Handle with care

Why the Netherlands must be cautious about recruiting migrant health workers

Position paper on the international recruitment of health and care workers for the Netherlands

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Summary

There are traditionally low numbers of foreign-born, foreign-trained health workers in Dutch healthcare. But Dutch healthcare workforce shortages are becoming more and more severe, and since Covid-19, this situation is compounded by labour shortages in the economy as a whole.

There have been pilots with the recruitment of international health workers in the early ‘00s, but these were not very successful. However, recent increases in numbers of Indonesians students working in Dutch long-term care, the growing numbers of 24/7 home carers as well as the rise in foreign-trained health workers in hospitals indicate an increased interest in deploying foreign-trained health and care workers to fill the vacancies.

Such international recruitment is not so straightforward. There are several legal obstacles, as well as practical and ethical considerations that influence its feasibility and desirability. Examples include the need to adequately prepare foreign-born, foreign-trained health and care staff for working and living in the Netherlands (recognition of diplomas and qualifications, language, culture) and the risk of creating a brain drain in the countries of origin.
The increases in the number of internationally recruited health and care workers, as well as in the number of recruitment agencies acting as intermediaries, seem to indicate a valid business model.

In addition, the recent publication of the Dutch Advisory Council on Migration (ACVZ), containing the advice to the Dutch government to design ethical skills partnerships with sending countries, could trigger increased, active and targeted recruitment of foreign-trained health and care workers.

On the basis of our long-standing engagement in global discussions on health worker migration, the WHO Code of Practice on the international Recruitment of Health Personnel, and the limited evidence on truly equitable and ethical skills partnerships, Wemos is following the developments in the Netherlands critically. Apart from the practical challenges and legal obstacles, many ethical considerations remain unaddressed.

We therefore recommend the Dutch government to:

- Remain extremely cautious about actively recruiting foreign-trained, foreign-born health workers, especially from countries with low health worker densities.
- Consult with a broad array of stakeholders before embarking on formal arrangements for the international recruitment of health personnel.
- Ensure thorough understanding of existing bilateral arrangements in other countries.
- Invest in more and better data about foreign health workers in Dutch 24/7 home care.
- Keep track of recruitment agencies and make reporting mandatory.
- Respect and actively promote labour and human rights of all migrant health workers active in Dutch health care.
- Invest in health systems worldwide.

Introduction

What's the issue?

Many high-income countries rely to some extent on foreign-born, foreign-trained health workers. Rather than investing in the training, education, deployment and retention of home-grown health and care professionals, some of them resort to international recruitment of health and care personnel. Both in the global health labour market and in the European Union's (EU) single health labour market, we see that the excessive and asymmetric flows of health workers mainly benefit the more affluent countries in the EU (the net 'destination countries') and undermine the health workforces in the less affluent countries (net 'source countries'), thus contributing to an unequal availability of health workers across the globe.

The Netherlands is a minor player in the international health labour market, because of its small size in comparison to economic giants like the USA, UK, Australia and, in the European context, Germany and France. Considering the insignificant proportion of foreign-born, foreign-trained health professionals in the Dutch health workforce, the Netherlands cannot be labelled as a driver of global or European health worker brain drain. This is not the result of intentional action, but rather circumstantial. However, the Covid-19 pandemic has had a dramatic effect on the Dutch health workforce, which even before 2020 struggled with increasing shortages. In the

wake of the pandemic, several developments indicate an increased interest in international recruitment to increase staffing levels. This focus of this paper is threefold:

- It describes practical, legal and ethical considerations in relation to the international recruitment of health personnel for Dutch health care;
- It reports the latest developments in the deployment of international health workers in Dutch health care; and
- It outlines Wemos' position on the topic.

Context

The Dutch health care sector has been struggling with increasing health worker shortages for some time already. As a result of the double aging of the population in the Netherlands (there are more and more elderly people, who are also getting older) in combination with an overall increase in the number of chronically ill, there is an increasing need for health and care personnel[1] – a development observed in many other countries as well. In 2017, the Dutch Ministry of Health, Welfare and Sport (MOH) therefore developed the 'Labour Market Agenda 2023: Working together for the elderly'[2]. And in 2018, MOH published the Action Programme 'Working in the care sector' [3], containing measures to meet the (then) forecast shortage for 2022 of 100 to 125 thousand employees in health and social care. This estimate has since been revised downwards several times; at the time of writing of this report, health care vacancies numbered 64.000.[4]

Efforts to fill those vacancies have been partially successful.[5,6,7] However, the Covid-19 pandemic has confused existing plans and ambitions. Updated estimates of health and care personnel shortages dating from late 2020 resulted in an official prognosis by the Prognosis Model Health Care and Well-being, for the years 2021 and 2031, illustrated in table 1.

[1] Zorg voor de toekomst. Over de toekomstbestendigheid van de zorg. Sociaal-Economische Raad. 2020.

[2] https://www.tweedekamer.nl/debat_en_vergadering/commissievergaderingen/details?id=2016A01154

[3] https://www.rijksoverheid.nl/documenten/jaarplannen/2018/03/14/actieprogramma-werken-in-de-zorg

[4] https://www.cbs.nl/nl-nl/nieuws/2023/07/arbeidsmarkt-in-vierde-kwartaal-iets-krapper

[5] https://zn.nl/338067458/Nieuwsbericht?newsitemid=4218290176

[6] https://www.werk.nl/arbeidsmarktinformatie/sector/zorg/

[7] https://www.rijksoverheid.nl/documenten/brieven/2019/05/22/monitor-actieprogramma-werken-in-de-zorg

Table 1: Projected stock and shortages for selected professions in health and care, for the year 2031.[8]

Health professions	2031		
	Stock	Shortage	%
Medical specialists	26.500	300	1,1
Medical support personnel	16.300	2.600	16,0
General practitioners and support staff	8.500	0	0,0
Mental health professions	20.100	5.000	24,9
Oral care	9.100	400	4,4
Social medicine	4.700	700	14,9
Specialised nurses	28.100	5.700	20,3
Elderly care physicians, physicians intellectual disability medicine, and supporting staff	3.400	1.100	32,4
Totals	**116.700**	**15.800**	**13,5**
Care professions	2031		
	Stock	Shortage	%
Care aide	165.100	100	0,1
Aid care & well-being	77.600	5.000	6,4
Carer	184.400	34.100	18,5
Nurses (basic levels)	123.900	24.900	20,1
GP assistant	31.900	2.800	8,8
Midwives and nurses (advanced levels)	74.700	9.200	12,3
Totals	**657.600**	**76.100**	**11,6**

Pressure on health facilities is enormous. News outlets regularly announce the temporary reducing of opening hours or the (partial) closing of facilities during the holiday periods, as a result of staff shortages, sick leave and holiday leave.[9] To help solve these challenges, the possibility of recruiting health workers from abroad is being mentioned explicitly as a way to increase staffing levels.

[8] Retrieved from https://prognosemodelzw.databank.nl/dashboard/dashboard-branches/totaal-zorg-en-welzijn--smal- on 6 August 2022.

[9] See for instance: Emergency GP care during out-of-office hours in Hedel, Bommelerwaard: closed from end July to beginning September; Emergency department Langeland hospital in Zoetermeer: closed for three days per week during summer period; Emergency GP care in the evenings in Oss: closed from beginning July to beginning September.

Pilots

Starting around 2000/2001, there have been several pilot projects to recruit healthcare personnel from abroad, with healthcare facilities recruiting nurses from low- and middle-income countries, including South Africa, the Philippines, and later Spain, Italy and Poland. It turned out that especially language problems, cultural differences and lower-than-expected knowledge and skills formed obstacles to the desired quality of care.[10] The pilots in question were therefore often not followed up and many of the care providers eventually returned home. Many pilot projects took place within the framework of so-called bilateral agreements, with the co-operation of governments on both sides, for a fixed period of time, and often with the aim of benefiting all parties: the individual care provider (higher salary, professional development), the country of origin (boost for their quality of care when the professional returns home) and the country of destination (relief of workforce shortages).

Pilot projects aside, health and care providers with a non-Dutch nationality and a foreign diploma can (and do) apply for vacancies in Dutch healthcare on their own initiative. The CIBG, one of the implementing agencies of the MOH, keeps figures on this. These can be consulted on the website of the BIG-register, the register of 'professionals for individual healthcare' registered in the Netherlands.[11] See table 2 for data on a select number of professions.

Table 2. Percentages of BIG-registrations with a foreign diploma, from the European Economic Area (EEA) and non-EEA, for 6 selected professions. Data retrieved 10 January 2023.

	BIG registrations	Number of foreign diploma and EEA nationality	% of total BIG registrations with foreign diploma and EEA nationality	Number of foreign diploma and third national (outside EEA)	% of total BIG registrations with foreign diploma and from outside EEA
Pharmacists	6.383	162	2,5	11	0,2
Physicians	80.678	3009	3,7	250	0,3
Physiotherapists	38.923	220	0,6	53	0,1
Dentists	12.697	1863	14,7	210	1,7
Midwives	5.151	132	2,6	9	0,2
Nurses	224.384	1768	0,8	240	0,1
Totals	**368.216**	**7.154**	**1,9**	**773**	**0,2**

[10] Arbeidsmarkt in Beeld; inzet personeel uit het buitenland. Transvorm, februari 2019.

[11] https://www.bigregister.nl/over-het-big-register/cijfers/buitenlands-diploma-en-nederlands-diploma.

In addition to these BIG-registered professionals, it is known that at least 500, but some estimates say up to 2,000[12], nurses from (mainly) Eastern Europe are employed as live-in home carers. They come from countries like Hungary, Romania, Czechia, Poland and Slovakia. These care providers can be placed in the Netherlands via recruitment agencies in the Netherlands and secondment agencies in the country of origin, to work with patients and clients who pay for this form of care (partly or completely) with a personal budget (PGB), obtained under the Social Support Act or the Long-term Care Act. Because these PGBs can be quite generous, the client is able to pay for salary as well as room and board of the live-in care provider. In addition, the client or the client's family sometimes also uses their own money to cover the costs. With the recent high inflation, however, increases in the PGB do not keep up with the increased costs for this type of care, making live-in home care a luxury item for the happy few.

Practical aspects

Practical aspects concerning the deployment of non-Dutch care and aid workers mainly concern the quality of the care and aid they provide, their language skills and their cultural compatibility. For individual professionals as referred to in the Individual Health Care Professions Act (the BIG Act, which concerns those who provide direct, clinical patient care), the quality of their professional actions and the required language skills are guaranteed by means of procedures for the recognition of diplomas and language tests. These procedures differ per profession, nationality and country where the diploma was obtained. For example, doctors, pharmacists, dentists, midwives and nurses with predefined diplomas obtained in Europe can be registered directly in the BIG register on the basis of the European Directive 2005/36/EC on the recognition of professional qualifications.[13] For professional groups other than these five categories, individual professionals need to prove that they meet the BIG requirements, or they will not be authorised to practice their profession in the Netherlands.

Not all care providers fall under the BIG Act, such as the aforementioned care providers in 24-hour home care. For them, quality of care is in principle guaranteed by the Dutch recruitment agencies, which check diplomas and/or experience and ensure that client and care provider can communicate with each other. Since the healthcare decentralisation measures of 2015, it is the responsibility of municipalities to monitor the quality of 24-hour home care, but this is a new task for them and still in development. Up till now, there is little or no systematically obtained

[12] Estimate by the author (CH) on the basis of informal conversations with a few Dutch recruitment agencies.

[13] https://eur-lex.europa.eu/legal-content/NL/ALL/?uri=CELEX%3A32005L0036

information about the quality of home care provided. And when clients pay for their home care entirely from their own resources, there is no supervision at all on the quality of the care, nor on the contractual arrangements.

With regard to language skills and cultural sensitivity, accredited recruitment agencies demonstrably ensure proper preparation of future care providers, often in the form of a course or training in the country of origin, so before they travel to the Netherlands. It is important to note that evaluations show that clients highly appreciate this 24-hour home care and are grateful for the opportunity to receive this form of care. A frequently heard comment is that Dutch care workers are no longer prepared to provide such intensive care at home. Recruiting healthcare providers from abroad is quite expensive, especially when language and culture courses are involved and all the more so when it turns out that employees return to their home country relatively soon (i.e. before the investment is recouped), for example because employment or working conditions have improved there. This does not happen very often but is a real business risk. However, the fact that international recruitment is happening on an increasing scale indicates that, all in all, the business model is valid and returns on investments are adequate.

Legal aspects

For non-Dutch people to work in healthcare, it is important to make the distinction between the free labour market and the regulated labour market. Admitted to the free labour market are all those who can be legally employed without the need for any permit. This includes Dutch nationals, other citizens within the European Economic Area (EEA) and their family members, who are allowed to perform paid employment in the Netherlands, thanks to the European internal market.

The Foreign Nationals Employment Act regulates the rest of the labour market. These regulations stipulate that an employer is prohibited from allowing a foreign national to perform work in the Netherlands if they do not have a work permit or a combined permit for residence and work, issued by the Employment Insurance Agency, for the performance of work with that particular employer, and for workers with up to (and including) MBO education level.[14] Because it is assumed that such workers are available on the EEA labour market and should receive priority treatment, the Employment Insurance Agency will always refuse these permits for

[14] Secondary vocational education, from one to four years (corresponding to levels 1-4).

foreign nationals from outside the EEA. Translated to healthcare: employers in healthcare cannot recruit staff up to and including MBO level from outside the EEA. This includes, for example, MBO nurses for hospitals, nursing and care homes, home care, care for the disabled and mental health care, care assistants, doctor's assistants and pharmacy assistants. And as we have seen in table 1, these are the categories of professions with the highest (expected) shortages.

For higher educated migrants (above MBO level), there are more possibilities to acquire a residence permit. For example, foreign students who have completed their studies in the Netherlands, are allowed to stay in the Netherlands temporarily on the basis of an orientation year and are allowed to perform paid employment without having to meet a salary criterion. After that year, they must meet conditions for more permanent admission (such as a European blue card, or the Highly Skilled Migrant scheme).[15] In order to be eligible for a residence permit under the Highly Skilled Migrant scheme, a certain salary criterion must be met. That salary threshold level is such that in practice this is only attainable for foreign students who have obtained a master's degree in the Netherlands at an institution for higher professional/vocational education (HBO) or scientific education (WO), and not for MBO level students.

Significantly higher salary criteria apply to health workers not graduated in the Netherlands. For companies in the private health and care sector it is relatively easy to meet these standards, but in the Dutch public healthcare sector the situation is different and very dependent on the level of education, degree of specialisation, and the (sub-)sector's collective bargaining agreements. Suffice it to conclude here that it should very well be possible for various medical professionals to obtain a residence permit as a Highly Skilled Migrant on the basis of the salary criterion. Of course, the obligation of obtaining a BIG registration still applies in order to be authorised to practice their medical profession in the Netherlands.
A last option is to let nursing students study in the Netherlands, in which case they are allowed to follow classes for one or two days a week, while also working for several days a week to practice their new skills. This option is becoming more popular among students, recruiters and (especially) nursing homes (see 'Recent developments').

In practice, the number of non-Dutch employees with a foreign qualification in Dutch healthcare is not very large (see table 2), although the figures are not totally reliable. Data is only available

[15] See Vreemdelingenbesluit / Aliens Decree 2000, 3: 30 a and 3:30 b.

for BIG-registered professionals, but strictly speaking these data only indicate that they are allowed to practice their profession here, not whether they actually do so. No substantiated figures are available about non-BIG-registered professions such as carers. Compared to other OECD countries, the Dutch numbers for all cadres are far below the OECD average.[16]

Ethical considerations

There are also ethical aspects to the deployment of foreign healthcare personnel in the Netherlands. For example, caution is needed concerning the existing employment arrangements for the live-in home carers. Although these employment contracts comply with the letter of the law – certainly when recognised Dutch recruitment agencies are involved – there are also known cases of exploitation. This concerns, for example, people who have a full-time employment contract, but who are expected to be available 24/7. Even if the 24-hour shifts are performed by two people (as often happens), in practice, this can lead to situations in which they have too little free time, measured by Dutch standards. Organisations such as Fairwork or Mondiaal FNV regularly deal with cases of such abuses and point out the lack of enforcement by the Labour Inspectorate in these vulnerable situations.[17]

Another problem that regularly arises is that of so-called 'de-skilling': the phenomenon that care providers with a foreign qualification often work below their level of competence. In the aforementioned 24-hour home care, care providers often have nursing qualifications, which means they are overqualified for the work they do. For healthcare providers, this is an important indication of the quality of the care they can provide, but of course de-skilling de facto degrades the individual healthcare provider. This is often referred to as ‘brain waste’.

Caution is also advised when actively recruiting foreign healthcare providers for Dutch healthcare because of the effect of (excessive) outflow from their countries of origin. After all, many of these people work in essential professions in their country of origin and often will have made use of public educational facilities there. For the country of origin, the loss of this labour force is a form of 'brain drain' and of capital destruction. It compromises their ability to build a strong and resilient health care system, with corresponding impact on population health. This

[16] OECD (2019), *Recent Trends in International Migration of Doctors, Nurses and Medical Students*, OECD Publishing, Paris, https://doi.org/10.1787/5571ef48-en

[17] Oral information.

'brain drain' has been extensively documented, both for countries outside the EEA[18] and within it.[19] The often-used argument that new recruits are unemployed in their country of origin may be factually true, but ambiguous nonetheless: many countries with high levels of health worker unemployment suffer simultaneously from low health worker densities. For example, Indonesia and the Philippines, two countries often cited as 'overproducing' nurses, have a nursing density of 9/10,000 population (2021) and 42/10,000 respectively (2021), compared to 111/10,000 in the Netherlands (2020)[20].

Code of Practice

Already in 2010, and in response to the rapidly increasing mobility in the global healthcare labour market, the Member States of the World Health Organization (WHO) adopted the Global Code of Practice for the International Recruitment of Health Personnel[21] (hereafter: the Code). In this Code, WHO Member States label the "active and targeted" recruitment of healthcare personnel from countries with critical staff shortages as unethical. The Code mainly serves to protect the right to health of residents of these countries with critical deficits. In addition, the Code includes articles that encourage countries with shortages to invest more in their own healthcare workforce, for example by organising and financing sufficient training places and creating employment opportunities in healthcare, good working conditions, continuous professional development and career prospects. Such investments can contribute to higher job satisfaction and lower (international) labour migration. The Code also calls for the use of development cooperation funds to facilitate these investments in healthcare personnel worldwide. In doing so, the authors explicitly acknowledge and highlight the increasing globalisation of the healthcare labour market and the increased interdependence of countries in protecting and promoting the health of their residents – the Covid-19 pandemic has made this interdependence conclusively apparent again.

The Code in no way disputes the right of individual health workers to migrate in search of better opportunities, and acknowledges the benefits of international work experience for their personal

[18] See for instance: https://www.un.org/africarenewal/magazine/december-2016-march-2017/diagnosing-africa%E2%80%99s-medical-brain-drain

[19] https://www.politico.eu/article/doctors-nurses-migration-health-care-crisis-workers-follow-the-money-european-commission-data/

[20] Data retrieved from WHO National Health Workforce Accounts, for latest available years. Average of 194 WHO Member States is 45,90/10,000, median 34,11/10,000.

[21] WHO Global Code of Practice for the International Recruitment of Health Personnel: https://www.who.int/publications/m/item/nri-2021.

and professional development as well as their ability to financially support their relatives. Financial transfers are an important factor for economies of the countries of origin. Globally, they have outpaced official development aid since the 1990s and are almost worth more than foreign direct investment[22], thus generously compensating for the investments made in their education and training.

Recent developments

The measures taken by the Dutch government to tackle the shortages in the health and care sector are mainly aimed at increasing the intake of students, rolling out a campaign to emphasise the appeal of working in health and care and urging health employers and facility managers to improve working conditions and increase retention.
However, in recent years the possibility of recruiting from abroad has been mentioned by influential stakeholders and thinktanks, such as in an important report by the Netherlands Scientific Council for Government Policy in September 2021 on the long-term sustainability of the Dutch health care sector.[23] Recommendation 8 includes a mention of 'targeted recruitment from abroad' to increase labour supply. The report stresses that an explicit government policy in this area has 'far-reaching implications, not just for healthcare but also for society, the economy, and government policy. This is why a broad-based political consideration is needed'.
More recently, the Dutch Advisory Council on Migration Affairs published a report exploring the opportunities and conditions for ethical labour migration policy for health workers[24]. The report has drawn from lessons from earlier experiences and shows an in-depth understanding of the practical and ethical pros and cons of international recruitment of health workers and translates these into concrete policy recommendations. It can therefore be considered a landmark publication that could trigger a change in official government policy.

The report focuses on the labour shortages in long-term care, concentrated in nursing and care-giving professions for workers with senior secondary vocational education (MBO) qualifications (level 3 and above). As explained before, MBO level health workers face several obstacles

[22] https://blogs.worldbank.org/peoplemove/data-release-remittances-low-and-middle-income-countries-track-reach-551-billion-2019

[23] English summary: https://english.wrr.nl/publications/reports/2022/05/03/sustainable-healthcare-a-matter-of-choice.-people-resources-and-public-support. (Full Dutch version published 15 September 2021)

[24] English summary: https://www.adviesraadmigratie.nl/publicaties/publicaties/2022/10/27/a-carefuly-considered-labour-migration-policy. (Full Dutch report published 28 September 2022)

under current legislation; one of the report's recommendations is therefore to invoke measures similar to the Highly Skilled Migrant Scheme to overcome those obstacles.
The document also posits the notion of the well-being approach: 'inviting scrutiny of conditions in terms of the here and now (such as the rights of migrant workers and their host society), the future (the long-term consequences) and elsewhere (the countries of origin). This can shed light on current problems with the existing Dutch labour migration policy for non-EU countries'. In addition, it points to the risks of the currently unregulated intermediary agencies who recruit health workers on behalf of health facilities. Such lack of regulation have led to several scandals regarding working and living conditions of migrant workers in other (non-health) sectors, [25] and repetition should be avoided at all cost.

Last but not least, a key recommendation in this report is that the Dutch government – if/when explicitly choosing for the option of international recruitment – should take the lead in the legal, administrative, labour law and other changes required and guarantee true triple win arrangements, and develop ethically responsible partnerships, benefitting the individual migrant, Dutch health care and the country of origin.

Meanwhile, news items are reporting regularly on health facilities that have started recruiting international students. These students follow classes for a couple of days per week, while doing their internship in a health facility for the remaining days. This is now happening in a number of elderly homes, employing mainly students from Indonesia and the Philippines. This has not gone unnoticed: several key stakeholders in the health sector are calling on the government to 'roll out the red carpet for health workers from abroad'.[26]

It is worthwhile to note that subsequent ministers of health have reiterated in their responses to questions in Parliament that international recruitment of health and care workers remains a last resort. As far as we know, existing laws and regulations have not (yet) been changed and international 'soft' agreements such as the Code are respected.

[25] See for instance https://www.nporadio1.nl/binnenland/25907-emile-roemer-mensen-wonen-in-bezemkasten-met-schimmel-op-de-muur (People live in broom closets with mold on the walls.)

[26] https://www.zorgvisie.nl/rol-voor-buitenlandse-zorgprofessionals-de-rode-loper-uit/ (Dutch only)

Conclusions

The Dutch government faces huge challenges in the health labour market, which post-Covid-19 are compounded by shortages in the labour market overall. Given current demographic developments, it will become very difficult for the Dutch government to achieve an 'incremental improvement' of health care for Dutch residents, as it is formulated in the right to health in the Universal Declaration of Human Rights and of which guaranteeing access to skilled and motivated health workers, for everyone, everywhere, forms an integral part.

Opting for international recruitment of health personnel may lead to major political and social debates and frictions, for which the earlier mentioned report by the Advisory Council on Migration Affairs may have paved the way. If the government opts for more labour migrants in Dutch healthcare from third countries, adjustments to the current legislation and regulations will be necessary. Additionally, and highlighted by the same report, measures must ensure that this recruitment takes place in an ethical manner, preferably in the form of bilateral agreements. Unfortunately, no concrete examples of what such agreements could or should entail have been given. In Wemos' experience, the success of such 'triple-win' arrangements depends very much on whom you ask.

The numbers of foreign-born, foreign-trained health workers in Dutch health care are low, both as percentages of the total workforce and compared to OECD averages. However, the numbers for BIG registered professions have increased from 511 in October 2020, to 773 in January 2023. More importantly, there are no reliable data for the health workers in 24-hour home care in the Netherlands, which could match, but will probably exceed, the number for BIG registered professionals.

Last but not least, it is important to acknowledge that if and when health and care workers are unemployed in their country of origin, the opportunity to come and work in the Netherlands offers many advantages to both parties, if only for the short-term. Also, while Western European countries are aging rapidly, the opposite is happening in Sub-Saharan Africa: more and more young people are entering the labour market, for whom there are too few jobs, resulting in high unemployment and feelings of hopelessness.[27] Opening the Dutch healthcare labour market to qualified, motivated young Africans can therefore help lower youth unemployment in the

[27] https://www.un.org/africarenewal/magazine/special-edition-youth-2017/africas-jobless-youth-cast-shadow-over-economic-growth

countries of origin and contribute to a more stable society. However, the fact that unemployment can co-exist with low health worker densities is totally ignored in all debates and should be explicitly addressed in any and all (bilateral) agreements the Dutch government is planning to develop.

Recommendations

Recent development in the Dutch health labour market give rise to a number of concerns. To guarantee that everyone, everywhere, has access to skilled and motivated health workers, Wemos recommends the following actions:

- Dutch government should remain extremely cautious about actively recruiting foreign-trained, foreign-born health workers, especially from countries with low health worker densities, irrespective of whether these countries are within or outside the European Economic Area.
- To understand the intricacies of global, regional and national health labour markets, Dutch government should make sure to consult with a broad array of stakeholders before embarking on formal arrangements for the international recruitment of health personnel, both in the Netherlands and in the country/ies of origin. These could include (inter alia): government officials, health labour market economists, trade unions, diaspora organisations, professionals associations and civil society organisations.
- In addition, Dutch government should ensure thorough knowledge of existing bilateral arrangements in other countries, including their strengths and weaknesses, and opportunities and threats. When embarking on bilateral arrangements, care should be taken to draw lessons from other countries by speaking to a similarly broad array of stakeholders as mentioned above.
- The Dutch government should invest in more and better data about foreign health workers in Dutch 24/7 home care: their numbers, provenance, original qualifications and working conditions.
- One of the ways to do this is to keep track of recruitment agencies that recruit and deploy these health workers and make reporting mandatory. Accreditation for these agencies should be considered.
- Labour and human rights of all migrant health workers active in Dutch health care should be respected and actively promoted. In the light of current anti-immigration sentiments, strict measures should be taken to protect migrant health workers from racism, bias and discrimination.
- Last but not least, the Dutch government should invest in health systems worldwide, in a coherent and consistent manner, including through the global health activities by the Ministry

for Foreign Trade and Development Cooperation and through the Pandemic Preparedness and Response ambitions of the Ministry of Health. In an increasingly globalised context, it is essential to recognise that national governments can only tackle the problems arising from the globalisation of the labour market through global, international cooperation. Unilateral solutions (such as trying to stop labour mobility altogether, or making as much use as possible of the possibilities of global mobility), and even bilateral solutions (through bilateral agreements) will not structurally solve the world's health labour market problems. Moreover, such solutions will only further increase the large global differences in access to good care and qualified care providers. This is undesirable, both from the point of view of international solidarity and from a well-understood self-interest: the Covid-19 pandemic has shown that 'no one is safe until everyone is safe'. It therefore pays to invest in good health systems all over the world, with sufficient, qualified and motivated healthcare providers.