are grouped into six priority areas, taking account of the need for influence on policy making, knowledge exchanges and financial transfers. The following is a summary of the group's recommendations for a focussed foreign and development policy and for the use of development assistance through global initiatives and bilateral and multilateral channels.

I. Political and strategic leadership and advocacy

The global health workforce crisis and global inequities in resource distribution and countries' ability to safeguard public health and health security are primarily a challenge to political and strategic leadership at the national and international levels. Given Norway's already prominent role in the efforts to achieve the health-related Millennium Development Goals, the country could make greater and more systematic efforts to ensure that solutions to the health workforce crisis are given high priority on the international agenda.

The workgroup proposes that Norway should support international leadership efforts to address HRH challenges, which must be based on **knowledge** of the facts, **coherence** between policies/policy instruments and **coordination** of measures across sectors and arenas.

- Effective political and strategic leadership will require better underlying data for assessing HRH status and a knowledge base with better documentation concerning which actions yield optimal results. These efforts need to be coordinated at the international level and should allow for accurate documentation of HRH status and evaluation of the results achieved.
- An outcome-oriented policy for addressing the health workforce crisis at national level while at the same time assisting the most vulnerable and hardest-hit countries to find solutions will require coherence between national trade, foreign and development policy instruments.
- Norway should pursue a more coherent policy in the international forums that address HRH issues, such as WHO, the WTO/GATS, the G8 and the Global Health Workforce Alliance (GHWA).

Norway can be particularly active as a leader in the following arenas:

- The Foreign Policy and Global Health Initiative launched by seven foreign ministers in 2006 to put public health security on the foreign policy agenda. HRH is one of the 10 focus areas of the initiative.
- Norwegian efforts to achieve the health-related Millennium Development Goals with an emphasis on maternal mortality. Adequate HRH is vital for results in this field.
- International/Norwegian efforts to improve coordination and safeguard the interests of developing countries, with a particular focus on their health sectors, in the WTO/GATS negotiations.
- Promoting greater knowledge of regional approaches/perspectives and better communication between regional organisations as part of Norway's negotiating position in WHO, the WTO, ILO, the EU/EEA and other multilateral forums in this field.

II. Improving the underlying data as a basis for policy-making and monitoring progress

There is no doubt about the reality of the global health workforce crisis, but the details are poorly documented. Data on the distribution of the various categories of health personnel and public access to services run by qualified personnel in individual countries are inadequate and fragmented. There is little information on training capacity and salaries, incentives and market factors, and the international migration of health personnel is poorly documented.

In order to find solutions and conclude reciprocal agreements/memorandums of understanding solutions, it is essential to obtain agreement on the kind of information needed and how it is to be obtained and systematised. Norway should be a driving force in the efforts to address these issues in multilateral forums.

The workgroup proposes specifically that Norway should:

1. Become involved in the co-operation in WHO, ILO and the IOM on developing better reporting procedures and data collection mechanisms on health personnel migration and in the relevant policy dialogues in the EU.
2. Support existing Norwegian expertise relevant to developing countries (at the University of Oslo) by means of development assistance funds specifically targeted at designing an HRH model for/including an HRH model in health information systems.

III. Measures to address health personnel migration

Health work is a universal profession and is the occupational sector with the highest degree of international migration. Although most health workers would prefer to work in their own countries, job opportunities, incentives and professional career opportunities are poor in low-income countries, and in an increasingly globalised labour market, rich countries with an inadequate self-supply of health workers are attractive destinations for health personnel. In addition, many countries are experiencing a drain of health personnel from the public to the private sector (in cases where the pay and working conditions are better) and from rural districts to cities.

Compensating sending countries for migrating health personnel is a global responsibility, and could be provided by taking measures to protect and strengthen the sending country's health system. It would be difficult to develop an agreed set of rules for a compensation scheme calculated per individual, and this would also involve major administrative transaction costs. However, in cases where a bilateral agreement is being negotiated, it would be natural to include specified forms of compensation. In the meantime Norway will make systematic use of foreign and development policy instruments to strengthen developing countries' health systems, and will refrain from active recruitment of health personnel from countries with poor HRH.

The workgroup proposes that Norway take steps in the following *three focus areas*:

1. Refraining from actively recruiting health personnel from countries with a shortage of HRH but seeking to influence the global consultation process on the Code of Practice for the international recruitment of health personnel. Norway wishes to strengthen the emphasis in the Code on the right to health services, which will depend on better health systems and strengthened HRH in developing countries. The Code of Practice will be the most important normative instrument in the field of HRH when it is hopefully adopted at the World Health Care Congress in 2010.
2. Making use of bilateral agreements on circular migration as part of development assistance activities, such as Norway's MDG 4 & 5 Initiative and the Migration and Development project . The workgroup does not consider bilateral health personnel exchange agreements with developing countries to be relevant as long as Norway is not a destination country for health personnel from developing countries.
3. Making use of the WTO as an international arena for developing an international framework for the temporary migration of health personnel across national borders based on GATS, and to facilitate closer coordination by destination countries of their recruitment policy/immigration programmes with developing /sending countries, particularly countries with a shortage of health personnel.

IV. Measures to strengthen countries' capacity for effective HRH policy and implementation

The main measures recommended here are not designed for any particular country but can be taylored in support of and by any of Norway's partner countries. They cover both planning and financing for implementation, and include financing models, health information systems, training and research. Norway supports global joint initiatives through organisations such as WHO, the World Bank and the GHWA that promote research, knowledge generation and the development of models and tools for implementation by individual countries. Norway also supports the World Bank's Human Resources for Health Trust Fund, which conducts research on the labour market and fiscal issues related to improving health workforce capacity. The

research results will be made available to the relevant countries to increase the knowledge base for their efforts to develop health personnel and retention policies.

In many low-income countries, HRH plans and working conditions for health personnel are an important part of retention policies. The fact that some of the key measures for meeting the health workforce crisis are outside the decision structure of the health sector itself implies that both developed and developing countries must aim at greater coherence between policies and sectors at the national level, for example through cross-disciplinary cooperation between sectors involved in labour market issues, training of health personnel, financing schemes and macroeconomic factors. Norway has already established programmes for supporting developing countries in higher education training, and the workgroup recommends that these be expanded and targeted more specifically at health personnel.

The workgroup has focussed on the following areas:

- encouraging embassies to play a facilitator role at national level in partner countries,
- earmarking and expanding Norwegian support for health personnel training through programmes at college and university level,
- concentrating Norway's efforts on particular countries in the fields of health, AIDS and higher education to allow long-term planning and promote synergies and effectiveness.

The workgroup recommends that Norway:

1. **Plays a facilitator role at country level**
   Norway could serve as convener in multi-partner cooperation at country level in areas such as education and training, health, research or HIV/AIDS. Each embassy should obtain information on the HRH status in the country and use the information as a basis for its strategy in the same way as for example is done on macroeconomic factors. It would be possible to support to the embassies through the existing health expertise and tools possessed by the Ministry of Foreign Affairs, Norad and the Norwegian health administration.
2. **Supports research and health personnel training**
   The following two approaches should be considered:
   a. The Norwegian Programme for Development, Research and Education (NUFU) and Norad's Programme for Master Studies (NOMA) could be given a grant component earmarked for measures for the health sector in line with section 2.2 of their respective programme agreements. Because many vital health services depend on personnel with education at Bachelor level, corresponding programmes for institutional cooperation on basic education in the field of health could be established. This could be linked with research by for example coordinating such studies with existing research.
   b. A comprehensive independent health programme could be established on the model of the NUFU and NOMA programmes that would cover all higher education levels (Bachelor, Master, PhD) and research.

   Before a decision is made the two approaches should be designed and appraised by experts with a view to assessing their effectiveness in achieving the relevant impacts.

V. Strategic use of development assistance funds

Development assistance through multilateral channels and global initiatives

Today Norway's support for HRH is channelled mainly through multilateral agencies and organisations. Norway's resources for health development are relatively small, about 3% of the total international development assistance to the health sector, and must therefore be used in contexts where they yield optimal results. The workgroup considers that channelling the largest part of Norwegian development assistance through these organisations is making good use of the funds and should be continued.

In the last few years various global health initiatives have been established in addition to the existing multilateral organisations, many of which have joined the initiatives together with bilateral and private donors and foundations. In order to ensure an optimal outcome, the allocation of assistance to HRH through multilateral organisations must be evaluated regularly, for example annually, in relation to context and performance. While some organisations, especially WHO, serve an important normative function, other organisations and joint health initiatives have a greater direct impact in terms of development assistance.

The workgroup recommends that:

1. Norway should continue to channel development assistance through multilateral agencies. The most important of these will continue to be WHO, GAVI, GFATM, UNAIDS, INGOs, GHWA-initiated activities and other global health initiatives and trust funds.
2. **Results-based financing (RBF)**
   - NOK 5 million per year to be allocated to a review exercise of the HRH-specific implications of RBF implementation in the various countries and to research in this field. Some of this should be normative process research, which would provide up-to-date knowledge concerning the programme impact and possible distortion effects so that the effects on the total HRH situation in the respective countries can be monitored.
   - RBF should also be considered for supporting research on other labour-market-related consequences for health personnel, in the same way as for example Norway's support for the World Bank's Human Resources for Health Trust Fund, which is NOK 5 million per year for six years.

Bilateral financial assistance to partner countries

Norway is currently involved in cooperation with Malawi in the health sector, in which HRH is a main focus area. In addition, Norway's MDG 4 & 5 Initiative in Tanzania is being included in the health sector cooperation with other health sector donors. The workgroup recommends that this should include an explicit HRH component, which is already being developed and could be further supported by providing RBF to the MDG 4 & 5 Initiative.

A large proportion (approximately 30%) of Norway's bilateral development assistance is channelled through civil society and NGOs. The health portfolio is substantial and should be maintained. Norwegian NGOs and private health organisations are also encouraged to engage in partnerships based on the model of for example the ESTHER programme for institutional cooperation. Finally the workgroup recommends a review of the humanitarian assistance portfolio with a view to supporting crisis training for health personnel in selected developing countries.

The workgroup recommends:

1. Support for capacity-development:
    i. in countries with which Norway has a health sector cooperation (Malawi) and in partner countries for Norway's MDG 4 & 5 Initiative (Tanzania, Pakistan, India, Nigeria),
    ii. in countries where Norwegian institutions and hospitals engage in institutional cooperation (such as Ethiopia, South Africa, Malawi),
    iii. in countries with which we have partnership exchange arrangements through FK Norway and the ESTHER programme,
    iv. in countries where Norway can contribute through its membership in the International Health Partnership,[1]
    v. by including HRH in its health and HIV/AIDS support,
    vi. by examining ways to provide more systematic support to regional health worker training over the budget allocation to humanitarian assistance, as part of crisis preparedness.

VI. Facilitating more targeted efforts by Norwegian institutions

Many Norwegian health institutions have for many years been involved in partnerships and institutional cooperation in developing countries. Their activities are concentrated on a variety of thematic areas and countries, but they have great potential as a foundation for future efforts to strengthen HRH and health systems. The Norwegian organisations and health institutions have expressed interest, and requests are regularly received from developing countries, for participation and partnership in this field.

In order to exploit the interest and utilise the resources of Norwegian health institutions, a financing scheme has been established under the health institution cooperation programme ESTHER, where strengthening of HRH is the main criterion for support. The workgroup recommends that the institutions be encouraged to set up a health network for development through which experience could be generated and exchanged, and members could be informed of best practices in the field.

The workgroup recommends:

1. That a coordinating body (a Norwegian health for development network) should be established and supported to improve coordination and assure the quality of the institutional partnerships engaged in by Norwegian health institutions and organisations, and as part of the efforts to improve international coordination.
2. That financial support should be given to partnerships and institutional cooperation, primarily through the ESTHER programme, in order to ensure predictability in the cooperation relations between the partners.

[1] The International Health Partnership, which was launched in 2007, is an inter-agency coordinated mechanism established to respond to the health-related MDG challenges that includes financing of activities. The process was initiated by the Norwegian and UK Prime Ministers together with the prime ministers of a number of other countries. The first countries selected for cooperation are Mozambique, Burundi, Ethiopia, Kenya, Mali, Nigeria, Zambia, Nepal and Cambodia.

1. Introduction

In Norway as in the rest of the world, the shortage of health workers[2] in developing countries in recent years has aroused increasing attention. Satisfactory national health systems are one of the most important preconditions for development. The proven link between a satisfactory health service and the health and prosperity of a population demonstrates the need for strengthened health systems, including primary health services. Most developing countries currently lack both sufficient capacity and sufficient numbers of qualified health workers.

The shortage of health workers is a serious limitation on many countries' potential for securing public health and economic development. The HRH crisis also increases vulnerability to global threats against health security in the form of infectious diseases, climate change catastrophes or other threats, where a well functioning health service is a critical element of disaster preparedness. There is currently no shortage of health workers in Norway, but there is a broad political consensus on covering our future need for health workers in ways that do not exacerbate the situation for developing countries as regards the critical shortage of health workers[3]. Only five per cent of the workforce in the health sector in Norway currently consists of foreign nationals, and very few of these come from developing countries. There are thus favourable conditions for agreement on a prudent policy for the future. However, when considering specific political measures, it is important to bear in mind the many dilemmas that characterise this policy area.

It also constitutes a considerable domestic and foreign policy challenge. Although the future need for health workers is difficult to predict, a certain shortage of health and care workers is indicated inter alia by the demographic development in Norway towards 2030, particularly nurses and auxiliary nurses, which will further increase towards 2050. Key factors are the high birth rate during the years immediately after World War II, followed by a sharp fall to a lower level from the 1970s, increasing life expectancy and improved medical facilities and rights. This manifests itself at the same time as the situation is becoming far more critical in many other countries and, in the final analysis, is a global challenge with impacts in a number of policy areas.

The white paper *Future Challenges for the Care Sector* (Report No. 25 (2005-2006) to the Storting) *states*: "The demographic challenges are both domestic and transnational. Increased ageing of the population, which will give rise to an increased need for care services, can therefore not be resolved by importing manpower. The Government wishes to stress that it will not carry out targeted recruitment of health and social care workers from developing countries, but will instead focus on ensuring adequate domestic training capacity and recruitment."

[2] For the purposes of this report, health workers refers to health service employees in public, private or non-governmental institutions with training providing formal qualifications specific to health services who work in various functions in the health system. When unskilled health workers are intended, this is specified.

[3] Proposition No. 1 (2006–2007) to the Storting – the National Health Plan for Norway, the Ministry of Health and Social Affairs, page 302: "Globalisation results in increased mobility of health workforce. There is currently a global deficit of four million health workers. The situation is particularly acute in developing countries where qualified health personnel are recruited to better paid posts in developed countries Norway plays an important role in a new global alliance on human resources based at the WHO, where migration issues are a key topic A precondition for increasing the success of developing countries in retaining their qualified manpower in the health sector is that rich countries pursue a policy that refrains from emptying poor countries of their qualified health workers. Norway aims to pursue such a policy."

This is followed up, among other places, in the white paper on Labour Immigration (Report No. 18 (2007-2008) to the Storting), which also concerns health workers: "It is important to limit the brain drain. Achieving this will necessitate both positive incentives that make it attractive for competent professionals to continue to live and work in their home countries, and national and international rules to prevent key personnel from being actively recruited by richer countries."

This report concerns what Norway achieves and can achieve in the future through foreign and development policy as part of an integrated Norwegian HRH policy. The Government has also appointed a working group with a mandate to assess the future health workforce needs and solutions in Norway.

This report is issued by the Ministry of Foreign Affairs. The working group that has assisted in its preparation was appointed and chaired by the Ministry of Foreign Affairs with members from the Ministry of Health and Care Services, the Ministry of Education, the Ministry of Labour and Social Inclusion and the Norwegian Directorate of Health. The secretary for the group was provided by Norad. Contributions by the members have given broad substance to the topics and the recommendations.

Mandate

The group's mandate[4] consists of following up the Government's intention to develop a policy for recruitment of health workers in the foreign and development policy area, inter alia, in the light of

- the Declaration of the Global Forum on Human Resources for Health held in Kampala, Uganda in March 2008
- the white paper on labour immigration (Report No. 18 (2007–2008) to the Storting)
- the white paper *Future Challenges for the Care Sector* (Report No. 25 (2005–2006) to the Storting)
- the National Health Plan for Norway 2007–2010
- preparatory work on a new white paper on international development policy

The group will also consider recommendations put forward in the report of 2007 from the Norwegian Directorate of Health, IS-1490 "Recruitment of Health Workers: Towards Global Solidarity" of relevance to the development policy area.

The group is furthermore to submit recommendations concerning the draft *Code of Practice* for international recruitment of health workers, consider schemes for mitigating negative effects on sending countries, consider existing and new instruments for assisting developing countries and the associated costs, consider bilateral and other agreements, show the links between research, training and measures designed to increase coverage and retain personnel in their home countries and examine how international fora and meetings can be used to influence practice.

[4] Whole mandate: Annex 1

2. Background

The HRH crisis has gradually become more recognised as an obstacle to the achievement of the Millennium Development Goals (MDGs), which were established by the international community at the turn of the millennium and which serve as guidelines for Norwegian development assistance in the area of health. Three of the goals are directly health-related (goal 4 *"Reduce child mortality"*, goal 5 *"Improve maternal health"*, and goal 6 *"Combat HIV/AIDS, malaria and other diseases"*, while a total of seven of the eight goals are more or less indirectly associated with improvement of the health of the poor. During the first years after the turn of the millennium, the high-level meetings on the MDGs identified the shortage of health workers as one of the most critical obstacles to achievement of the goals.

The international debate and international efforts have focused partly on the following:

1. *Knowledge gathering*: During the first phase after the turn of the millennium, we acquired new, updated knowledge of what the HRH crisis consists of and of its implications. The report of the *Joint Learning Initiative*[5], (2004), which studied the global HRH situation, established that:
   - The spread of HIV/AIDS results in increased disease burden and a need for more personnel, while, in the countries most affected, health workers themselves are afflicted
   - Labour migration from countries that have least resources and the weakest health systems is increasing, these countries are hit hardest by the brain drain
   - Long-standing chronic underinvestment in development of the health workforce and unsuccessful sectoral reforms in developing countries has frozen recruitment to the health sector.
   - The survey showed that countries with a low density of health workers had high mortality rates, while countries with high density had low mortality rates. There is a particular positive correlation between high maternal mortality with low health workforce density in a given population.
   - The crisis involves not only *shortage* of health workers; it also involves imbalances in the *composition* of worker categories and in their *distribution*. The unsatisfactory *employment conditions* in developing countries result in poor services, and the *quality* and expertise of the personnel is often too weak.

2. *Influencing activities*: This work involves active international foreign and development policy dialogue aimed at stimulating the interest of political leaders and promoting their awareness of issues. In this case, it involves gaining support to place the HRH crisis on the agenda. Major international, regional and national institutions, professional associations, the private sector and civil society have been involved in the dialogue which led to the establishment of a *Transitional Working Group* and then of the *Global Health Workforce Alliance*[6] (GHWA). The World Health Organisation (WHO) administers and hosts the Alliance. It consists of a board, a secretariat and regional networks. The GHWA has appointed three expert groups, respectively, *i)* financing of health workers, *ii)* training and *iii)* migration. The Global Health Workforce Alliance enjoys wide support as an arena for

[5] Human resources for health. Overcoming the crisis. 2004 Harvard University, USA, Joint Learning Initiative. ISBN 0-9741108-7-6.

[6] The GHWA http://www.who.int/workforcealliance/en/ was established in 2006, and has a broad membership: Industrialised countries, developing countries, professional associations, knowledge centres, the private sector, donor organisations, civil society organisations, multilateral organisations including the WHO, the World Bank, etc.

multi-partner cooperation and as a driving force for creating the basis for both short-term and long-term solutions.

3. *Commitments*: The WHO has focused attention on the HRH issue, and has involved all member countries:
   – *World Health Report* for 2006[7], *Working Together for Health*, continued the work on knowledge and influencing activities initiated by the *Joint Learning Initiative*, and was a key topic at the World Health Assembly in 2006. The HRH agenda received considerable attention and support.
   – *The Kampala declaration*[8] *and a joint agenda for global action*: At the Global Forum in March 2008 in Kampala, the Global Health Workforce Alliance succeeded in gathering a wide range of actors and stakeholders on support of a joint action plan to deal with the crisis.

   A key part of the Kampala action plan is the final part, which describes how these areas are to be followed up, primarily by means of national plans and measures with an emphasis on the elements that constitute the greatest bottlenecks in each country. In these efforts, the GHWA will help to bring the actors together, provide support and help to clarify the issues. The GHWA will also be a platform for learning what works. The GHWA will make it possible to keep track both of what is now being done and what is not being done, and of the consequences. A Global Forum will be arranged every other year.
   – *Focus on primary health services:* Thirty years after the Declaration of Alma-Ata on Primary Health Care, the WHO has once more focused on Primary Health Care. The World Health Report for 2008 is entitled *Primary Health Care – Now more than ever.* Primary health care is also one of the main topics of the World Health Assembly 2009. One of the preconditions for a well functioning primary health service is that there are sufficient qualified health workers for it to function successfully.

4. Specific proposals for a new global *Code of Practice* for international recruitment of health workers are planned for inclusion on the agenda of the World Health Assembly in May 2010. Improvements have been made to the Code by the GHWA's working groups and the *Health Worker Migration Policy Advisory Council, among others*. Mr. Erik Solheim, the Minister of the Environment and International Development, is a member of this council.

Preparation of matters for consideration by the World Health Assembly is carried out by WHO bodies and by means of national and regional consultations. *The Health Worker Migration Policy Advisory Council* is one of a number of platforms that seek to develop views and knowledge, and gather support from many stakeholders and groups ahead of the World Health Assembly and other arenas.

[7] WHO 2006 World Health Report. Working Together for Health http://www.who.int/whr/2006/en/index.html
[8] The Kampala Declaration and Agenda for Global Action: http://www.who.int/workforcealliance/Kampala%20Declaration%20and%20Agenda%20web%20file.%20FINAL.pdf

Norwegian efforts
Norway was one of the initiators, and is the largest single financial contributor, to the GHWA. International consultations have twice been held in Oslo, in 2005 and 2006. *The Transitional Working Group* with Norway as an active participant played a catalytic role in the establishment of the GHWA in 2006. The topic of HRH was likewise raised in the boards of the global funds GFATM and GAVI, in UNAIDS and in various technical and development policy fora where Norway has taken part.

Norway has stated its policy during consideration of the HRH issue by the World Health Assembly and by the WHO's Regional Committee for Europe.

Norway has contributed to bilateral cooperation on development policy through health sector programmes in Mozambique and Malawi as well as through support to civil society in these and other countries, e.g. an HRH-specific project in Botswana 2005–2009. Some Norwegian NGOs and groups of health institutions and researchers are involved in large and small HRH projects in developing countries.

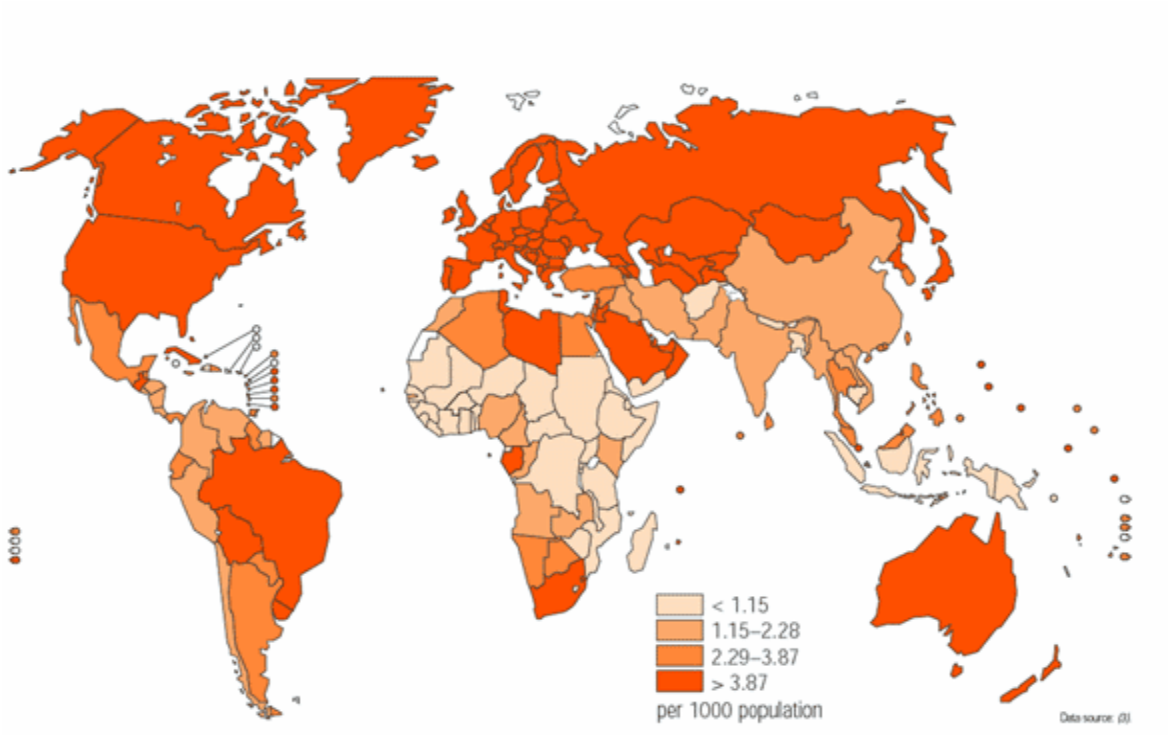
The Government's kick-off of the Norwegian policy development process was a *ministerial breakfast meeting* on the topic attended by four ministers in February 2007, the Minister of Health and Care Services, the Minister of Labour and Social Inclusion, the Minister of the Environment and International Development and the Minister of Education. Norway had then already espoused a principle of not divesting poor countries of their few qualified health workers, and then undertook to develop a policy conducive to compliance with this principle. In this area, Norway is seen to be in the forefront among industrialised countries. Another ministerial breakfast meeting on the same topic was held in January 2009.

3. The HRH situation in developing countries

3.1 General sources of data, with a focus on certain partner countries

Of the 57 countries regarded by the WHO in *World Health Report 2006* as having too few health workers in relation to a minimum standard, 36 are in Africa. Many of these are partner countries of Norway, e.g. Malawi, Mozambique, Zambia, Kenya, Tanzania, Uganda, Ethiopia and, in Asia, Pakistan, India, Afghanistan and Sri Lanka.

Countries that, according to the WHO, have less than a minimum level of health workforce density are in light colours[9]*:*



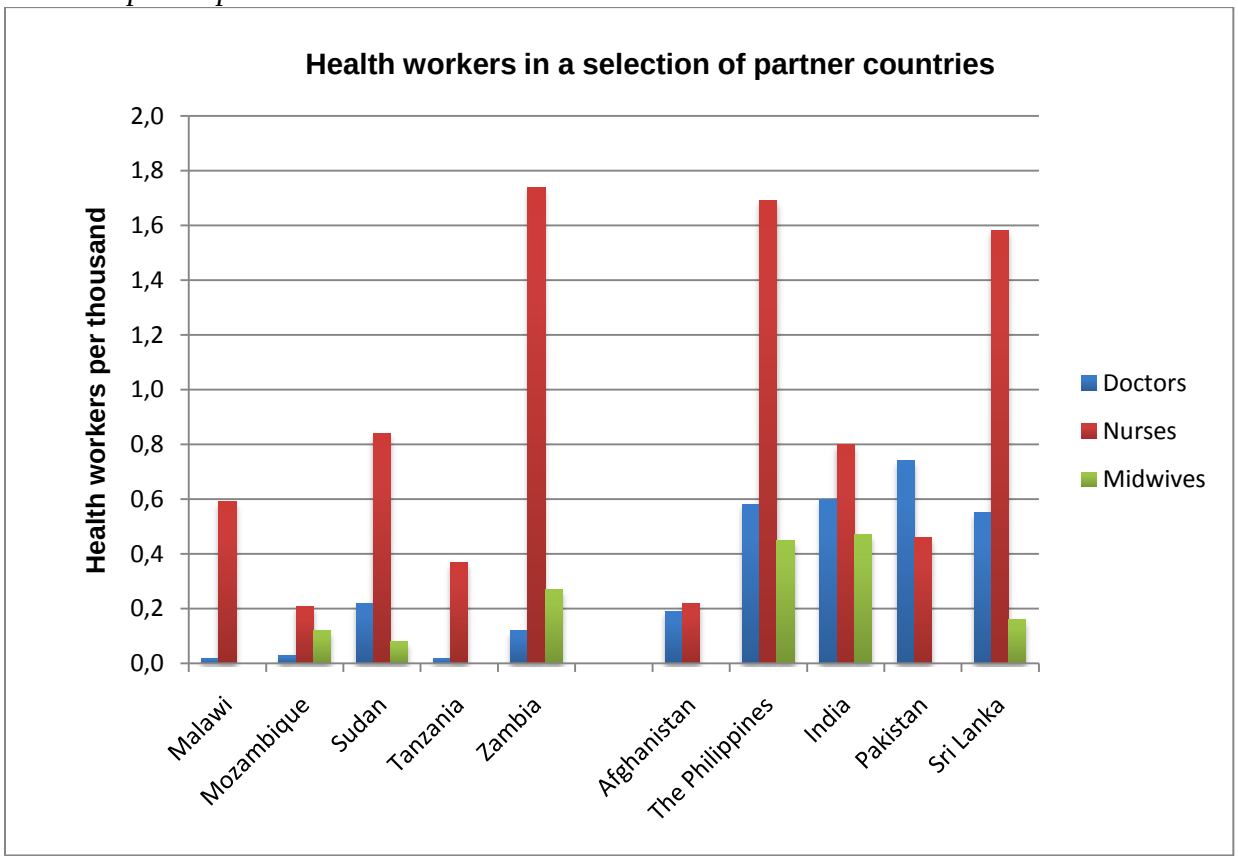
Countries south of the Sahara have been hardest hit by the crisis. Africa has approximately 25 per cent of the world's health burdens but only 3 per cent of health workers[10]. Otherwise, countries in South-East Asia are particularly short of health workers, as well as Haiti. There are also major variations in the composition of medical professions. There may be political, socio-cultural and other reasons for this. While most countries have far more nurses than doctors, Bangladesh has approximately 34 000 doctors, but only approximately 14 000 nurses[11]. However, in relation to a population of approximately 140 million, there is regardless a shortage of all categories of health workers.

[9] WHO, World Health Report 2006 (http://www.who.int/whr/2006/en/index.html). Note that the countries' health workforce statistics are often of uncertain and poor quality. From some countries one may get figures other than those of the WHO. The map fails to reflect important factors that also affect people's access to health workers, such as geographical distribution within the countries, skill mix and health professions, the relationship between the public and the private sectors, financing of the services, etc.
[10] The Lancet, Volume 371, Issue 9613
[11] World Health Report 2006, WHO

Health workers per 1000 inhabitants[12]

	Doctors	Nurses	Midwives	Dentists	Pharmacists
Africa:					
Malawi	0.02	0.59	...	...	...
Mozambique	0.03	0.21	0.12	0.01	0.03
Sudan	0.22	0.84	0.08	0.03	0.10
Tanzania	0.02	0.37	...	0.01	0.01
Zambia	0.12	1.74	0.27	0.04	0.10
Asia:					
Afghanistan	0.19	0.22	...	0.03	0.02
The Philippines	0.58	1.69	0.45	0.11	0.03
India	0.60	0.80	0.47	0.06	0.56
Pakistan	0.74	0.46	...	0.05	0.05
Sri Lanka	0.55	1.58	0.16	0.06	0.06
Norway	3.13	14.84	0.49	0.82	0.37

Graphic representation:



(A column for Norway would far exceed the above framework, cf. the figures in the table at the top of the page.)

[12] WHO 2006 World Health Report. Working Together for Health http://www.who.int/whr/2006/en/index.html

3.2 Some national challenges and strategies in relevant developing countries

The significance of the health workforce for the state of health in countries
It is not unequivocal that the state of health of the population is correlated with the number of health workers. The health workforce is only one of a number of factors that must be in place, but for some patient groups access to qualified personnel is of major importance. This particularly applies to the field of obstetrics. Countries with the lowest health workforce density have the greatest maternal mortality (from *World Health Report 2005*).

The health workforce plans
Some developing countries, such as Mozambique, Zambia and Malawi, have in the course of time developed overall, cost estimated *health workforce plans*. These have only partly been implemented. Recurrent problems associated with implementation include

- health ministries with particularly poorly equipped health workforce departments, as regards both personnel and financial resources, organisation and status
- lack of clarity concerning the actual financial scope and potential of the country's economy to increase the number of health workers
- financial support from development partners/donors is not sufficiently predictable and durable
- lack of participation by government sectors outside the health sector (finance, labour and education authorities)
- lack of private sector involvement in planning and implementation
- lack of exact knowledge concerning the types of retention measures/packages (i.e. measures for retaining personnel) that would actually work
- failure of other parts of the health system, e.g. management and organisation, access to equipment and medicines
- competition for the best health workers in the country between health institutions with special interests results in exodus from basic services, and understaffing in some parts of the country and in major areas of the health service

Redistribution of the responsibility for services between personnel categories (task shifting)
Many attempts have been made in many countries to transfer tasks from one personnel category to another, often from one with higher to one with lower qualifications (e.g. from doctor to nurse, from doctor to *medical assistant*[13], from nurse to *nursing assistant* with shorter training). This has often been done owing to a shortage of doctors or nurses, and as the only possibility for providing the necessary medical services. With satisfactory guidance, this arrangement could have functioned better than it often does, since the necessary guidance is often not provided. This gives rise to a considerable risk of erroneous treatment, which may result in loss of confidence in the health service and the spread of infectious diseases while many patients continue to suffer without receiving treatment. Task shifting has had varying effects, and its success is dependent on satisfaction of a number of criteria. In 2008, the WHO issued a guide to task shifting (to which Norway contributed support) for the benefit of both public authorities and development actors[14].

[13] Designations for this vary from country to country
[14] WHO 2008: Task shifting : rational redistribution of tasks among health workforce teams : global recommendations and guidelines http://www.who.int/healthsystems/TTR-TaskShifting.pdf

In addition to this, several countries have established a category "lay health workers", who, after attending short courses, have particularly been employed in rural areas in carrying out simple routine tasks in health information/primary health care. Here too, the results vary as regards the effect of these activities on public health. A systematic review in which the Norwegian Knowledge Centre for Health Services took part, shows that the effect depends on specific criteria[15]. The employment of midwife assistants (ashas) in Afghanistan and India results in more women going to maternity clinics to give birth instead of giving birth at home. This measure has helped to reduce maternal mortality. In India, there are indications that the effects of employing ashas can be reinforced by offering financial incentives to the mother when she comes to the clinic to give birth rather than giving birth at home.

HIV/AIDS

In countries with a high incidence of HIV/AIDS, this places an additional burden on the health service owing to the increased disease burden and the larger number of patients. There are also HIV/AIDS victims among health workers. In Zambia, death from AIDS is the main cause of health worker attrition (2004 figures), ahead of migration. In cooperation with the ILO, among others, the WHO has prepared a guide called *Treat, Train and Retain* addressing the specific health service needs of health workers. HIV-positive health workers, for example, are particularly vulnerable to stigma, and need special attention in order to safeguard their access to treatment in view of their role in providing health services to others. Some countries have special programmes for this, but few countries have programmes that succeed in providing help to all who need it.

The brain drain/migration

See also chapter 5. Partly owing to the lack of data and harmonised definitions, it is very difficult to obtain an overall view of the mobility patterns of health workers from developing countries[16].

In some countries, this has proved to be a major problem, but the shortage of health workers is not only caused by migration. The OECD report *International Migration Outlook 2007* found that

"All African-born doctors and nurses working in the OECD represent no more than 12% of the total estimated shortage for the region. The corresponding percentage is even lower (9%) for the region with the greatest need in absolute terms: South East Asia." In response to this, it might be observed that some major destination countries for health worker migration, such as the Arabian states, are not OECD member states.

World Health Report 2006 (WHO) established that almost a quarter (23%) of doctors trained in Africa work in OECD member states, and one out of 20 nurses. Some countries are affected more than others. For example, 29% of Ghana's doctors work abroad and 34% of Zimbabwe's nurses.

[15] Systematic review Lay health workers in primary and community health care. SA Lewin, J Dick, P Pond, M Zwarenstein, G Aja, B van Wyk, X Bosch-Capblanch, M Patrick. Cochrane Database of Systematic Reviews 2008 Issue 4. Conclusion: "LHWs show promising benefits in promoting immunisation uptake and improving outcomes for acute respiratory infections and malaria, when compared to usual care. For other health issues, evidence is insufficient to justify recommendations for policy and practice. There is also insufficient evidence to assess which LHW training or intervention strategies are likely to be most effective. Further research is needed in these areas."

[16] OECD 2007: International Migration Outlook: SOPEMI 2007 Edition

Another example from the same report: the share of doctors in the UK and Ireland from India, Pakistan, Sri Lanka, Malaysia, the Philippines, Bangladesh and other countries in this region increased from 9.6% to 37.3% from 1997–98 to 2002–03[17]. As shown in chapter 5, Norway has not nearly as much migration from developing countries as for example the UK and the US. Norway mainly receives foreign health workers from neighbouring countries, and the proportion is lower.

OECD figures are lower, but also older. In OECD countries in 2000, an average of 10.7% of nurses and 18.2% of doctors were born abroad. Over a quarter of foreign-born doctors in OECD member states come via mobility from another OECD member state. There are considerable variations between countries, where, for example, Poland and Finland had a proportion of less than 5% foreign-born doctors, while Luxembourg had a proportion of almost 47%. Countries such as the UK, Canada, Ireland, Australia and New Zealand also had a high proportion of foreign-born doctors. Of the foreign doctors in OECD countries, 7.2% came from North Africa and 7.8% from the remainder of Africa. Particularly in France, there are doctors with a background from North Africa. From the remainder of Africa, doctors particularly go to Portugal, the UK, Canada, New Zealand and Australia. In a number of OECD member states, this is closely associated with historical reasons, such as colonial connections, common language and to some extent common education systems.

However, migration flow may occur in stages or chains which also include Norway, and where the US and partly Canada are the largest final destination countries[18]. There is reason to be watchful of a possible domino effect where some of Norway's traditional neighbouring sending countries (e.g. Germany, and increasingly Poland and other Baltic states) may resupply their own needs with personnel from other countries, eventually developing countries. As yet, no statistics or research demonstrate the possible scope of this. However, new research projects are ongoing, e.g. those for the EU Seventh Framework Programme, such as the "Mobility of Health Professionals" project being carried out by the *International Organisation for Migration* (IOM) in cooperation with a German research institute.

Since many foreign-born workers migrated to OECD countries at an early age with their families or as students, the proportion of health workers in OECD countries with *training* from abroad is lower than the proportion of *foreign-born* health workers.

Only a small proportion of health workers in OECD member states come from the poorest developing countries. However, this gives little indication of the effect of the brain drain on the sending countries, since many of these already have a very low degree of coverage of health workers. African and Caribbean states stand out as particularly affected by the brain drain of health workers. Around 2000, several Caribbean states and the African states of Mozambique, Angola, Sierra Leone, Tanzania and Liberia had more doctors working in OECD member states than in their native countries.

There is a greater tendency for people with higher education to migrate abroad than for those without it. In 2000, foreign-born health workers were not overrepresented among immigrants in OECD member states compared with other corresponding occupational groups with higher education. This picture may have been changed somewhat by the migration of health workers in recent years (since 2000).

[17] Birrell, R. Australian Policy on Overseas-Trained Doctors. *The Medical Journal of Australia.* 2004;**181**:635.
[18] Re: Buchan's Europe Study on "cascade migration"

The WTO/GATS agreements have implications for migration. In some quarters, it is maintained that the ongoing WTO negotiations on trade in services, GATS, may result in an increase in the brain drain of health workers from developing countries. Increased movement of service providers across national borders, including health workers, is a topic in the discussion on service sector liberalisation. The purpose of the WTO negotiations is to establish common multilateral and transparent rules for trade in services. If these negotiations succeed, GATS may become an important mechanism for ordering south-north migration. For example, GATS will be able to contribute to increased international harmonisation of the competence and qualification requirements regarding health workers.

Developing countries represent a variety of interests and approaches in the GATS negotiations, including the issue of increased market access for service providers from developing countries. While the Philippines has made an industry of exporting health workers, Bolivia, for example, has adopted a diametrically opposite course, and takes the view that temporary migration of health workers across national borders should be taken out of GATS. The country has therefore withdrawn its commitments concerning market access to the health sector. A number of African states have well thought out strategies and perspectives associated with export of health services and issues associated with the brain drain, while others see conflicting sectoral interests in the public authorities of the various states, which may result in depletion of their own health sectors.

GATS only concerns temporary movement of persons across national borders. Very few industrialised countries have currently undertaken commitments giving health workers from developing countries access to their domestic markets, and GATS cannot therefore be said to be a major cause of migration of health workers or of the brain drain from developing countries.

Development cooperation and assistance have also proved to have a non-intended potential to influence the HRH situation in partner countries. Development actors such as NGOs and bilateral and multilateral organisations have been criticised for remunerating their employees better than the public health services, thus depleting basic services, e.g. in favour of disease-specific donor priorities[19]. As a result of this, donors have cooperated on developing better coordination mechanisms for strengthening of health systems, as in the *International Health Partnership (IHP+)*[20]. IHP+ is still under development with a preliminary focus on a small selection of countries: Mozambique, Burundi, Ethiopia, Zambia, Kenya, Mali, Madagascar, Nigeria, Nepal and Cambodia.

It is important that the countries themselves take control of finding solutions and implementing them. This requires that public authorities and the voluntary and private sectors in the countries adopt common strategies. Development assistance may support such strategies by helping to build capacity.

[19] Global Health Initiatives /GFATM study
[20] International Health Partnership http://www.internationalhealthpartnership.net/

3.3 Regional conditions and regional efforts.

Regional efforts and platforms have been created to
a) conduct regional monitoring of the HRH situation and
b) achieve potential regional coordination benefits.

Observatories:
Africa Health Workforce Observatory http://www.afro.who.int/hrh-observatory/
Asia-Pacific Alliance on Human Resources for Health http://www.aaahrh.org/
The Latin-America and Caribbean Observatory in Human Resources for Health http://www.lachsr.org/
European Observatory on Health Systems and Policies http://www.euro.who.int/observatory

Either through participation or through cooperation with the observatories, the WHO also provides all of its member states with a source of knowledge and a dialogue platform beyond the public sector. For example, non-public partners of significance to the HRH situation can participate here. There is often too little such participation, and the health sector works too much in isolation while openness towards other partners and sectors is key to action. There is an increasing recognition of the need for a broader catchment area than the public sectors, but the observatories have not yet provided the potentially dynamic platform that is needed. An exception is the Asia and Latin America platforms, where developments are more dynamic. But participation by private and non-governmental actors, in OECD member states too, is under-utilised.

Regional cooperation, including knowledge generation, research and investment in health professional environments – distribution and coordination of resources – has been ineffective, and is a challenge for further development.

4. Status of the international HRH agenda and development cooperation

4.1 Development of the HRH agenda

The international HRH agenda evolved in the wake of decisions concerning the MDGs. The HRH crisis turned out to be a critical obstacle to achievement of the health-related goals.

Some of the most crucial processes began with the increase in awareness of the crisis that emerged in full force at the high-level meetings on the MDGs from 2004 and onwards. Knowledge development concerning the problem, which was introduced by Joint Learning Initiative 2004 and World Health Report 2006, prepared the ground for mobilisation of a broad range of stakeholders at regional and international meetings, including G8 and UN contexts.

The establishment of the Global Health Workforce Alliance (GHWA) in 2006 succeeded in gathering actors to more targeted efforts, and at the *Global Forum on Human Resources for Health 2008* a consensus was reached on a Kampala Declaration and Global Agenda for Action. The Agenda for Action sets out six strategies:

1. Building coherent national and global leadership for health workforce solutions
2. Ensuring capacity for an informed response based on evidence and joint learning
3. Scaling up health worker education and training
4. Retaining an effective, responsive and equitably distributed health workforce
5. Managing the pressures of the international health workforce market and its impact on migration
6. Securing additional and more productive investments in the health workforce

The form taken by the health workforce agenda has also been influenced by other international milestones, both regional and global[21].

[21] High-level meeting on the MDGs, Geneva 2004. WHA57.19 2004 and WHA58.17 in 2005. Joint Learning Initiative Report 2004. High-level meeting on the MDGs, Abuja 2004. African Union meeting, Abuja 2004. Oslo Consultation, February 2005: Transitional Working Group on HRH established. WHA58.17 2005. Africa Commission Report 2005. G8 meeting at Gleneagles 2005. Africa Stakeholder Consultation, Brazzaville 2005. Asia Network Bangkok 2005. Africa regional Health Ministers meeting, Maputo 2005. UNGA (UN General Assembly), New York 2005. PAHO Observatory (American countries), Toronto 2005. AU's health minister meeting, Gaborone 2005 (and Johannesburg 2007). High-level meeting on the MDGs, Paris 2005. Oslo Consultation II, February 2006. World Health Report 2006: Working together for Health. Global Health Workforce Alliance (GHWA) established, 2006. High-level meeting on Migration and development, New York 2007. GHWA Task Forces established: Training, migration, financing. 2007. Global Forum on Human Resources for Health, Kampala 2008. World Health Assembly 2008. Presentation of report on intensified health worker training, 2008. International Health Partnership (IHP) established with HRH on the agenda, 2008. PEPFAR (The US President's Emergency Plan for Aids Relief) including HRH, 2008. The twelfth International AIDS Conference, Mexico 2008. G8 meeting in Hokkaido 2008. Migration: Draft of Global Code of Practice for recruitment of health workers presented by the WHO Secretariat 2008.

4.2 Norwegian international policy influencing activities

The GHWA
Norway, represented by the Ministry of Foreign Affairs and Norad, has participated in the international development-related processes concerning the HRH crisis from the start of talks after the turn of the millennium, and has also taken a lead in setting the agenda. Prior to the establishment of the GHWA, two international consultation meetings were hosted by Norway in Oslo (2005, 2006). Here was established the *Transitional Working Group* (2005), which formed the framework and direction for the work until this was taken over by the GHWA. Norway, represented by the Ministry of Foreign Affairs, then joined the board of the GHWA, supported by Norad. To date, Norway has supported the GHWA with annual contributions of NOK 20 million in 2006, 2007 and 2008, and is its largest individual donor. Since May 2008, Norway, represented by the Ministry of Foreign Affairs, has chaired the GHWA Board. During the preparations for the Global Forum in Kampala in 2008, Norway chaired the organising committee.

Support for research at the World Bank
In 2005, Norway contributed NOK 15 million to the World Bank's *Human Resources for Health Trust Fund*. The Fund has conducted research into a number of areas affecting the health workforce in a selection of African countries: labour market conditions, incentive policy, financial implications of increasing health worker density, etc. In 2008, Norway granted a further NOK 15 million over three years to a phase II of the project. The results of this research will provide input to the processes in fora where Norway actively participates, e.g. the GHWA, the WHO, the global health funds, and in other consultations concerning health systems financing and donor modalities.

The WHO
Norway supported the World Health Assembly resolutions in 2004 (WHA57.16) and 2005 (WHA58.19) on global guidelines (*Code of Practice*) for international recruitment of health workers. In this matter, Norway is represented at the WHO by the Norwegian Ministry of Health and Social Affairs and the Norwegian Directorate of Health. The point of departure for the resolution is that developing countries must be shielded from the market forces and recruitment practices of industrialised countries to prevent further deleterious effects on their health systems and the right of their populations to health services. At the same time, there is a delicate balance between this and the right of individuals to seek employment in other countries. Until now, the WHO's member states have weighted these considerations differently. Norway holds the view that the primary consideration of the Code of Practice must be the population's right to health, and that policy should be directed towards securing this right by means of incentives and regulations.

Global funds, programmes and health initiatives
In various regional and international contexts and meetings, including HIV/AIDS agendas and the boards of UNAIDS, GFATM and GAVI, Norway has sought inclusion of HRH considerations on the agendas and in instruments. Norway has supported *Health Systems Strengthening* (HSS) financing in GAVI, and is involved in matters concerning the HRH component through our indirect board representation in GFATM (Point 7). Norway wishes to see a global view of AIDS and health-related funding. HRH has likewise been a key topic of the Prime Minister's speeches at the United Nations and other fora on the focus on MDGs 4 and 5.

Foreign policy and global health
In September 2006, the foreign ministers of Brazil, France, Indonesia, Norway, Senegal, South Africa and Thailand launched an initiative that aimed to give renewed attention to the relationship between foreign policy and global health. There are meetings between ministers, joint action where appropriate and regular contact between health experts appointed by the ministers. The initiative is founded on the recognition that foreign policy measures and instruments may have major consequences for public health in the countries involved. At the same time, foreign policy instruments often need to be employed in safeguarding global health security challenges.

A joint declaration in March 2007 provided a joint agenda with a total of 10 priority fields within three key topics:

- **securing capacity for health security**, by developing crisis management, combating infectious diseases and addressing the global HRH crisis
- **addressing the threats against global health security**, in conflict situations, in natural disasters, by addressing the HIV/AID epidemic and in the threats against the natural environment
- **ensuring that globalisation is of benefit to all**, in international development policy, in trade and agreement policy and through development of better systems of government.

The HRH crisis is thus one of the ten topics that the seven foreign ministers call attention to in the meeting between foreign policy and global health. It is stressed that the current shortage and skewed distribution of qualified health workers, particularly nurses, is one of the greatest obstacles to the realisation of health preparedness and health security at national and global levels. The causes of the crisis are interlinked with economic development, migration patterns and agreements concerning services, which indicates that the solutions cannot be found in health sector measures alone. At the same time, human resources must be developed within the broader framework of the health system as such, where financing and effective management are key factors.

4.3 EU/EEA, ILO, WTO, GATS and international trade in health services

EU policy and measures
In October 2008, the EU adopted the European Pact on Immigration and Asylum, which describes the main elements of EU policy for the future. The Pact expresses agreement on a policy designed to promote temporary and circular migration, and states that this policy must not reinforce the brain drain. In 2005, the EU adopted a strategy for measures to counteract the HRH crisis in developing countries[22]. A year later, an action programme was adopted[23]. The Commission has also launched a *Green Paper* on HRH in the EU[24], which also addresses the issue of avoiding depletion of the health workforce of developing countries. The Ministry of Health and Social Affairs has circulated the Green Paper for comments with an input deadline of 31 March 2009. The strategy from 2005 takes as its point of departure that the shortage of health workers is an obstacle to achieving MDGs 4, 5 and 6. A number of

[22] "EU Strategy for Action on the Crisis in Human Resources for Health in Developing Countries (COM(2006)642 final
[23] A European Programme for Action to tackle the critical shortage of health workers in developing countries (2007-2013) (COM(2006)870 final)
[24] "Code of Conduct and follow-up on Ethical Cross-Border Recruitment and Retention"

measures are listed at country, regional and global levels. These are set out in concrete terms in the action programme from 2006.

At country level, the health workforce is to be included as a separate item in the political dialogue concerning the country's own planning, poverty alleviation and health policy and the focus on improved data access. It is proposed that there be heavier involvement of civil and private sectors, standardisation of measurements, research and labour market studies, dialogue with professional associations and trade unions, cooperation between training institutions and development of incentive packages that go beyond pure wage criteria. Budget support is viewed as an effective instrument, preferably associated with indicators for goal achievement ("*performance milestones*") that the EU cooperates with others on improving (*Health Metrics Network*, an initiative under the auspices of the WHO). At the regional level are proposed measures particularly for Africa (cf. a general focus on Africa adopted in recent years). Priority is given to measures associated with development of African regional cooperation, particularly concerning migration issues (e.g. regional agreements on *knowledge sharing*), and support of regional training capacity, research capacity and increased use of information technology.

At the global level, it is proposed that the EU adopt a separate "*Code of Conduct*" for ethical recruitment. It is further proposed that there be increased support for global funding instruments, better health planning in the EU and promotion of circular migration and cooperation with diaspora (cf. 4.4 of the European Commission's report on Migration and Development). The EU is allocating EUR 40.3 million to the action programme for the long-term period 2007–13.

A "*Progress Report*" of September 2008 from the General Secretariat of the Council[25] gives an impression of weak follow-up by member states so far. Although it is true that the report is based on feedback from only 18 out of 27 member states obtained only 18 months after adoption of the action plan, its conclusions nevertheless provide an indication of pace and direction. In the introduction, it is noted on the positive side that EU member states support health programmes with an HRH component in 51 of the 57 countries said by the WHO to have an HRH crisis, that the EU supports regional research and capacity building and is developing measures aimed at circular migration. However, it is acknowledged that this mainly concerns poorly coordinated efforts with weak effects as regards the health workforce. The source data is otherwise too weak to establish the EU's total efforts in the field and whether these have increased. There has been little progress in drafting a code for ethical recruitment. The report's conclusion identifies four areas for intensified efforts: (1) aid effectiveness, (2) greater capacity at country level, which includes strengthening of destination countries' planning and control of the health workforce, (3) accelerated implementation of a European *Code of Conduct* and measures to promote circular migration and (4) a general call to the Commission to use its mandate to promote better coordination of member states' policy. In the Council Conclusions of 8 November 2008 concerning the report, an increased pace and strengthened efforts are requested both from the Commission and from member states.

Green Paper on the European health workforce: A point of departure is taken in the general health workforce problems in the EU that can be solved by means of measures that supplement national policy. In the development policy field, the action plan and progress

[25] "A European Programme for Action to tackle the critical shortage of health workers in developing countries (2007-2013). Progress report on implementation" (SEC2008)2476

report of 2008 are focused upon. Reference is made to the adoption in 2008 by the hospital sector itself of a code for ethical recruitment[26], to the EU's self-imposed obligation to develop a corresponding code and to countries in the lead, including the UK, Norway and the Netherlands. It is also stated that such a code must be accompanied by measures to stimulate circular migration. A separate item raises the issue of faults in the source data, primarily due to differing criteria for statistics from country to country. In November 2006, the project "*The European Migration Network*" conducted a survey of "*managed migration*" in the health sector, and concluded that the source data, particularly in the case of the citizens of third countries, was limited. Projects for improvement of the data material are under development.

The EEA Agreement
The significance of the EEA Agreement (to which Norway is party) in relation to the health workforce concerns *participation in the internal European market involving the four freedoms*, i.e. *free movement of goods, persons, services and capital.* A product that is approved in one country will as a general rule also be lawful in the other 27. Workers and students from other EEA member states are as a general rule entitled to treatment equal to that of the host country's own citizens, including in matters concerning social security benefits and recognition of vocational qualifications for regulated professions. Service providers are as a general rule entitled to offer their services on an equal footing with national service providers.

The internal European labour market is open to all citizens of the EEA/EFTA member states. No rights to mobility from the remainder of the EEA area to Norway ensue for citizens of third countries. Citizens of third countries may obtain residence in Norway pursuant to third country rules and also to a certain extent pursuant to the EEA rules associated with free establishment and for provision of services and as a family member of an EEA citizen.

The GATS Agreement
The General Agreement on Trade in Services (GATS) includes both general provisions that apply to *all* service sectors and with more specific commitments for individual sectors.

In GATS, specific commitments are laid down in national schedules of specific commitments containing the commitments of the country concerned as regards access to their domestic markets by foreign service providers. *The country concerned is free to choose which services it will commit itself to*. As regards the specific commitments in individual sectors, the agreement commits the members to record in their schedules of specific commitments all limitations of market access and national treatment. The member states record their commitments in the schedules of specific commitments on the basis of four supply modes for services:

- Delivery mode 1: Supply of services across national borders, i.e. directly from abroad, e.g. telemedicine.
- Delivery mode 2: Consumption abroad, i.e. the service is supplied and consumed abroad, e.g. health tourism.
- Delivery mode 3: Establishments, i.e. the service is supplied in Norway via local offices.
- Delivery mode 4: Presence of persons on a *temporary* basis, i.e. a foreign person supplies services in Norway on the basis of a temporary work permit. This delivery mode applies

[26] "Code of Conduct and follow-up on Ethical Cross-Border Recruitment and Retention"

only to persons given employment *prior to* entry. This is the delivery mode that is most relevant for migration of health workers.

The GATS Agreement further established the right of member states to regulate and to issue new regulations stipulating compliance with national policy goals. An example of this is Bolivia's withdrawal of its health sector commitments in GATS. The GATS Agreement does not limit national freedom to organise the public sector as a country wishes. There is nothing in the WTO rules to prevent the member states from deciding for themselves how they wish to organise their public services, e.g. education and health. However, withdrawal of commitments must be compensated in some way.

Health and social services in GATS

According to the GATS classification system, health and social services includes operation of hospitals and other health and social services provided in connection with institutions offering institutional care. Norway has not undertaken commitments for Health and social services in its schedules of specific commitments.

However, medical and dentistry services, nursing and physiotherapy services not provided in connection with an institution with nursing capacity are not regarded as "health and social services" in GATS, but as "commercial" or "professional" services. Here, Norway has undertaken commitments for market access by foreign personnel, but with specifications of the national rules that apply to service providers on a temporary basis.

Developing countries' claims regarding liberalisation of delivery mode 4 in the Doha round

In the ongoing negotiations in the Doha round, the most important demand of the developing countries' in the service area is that developed countries give better market access to service providers from developing countries, i.e. supply mode 4.

This claim has been put forward by 15 countries spearheaded by India. In addition, in a separate claim, the LDC[27] group stated delivery mode 4 to be one of the few areas where they consider themselves to have a comparative advantage. The claims include all categories of health workers defined within "professional services", such as doctors, dentists, nurses, midwives, physiotherapists, assistants, etc.

Although movement of persons in relation to supply mode 4 by definition concerns *temporary arrangements,* there is such a clear association with issues concerning labour immigration that delivery mode 4 commitments are sensitive in almost all countries.

There is agreement in the working group that the rules for trade in services are relevant for labour migration and migration of health workers. All GATS delivery modes have a certain thematic relevance, but there is a need to limit the focus, and the working group therefore views it as desirable to focus on migration of health workers, i.e. delivery mode 4, without excluding focus on the other delivery modes where this may be relevant.

Norway wishes to accommodate developing countries within existing WTO rules concerning trade in services. The Doha round, in which the GATS negotiations are taking place, takes as its point of departure that the agreement must favour the interests of the developing countries.

[27] LDC= Least Developed Countries, cf. OECD classification

Norway has adopted a positive approach to the LDCs' initiative on the establishment of a preference arrangement for services from LDCs, as currently exists for customs duty in the WTO agreement.

In the working group's discussions, it has been pointed out that Norway has domestic regulations that may be perceived as discriminating against service providers from developing countries. For example, Norwegian requirements regarding qualifications and Norwegian language proficiency to practise in Norway may place limits on access to the Norwegian labour market. However, the background for language requirements for health workers is not discrimination, but securing patients' rights and sound professional practice. On the other hand, the provision of services under delivery mode 4 enables health workers to reside in Norway in order to work and to acquire competence that can be used in their home countries on completion of their service here.

The working group has discussed whether service delivery mode 4 may be conducive to increased temporary mobility from the poorest countries to countries such as Norway. Conflicts between sectors or the absence of specific sectoral considerations in positions put forward by the same developing countries in various fora constitute a problem. It is therefore important to be aware of coherence in the positions of both developing and developed countries in multilateral fora such as the WTO and the WHO as regards labour migration and health sector considerations.

A particularly relevant issue is the conflict between the countries that wish to send health workers and the countries that attempt to limit access to their labour markets. This applies to both India and the Philippines, which have espoused export of health workers, and which now demand that the industrialised countries open up their markets to individual service providers. In such a context, it is important to view the developing countries' demand for market access for health workers in relation to the need for health workers of the sending countries themselves. It is reasonable to assume that the sending countries themselves must assess this balance, and that, as long as they demand increased market access for health workers, the destination countries must decide to what extent they can comply with these demands.

ILO's *Decent Work agenda*

Norway supports ILO in the amount of NOK 100 million in the programme agreement for 2008–2009. Half of these funds are strategically earmarked for gender equality work and for efforts to combat forced labour and human trafficking. NOK 25 million of these funds are earmarked for ILO's work on promoting social dialogue and strengthening labour inspection. ILO's *Decent Work* agenda is relevant to the HRH crisis in that a substantial strengthening of workers' rights, social dialogue and labour inspection are key instruments for retaining competence in countries that export health workers. ILO has focused attention on the need for countries that train and export health workers to promote workers' rights and social dialogue in the health sector at the local level in order to prevent migration owing to unsatisfactory employment conditions. ILO's efforts are addressed to the full range of employment conditions, such as pay, working hours, the right to join unions, gender equality, etc.

The Government supports this work through a seven-point strategy for decent work. This includes Norway's commitment to renewing its efforts to promote workers' rights at the global level, playing a catalytic role in promoting the importance of decent employment conditions and improving monitoring of the working environment in other countries. These are measures that directly affect the HRH crisis since improved employment conditions in

sending countries may enhance the health sector's capacity to retain and attract competence. In 2005, ILO also launched its action programme "International Migration of Health Care Workers." This initiative, which investigates six typical sending countries of health workers, seeks to develop strategies and "best practice" in order to enable the migration of health workers to be handled from the point of view of the sending countries.

4.4 Interface to the project Migration and Development, the Pakistan Pilot Project

The project International Migration and Development
Since 2006, the Ministry of Foreign Affairs has conducted a project on international migration and development. The project focuses on development-promoting effects of international migration and ways of maximising these. This is carried out through participation in dialogue and policy development at global, regional and national levels. The project cooperates closely with the Ministry of Labour and Social Inclusion on promoting development of an integrated policy, originally on the basis of a joint working group report[28]. Norway is a member of the steering group for the *Global Forum for Migration and Development (GFMD)*, which is an intergovernmental initiative based on the UN high-level meeting on the same topic in 2006. Norway has taken an active part in the forum's conferences in Brussels (2007) and Manila (2008)[29]. Questions associated with the brain drain with an emphasis on health workers have been among the main issues addressed by the project during the first years. Another major area concerns improved involvement of persons of immigrant background in development cooperation.

Participation of persons of immigrant background in development cooperation
Resource persons in Norwegian immigrant communities have competence that can be made better use of in Norwegian international development policy and cooperation. In these communities, there is considerable interest in greater participation, particularly in efforts directed towards their own countries of origin. The authorities are considering various instruments for increasing contact and involvement. It is also important that competence in immigrant communities is more used by Norwegian NGOs.

[28] Migrasjon og utvikling – bedre sammenheng og samordning [Migration and development – better coordination], 2006.
http://www.regjeringen.no/nb/dep/ud/dok/rapporter_planer/rapporter/2006/Migrasjon-og-utvikling---bedre-sammenheng-og-samordning.html?id=278523
[29] See http://government.gfmd2008.org/

The Pakistan pilot project
The Pakistan project is a pilot project for development cooperation implemented after a dialogue between public authorities, immigrant communities and aid organisations. It is based on joint financing provided 50/50 by private funds and public development assistance funds. Development of the pilot project has its roots in both the immigrant communities and in relevant NGOs. The guidelines for the pilot project comply as far as possible with the guidelines from Norad for support of NGOs. Professional assistance is provided by Norad. By agreement with Norad a secretariat (the Development Fund and Norwegian Church Aid) provides quality assurance and competence building. Depending on experiences of the pilot project, it may later be extended to more immigrant communities in Norway. Inclusion of health-related projects and health workers will depend on the projects that receive support.

Money transfers
Immigrants and Norwegians of immigrant background remit large sums of money to their families and other relatives in their countries of origin. A report on such money transfers prepared by the Peace Research Institute, Oslo (PRIO) in 2007 shows that large sums are retained by middlemen. It is unacceptable that immigrants must pay up to 20 per cent in fees to send money to their families. In world terms, private money transfers from approximately 200 million migrants constitute at least USD 300 billion. This is three times as much as the total of all international development aid. These are enormous sums of money that are important for development in many countries. They are used to finance health services, education and industry. From both a humanitarian and a development perspective, it is important to provide for cheaper, more efficient and more open money transfers. Cheaper and more efficient transfers via lawful channels will at the same time reduce the use of informal and unlawful forms of money transfer. However, it is much debated whether public policy can or should influence the use of privately transferred funds in countries of origin.

4.5 Norwegian development assistance to the health workforce of developing countries

4.5.1 Bilateral government-to-government development cooperation

In recent years, Norway has supported **the health sector programmes** by means of sector budget support to:

a) *Malawi*
b) *Mozambique* (specific health sector support is to be discontinued from 2009 (see below)).

In both countries, health sector cooperation is part of multi-donor cooperation coordinated by the national health authorities in what is termed a *Sector-Wide Approach (SWAp)*. This means that the support is placed in the same donor basket in the recipient country's health authorities, and that the authorities through dialogue with the donors set priorities for use of the funds. The effect is measured in the process on the basis of specified indicators, and is discussed regularly and at annual sector meetings. In view of this donor modality, it is not possible to say how much of the Norwegian support goes to specific health measures such as HRH, since all funds are placed in a single basket.

For each country, annual health sector support from Norway amounted to between NOK 60 million and NOK 90 million. In both countries, the HRH measures are an essential component

of the sector cooperation, and include knowledge generation concerning the HRH situation, training and coordination of training, incentives to prevent attrition from the sector, migration, etc.

Support to Malawi will continue in accordance with the current Memorandum of Understanding between Norway and Malawi. In Mozambique, this has been changed to *general budget support* with effect from 2009. This means that the specific health sector support has been discontinued in favour of support to the Ministry of Finance where sectoral considerations are included in a larger *Poverty Reduction Strategy,* where priorities are decided by the parliament.

4.5.2 Norway's MDGs 4 & 5 Initiative

The initiative focuses on MDGs 4 and 5 (respectively child and maternal health) and involves cooperation agreements with four countries:

a) India
b) Pakistan
c) Tanzania
d) Nigeria

The cooperation with each of these countries is based on agreements at the prime ministerial level, and is associated with a major global initiative, *the Global Campaign for the Health MDGs,* involving a number of donors and developing countries.

No HRH funds have been earmarked in this initiative, but there are HRH-strengthening components in the application of the funds.

The Norwegian support totals NOK 100 million per year to India and NOK 50 million to each of the three other countries.

4.5.3 Projects involving Norwegian health actors

Projects in health workforce training supported directly from Norwegian embassies (Malawi, Ethiopia, Tanzania, Botswana, South Africa, Afghanistan) often involve Norwegian actors – public and private hospitals, health enterprises, NGOs and foundations.

These activities vary in size and focus, but several of them have health workforce as a main component. Examples:

Norwegian Church Aid (network coordinator) operates networks for training of nurses in Malawi. There are six Norwegian training institutions in addition to the Norwegian Nurses' Association, which cooperates with a total of eight training institutions/hospitals in Malawi. The project is in two parts: 1) strengthening training of Malawian nurses, 2) improving and maintaining colleges of nursing. The project is associated with CHAM – the Christian network of health institutions in Malawi.

The Department of International Collaboration at Haukeland Hospital, Bergen is administering a project over a three-year period involving NOK 45 million for support of Norwegian health workers in Botswana, for which extension for a further three years is under

consideration. Medical training for Botswanans is provided at the University Hospital of Northern Norway. In Tanzania, Norwegian funds for research into the HRH situation are provided via the Chr. Michelsen Institute. Haukeland Hospital and Ullevål Hospital cooperate with hospitals in Malawi on maternity clinics. The amount and duration of support have not been clarified, but the cooperation is supported for the time being with other funding.

The Norwegian Volunteer Service: The Norwegian Volunteer Service supports a considerable number of Norwegian health actors' partnerships with undertakings and organisations in the South. The Norwegian Volunteer Service is part of a Norwegian government development assistance administration which operates according to a revised model with the status of special administrative body decided by the Storting (1999) and placed under the Ministry of Foreign Affairs.

The following are examples of measures supported by the Norwegian Volunteer Service:

- Ålesund University College – Establish training of operating theatre nurses in Ethiopia (pilot project support from the Norwegian Volunteer Service)
- Cooperation between Sørlandet Hospital and Haydom Hospital in Tanzania (including exchange of doctors – sabbatical leave for consultants is used at Haydom)
- Haukeland – Ethiopia, hospitals in Addis Ababa (Burns Unit)
- Cooperation between South Sudan and Haukeland Hospital (planning of hospital extension – Juba Teaching Hospital) – so far no Norwegian financing.

In 2007, approximately 16% of the total budget of the Norwegian Volunteer Service was applied to the support of health cooperation measures.

4.5.4 ESTHER – hospital-to-hospital cooperation[30]

In 2008, Norway joined ESTHER, a scheme for hospital-to-hospital cooperation including exchange of health workers North-South and South-South. In Norway, the scheme is administered by the Norwegian Volunteer Service as a part of the Norwegian affiliation to the French-initiated international network of such schemes. In the Norwegian initiative, the HRH component is the most prominent.

Annual support of NOK 10 million has so far been allocated for 2008 and 2009. The scheme is application based.

ESTHER ensures a financing mechanism for new measures and for many ongoing measures. Until now, the measures have had a number of different and somewhat arbitrary sources of funding. It is doubtful whether the grant will cover the whole of the need, but it will make a big difference, and will also form the basis for a Norwegian health development network for training exchange. Many Norwegian health institutions have contact with partners in the South, and wish for a development towards more predictable, systematic and targeted collaboration.

[30] ESTHER ("Ensemble pour une Solidarité Thérapeutique Hospitalière en Réseau") is a French-initiated model for hospital-to-hospital cooperation between, to date, 10 countries in Europe and countries in the South with particular emphasis on HIV/AIDS, but also with other topics for cooperation. In November 2008, Norway joined the European ESTHER programme with a declaration signed by the Minister of the Environment and International Development.

To date, ten European countries have joined the scheme, with partner countries in Africa, Asia and Latin America. It has been proposed that a joint European secretariat be placed under the EU, and this will be considered in 2009/2010. Each European partner country has its own collaboration variant under the scheme, and HIV/AIDS is the common denominator of most of these. The Norwegian model has larger scope and is more oriented towards health system components.

4.5.5 Multilateral channels and global funds

Support is provided over various fiscal budget items. Some of the most important are:

a) *The World Health Organization* (WHO) will receive NOK 215.5 million for 2009 in the form of so-called voluntary funds (outside the membership fee). These funds are partly applied to health system and HRH work in the organisation, also carried out in cooperation with the GHWA.
b) *GAVI*, which provides a separate financing window for Health Systems Strengthening (HSS), receives an annual Norwegian contribution of NOK 500 million. The objective of GAVI HSS is to strengthen health systems in order to increase and maintain vaccine coverage. Attempts are made to achieve synergies with other mother/child health services through the scheme. There are three HSS key topics: i) The health workforce, ii) Infrastructure, access and distribution of equipment and medicines/vaccines, iii) Organisation, management and administration of service provision.
c) *The Global Fund* (GFATM) adopts an approach whereby strengthening of health systems must either be integrated as part of a disease-specific application or by countries adding a separate health system component to the disease-specific application (benefiting treatment of more than one disease). Norway contributes approximately 1.5% of the Global Fund's total budget. In 2008, Norway contributed NOK 375 million
The aim of the Global Fund's health systems strengthening[31] is to improve public, private and local health systems so that the burden of AIDS, tuberculosis and malaria can be reduced over time. Unlike GAVI, the Global Fund does not have a separate window for HSS applications. While countries cannot apply for funds for a general health system component separate from the disease-specific application, this will be considered separately. The disease-specific application may thus be rejected, whereas the health system component is approved.
d) Support over four years for the World Bank Trust Fund on *Human Resources for Health*, NOK 15 million since 2005 (an extension for a further three years was recently agreed, involving a further NOK 15 million). This applies to research.
e) Research, including Norwegian research institutions and the *Alliance of Health Policy and Systems Research, Global Forum for Health Research*, etc. where Norwegian institutions participate and cooperate.
f) Support for *Results Based Financing Trust Fund*, which is incentive-based financing of health personnel/health clinics in Afghanistan, Rwanda, DR Congo, Zambia, Eritrea, etc. and associated with the MDGs 4 and 5 initiative. The project is administered by the World Bank (NOK 125 million per year).
g) Norway provides annual support to the GHWA of NOK 20 million (2006, 2007, 2008 and also proposed for 2009). The funds are used for operation of the secretariat, for catalytic financing of so-called "*Pathfinder Countries*" for health workforce planning, and for research and conferences for knowledge generation and catalytic efforts.

[31] http://www.theglobalfund.org/ documents/rounds/8/R8HSS_Factsheet_en.pdf

4.5.6 Training of health personnel, research

The preceding chapter refers to research funds distributed via multilateral institutions. Education and health are both knowledge-heavy sectors with many of the same challenges as regards development cooperation. Not least, they share the risk of the brain drain.
In higher education, this has long been a major worry. Questions were first raised in the 1980s when students from developing countries were admitted to courses in Norway held in Norwegian with a right to full support via the State Educational Loan Fund for the whole cost of studies including introductory courses in Norwegian. This arrangement was referred to as the "developing countries' clause" after the clause concerned in the rules of the State Educational Loan Fund where the support was authorised.

It became gradually obvious that people who had studied in Norwegian and resided in Norway for perhaps ten years, who had built up a Norwegian social network, possibly even including Norwegian family, and who could easily find employment, for example, in Norwegian training institutions, were unlikely to choose to return to an insecure future in a home country they might not even have visited for many years.

At the start of the 1990s, the matter was raised politically, and it was decided to replace the developing countries clause with arrangements involving a more targeted use of Norwegian resources for development purposes.

The most important of the new measures have been the Quota Programme, the Norwegian Programme for Development, Research and Education (NUFU) and Norad's Programme for Master Studies (NOMA), formerly Norad's Scholarship Programme. There are also other similar programmes. The programmes all have in common that they are based on permanent partnerships between institutions and on the students' continuing association with studies and working life in their home countries, regardless of where they reside during their studies. Possibly most important of all, is the attempt to limit the stay in Norway to a minimum. There have so far been few systematic studies of the long-term effect of the programmes, but those that have been conducted indicate that we increasingly, and to a greater extent than other countries, succeed in encouraging graduates to take up responsible positions in their home countries, where both they and their countries benefit from their increased competence.

The other major issue we encounter in addition to the brain drain involves ensuring that durable capacity and competence is actually created in the South, since many factors favour activities at institutions in Norway. All kinds of resources are available, there is already satisfactory infrastructure, educational institutions have higher prestige, students from the South prefer to come to Norway, etc. This "inverse gravitation" towards the north naturally combines with the brain drain to reduce the benefit of the development efforts.

Norad's Programme for Master Studies (NOMA) was established in 2007 as a replacement for Norad's Scholarship Programme to ensure establishment of masters programmes at institutions in the South with Norwegian help. In practice, there has proved to be resistance in both the North and the South against completely discontinuing residence in Norway, but measures based in their entirety in Norway will not be continued.

An important point is that, by placing such provision and professional resources in the South, one also establishes strong professional units in the South. In this way, one not only strengthens training capacity and the capacity for future self-sufficiency, but also lays the basis for an attractive labour market for graduates, a possible disincentive to travel abroad to

practise. For the health sector, which traditionally has such close cooperation between the best treatment institutions, research at a high level and training of new cadres, this should be a fundamental strategy.

The training capacity in the health care disciplines in Norway is limited. It must be considered whether funds are to be earmarked for increased training capacity for this group. Circumstances associated with practice positions must be considered at the same time. Increased North-South cooperation on health care training may have a positive effect on Norwegian universities and university colleges, as is generally true of the North-South involvement in the higher education sector.

These remarks on training can probably be applied more generally to measures in the health sector aimed at improving the availability of health workers in developing countries. Of course, training is already an important constituent of these efforts, and the training programmes already produce a number of health workers of different types. In the present report (chapter 6), the working group recommends, in addition to extending the scope of training initiatives, that professional cooperation, for example, on research, development and trials of new treatment methodology and technology, publications, etc., should be made permanent details. Norwegian partners need not only be training institutions. All types of health enterprise should be able to engage in professional cooperation with partners in the South according to the same principles.

4.5.7 Results-based financing for health services

Through Norway's initiative in support of the health-related MDGs, a central role is played by Norway. Results-based financing (RBF) is one of a number of strategies for achieving these goals in health cooperation with low-income countries. The funding scheme may, for example, be so designed that it includes incentive packages that may both make it attractive to work in the health service and to do one's best to achieve specific results.

Norway has, among other things, established a multi-donor fund in the World Bank for work on various forms of RBF, where major roles are played by technical and financial support for implementation and research in 6–7 countries and by global learning. RBF is also an important element of Norwegian bilateral agreements with selected partner countries under the MDGs 4 and 5 programme, with a focus on reducing child and maternal mortality.

The terms *result-based financing* and *pay-for-performance* are used synonymously, and involve measures on either the supply side or the demand side. Examples are cash payments to families to encourage them to allow their children to be vaccinated or to women to encourage them to give birth at clinics or hospitals ("*conditional cash transfers*"), coverage of transport costs for giving birth at hospitals and food subsidies during hospital stays, etc. Service providers (doctors, nurses, hospitals, district health teams, NGOs, etc.) may also be given additional financing or other benefits on the basis of results actually achieved.

In Tanzania, Norway has taken the initiative to establish an RBF system, partly based on the supply side, whereby health workers may attain bonuses based on the institution's achieved results in relation to the health of mothers and new-borns. The selected indicators are simple and accessible, and function at the same time as measures of contact with the health service in various phases (including the number of births at clinics/hospitals, malaria prophylaxis for pregnant women, vaccines for infants, and the filling in of health information forms). The

funding scheme is a small addition to the remaining funding. The background for this is the poor motivation and high level of absenteeism among health workers. Implementation of the programme is expected to begin in spring 2009.

RBF may also be viewed as part of a wider focus on results, e.g. as part of what is termed *result-based management*. RBF includes schemes aimed at various different levels of the health service: recipients of services, health workers, health institutions, private sector organisations, public sector organisations, municipal authorities and national authorities.

The experiences of RBF by low and middle income countries are increasing, but the published literature in the area is still limited. There are few methodologically sound studies of RBF, and the effects of such schemes are therefore poorly documented.

A review conducted by the Norwegian Knowledge Centre for the Health Services[32] at the request of Norad found ten systematic overviews that met the criteria for inclusion. The review found that financial incentives appear to be effective in the short term for simple, limited and clearly defined behavioural objectives. There is less knowledge concerning whether financial incentives result in lasting changes. There is still uncertainty concerning the effect of RBF in low and middle income countries. However, there are grounds for trying out this approach in attempts to solve various aspects of the health worker shortage in developing countries as a means of improving public health.

4.6 The need for innovation and creative thinking

Retaining health workers in poor countries involves considerable challenges.

The research of recent years, much of it focusing on the HRH crisis, suggests that the problem is systemic. It must be solved, not by individual measures, but by a combination of measures. No single actor or party can succeed in creating solutions without participation and "synchronisation" with other stakeholders.

The normal channels for development cooperation are not adequate to solve the problem. In destination countries, it is not only a matter of the health sector seeking solutions; solutions are also dependent on other sectors and on political leadership. One challenge involves persuading low-income countries suffering from shortage of resources to give priority to investments in health and development of the health workforce.

Part of the problem lies with coherence. For the donor countries, the effects of sound development and assistance policy may be neutralised if other parts of the administration or the private sector in the donor countries advocate active recruitment from developing countries, and counteract the effect of the development assistance. This must partly be solved by adopting coherent policy in individual countries and partly by countries collectively adopting more or less the same approach.

[32] Oxman, Andy. An overview of research on the effects of result based financing. Report from Norwegian Knowledge Centre for the Health Services No. 16 –2008

One challenge involves encouraging countries such as the US, Canada and certain EU member states to achieving a greater degree of self-sufficiency, to regulate recruitment from foreign countries and to agree on ethical standards for recruitment (e.g. a *Code of Practice*).

Moreover, we must exploit and mobilise under-utilised resources, such as the diaspora in destination countries. An example of this is the Pakistani pilot project under *Migration and development*. In some cases, *return migration* and circular migration have been promising, but they do not on their own provide major effects or constitute permanent solutions.

It is not primarily new, untried measures that are needed. New approaches will consist of coordination of existing measures. The following areas may be appropriate for future action:

1. International dialogue and catalytic efforts in foreign and development policy contexts
2. Bilateral and multilateral development cooperation
3. Strengthening of the developing countries' negotiating position in international fora, e.g. WTO, GATS
4. A Norwegian initiative to achieve approximate self-sufficiency in its own health workforce in the near future
5. Mutual bilateral agreements between sending countries and Norway as a destination country based on potential win-win measures (training in return for "loan" of health workers/exchange, research)

5. Migration of health workers

Some general features of health worker migration are discussed in 3.2. This chapter describes features of this migration that may be relevant for measures.

The factors that motivate health workers to migrate on a scale that makes it a structural feature are by and large the opposite of each other in, respectively, sending countries and destination countries. They are the so-called "*push*" factors (in developing countries) and "*pull*" factors (in industrialised countries). The push and pull factors[33] regarded as strongest are:

"Push" factors:	**"Pull" factors:**
• Low pay (absolute or relative) • Unsatisfactory working conditions • Lack of resources to carry out the work effectively • Shortage of posts and career opportunities • Limited opportunities for training and further training • Burden of infectious diseases, such as HIV/AIDS	• Higher pay (and possibility of sending some of this home) • Better working conditions • Well-financed health systems • Career opportunities • Opportunities for further training • Political stability • Travel opportunities • Career opportunities with NGOs and international agencies

[33] Buchan, J. "Nurse Migration and International Recruitment". Nursing Inquiry. Available from: http://www.blackwell-synergy.com/doi/full/10.1046/j.1440-1800.2001.00112.x. 2001

• Unstable and hazardous working environment • Political and financial framework conditions, instability, systems of government and human rights	

In developing countries, these factors are assumed to represent the most important areas for measures to increase the attractiveness of the health sector and prevent attrition, while upscaling recruitment, training and financing for implementation and further strengthening of health systems result in a higher cost level.

5.1 Current arrangements for regulation (ethical guidelines, bilateral agreements, the WHO's work on a Code of Practice)

There are currently a considerable number of regional and bilateral guidelines and agreements concerning recruitment and migration of health workers. The major destination countries, such as the UK, Ireland and Australia, have agreements of this kind with sending countries such as the Philippines, South Africa and Ghana. There is a joint regional agreement between the Caribbean states on guidelines for mutual exchange in order that countries with a shortage of a given category of health workers can easily obtain workers from another country. Training and planning are likewise covered by the agreement in certain respects.
There are also agreements between some developing countries. There is, for example, an agreement between Kenya and Namibia whereby Kenyan nurses are able to work in Namibia (which has a shortage of nurses) while Namibian student nurses receive training in Kenya. In Kenya, there is unemployment among nurses. Its health system does not have sufficient resources to employ all the nurses it needs.

A Global *Code of Practice* (COP)
for recruitment of health workers is being prepared by the WHO. The World Health Assembly decided on the preparation of such a code in 2004[34]. Part of the background for this was the statement by the World Health Assembly that low-income countries lost valuable personnel through migration and that a code of practice for international recruitment was needed. The COP will not be legally binding (a *convention*, that could have provided a stronger legal mechanism, was not successful in gathering sufficient support), but the COP will constitute a common international standard, which has so far been lacking.

A draft COP submitted to the WHO's board meeting in January 2009 is subject to further drafting. In Norway's view, consideration for the health systems of low income countries must be safeguarded and reflected more clearly in a COP. The regard for the populations' right of access to health services must be weighed and balanced in relation to health workers' right to seek employment elsewhere. The view of the working group concurs with the view put forward by Norway to sitting members of the WHO's board meeting (and previously at the World Health Assemblies).

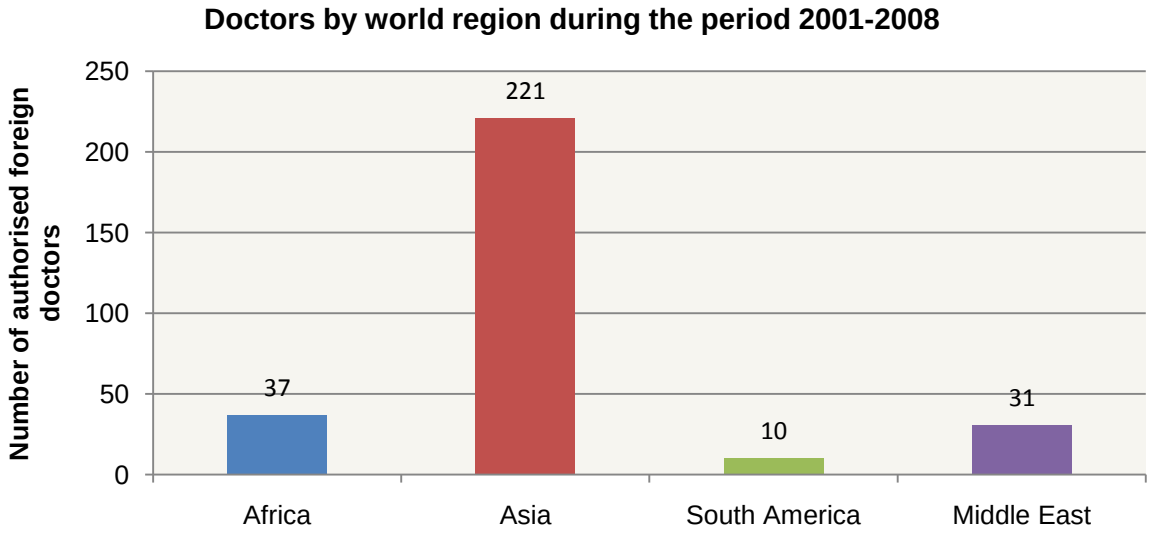
[34] Resolution WHA57.19 and repeated in Resolution WHA58.17 – www.who.int

5.2 Norway as a destination country for foreign health workers

The working group has obtained information from the Health Personnel Register of the Norwegian Registration Authority for Health Personnel (SAFH). The overview applies to persons of foreign nationality who, during the period 2001–2008 have been granted authorisation in Norway. These figures show the countries of origin of those who apply for recognition of their health care training in Norway, but provide no indication of whether they actually practise their professions in Norway. Nor do the figures provide any indication of grounds for residence of those who practise their professions in Norway, whether they came here as labour immigrants, asylum seekers or on the basis of family reunification or establishment. More comments on the statistics can be found in 4.3.

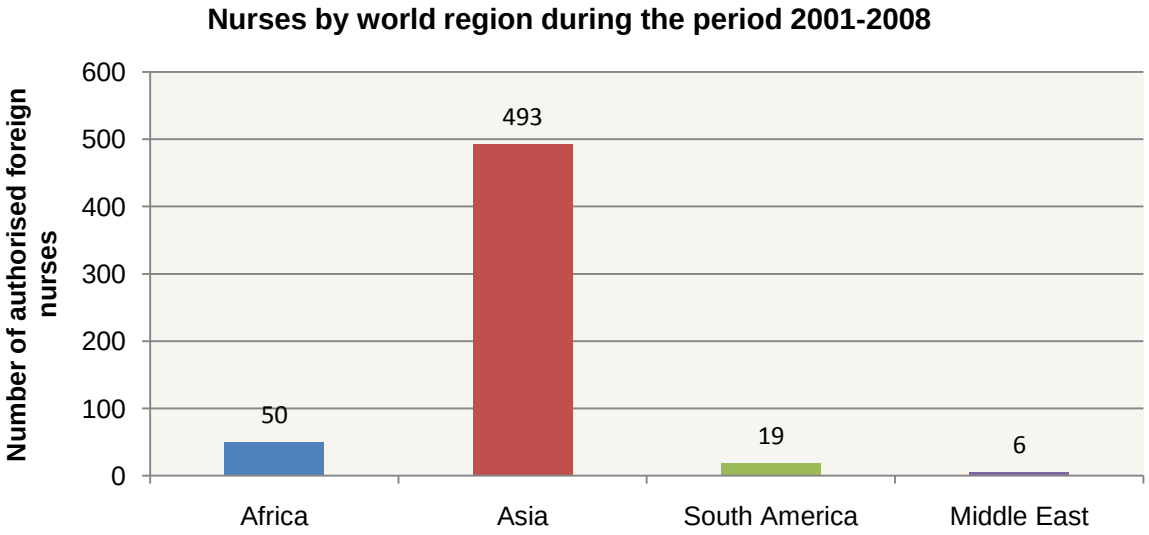
The overview shows that Norway is only to a small extent a destination country for health workers from developing countries. Overview of authorisation granted respectively to doctors, nurses and auxiliary nurses:

Doctors:



A total of 6845 authorisations have been granted to foreign doctors during the period 2001–2008 to work in Norway. Of these, 299 come from Africa, Asia, South America or the Middle East. The largest group come from Asia (221 persons), primarily from Iraq (114), Pakistan (34) and Iran (23). A total of 37 are from Africa. Eleven of these are from Sudan and nine are from Ethiopia. The largest group from the Middle East is from Israel (11 doctors), followed by Syria (9).

Nurses:



Of the total number of granted applications for authorisation from foreign nurses during the current period, the largest group is from Sweden, followed by Denmark, Finland and Germany. Since 2004, there has been a certain increase in the number of nurses from Poland, Estonia and Lithuania.

In total, authorisation to practise as nurses in Norway has been granted to 13 482 persons of foreign nationality during the period 2001–2008. Of these, only 568 come from Africa, Asia, South America and the Middle East. The largest group of these are nationals of countries in Asia (493), mainly the Philippines (314), South Korea (52), India (42) and Iran (35).

From 2002 to 2004, between 50 and 100 nurses from the Philippines were granted authorisation each year. Since 2005, this has stabilised at approximately 25 authorisations per year. Conditions in the rules regarding academic background or motivation and willingness to adapt may give rise to differences between persons from the Philippines and other groups as regards authorisation as nurses. For the same period (from 2005), we see a considerable increase in authorisations to auxiliary nurses from the Philippines (from 19 in 2005 to 270 in 2008).

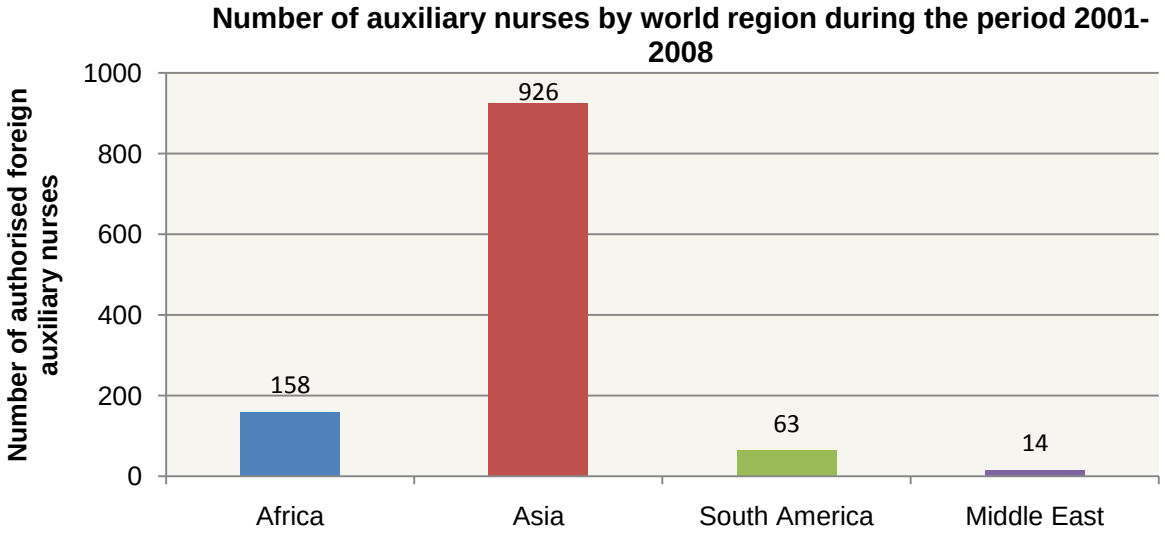
The 50 nurses from Africa granted authorisation during the period 2001–2008 are divided between 18 countries. Only two persons came from North African countries (Morocco and Algeria). Eleven persons came from Ethiopia during this period, and this is the largest group from a single African country.

The SAFH's annual report for 2007 states that there has been an increase in *licences* granted to nurses from countries outside the EEA area. The figures also show that applications for licences primarily come from persons with nationalities of countries outside the EEA area.

Licences are often granted to nurses from countries outside the EEA area as part of a training programme leading to authorisation. An applicant may for example lack formal qualifications in certain subdisciplines. A licence may then be granted to work (obtain practice) under guidance and assessment in the areas where the person concerned lacks qualifications. One reason for applying for a licence may be that such a work permit provides lawful grounds for residence in Norway. The professional limitation of such provisional licences is that the

holder is not entitled to practise nursing activities of an independent nature, but is subject to the daily guidance and supervision of an authorised nurse.

Auxiliary nurses:



Since 2004, there has been an increase in the number of authorisations of auxiliary nurses of foreign nationality. This also includes the largest group from the Nordic area, primarily from Sweden.

A total of 5 661 persons of foreign nationality have been granted authorisation as auxiliary nurses in Norway during the period 2001–2008. Of these, 1 161 persons come, respectively, from Africa, Asia, South America and the Middle East.

The largest group (926 persons) comes from Asia. The four main countries are the Philippines (623), India (128), Iraq (40) and Thailand (38). The number of authorisations granted to persons from the Philippines increased markedly from 2006 (45) to 2007 (196). In 2008, 270 applications were granted after the third quarter.

From Africa, 158 auxiliary nurses were granted authorisation during the period, divided between 26 different countries. Ethiopia contributed most (30), followed by the Congo (15), Somalia (15) and Burundi (13).

From South America, auxiliary nurses from Brazil (18) and Chile (16) have been granted authorisation, and constitute the largest groups from this region.

5.3 Comments on statistics obtained

There are deficiencies in the statistics regarding the number of foreign health workers currently employed by the Norwegian health service. The Norwegian Health Personnel Register includes all who hold authorisation to practise their professions as health workers in Norway. All qualified health workers may apply to the SAFH for authorisation or a licence to work as health workers in Norway. According to the SAFH, *authorisation* is a professional recognition without limitations (section 48 of the Health Personnel Act), valid until the holder

is 75 years of age, while a *licence* is a limited professional recognition. The limitation may apply to duration and/or content.

The data show only the authorisation of health workers for practising their professions as health workers in Norway. No information is provided concerning the immigrant backgrounds of these persons, whether they came to Norway as labour immigrants, in connection with family reunification or as asylum seekers. Of the 299 doctors from Africa, Asia, South America or the Middle East who were granted authorisation during the period 2001–2008, as many as 114 came from Iraq. There is thus reason to believe that a large proportion of the foreign health workers from these regions came to Norway for reasons other than taking up employment here. As regards sending countries, there are variations between the various professional groups, and there will also be variations in the grounds for residence.

The database does not show whether or where holders of authorisation are currently employed as health workers in Norway. Such statistics must therefore be obtained elsewhere, for example from Statistics Norway, the National Population Register/tax authorities, health service employers or the like.

There is no system for recording persons who leave the country or for recording whether those who are granted authorisation actually take up or are offered employment in Norway.

The statistics obtained by the working group have been used as the basis of an overview of foreign health workers (nationalities) who have been granted authorisation in Norway during the period from 2001 to 1 October 2008. Europe, the Baltic states, East-European states, North America and Australia are not included in our overview, but some references are made to these groups.

The majority of health workers of foreign nationality come from the Nordic countries and Northern Europe.
Very few (less than 50 persons per category) midwives, dentists, physiotherapists and medical laboratory technicians who have been granted authorisation in Norway during the period 2001–2008 come from Africa, Asia, South America or the Middle East. This may be owing to differences in training courses, particularly for midwives and medical laboratory technicians. It may therefore be difficult to receive authorisation without taking additional training, for example, in Norway.

5.4 Commercial Norwegian agencies' recruitment to Norway

The working group has held meetings with five of the Norwegian recruitment and placement agencies for health workers. Here it was stated that approximately 50% of hired personnel are hired by the specialist health service (health enterprises/hospitals), while 50% are hired by the primary health service (the municipalities). One of the largest agencies states that it annually hires out approximately 500–600 full-time equivalents.

The largest group supplied by the agencies consists of nurses, while doctors constitute a much smaller share. Doctors, who often come from Germany, seem to be hired directly by health enterprises and municipalities, rather than via agencies. However, doctors are included by the health enterprises in the next tendering round. An agency that primarily hires out nurses also hires out auxiliary nurses and medical secretaries.

Only one agency actively recruits from outside the EEA area (the Philippines). The agencies mainly recruit from Sweden (from 30–80% at four of the agencies). Health workers in Sweden often take contact themselves and commute from Sweden. Most health workers have permanent employment in Sweden and work rotas that include free days and weeks. They earn more in Norway than in Sweden. From 5 to 10% are Finnish or Danish. Summer holidays in Norway necessitate use of this type of personnel. One agency has some health workers from Estonia while another agency has an increasing number of Polish workers. It is attractive for these workers to settle in Norway with their families.

None of the four largest agencies have plans to recruit personnel outside the EU. They mainly concentrate on the Nordic area. This is because this area has straightforward rules, for example, for work permits and residence permits. One company informs that recruitment from certain new EU member states that lack sufficient health workers themselves may result in an unintentional domino effect whereby EU countries replace these workers with health workers from developing countries.

An agency that prepared an internal report in 2008 on authorisation and rules for recruitment of Indian nurses, has shelved the study and has decided not to proceed with this for the time being.

A company that only recruits nurses from the Philippines employs them in the company before placing them in the Norwegian health service. A major challenge is language instruction. This is begun in the Philippines and continued in Norway. The company has recruited 300 nurses so far. Of these, only two have returned. The remainder have settled in Norway.

There is at present no specific demand in the health sector for health workers from outside the Nordic and EEA areas. Needs are supplied within Norway and from areas geographically close to Norway. Use of personnel from countries outside the Nordic and EEA areas involves challenges in connection with language and authorisation. The large recruitment and placement agencies regard ethical considerations as important, but there are small actors that operate differently. In spring 2008, the professional journal *"Sykepleien"* ran a series of articles on import of nurses where it was revealed that agencies in developing countries often provide information on the possibility of applying for authorisation in Norway, giving the impression that those granted authorisation are offered employment as nurses. In reality, it may be difficult to obtain employment owing to Norwegian language proficiency requirements.

5.5 Norway's projected needs for health personnel

In 2008–2009, Statistics Norway produced a forecast updated to 2030 of Norway's health personnel needs based on the estimation model *HELSEMOD 2007*. This shows an increase in needs compared with the previous estimate (2006). There are expected to be shortages of nurses and of health workers without higher educational qualifications. The main impacts of these shortages are expected to be felt in the municipal and nursing sectors. Shortages are not expected in other medical professions. However, this is based on the assumption that a considerable proportion of Norwegian nationals will still be trained as doctors abroad (approximately 20%).

The working group on measures for the health workforce in Norway deals with this topic in detail in its report (February 2009).

5.6 The issue of compensation to sending countries or institutions

Many arrangements have been proposed in different contexts but, beyond a number of not very specific formulations in certain bilateral agreements regarding mutual benefits for sending countries, destination countries and the health workers themselves, no practice or pattern has been established. The term "compensation" can also be interpreted in a number of ways, not only financial.

One proposal, initially put forward by developing countries in international fora after the turn of the millennium, was that the training cost should be determined per health worker lost from developing countries to developed countries. However, it has not been possible to agree on a formula for estimating the training cost, among other reasons, because costs in the countries of origin vary from country to country, and they have been borne both by private parties and the candidates themselves as well as by the state, local authorities, etc. It is therefore difficult to assess how compensation should be calculated.

Another complicating factor in the debate has been the question of how to handle the many cases where migrants move from one destination country to another, etc. Such arrangements may involve extensive administration and bureaucracy, with probable undesirable side effects that might impede a "flow" that may otherwise have beneficial aspects.

Bilateral or institution-to-institution agreements have been tried out, and have varying character. Few of these would be re-useable for other agreement parties because they are specific to a country or party, and possibly also to the time when they were concluded. Agreements may also be concluded between two countries when cooperation indicated by political and cultural ties is based on mutual benefit without this being calculated in financial terms. In such cases, the "compensation" is constituted by the mutual benefit.

The working group has taken note of experience regarding some of the existing bilateral agreements between two or more countries. This may involve training and practice institutions in the countries concerned. We envisage cooperation between Norway and one or two developing countries. It may also be appropriate to develop multi-party cooperation with developing countries via regional institutions such as SADC and the EEA/EU.

An illustration: although Ghana may not be the most natural choice of partner country in view of the fact that we have closer cooperation with other countries, we are aware that Ghana trains 3 000 nurses per year, but receives 64 000 applications from candidates for the training. "Could anyone envisage investing in our training of the workforce reserve of 61 000 persons not offered places on our training programmes?", asked Ghana's Ministry of Health representative at a recent seminar in Norway.

A number of developing countries have recently voiced support for assessments and negotiations concerning possible "win-win" solutions between countries. They wish to be regarded as equal parties to negotiations rather than as recipients of development assistance.

6. Recommendations regarding Norway's HRH focus in foreign and development policy

6.1 Introduction

Norway's efforts regarding health workers in developing countries cannot be exclusively associated with measures in relation to the low-income countries from which Norway receives health workers. The flow of such migrants to Norway is much too small and insignificant for that since the main destinations are countries with historical and linguistic ties (particularly from colonial times), such as the US, Canada and the UK.

Norway's focus must have the skewed global distribution of HRH resources in general as its point of departure. It must contribute to the safeguarding of public health and health security through cooperation between equal international partners regardless of their status as developing or developed countries. Development cooperation with the most vulnerable countries may also help these countries to resolve their acute needs and build capacity.

The multilateral channel is the most important one for Norwegian HRH assistance. In relation to the total needs, Norway's resources are limited. Norway has a significant involvement in international development policy, and has taken on a catalytic role in issues regarding health workers. Our efforts are most effective when channelled through multilateral cooperation and assistance. Norway should therefore play an international role in increasing the focus on this area and on coordination of the measures for improving the effect of the efforts made. Here, our legitimacy is dependent on our strengthening and coordination of our own national efforts. The recommendations in the area of international development and foreign affairs must stand to be compared to approaches adopted in our own country.

Norway has acceded to the Paris Declaration[35] (OECD) as a basic principle of its development assistance. A specific Norwegian thematic focus on HRH at country level cannot therefore be carried out without accommodating the principles of harmonised approach and the partner countries' national ownership and responsibility. In compliance with the declaration, which has broad support from both developing countries and donors, any earmarking of development assistance must at least be agreed between the donor and the recipient.

At the same time, the international health development architecture is undergoing radical transition as a result of the emergence of untraditional donors and considerable funds: global funds and alliances, wealthy private donors (e.g. the Gates and Clinton foundations), and certain politically led initiatives associated with the UN MDGs (e.g. *International Health Partnership* and the *Global Campaign for the Health MDGs*). Health workers are a common denominator of these donors, and require particular regard to coordination, synergies and instruments. All development assistance to the health sector must be carefully monitored and assessed on the basis of whether it alleviates or exacerbates the HRH problems of the country concerned.

[35] http://www.oecd.org/document/18/0,3343,en_2649_3236398_35401554_1_1_1_1,00.html

Norway's MDGs 4 & 5 Initiative is a response to recognition of the fact that more outcome-oriented efforts may bring the world closer to achievement of the MDGs and that more traditional forms of development assistance lack the necessary strength and dynamics.

Such innovative approaches may also open the way for fruitful solutions based on collaboration between Norwegian health institutions and corresponding institutions in developing countries. Many such activities, initiated and kept going by Norwegian health actors, have long been in operation. However, these must be strengthened and targeted so that they are more commensurate with the challenges brought about by the extent of the crisis.

6.2 Political and strategic leadership and catalytic efforts

Catalytic efforts and influence on policy-making in international fora are a priority area where Norway can make a difference owing to its prominent role in efforts to achieve the health-related MDGs. Norway has been particularly active in the many initiatives relevant for the HRH crisis, and can make particular efforts in support of three key conditions on which the solutions depend: **Knowledge** of the realities, **coherence** and **coordination** across sectors and arenas.

Knowledge: Effective political and strategic leadership requires better underlying data for assessing HRH status and a knowledge base with better documentation concerning which activities yield the best results. These efforts need to be coordinated at the international level and enable documentation of HRH status and assessment of the results of measures.

Coherence: An outcome-oriented policy for addressing the HRH crisis at the national level, while assisting the most vulnerable and hardest-hit countries to find solutions, will require coherence between national, trade, foreign and development policy instruments.

Coordination: Norway should pursue a more coordinated policy in the international fora that address HRH issues such as the WHO, the WTO/GATS, the G8 and the Global Health Workforce Alliance (GHWA).

Norway can be particularly active as a leader in the following arenas:

- The Foreign Policy and Global Health Initiative launched in 2006 by the foreign ministers of seven countries to put public health security on the foreign policy agenda. HRH is one of 10 focus areas of the initiative.
- Norwegian efforts to achieve the health-related MDGs with a main emphasis on maternal mortality. Adequate HRH is crucial to results in this field.
- The efforts to improve coordination and safeguard the interests of developing countries, with a special focus on their health sectors, particularly in the WTO/GATS negotiations. The poorest countries must be able to benefit more from an open and rule-based international trade regime, including the service area. The possibility of a preference arrangement for the poorest countries (LDC) for better market access for service providers must be viewed in relation to the same countries' need to safeguard coverage of these services for their own populations. It is therefore important to assess the consequences and effects of such arrangements for developing countries and for Norway in order that developing countries may utilise migration positively.
- Promoting greater knowledge of regional perspectives and better communication between regional actors as part of Norway's negotiating position in the WHO, the WTO, the ILO,

the UN Global Forum on Migration and Development and other multilateral bodies working on these issues.
- Norway should seek active cooperation with the EU in its coordination of European and global HRH initiatives. Norway should contribute input to the EU Green Paper on the European Workforce for Health.

6.3 Measures that address health worker migration

International migration is not always the largest factor contributing to attrition from the sector. Were migration to stop altogether, the HRH crisis would still be serious in most countries. It is nevertheless important to manage and control migration. At worst, it may result in serious depletion of an already weak resource base in the sending countries, examples of which exist today. If correctly managed, migration may also have positive effects for sending countries (e.g. in the form of money transfers from migrants to their home countries, circular migration, involvement of diaspora, etc.).

One of the main reasons why health workers in developing countries migrate is that the working conditions in their own countries may be highly unsatisfactory. There is a shortage of medical aids, medicines and transport. The potential for referral is limited, and health workers have low status and meet mistrust and aggression from patients because they are unable to provide (sufficient) help in critical situations or can only provide diagnoses but not treatment. Supervision and management are weak, in addition to unsatisfactory levels of pay in many countries. Living conditions in general can be characterised as politically and economically unstable. Educational facilities for one's own children are poor. Motivation is reduced. Health workers are in demand in central areas of their own countries and in other countries, and many view migration as a solution. The result is ineffective health services and unequal access to qualified health workers in individual countries.

Migration flows are mainly subject to labour market forces towards the richer countries of the region concerned and across regional boundaries. In many countries, personnel are also lost from the public to the private sector (owing to better pay offers and better quality of workplace) and from rural to urban areas. And, if the richer countries have low self-sufficiency of health workers, there is a greater workforce demand and these countries become attractive destinations.

6.3.1 Code of Practice (COP) for international recruitment of health workers

Work on a COP involves seeking global solutions to a global problem. Norway wishes to strengthen the draft Code in the direction of the right to health, which requires better health systems, including a stronger HRH status in developing countries. The COP is currently being considered by the WHO's governing bodies. The COP will be an important normative instrument when, as is hoped, it is adopted by the Health Assembly in 2010.

Norway's view is that the COP must be based on a higher required level of self-sufficiency of health workers in richer countries, capacity building in developing countries, and avoidance of active recruitment from countries with a shortage of health workers. It is proposed that the first draft being considered by the WHO's board in 2009 be strengthened and provided with

explicit formulations on these issues for the COP to be better designed to protect the health systems of low-income countries against depletion of health workers through migration.

6.3.2 Bilateral agreements

Attempts to achieve bilateral agreements have included compensatory mechanisms and involve very demanding processes. It is the assessment of the working group that compensation calculated per health worker is not very appropriate, among other reasons, because this entails large administrative transaction costs. Compensation must be viewed as a shared global responsibility. Agreements must be adapted to conditions in the country concerned, and must be based on thorough information. There are currently many different types of bilateral agreement. In the case of Norway, which has few health workers from developing countries, there is no urgency to conclude such agreements, and any specific proposals that may be put forward must be examined thoroughly.

Various sets of instruments may be included in cooperation agreements. These include financial support, personnel exchange, capacity development and institution building, specialist training and research. Existing arrangements (e.g. Norad's Programme for Master Studies (NOMA) and the Norwegian Programme for Development, Research and Education (NUFU)) can be included. Cooperation agreements should be founded on the principles and ethical recruitment norms of the COP.

The effect of the measures must be
- more health workers in partner countries
- better quality of health worker training and health workers' performance in partner countries
- increased quality of migrant health workers through training and residence in Norway
- planned/controlled and increased supply of short and medium-term migrant workers will result in more health workers in Norway (combined stay including both further training and work)
- broader basis in Norway in order to handle effects of increased globalisation of the health sector, by actively involving more areas/sectors of Norwegian public administration in these efforts

The WTO may be an important international arena for establishing international frameworks for temporary movement of health workers across national borders on the basis of GATS. In view of the WTO's multilateral nature, the organisation can also facilitate greater coordination by destination countries of their recruitment policy/immigration programmes with developing countries/sending countries, particularly the countries that have a shortage of health workers, in order to avoid active recruitment in these countries.

Circular migration

Circular migration is often referred to in positive terms, and positive effects of such arrangements have sometimes been seen, although such effects have rarely been extensive. USAID, for example, has a small programme enabling qualified South Sudanese in the US to return to the Sudan for shorter or longer periods to assist in rebuilding capacity[36].

[36] This refers to material concerning a number of international programmes, under the auspices of IOM and UNDP, among others, and projects from various countries, e.g. the Netherlands and the UK. MPI report http://www.migrationpolicy.org/pubs/Insight-IGC-Sept08.pdf

Management of circular migration will require both resources for incentives and administrative capacity . In its form, it is reminiscent of the former practice of technical assistance in Norwegian development cooperation, except that consultants are now recruited from diaspora. It may be difficult to succeed in establishing projects involving circular migration of a sufficient magnitude to help significantly counteract the shortage of health workers in the South. However, with the increasing involvement of diaspora groups in development cooperation, for example, through the Migration and Development Project and other measures, programmes for systematic encouragement/incentives regarding circular migration should be considered.

The working group recommends that:

- in connection with Norwegian bilateral *development* initiatives, e.g. MDGs 4 and 5, Migration and Development, etc., consideration be given to adding a component involving circular migration.
- bilateral agreements between Norway and developing countries on migration per se not be considered for the time being. If it should become appropriate, the potential benefits should be considered, while assessing how to counteract undesirable side effects, for example, for the migrants themselves. Agreements must at least be founded on the standards laid down in a future COP, and comply with the provisions of the WTO/GATS agreements.
- Norway involves itself in the cooperation in the WHO, the ILO and the IOM for development of improved reporting and data collection mechanisms on health worker migration.

6.4 Measures that help to strengthen countries' capacity for efficient health workforce management

The principal measures discussed in this chapter are not reserved for specific countries, but can be implemented in and by any of Norway's partner countries. They include both planning functions and financing for implementation, e.g. financing models, health information systems, training and research. Norway supports global joint initiatives through organisations such as the WHO, the World Bank and the GHWA that promote research, knowledge generation and development of models for what countries can do themselves.

In this connection, the working group wishes to draw attention to products of working groups in the GHWA concerning, among other things,

- financing of the health workforce (macroeconomics, wage conditions; "What countries can do now" – a specific tool developed by a task force)
- the planned and regulated role of private health institutions in the health systems. Improving the knowledge base for health workforce management by the state that includes the private market
- development of tools for development of health workforce plans.

Other international initiatives to examine and coordinate the financing of health systems and social security systems are being carried out with active participation by Norway.

Norway's support via the World Bank's Trust Fund provides knowledge that must be applied actively and be offered to appropriate countries to improve their knowledge base for development of for health workforce and retention policy.

6.4.1 Capacity development of the HRH component in national health systems

It is the countries themselves that must make plans and devise strategies for solutions. Donor countries may support these plans and strategies, but the countries themselves must be responsible for implementation.

The individual countries' plans must be founded on knowledge of what may work. All countries may participate in acquiring this basic knowledge, as prepared for by the Kampala Declaration and the GHWA Global Agenda for Action. This requires that all of those involved in multi-party HRH collaboration in each country agree on a single common agreed baseline and set of priorities, and then contribute according to their role and comparative advantage.

The overall priority is development of robust health systems in the countries. Key issues in this connection are sustainable health financing, the capacity to exploit the potential that the national economies may have for upscaling of the number of health workers, retention policy, the capacity and quality of the services and the training and coordination with NGOs and commercial actors.

The recognition that key components of HRH issues lie outside the jurisdiction of the health sector means that national coordination, in both developed and developing countries, must be improved in the direction of increased coherence. Among other things, this requires safeguarding of the relations between labour market measures, training, HRH financing and macroeconomic conditions.

States' responsibility for ensuring that they have adequate and robust health workforce units must be developed. In almost all low-income countries with an HRH crisis, these structures are too weak.

Instruments that can be employed (planning tools, *best practice* identification, research, influencing activities) are in rapid development in international health contexts. Norway can take part in the global fora for this development. Particular challenges, such as the effect of HIV/AIDS on the HRH situation, require special attention in many countries. Health and HIV/AIDS measures must be viewed in context at country level.

The working group recommends:

- Norway can function as a "convenor" for multi-party efforts at country level – in relation to cooperation on training, health, research collaboration or AIDS. Each embassy should be able to gather information on the HRH situation in the host country, and include this in the basis for its strategy in the same way as one otherwise takes macroeconomic conditions into consideration. The health expertise of the Ministry of Foreign Affairs, Norad and the Norwegian domestic administration may provide the embassies with simple instruments for this purpose.

6.4.2 Increased efforts to strengthen health workforce training and research collaboration

The shortage of health workers has complex causes. One possible solution lies in programmes between institutions in Norway and the South that combine

- collaboration on training in accordance with well-tried models
- capacity development at important health institutions and health care *training* institutions through equal partnerships with corresponding institutions in Norway
- investments in infrastructure, professional cooperation, conference attendance/ supplementary training, project financing, access to specialist literature, etc.
- potential for professional exchange/updating/study visits within frameworks that counteract the brain drain
- research potential in the South for Norwegian health research institutions.

An integrated strategy to alleviate future personnel shortage in the Norwegian health sector without affecting the capacity of partner countries in the South may involve combining measures for training personnel with capacity building on a broad front in the sender country with elements of internship/obligatory service in Norway. Such a strategy may at least be a way of compensating for the migration within a responsible framework. As part of the strengthened coordinated focus on competence building in the health sector in the South, the working group will also recommend that importance be attached to coordination of the Norwegian measures and systems with those of other countries and international organisations. This will include assessment and exchange of experience in order to strengthen coordination and the effectiveness of the measures.

The working group recommends:
A coordinated focus on competence building in the health sector in the South:

1. The following two approaches to strengthening of training and research may be considered:
   a. The NUFU programme and the NOMA programme can be provided with grants earmarked for health sector measures in accordance with section 2.2 of their respective programme agreements. Since many vital health services require personnel with competence at Bachelor level, a corresponding programme may be established for collaboration between institutions on basic health care training, or
   b. A full independent health care programme can be established on the NUFU and NOMA model, including components at all levels of training (Bachelor, Master, PhD) and research.
2. In the view of the working group, it is important to draw health institutions in the North and the South directly into the cooperation, in association with educational institutions and with possible research components coordinated with this initiative.

It is recommended that consideration of the choice of approach be given priority so as to enable rapid implementation. Universities and university colleges will play an important role as collaborative partners in this. The question of whether these components are to be integrated into existing programmes or established as separate programmes must be considered in the ultimate programme design.

The working group has not made any specific cost estimates, but assumes that for a programme to have any measurable effect considerable funding is required. It is assumed that an initial four-year pilot phase from 2010 will cost NOK 150 million.

6.4.3 Improve the basic data as a basis for policy-making and monitoring progress

For the authorities of a country to be able to plan the need for and distribution of health workers, knowledge is needed concerning the number of active health workers in the health sector, how they are distributed and their skill mix. Knowledge is also needed concerning those who are training for future employment in the health sector and concerning the degree of attrition from the sector and the reasons for it. A health information system with a specific HRH component will help to provide sound underlying data for access to and availability of health workers with appropriate expertise where they are needed. A reliable and robust information system for health workers is crucial to the development, implementation and assessment of HRH plans at regional, national and international levels. The underlying data is often poor, and health information systems are weak in most developing countries. Up-to-date technical tools (information technology solutions) are lacking. The University of Bergen is currently developing an innovative model for data collection involving use of mobile telephones.

Since 1994, a group at the University of Oslo, in cooperation with the University of the Western Cape in South Africa have worked on health information systems in developing countries: "*The Health Information System Program*" (HISP) is now coordinated by the Department of Informatics at the University of Oslo.
Major components of the programme are:

- developing a "minimum data set" for the primary health service associated with key indicators
- developing a flexible software package (*District Health Information Software*) that allows data entry, validation and analysis at the local level, while ensuring that regional and national authorities receive the data they need.
- systematic training of health workers and managers at all levels, from health centres to national authorities.

The main focus of HISP is user control and capacity building achieved by establishing local HISP groups, as opposed to traditional software development, which is usually technology driven. The HISP network, employing DHIS software, has been a success, and was implemented as a national standard in South Africa in 1999. Today, HISP cooperates with many African and Asian countries.

HISP is internationally recognised since it is part of the WHO's *Public Health Toolkit*. It consists of three types of software which cover the need for health workers treating patients at clinics and health administrators at district and regional level and at national level. HISP is also cooperating closely with the *Health Metrics Network* on establishing an international framework for standardisation.

The working group recommends:

- Support for the UiO/HISP network with development assistance funds, involving development of a pilot version with an HRH module in the health information system. Support for further development of information technology and mobile telephone solutions at the University of Bergen.

6.4.4 Results-based financing as instrument

Since there is a lack of sound knowledge concerning the impact, cost effectiveness and risk of undesirable side-effects to the use of financial incentives, it should be carefully assessed whether the implemented RBF arrangements function according to intentions. Thorough assessments must be carried out in order to single out the effects of financial incentives from a larger package of measures. A randomised experiment, if it can be carried out, is the ideal method for such assessments because this allows control of the many factors that may affect the results. Such an experiment may moreover provide rapid and reliable answers. There is also a need for both quantitative and qualitative process assessments, not least in view of the complexity concerned here as regards measures, professionals' behaviour and systems.

The working group recommends:
Allocation of the following funds:

a) *NOK 5 million per year for review of and research into the implications of RBF implementations specific to HRH in the various countries. This will partly involve impact assessments that will provide continuous knowledge updates on the effects and possible distortive side-effects of the programme, so that its impact on the total HRH situation in the respective countries can be monitored.*
b) This instrument will partly be viewed in relation to support of research into the remainder of the labour market-related implications for health workers, as is done through the Norwegian support over a total of six years for the Human Resources for Health Trust Fund in the World Bank (NOK 5 million per year).

6.5 Development assistance via multilateral and international channels and actors

Norway's support for HRH currently takes place, and may if appropriate be extended, through multilateral channels and global initiatives. Viewed in the larger context, Norway's resources for health development are relatively small, amounting to approximately 3% of total development assistance to the health sector, and must therefore be used in contexts where they yield optimal results.

The WHO
In November 2008, Norway concluded a new two-year programme agreement with the WHO, committing the transfer of NOK 215.5 million per year. According to the agreement, NOK 25 million per year is to be applied to strategic goal 10: "Improvement of organisation, administration and supply of health services".

GAVI and the health systems strengthening component (HSS).
The goal for GAVI HSS is to strengthen health systems in order to increase and maintain vaccine coverage. HRH is one of the three HSS key topics. A total of USD 800 million has been allocated to HSS. Approximately 89 million has been allocated to interventions associated with health workers.

Potential for further strengthening of the HRH component in GAVI: strive to achieve greater flexibility in the use of the funds in the direction of more general HRH strengthening (not only explicitly earmarked for vaccine) and recommend in the guidelines that the funds be used to help solve the HRH challenge in general.

The Global Fund – GFATM – health systems strengthening
The goal for the Global Fund's health systems strengthening is to improve public, private and local health systems so that the burden of AIDS, tuberculosis and malaria can be reduced over time. The WHO has defined six essential building blocks for a well-functioning health system. These also underlie the mandate of the Global Fund.

Norway has proposed that the Fund be given a role, but that singling out health systems as a separate component would be to exaggerate the financing role of the Fund. Norway also proposes that the work of the Fund in this area be assessed and coordinated with the efforts of GAVI, the World Bank, the WHO and others.

UNAIDS
In 2008, Norway contributed NOK 160 million to UNAIDS, and is its fourth largest donor. UNAIDS is not a donor organisation, but was established to ensure coordination at country level and an integrated approach to combating HIV and AIDS. The intention behind the programme is to ensure global leadership in this field by following up, monitoring and assessing the epidemic and by coordinating the totality of efforts made in combating the disease. A central role is played by efforts to achieve universal access to prevention, treatment, care and support.

UNAIDS directs its efforts towards achieving a closer association between work on health systems and work on AIDS. Effective AIDS responses also strengthen health systems as regards treatment of other diseases and help to achieve the global health-related MDGs. In 2007, at least NOK 1 billion of AIDS funding was applied to the strengthening of health systems. In 2008, UNAIDS appointed its first adviser on health systems and multisectoral response. Norway will work to achieve the best possible association between the health system responses of the funds and multilateral organisations and of the countries themselves.

GHWA-initiated products from working groups and co-production with other bodies, such as the World Bank and the WHO, receive support via the Norwegian financial contribution to the GHWA (NOK 20 million per year). Both the knowledge products and the tools for strengthening of HRH plans and other health system components are made available to developing countries free of charge.

The INGO channel, civil society (International NGOs)
This channel is important for maintaining catalytic and "watchdog" functions. Rights issues in the area of health (gender equality/women's rights), are already a thematic framework for this fiscal budget allocation. Particularly where the COP is concerned, it is important to help ensure that the guidelines are both implemented and practised in accordance with the prescribed standard. Moreover, it is possible here to take into consideration the gender dimension in health worker migration. Women are vulnerable as migrants, and they leave behind an important care burden in their home countries. This allocation may be applied to important small-scale measures in HRH issues.

The working group recommends that:
- Norway continues development assistance for the strengthening of health systems, including HRH components, via multilateral channels.

6.6 Bilateral financial assistance to partner countries

There are various components in Norway's bilateral development assistance portfolio:

1. Health sector cooperation Malawi:

Norwegian development assistance and participation in sectoral cooperation with other donors ("basket funding"), of which health system support and HRH form a key component and are included in government plans. Malawi has an HRH plan.

Development assistance and cooperation via the channel for civil society. Training of nurses, for example, is part of the strategic cooperation with Norwegian Church Aid and with local institutions in Malawi.

Support schemes involving Norwegian health institutions (Ullevål Hospital, Haukeland Hospital – financing via the Norwegian Embassy in Lilongwe) which cooperate with hospitals in Lilongwe.

2. Health sector cooperation Tanzania:

Sector-Wide Approaches (SWAp) were adopted in 2008 as a mechanism for implementing Norway's MDGs 4 & 5 Initiative in Tanzania. HRH is a subtopic of the sectoral cooperation between the donors, including Norway, and the authorities, particularly through the bonus scheme for health workers for results associated with pregnancy and childbirth, i.e. results-based financing.

3. Norway's MDGs 4 & 5 Initiative in Nigeria, Pakistan and India:

As described in 4.5 b, with strengthened integration of the HRH component in the initiative.

4. Civil society / NGOs

The support is provided via civil society with NGOs as strategic partners according to the model of Norwegian Church Aid, Malawi and the nursing training project. Consider extension and coordinate with efforts of Norwegian health institutions that cooperate with institutions in the partner countries (cf. 6.6).

5. Humanitarian assistance

To a lesser extent, this channel is used in relation to HRH as a critical factor for production of health services, through technical assistance and specific measures for mobilisation of local/national/regional personnel. Consider the potential for supporting regional training of health workers as a resource for emergency situations.

The working group recommends:

Efforts for strengthening of capacity

i) in countries with which we have health sector cooperation (Malawi) and in the partner countries for Norway's MDGs 4 & 5 Initiative (Tanzania, Pakistan, India and Nigeria)
ii) in countries where Norwegian institutions and hospitals collaborate with institutions (e.g. Ethiopia, South Africa and Malawi)
iii) in countries where exchange schemes are established through the Norwegian Volunteer Service and the ESTHER model
iv) in countries where Norway can contribute via the IHP mechanism[37] in which Norway participates
v) by equal inclusion of HRH in both Health and HIV/AIDS initiatives
vi) by assessing the possibility of more systematic support of regional health workforce training over the humanitarian budget allocation as contingencies for crises and disasters

[37] IHP – International Health Partnership was established in 2007 with the Prime Ministers of Norway and the UK among the initiators: a donor coordination initiative for health sector cooperation with potential for financing. A number of countries have been selected for coordination of cooperation, initially Mozambique, Burundi, Ethiopia, Kenya, Mali, Nigeria, Zambia, Nepal and Cambodia.

6.7 Providing for more targeted participation by Norwegian health actors

Particularly in bilateral contexts, it is appropriate to involve specialist environments and institutions in Norway that wish to participate. Many Norwegian institutions are already involved in partnerships with institutions and organisations in the South. From the private sector and public health institutions, this includes participants in the ESTHER cooperation, the Norwegian Volunteer Service, research, professional associations and NGOs. A Norwegian health network for development which has HRH as a main concern is being established on a platform that the Norwegian Volunteer Service, Norad and the Norwegian Directorate of Health will participate in facilitating. This should be supported. In the case of groups emerging from Norwegian health enterprises, activities must be adapted to the mandate provided by the Norwegian health sector and the Norwegian health authorities.

The following principles are appropriate:
- that participation is coordinated via targeted grant schemes and exchange of experience
- that targeted results are achieved through the engagement
- that development assistance activities are commensurate with the most central domestic needs of partner countries, and are included in high-priority initiatives
- that initiatives involve national/local ownership in the partner country and enduring capacity development
- that a platform is established in Norway for exchange of experience gained in cooperative relations (e.g. a Norwegian health network for development).

The working group recommends:
- A coordinating body (a Norwegian health for development network) should be established and supported to improve coordination and assure the quality of the institutional partnerships engaged in by Norwegian health institutions and organisations, and as part of the efforts to improve international coordination.
- Financial support should be given to partnerships and institutional cooperation, primarily through the ESTHER cooperative model, in order to ensure predictability in the cooperation relations between the partners.

6.8 Financial and administrative consequences of recommendations

To the extent that it has been possible, the working group has provided financial estimates for each recommendation. However, in the case of certain recommendations, separate studies will be required to calculate the financial consequences. These estimates should preferably be made in relation to decisions on measures or orientation of HRH policy. In the view of the working group, decisions can be made without separate assessments, since the recommendations are largely based on the understanding that the overall use of resources will not be increased. The effectiveness of Norwegian health policy in Norway's foreign and development policy will mainly be improved by means of focusing, coordination and reorientation. Accomplishing this may involve rather more than budgetary focusing and reordering of individual project priorities.

On the other hand, a separate mechanism is proposed for accountability, which has *administrative* consequences. In the view of the working group, the focusing, gathering and coordination of all the priority areas affected by the HRH field requires coordination.

Responsibility for this should be assigned to a specific unit, while at the same time safeguarding multisectoral participation.

It is natural to place the responsibility for follow up and coordination at the Ministry of Foreign Affairs, which has the constitutional responsibility for most of the measures included in the recommendations.

In addition to this, a separate reporting procedure should be required for the HRH initiative in the area of foreign affairs and international development. As a minimum, this should take place through the fiscal budget process, in Proposition No. 1 to the Storting each year.

The working group recommends:

- The responsibility for coordinating and targeting Norwegian HRH policy in foreign and development policy is placed with the Ministry of Foreign Affairs, with the support through permanent participation of the Ministry of Health and Care Services, the Ministry of Education and the Ministry of Labour and Social Inclusion in an advisory committee.
- An annual report is to be submitted concerning follow-up and results of the HRH initiative.

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ANNEX: Mandate

Working group on migration of health workers. Mandate.

Background:

The Government has decided that two working groups will be established under the auspices of the Ministry of Health and Social Affairs and the Ministry of Foreign Affairs. The two working groups will consider, respectively, domestic measures and any measures in the development assistance area regarding recruitment of health workers.

It is an unequivocal objective for this government that Norway refrains from active and systematic recruitment of health workers from developing countries. In its Annual Report for 2006, the WHO draws attention to the fact that 57 countries are regarded as having too few health workers to achieve the UN Millennium Development Goals. Thirty-six of these countries are in Africa. The countries with the greatest critical shortage of health workers also have the heaviest health burdens.

Norway invests efforts in many contexts throughout the world to counteract the global shortage of qualified health workers. This is a key issue of the Foreign Ministers' Network for Global Health and Foreign Policy initiated by Norway. The Global Health Workforce Alliance hosted by the WHO, has established several working groups to develop and create agreement on a common frame of reference for measures at national, regional and global levels regarding ethical recruitment, financing, training and partnership. The Minister of the Environment and International Development participates in a high level group, the Global Health Workforce Advisory Council, associated with this Alliance. An action plan for further work was prepared at a high level forum for the Global Health Workforce Alliance in Kampala in March 2008.

As a basis for the working group's investigations, we refer to the white paper *Long-term Care – Future Challenges – Care Plan 2015* (Report No. 25 (2005-2006) to the Storting) and the National Health Plan for Norway. We refer also to the Government's policy as regards labour migration, which is discussed in the white paper on labour immigration (Report No. 18 (2007–2008) to the Storting), and to ongoing processes in WHO/GHWA and WHO Europe regarding development of proposals for ethical guidelines for international recruitment of health workers. The working group will consider recommendations set out in Report IS-1490, *Recruitment of Health Workers: Towards Global Solidarity* of relevance for the development policy area.

Mandate for the working group:

1. Examine relevant content and prepare a report to the ministries participating in the working group concerning follow-up of the Government memorandum on "An equitable policy for recruitment of health workers" in the development assistance area, including an assessment of any political, administrative and financial consequences of such follow-up and of the possible need for a further Government memorandum. The follow-up will be viewed in the light of the conclusions of the Global High Level Forum on the Health Workforce in Kampala, 2–7 March 2008. The follow-up will also be viewed in the light of the Report to

the Storting on labour immigration and its recommendation concerning standards for counteracting active recruitment from developing countries of workers with higher education and qualifications that are in short supply in developing countries. The report will also seek to include any relevant guidelines inherent in the ongoing work on a new White Paper to the Storting on international development policy.

2. In cooperation with the working group of the Ministry of Health and Care Services, assess what measures may be proposed by Norway in relation to the international processes (WHO/GHWA and WHO Europe) as regards drafting of a "Code of Conduct" (ethical recruitment). Assess the status of work on international guidelines for ethical recruitment and the way forward.
3. Review the relevant points of the action plan adopted at Kampala, and consider in what ways Norwegian support may be of special value through the various development assistance channels and advocacy via foreign and development policy and building of alliances.
4. With a view to training and capacity building in the health area in developing countries and any schemes for mitigating negative effects; if possible, identify which developing countries supply health workers to Norway and how long these workers stay in Norway. Assess the HRH status in the countries that supply health workers to Norway and identify the type of health workers needed by these countries and the nature of training provided in the home country. Then consider what type of support should be provided and what this will cost.
   Consider the use of existing instruments and what need there may be for new ones. Consider what types of contracts/agreements/partnerships may be appropriate and propose how these might be financed.
   An existing incentive is that the State Educational Loan Fund cancels all debt if immigrants who have received their training in Norway, return to their home countries.
5. Select some countries where we provide various types of development assistance to the health sector and which themselves have a major need for health workers.
   Examine possible measures for encouraging these developing countries to do the necessary work to create an overall plan for multi-partner cooperation (cf. the Kampala Action Plan) in order to upgrade the HRH status in their respective countries and encourage trained health workers to remain in their home countries.
6. Demonstrate the relationship between research, training and measures to increase coverage and retain health workers in the service in developing countries.
7. Consider how international meetings at the political level can be used to promote efforts to strengthen the HRH status in poor countries.
8. Make an overview of measures for capacity building in the area of health and strengthening of the HRH status in developing countries that already receive Norwegian support (e.g. ESTHER).
   Identify the items in the development assistance budget where such support is allocated and the potential for enlarging the framework/establishing new items.

The final date for submission of the report is set to 30 January 2009.

Consideration by appropriate bodies

On completion, the report of the working group will be circulated to relevant non-governmental organisations for their comments.

Composition of the working group
Representatives from the Ministry of Labour and Social Inclusion, the Ministry of Education, the Ministry of Health and Care Services, the Ministry of Foreign Affairs, Norad and the Norwegian Directorate of Health.

Time frame
The final date for submission of the report is set to 30 January 2009.