Ad-Hoc Query on ethical recruitment of third country health workers

Requested by COM on 18th December 2013

Reply requested by 31st January 2014

Responses from Belgium, Bulgaria, Czech Republic, Estonia, Finland, France, Germany, Hungary, Italy, Latvia, Lithuania, Luxembourg, Netherlands, Poland, Portugal, Slovak Republic, Sweden, United Kingdom plus Norway (18 in Total)

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1. Background Information

The European Commission Action Plan for the EU health workforce sets out areas for European action to address health workforce shortages in many EU Member States[1].

The Action Plan aims to strengthen the EU's response to the ethical recruitment of healthcare professionals outside the EU within the context of the WHO Global Code of Practice on the International Recruitment of Health Personnel[1]. The WHO Global Code is a voluntary instrument that can help Member States in designing and implementing fair recruitment and effective utilization of foreign health workers policies.

[1] Commission Staff Working Document on an Action Plan for the EU health workforce, SWD (2012) 93 final of 18 April 2012

1 http://www.who.int/hrh/migration/code/WHO_global_code_of_practice_EN.pdf

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Importantly, the EU Blue Card Directive[2] allows Member States to reject applications in order to ensure ethical recruitment from countries suffering from a lack of qualified workers, for example in the health sector. The Directive refers to the European Programme for Action to tackle the critical shortage of health workers in developing countries and to the Council Conclusion on strengthening health systems in those countries[3]. Ethical recruitment policies and principles should be developed in the health sector.

Within this context, the European Commission requests the following information on ethical recruitment measures in your country for third country nationals working in the health sector.

Questions:

1) Has your country taken any steps, including legislative or any other action such as communication, procedures, stakeholders' involvement, etc. to implement ethical recruitment in the health sector for third country nationals? If yes, please provide some details and/or reference.

2) Does your country have bilateral or multilateral agreements on international recruitment of health personnel? If yes, please briefly describe scope (occupation concerning e.g. doctors, nurses; private or public health care institutions; private recruitment agency for active recruitment) and main provisions of the agreements related to health professionals.

3) Does your country have any guidelines, policy or other tools to facilitate, circular and temporary migration which would minimise negative and maximise positive impacts of highly skilled immigration on developing countries? This could include managed return migration, knowledge exchange from health professionals and/or education of health professions etc.

We would very much appreciate your responses by **31st January 2014**.

[2] Directive on the conditions of entry and residence of third-country nationals for the purposes of highly qualified employment (2009/50/EC)
[3] Council Conclusion on 14 May 2007 (7189/07)

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2. Responses

	Bulgaria	**Yes**	1) No. 2) No. 3) No.
	Belgium	**Yes**	1.Over all, international recruitment of healthcare professionals is relatively small-scale in Belgium, even though it has been on the increase in recent years[2]. Three possible solutions are generally suggested as a means of filling the gaps: (1) increasing the job appeal, (2) implementation of an active recruitment policy from the labour reservoir and (3) recruitment of personnel from abroad. Up to now, Belgian policy has mainly focused on the first two options. In Belgium, the recruitment of foreign personnel is certainly not a widespread strategy. It has only been recently that recruitment agencies have begun to develop activities in this sector. The key countries where medical personnel have been recruited are Poland and Romania in Europe, as well as the Philippines and Lebanon. In most cases, this amounts to only a few dozen nurses each year. Most foreign-born doctors and nurses working in Belgium have a Belgian qualification. The proportion of nurses or GP‘s (General Practitioners) active in Belgium with a degree obtained obroad remains below 3% of professional assets. If immigration of care personnel is rising, the flow from countries outside Europe remains relatively low[3]. This said: health personnel are recruited internationally using mechanisms that allow them to assess the benefits and risks associated with employment positions to make timely and informed decisions regarding them. Health personnel is hired, promoted and remunerated based on objective criteria such as levels of qualifications, years of experience and degrees of professional responsibility on the same basis as the domestically trained health workforce. Migrant health personnel enjoy the same opportunities as the domestically trained health workforce to strengthen their professional eduction, qualifications and career progression. Belgium has invested in the development of national capacity of life-long-training since 10 years, ensuring that migrant health workforce is as well trained as the domestically trained health workforce (for example our legislation on GP’s: a migrant doctor has the same opportunity to update his knowledge than a domestically trained doctor.

[2] King Baudouin Foundation: “The potential and difficulties of recruiting international healthcare personnel in Belgium (2011)” http://www.kbs-frb.be/publication.aspx?id=289098&langtype=2060&hq_e=el&hq_m=1590070&hq_l=10&hq_v=b028cff2ae

[3] King Baudouin Foundation: “The potential and difficulties of recruiting international healthcare personnel in Belgium (2011)” http://www.kbs-frb.be/publication.aspx?id=289098&langtype=2060&hq_e=el&hq_m=1590070&hq_l=10&hq_v=b028cff2ae

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			Whilst international recruitment is still in its infancy and some agencies are still in the pilot phase, several healthcare establishments (such as the Cliniques d'Europe in Brussels) have already had positive experiences. These agencies provide tailor-made services and undertake, to various degrees, to facilitate the worker's integration into Belgian society, notably via language courses and taking charge of administrative formalities. The Belgian State however cannot directly impose hospitals to hire international health health personnel or not, because Belgian hospitals are not Belgian State's institutions. The Belgian government is thus not involved in the recruitment for the health sector as this resorts under the private sector, causing some practical difficulties for the application of the Code. However, State's services can ensure the same rights to international health workforce and are more and more open to this issue. The European directive 2005/36 (modified by the directive 2013/55/EU) of the European parliament and the Council enables free movement of health professional, not only from one Member State to another but also from a third State to a Member State. International migrants can thus apply for being recognized as health practitioners in Belgium. Belgium is also undertaking extensive research in health personnel migration. During the Belgian Presidency of the Council of the European Union in 2010 health workforce issues were a priority: a ministerial conference was organized during our presidency on „Investing in Europe's health workforce of tomorrow: scope for innovation and collaboration". The conference led to council conclusions in which the WHO Code of practice was explicetly mentioned to be taken into account. At European level this resulted in a EU Action Plan for Health Workforce as wel as in a European Joint Action on health workforce planning and forecasting for which Belgium has taken the lead. Belgium also invested in targeting the "Southern" elements of the CoP. The Belgian Medical NGOs prepared a document at the beginning of 2005 aiming to set up a dialogue with the Belgian Development Cooperation to take up the question of "rethinking the human capital" and pleading for the Belgian Development Cooperation to have a free and open dialogue on this question, not excluding the possibility of co-funding salaries and/or performance fees for local health workers. Considering the previous, and inspiring from the Charter on drug quality developed in 2008 by Be-cause Health, its Working group on Human Resources took the initiative to develop a Charter aimed at better harmonizing and increasing the equity and effectiveness of Belgian Cooperation Stakeholders' practices in the field of recruitment and support to health workers coming from partner countries. This is considered as an essential aspect in the efforts towards universal health coverage. As the Charter aims to encourage the implementation of the WHO CoP (Code of Practice) in Belgium, it translates several of its orientations into concrete commitments and to the reality of our international cooperation. It is voluntary and it encourages respecting a number of principles with regards to partnerships and harmonization, HRH policies and development plans, training, recruitment, as well as in our environment in Belgium. The signatories are member organization from Be-cause Health that adhere to the principles and have the ability to sign it. Even if they could not sign the Charter, the Belgian federal ministries of Cooperation and Health supported the process. By signing the Charter, the organization commits to respecting a number of principles that aim, on the one hand, to actively support capacity building of health workers and reinforce sustainable systems; and on the other hand, to limit the negative consequences that international recruitment of health worker from partner countries may have on local capacities.

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			2.Bilateral: No For the multilateral agreements, we must refer to GATTS 1994 with its wide application range, in particular its mode 4: "movement of natural persons". It covers natural persons who are either service suppliers (such as independent professionals) or who work for a service supplier and who are present in another WTO member to supply a service. This mode however is not subject to any commitment of Belgium when it comes to the health sector. Moreover, in the commercial bilateral agreements, we ensured that no supplementary commitment was taken in this area. 3.The Federal Public Service for Health in Belgium (department DGGS) facilitates the granting of authorisation to exercise a profession so that the specialization internships of foreign doctors in Belgium are not limited to observation internships (ART 49ter – AR n°78). In fact, within the context of the medical and scientific cooperation with countries that are not Member states of the EU, a special dispensation can be granted to individuals (even non-graduated/qualified), based on the advice of the Royal Academy of Medicine in Belgium, for the exercise of certain acts in order to acquire further clinical training. The criteria to obtain this dispensation are included in the article 49ter (Arrêté royal n° 78 relatif à l'exercice des professions des soins de santé)
	Czech Republic	**Yes**	1. The Czech Republic is now in the process of preparing new legislation acts embracing the recognition of qualification of healthcare workers from third countries and recruitment of third country nationals. 2. No, the Czech Republic still does not have any bilateral or multilateral agreements on international recruitment of health personnel. 3. In year 2014 The Czech Republic is preparing information multi-language guidelines or booklet including recruitment health workers from third countries. The booklet will be available from website of the Ministry of health of the Czech Republic. Information about the recognition of qualification of health workers from third countries and recruitment in health sector for third country nationals has been continuously discussed on the meetings of the health management experts.
	Estonia	**Yes**	1. In Estonia the regulation of persons who´s qualification in health sector is acquired abroad is regulated by Health Services Organisation Act § 30. Fulfilling the regulation is a precondition in obtaining the right to work in Estonia. 2. Estonia has implemented the directive 2005/36/EU on recognition of professional qualifications, into national law, which simplifies the free movement of EU citizens, but we don´t have any specific bilateral agreements with third countries.

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			3. No. In Estonia we don´t have any migration policy on ethical recruitment measures to third country nationals who´s planning to come to Estonia for living/working or study purposes.
	Finland	**Yes**	1. The new Future of Migration Strategy 2020 states that in the social and health care sector international recruitment and the cooperation for this must be developed and modelled. Future of Migration 2020 strategy is now to be implemented in action; there are yet no new procedures to report. Ministry of Employment and the Economy has implemented since 2009 a strategic program, HYVÄ, which aims to develop labor and industrial policies in social and health care services. The programme's objectives are to enhance the requirements of social and health care service provision, and to develop the sector into an internationalizing growth industry. According to the demands of skilled labor, the HYVÄ programme has so far (1) examined the social and health care service industry's demand and supply of labor force up to 2025and created a model for predicting changes in labor demand and supply, which can also be applied to other industries, (2) instituted, in cooperation with the Ministry of Social Affairs and Health, an education aiming for assisting duties in the industry, which is based on certain modules for the practical nurse diploma and (3) launched an extensive collaborative mapping of development needs in practices of international recruitment of nurses and for creating an ethically sustainable business model for recruitment. During year 2014 The Ministry of Employment and the Economy, the Ministry of Social Affairs and Health and the Ministry of Education and Culture are preparing jointly drafted proposals for short-term and long-term measures, which aim at ensuring the availability of competent labor force for the social and health care services. These measures will also include proposals for improving integration, language learning and skill development of social and health care service personnel recruited the EU/EEA area and beyond. 2. No. Only private recruiting companies have conducted pilot projects regarding recruitment of health personnel. For example private recruiting chain Opteam has established partnership in the Philippines. Opteam and The Hospital District of Helsinki and Uusimaa completed in cooperation with Laurea University of Applied Sciences a recruiting project in 2013. In the abovementioned project The Hospital District of Helsinki and Uusimaa recruited 20 nurses from Philippines. The recruited were given extensive Finnish language teaching, and had to pass an entrance exam for Laurea University of Applied Sciences. 3. Finland does not have guidelines or policy concerning circular and temporary migration.
	France	**Yes**	1. There is no specific provision depending on the nationality of the applicant regarding ethical recruitment in the health sector for third country nationals. However, these occupations are regulated. The diploma and the State which delivered it are taken into account.

			2. France signed in 2008 an agreement with Quebec within the framework of a mutual recognition agreement of professional qualifications. This agreement aims to accelerate and simplify the process of mutual recognition of qualifications in order to be able to practice regulated occupations. It states the conditions to be able to practice and the compensatory measures (internship, aptitude test, extra training) that can be required. This agreement came into effect in 2010 and 2011 for health professionals (nurse, midwife, doctor, and pharmacist). Generally these professionals have to do an internship after which their diploma is recognized and they can start practicing. France signed also with Senegal a concerted management agreement for migration flows. In the article 61 on "Cooperation in the health sector", France undertakes to establish partnerships between French and Senegalese university hospital centers, which might theoretically facilitate recruitment of Senegalese health students. In addition, France signed many recognition agreements of diploma with third countries but not particularly on health diplomas. 3. France proposes several possibilities of training (education programm) for foreign students or professionals in the health sector. -The third country postgraduate students studying medecine or odontology can do 3-month internships (renewable once) related to their studies, in particular through university parternships. -The measure of "diploma of specialised medical training and diploma of specialised medical in-depth training" allow third country doctors and pharmacists to access theoritical classes and practical training internships in order to specialize partly or totally in France. This measure applies only to doctors and pharmacists holding a diploma allowing them to practice in their origin country or in the country where they got their diploma. -Third-country doctors and pharmacists can do a practical internship in a public health care facility in order to develop new skills or to improve their practice. This training is possible within the framework of an international cooperation led by a French public health care facility with a public or private law person who hires this foreign doctor in its origin or residence country. This measure concerns doctors and pharmacists holding a diploma allowing them to practice in their origin country and in the country where they got their diploma, and was extented to nurses as well. In addition, cooperation agreements with Saudi Arabia, the United Arab Emirates, Bahrain, the Sultanate of Oman, Kuwait and Qatar allow their national doctors, specializing or already specialized in their countries, to register to a specialised studies diploma in the field of their choice in France and to be affected in a public health care facily to follow a practical training. The Saudi, Emirati and Kuwaiti doctors can also be hired as an attached practioner during their last year of traning and after getting an ministerial authorisation.
	Germany	**Yes**	1. Yes, the German Employment Regulation was amended as of 31 October.2013. For 57 countries which are themselves in need of health workers, a ban on the recruitment of nurses and caregivers by private recruitment companies and agencies was introduced. With this, the Federal Employment Agency has an exclusive right of recruitment which, however, it does not actively make use of, taking account of the

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			World Health Organisation's Code of Conduct. Individually motivated immigration efforts of persons from these countries remain unaffected. For these cases, immigration is regulated by means of the positive list. 2. In EU Member States, the Federal Employment Agency is advertising for specialists from the health and caretaking sector especially by using the EURES (European Employment Services) network. In consultation and cooperation with the EURES partners in the respective state, the Federal Employment Agency organises information events like European Job Days and Job Fairs abroad, concentrating its efforts on Member States with a relevant number of job seekers due to the situation on the local labour market. Considering various factors like the unemployment rate and so-called brain-drain effects, four main target countries were identified. Therefore, activities for the procurement of specialised staff for the health and caretaking sector are focused on Greece, Italy, Portugal and Spain. For example, there are seven more events in the health care sector in Spain on schedule in 2013. Since the beginning of 2013, the Federal Employment Agency has made agreements with the public employment services of Serbia, Bosnia-Herzegovina, the Philippines and Tunisia on the procurement of caretaking specialists. The process of placement and integration is supported by the German Society for International Cooperation (GIZ) within the framework of a cooperation agreement with the Federal Employment Agency (Triple Win Project). Furthermore, the Federal Employment Agency has entered a project-related agreement with the Chinese Employment Service regarding the procurement of 150 Chinese nursing specialists for the elderly care sector. The project is conducted by the Care Sector Employers' Association (*Arbeitgeberverband Pflege – AGVP*) and the Confederation of German Employers' Associations (*BDA*).
	**Hungary**	**Yes**	1, Outflow migration is more typical for Hungary, while the immigration of health professionals is insignificant (2009-2013: 52 persons). Therefore, there are no significant joint governmental measures taken in order to implement provisions on ethical recruitment. The primary objective of Hungarian health policy is to manage the existing human resources crisis, to reduce outflow migration and to improve the ability to retain professionals in Hungary. 2, In line with the answer given to the first question, it does not seem necessary to sign any bilateral or multilateral agreements on (ethical) recruitment with regard to third countries. Nevertheless, there are examples of inter-institutional cooperation; however, they are typically in the EU context. For example, there is a bilateral agreement on the exchange of pathologists between Semmelweis University and the Swedish Karolinska Institut, in the framework of which Hungarian professionals may gain professional experience abroad, and after their return to the Hungarian system they can benefit from their professional experience, while in return, the shortage of pathologists in Sweden may be temporarily alleviated by this agreement. 3, Hungary does not take measures aimed at supporting the return of migrants arriving from third countries, due to the migratory situation presented above. However, Hungary does employ multiple tools in order to reduce outflow migration as well as to promote the return of

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			emigrated Hungarian professionals. For example, professional experience earned abroad is calculated as part of further training points. However, these measures are intended to help the return and reintegration of emigrated migrants. We should also mention among other tools the SIMIGRA Project, which mainly supports the integration of foreign professionals in line with the related provisions of the WHO Global Code of Practice on the International Recruitment of Health Personnel on the appropriate inclusion and integration of migrants.
	Italy	**Yes**	1. Legislative decree n. 108 of the 28th of June 2012, which entered into force on the 8th of August 2012, implemented the Directive 2009/50/EC on the "entry and stay conditions of third-country nationals wishing to carry out highly qualified activities". This decree establishes that highly qualified workers can now enter Italy regardless of the yearly established entry quotas. In order to be considered "highly qualified", a foreign worker must have completed at least 3 years of high school in his/her country of origin, and must have obtained a professional qualification which is recognized in Italy and which falls within the levels 1, 2 and 3 of the Istat classification of Occupations CP 20113. Health sector personnel can be recruited under this new regime as doctors and nurses meet the criteria of highly qualified workers under levels two and three, respectively. In Italy, the significant labour shortage in the health sector has been ongoing for the past several years. This is evident if we consider that about 10% of the nurses already employed in Italy is of foreign origin and that the unsatisfied demand for nurses amounts to several thousand every year. Before adopting Directive 2009/50/EC, Italy had previously attempted to solve this problem with immigration laws (art. 27 of the T.U.I., as amended by Law no. 189/2002) which already allowed the recruitment of third-country national nurses directly from their countries of origin and out of the entry quotas. On the other hand, a concrete obstacle for the recruitment of third-country nationals in the Italian health sector is the fact that most of the available posts are public. However, the requisite of citizenship for full recruitment in the public sector as foreign physicians and nurses has been placed under discussion by several court ruling in the past years. For example, based on Legislative Decree 286/98, which sanctions full, absolute equality between Italian, EC and non-EC citizens, the Court of Pistoia upheld the appeal of a non-EU physician on May 7, 2005, granting him the right to participate in a public competition for the Director of Cardiology, and, in March 2006, the Court of Appeals in Florence, confirmed the first-degree sentence of the Court of Pistoia, defining the exclusion of foreign physicians from a public competition for healthcare directors as illegitimate. 2. At the National level, a bilateral agreement was signed in 2009 between the Ministry of Labour and Social Policy and the homologous Ministry in Tunisia. This agreement has promoted the recruitment, training and placement of tunisian nurses in the Italian health sector. Moreover, at the local level, the Region of Veneto has signed an agreement with specialized training institutes for nurses in Romania, concretely in Bucarest and Pitesti, and the Province of Parma has signed an agreement with the Province of Cluj-Napoca, also in Romania. 3. The Italian ngo "African Medical and Research Foundation" has adhered to the project "Health Workers for All, All for Health

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			Wokers", a European civil society initiative funded by the European Commission whose objective is the implementation of the World Health Organization (WHO) Global Code of Practice on the International Recruitment of Health Personnel which aims to achieve a sustainable health workforce world-wide. Under this agenda, it was launched a campaign called "Health Personnel for All!" ("Personale Sanitario per Tutti!") and a manifesto for the reinforcement of job placement in the health sector in Italy (www.manifestopersonalesanitario.it) which has been signed by over one-hundred organizations active in the fields of international health cooperation, the Public Health Service and international migrations. Moreover, under the framework of the "European Programme for Action to tackle the critical shortage of health workers in developing countries (2007–2013)", Italian International Cooperation has been intervening in developing countries (although indirectly) by promoting an approach to health in developing countries which is based on the protection of the population's health and the improvement of public health systems.
	Latvia	**Yes**	1. As Latvia does not carry out any recruitment in the health sector, no legislative or any other actions have been implemented. 2. Latvia does not have any agreements regarding recruitment. 3. Legislative acts of Latvia do not stipulate the minimum term a foreigner should reside in the country and it could facilitate circular migration. It means that a foreigner can obtain a temporary residence permit and the return to his/her country of origin will not leave an impact on the residence permit, issued in Latvia. Of course, all procedures, related to the employment, should be carried out (employer should agree that an employee is leaving the employment temporarily and these changes should be reported to the Migration Service).
	Lithuania	**Yes**	Lithuania has no experience in this field.
	Luxembourg	**Yes**	1.No. 2.No. 3.No.
	Netherlands	**Yes**	1. The Netherlands is a signatory to the Recruitment code ;WHO Global Code of Practice on the International Recruitment of Health Personnel of May 2010. A translated version was dessiminated to the relevant actors in the field. Dutch Unions and Employer organisations in the health care sector (the Unions Abvakabo FNV, CNV Publieke Zaak and NU'91 and the employer organisation NVZ) support the EPSU-HOSPEEM code of the European Federation of labour unions in the public sector and

European employers in hospitals from April 2008. The EPSU-HOSPEEM code is in line with the WHO-code but does not cover recruitment in developping countries.

2.No but in the currrent economic situation there are no substantial substantial shortages that require recruimtent from third countries.

3.MOU d.d. 13-12-2011 between The Kingdom of Netherlands and the Republic of Suriname signed on 2 January 2012 by the government of Suranme on claused registration of physicians in the Dutch Register for professional health care professionals. It allows Surinam physician to practice in the Netherlands but only for the relevant time of training in a medical specialism and ends once the study is completed.

The Netherlands participate in the follwing projects:

Action to support Technology Development and Transfer	**Description**	**Sector**	**Financial contribution**
You care, you share, a project by Stichting Marokkofonds Duration: 1 December 2012 – 30 November 2015	The project aims to strengthen the health care sector in Morocco, more specifically in the Rif area, through temporary assignments for 40 Moroccan migrants living in The Netherlands.	Health care	EUR 565,904.00
Maximizing the value of the Kenyan diaspora, a project by Voluntary Services Overseas (VSO) Duration: 1 February 2014 – 31 January 2016	Main objective is the sharing of expertise of 15 members of the Kenyan diaspora with host organisations in Kenya, mainly small and medium-sized businesses. The project will contribute to closer relations between Dutch and Kenyan businesses, socioeconomic development in Kenya and	Not one specific sector.	Eur 264.687

				capacity building of implementing organisations themselves.			
			Temporary Return of Qualified Nationals III, an IOM project Duration: 1 December 2012 – 30 November 2015	The project's objective is to make a contribution to the national development policies and strategies of a number of selected countries by engaging their overseas migrant communities in improving the capacity of governmental and non governmental institutions. The selected countries are Afghanistan, Armenia, Cape Verde, Georgia, Ghana, Iraq, Morocco, Somalia and South Sudan. The project's duration will be three years. IOM will facilitate 405 skills transfer assignments. The programme builds on the lessons learned and achievements of two previous TRQN projects. TRQN II facilitated over 370 temporary return assignments.	Not one specific sector. All is tailored to the needs of the target countries. Selection of participants is ongoing. In TRQN II, some of the sectors involved were: education, health, infrastructure, water management, agricultural development, food security, rural development, private sector development.	EUR 4,877,481.80	
	Poland	**Yes**	1. The Ministry of Health has informed its partners about the WHO Global Code of Practice on the International Recruitment of Health Personnel. 2. No. 3. The principal tool influencing migration of health care professionals from third countries is the directive on the recognition of				

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			professional qualifications. Its strict provisions on recognition of qualifications practically prevent employment of foreign staff (for example because of differences in training programs for nurses).
	Portugal	**Yes**	1. Portugal has been developing a set of programs aimed to reduce immigrant over-qualification, in particular in the health sector. These programs were fostered by civil society organizations with subsequent support of public administration. The Program Professional Integration of Immigrant Doctors, promoted with the purpose of supporting the integration of 150 third-country nationals legally residing in national territory, who have graduated in medicine (ISCED level 5) in non-EU countries and with which Portugal does not have an agreement for automatic recognition of qualifications, and who are engaged in professional activities that are different from those in the area of their medical training (Ordinance 925/2008, of August 18). This program was developed in partnership with civil society (Calouste Gulbenkian Foundation and Jesuit Refugee Service) and governmental bodies (Central Administration of the National Health System, and support of the Ministries of Foreign Affairs and Internal Affairs, as well as the Portuguese Faculties of Medicine); it was also included in the Program for Immigrants Integration 2007-2009 (Resolution of the Council of Ministers number 63-A/2007, of May 3) on measure 27 (Program for professional integration of immigrants with medical qualifications). The Program (Professional Integration of Immigrant Doctors) provided the granting of a set of financial support [bursary for a maximum of 12 months, by an amount equivalent to two times the minimum wage; reimbursement of expenses incurred with translations of documents relating to the application to the program up to a maximum of €800; reimbursement of expenses relating to registration fees in Faculties of Medicine, issuance of certificates of equivalence and registration on the Portuguese Medical Association (Ordem dos Médicos)], training support (training actions for improvement of skills in Portuguese language, providing literature for preparation to the exam demanded by Medicine Faculties), logistics support (providing support on authentication of the necessary documents for participation in the program; executing the application for equivalence of qualifications) and social support (assisting on search for accommodation, employment for spouses and search for nursery/kindergarten for dependent children). 2.On the other hand, with the purpose of fulfilling the need of doctors in the National Health Service, several bilateral and multilateral agreements were concluded, thus ensuring a limit to the number of professionals to be recruited and complying with the guiding principles of the World Health Organization provided in the Global Code of Practice on the International Recruitment of Health Personnel, more specifically transparency, fairness and promotion of sustainability of health systems in the countries of origin. 3.The policy of attraction/contract of highly skilled immigration for the health system is developed accordingly point 2, the guidelines tools to facilitate, circular and temporary migration are defined in the bilateral and multilateral agreements.
	Slovak Republic	**Yes**	1. No. The Slovak Republic did not take or is currently not taking any steps in developing any legislative or political measures,

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			communication strategies or procedures aimed at the ethical recruitment in the health sector for third country nationals. 2. No. The Slovak Republic does not have any such agreements. However it should be noted that the Slovak diplomatic missions have in last period recorded individual interest of Ukrainian doctors and medical personnel who respond to vacancies in health facilities in Eastern Slovakia. The most wanted specialisations are dentists and technicians. The Falck rescue service, for instance, acquired medical personnel from Ukraine through recruitments. This is however dealt by on an individual basis between the institution publishing the vacancy and the candidate. 3. No. The Slovak Republic does not have any polices or measures facilitating or promoting circular or temporary migration. The issue of circular migration is mentioned in the Migration Policy of the Slovak Republic with the Perspective until 2020, however no concrete steps have been taken so far.
	Sweden	**Yes**	1.The Swedish system for labour immigration from outside the EU/EES – in place since 2008 – differs from the approach taken by other EU Member States, both with regards to highly qualified, skilled experts, as well as less qualified, unskilled workers. The Swedish system does not foresee any quantitative or qualitative limits to the immigration of workers. The general approach is that labour immigration should be driven by the recruitment needs of employers – irrespective of qualification level or sector. In short, a third country national with a job offer from an employer with a vacancy in Sweden will be granted a temporary work/residence permit (after the position has been posted on the EURES network for a minimum of 10 days) as long as the terms of employment, i.e. salary, working conditions, insurance coverage etc., are on par with the relevant Swedish collective agreement for that specific sector and position. 2. No. 3. In order to improve possibilities of circular migration to Sweden, the Swedish government appointed in July 2009 an independent Parliamentary Committee to examine the link between circular migration and development. The point of departure being the government's belief that spontaneous movement allows migrants to be active in the development in their countries of origin and that spontaneous movement can take place when there is an enabling legislative framework that facilitates mobility. The Committee's task was to map out circular migration and identify factors that influence migrants' opportunities to circulate, i.e. to move from Sweden to their countries of origin and back to Sweden again. The final report was presented in 2011. The report contains proposals both for legislative changes and other recommendations aimed at facilitating increased back-and-forth mobility between Sweden and migrants' countries of origin, in order to promote its positive development effects. It also contains proposals regarding the Diasporas' role as agents of development. The recommendations and proposals of the Committee have been reviewed and analysed within the Government Offices and a large part of the proposals are being launched during this spring 2014. Separated from the initiatives deriving from the Parliamentary Committee (above), the Swedish International Development Cooperation

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			Agency _ Sida, launched in September 2013 a joint project with IOM and UNDP to support experts of the Somali diaspora to return temporarily to contribute to development in Somalia. The project encompasses three sectors, in addition to the health sector also financial governance and the judiciary. The expert contracts are for one year and the aim is to enrol twenty experts per year for expert positions at Somali state agencies.
	**United Kingdom**	**Yes**	1) • The UK remains committed to ensuring ethical recruitment practices operate within the NHS and adheres to the World Health Organisation (WHO) Code of Practice. The WHO Code reflects the principles and benchmarks already embedded in the UK *Code of Practice for NHS organisations involved in the International Recruitment of Healthcare Professionals* which was first published in 2001. It is worth noting that the UK was the first developed country to implement and review systematic policies that explicitly prevent the targeting of developing countries in the area of international recruitment. • The Department of Health has worked together with the Department for International Development to produce a definitive list of developing countries, which should not be targeted for recruitment of healthcare professionals. The list is based on the economic status of the countries and how many healthcare professionals are available. **2)** • Changes in the immigration rules and the move towards self-sufficiency has reduced the need of the NHS to recruit to job and training opportunities over recent years. Therefore, the focus on recent Memorandums of Understandings (MoUs) have turned away from the recruitment of healthcare professionals and more towards trade and growth. • However, the UK continues to support the collaboration with other countries on health issues. Recent MoUs have focussed on development of healthcare systems, primary care, education and training, non-communicable diseases, maternity and child health, etc. **3)** • The UK is committed to the goal of supporting global health development through delivery of the Millennium Development Goals, overseas volunteering by UK health professionals, and through the Medical Training Initiative (a two-year training scheme delivered through Tier 5 of the Points-Based System) and the Department for International Development-led Health Partnership Scheme. The UK continues to support the goal of increasing overseas volunteering by UK health professionals to contribute effectively to global health development and to bolster the skills of the UK health workforce once the volunteer returns
	**Norway**	**Yes**	Norway is not bound by directive 2009/50 and we do not have any similar agreements about ethical recruiting.

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			1.Though we were not able to unearth any programs that ensure ethical recruitment of health personnel in Norway in this brief survey, we can highlight a number of laws, rules and regulations that monitor this kind of issue in general. We have also provided some relevant links to reports in English. Norwegian authorities have consistently worked to provide safe and fair places of work for everyone through health, occupational environment and security measures (HMS). A law (The Working Environment Act) which stipulated these kinds of protection measures was first put into effect in 1956 and revised in 1977, in 2006 and amended as recently as Dec. 2012. http://www.arbeidstilsynet.no/binfil/download2.php?tid=92156 There are provisions in place in Norway that protect against exploitation once employed, but which do not stipulate recruitment practices. However, the Norwegian government has been working against discrimination in the workplace and unfair recruiting practices for at least 20 years. These efforts have been addressed to all areas of employment, not only the health care sector. Many of the measures taken have been addressed in such a manner as to protect all possible applicants. In the official government *State Employee Manual/Civil Service Staff Handbook* there are extensive guidelines in how to openly and fairly recruit employees to any position. These guidelines include how to fairly represent the position, the demands, the requirements of the job etc. not least of all in order to protect those who do not have Norwegian as a mother tongue, or for those who possibly have some kind of disability that could be perceived as reason for exclusion. These guidelines are meant to protect everyone actually. However, private industry does not have to live by the good example that government agencies exhibit, though generally, there are not many reported cases of exploitation among employees in the private sector. This is a link to publications in English issued by the Norwegian Directorate of Health. See manuals published by The Ministry of Local Government and Modernisation http://www.sph.dep.no/Statens-Personalhandbok/2Tilsetting-og-opphor-av-tjeneste/23Kunngjoring/232Hva-skal-sta-i-kunngjoringen/#SPH-2.3.2.3 and http://www.sph.dep.no/Personalmeldinger/2010-PMer/PM-2010-08-Inkluderende-arbeidsliv-HMS-arbeid-og-mangfold-i-staten/ as well as this report from the Directorate of Health http://helsedirektoratet.no/english/publications/norway-and-health--an-introduction/Publikasjoner/norway-and-health-an-introduction.pdf The Health Care Personnel Act sets out regulations with regard to the authorization and licensing of health personnel. The Norwegian Registration Authority for Health Personnel (SAK) is responsible for granting professional authorization. Authorization represents permanent approval of qualifications, while a license has certain limitations. The National Council for Physicians Distribution and Specialist Structure (http://www.shdir.no/ **nasjonalt** rad/utredninger/**spesialist** og etterutdanning **for** leger 53926) advises the Ministry of Health and Care Services. The Norwegian Board of Health (Helsetilsynet) is responsible for monitoring health services in Norway. www.helsetilsynet.no In Norway, immigration law does not have any resolutions which allow for denying a work/residence permit in order to ensure ethical

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			recruitment of foreign personnel: in other words, there is no parallel to the options provided in the Blue Card Directive. This is also true regarding the rules and regulations related to verification of credentials: there are no resolutions which allow for denying verification in order to ensure ethical recruitment/ prevent exploitation of foreign personnel. There are no parallel options as those provided by the blue card directive which would open up for simplified procedures for labour immigration from non-EU countries and probably lead to brain drain. Norwegian rules and regulations and authorized work permits ensure that not only professionals from the health sector, but in fact, all foreign employees, are protected from exploitation by their employer in Norway. Norwegian immigration law and regulations require a concrete offer of full-time employment with salary and working conditions that adhere to Norwegian wage agreements (tariff). A work permit cannot be issued prior to approving such offers of employment, salary, and working conditions which cannot be worse than what would be offered to a resident of Norway in accordance with the law. An employer that does not uphold these responsibilities can be denied the opportunity of employing foreign labour (through administrative measures) and in some cases, they can be prosecuted for a criminal offence. 2.The Norwegian Registration Authority for Health Personnel (SAK) and the Norwegian Directorate of Health have agreements with Russia as well as The Philippines. SAK is responsible for authorization of foreign health personnel. The Norwegian Labour and Welfare Service administration (NAV) has initiated a research and development project for the recruitment of immigrant labour which was scheduled to start in 2013. In the Proposition for the Parliament (Stortinget) for the budget year 2014, the pilot project will start in the Norwegian embassies in New Dehli, India, and Murmansk, Russia, and will provide an internet program that guides potential labour immigrants through the process of obtaining job offers and work permits. The Norwegian Directorate of Immigration is a partner in cooperation with NAV on this project. 3.Norway does not have any agreements on circular migration for this target group as far as we could ascertain in this quick survey. We include link to a relevant article from The Norwegian Agency for Development Cooperation. http://www.norad.no/en/thematic-areas/global-health/news/the-norwegian-response-to-the-global-health-workforce-crisis We also include a link to another report related to this issue, published by the Norwegian Ministry of Foreign Affairs. http://www.aspeninstitute.org/sites/default/files/content/images/Proposal%20for%20Norway.pdf

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