PERSPECTIVE

LABOUR AND SOCIAL JUSTICE

GLOBAL SKILLS PARTNERSHIPS ON MIGRATION

Challenges and Risks for the Health Sector

Remco van de Pas, Corinne Hinlopen
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Global skills partnerships (GSPs) can contribute to global health workforce development, if they balance the interests of source countries, destination countries and migrant health workers.

Most GSPs are concerned with short-term return on investment in the destination country and ignore (inclusive) development objectives in the country of origin.

Many GSPs are constructed as public-private partnerships, with public finances subsidising commercial interests, rather than the other way around. GSPs should be based on existing normative and ethical policy frameworks that guide health labour development and mobility.

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Content

1. INTRODUCTION

World demand for health care services is growing, with global health care expenditure projected to increase from $7,724 trillion in 2017 to $10,059 trillion in 2020 (Kirton and Kickbusch, 2019). The expected creation of forty million jobs in the health care sector worldwide generates pull factors encouraging health workers to migrate from low- and middle-income settings to high-income countries. At the same time there is a global shortage of eighteen million health workers, largely in low- and middle-income countries (WHO, 2016). The Covid-19 pandemic has underlined how essential health care workers are to societies and economies in times of crisis (Mogo and Oni, 2020).

Global Skills Partnerships (GSPs) among countries, as defined in the UN Global Compact for Safe, Orderly and Regular Migration (GCM), »strengthen training capacities of national authorities and relevant stakeholders, including the private sector and trade unions, and foster skills development of workers in countries of origin and migrants in countries of destination with a view to preparing trainees for employability in the labour markets of all participating countries« (United Nations, 2018). GSPs are also proposed by some actors as a potential mechanism to address the skill shortages in high-income countries by investing in training in low- and middle-income countries (LMIC) and sourcing skilled labour from them. They are regarded as a cost-effective short-term solution with potential developments benefits for source countries (Dempster and Smith, 2020; Azahaf, 2020).

There are, however, also risks associated with GSPs. How are benefits and negative side-effects distributed and governed in these new forms of skills mobility partnership? Development of any type of GSP needs to ensure decent work, labour rights and inclusive participation of trade unions and civil society. Sustainable development, human rights and equity must be fully integrated in these discussions, particularly where critical skills such as health care and education are concerned. International norms, such as the UN and International Labour Organisation (ILO) conventions on migrant workers and the WHO Global Code of Practice on the International Recruitment of Health Personnel (WHO Code), represent important starting points. This publication provides recommendations concerning the future development and implementation of GSPs in the health care sector.

2. WHAT ARE GLOBAL SKILLS PARTNERSHIPS?

The idea of international and global dimensions in skills partnerships in the health care sector is not new. There are very many examples of training partnerships between countries and institutions aiming to build capacity and train health care workers. These are often rooted in development cooperation or bilateral exchange programmes, and funded through government-to-government schemes. States like Cuba and organisations such as the Tropical Health and Education Trust (THET) have decades of experience training health care workers in the context of international cooperation (Feinsilver, 2010; THET, 2019).

There is, however, a subtle difference between more traditional, often publicly funded, training partnerships and the GSPs foreseen in the GCM. The Center for Global Development (CGD) has been of the main promotors of GSPs as a policy option and advocated for GSPs to be included in the GCM (Clemens, 2017). In the CGD's vision, GSPs are a partnership that includes private actors and functions as a vehicle for investment in human capital – which is expected to generate solid returns. Education and training are outsourced to a third country, with the expectation of benefits in the destination country for the government (staffing of its health services), for employers (supply of well educated but relatively cheap health workers), and for labour migrants (decent jobs and income security). The source country gains income derived from tuition fees and other education revenues, as well as skills enhancement in its domestic labour market. One central question is whether these revenues will be reinvested in decent employment, sustainable education and health system development in the country of origin. Another concern is whether the labour rights of the migrant workers are respected by employers and recruitment agencies.

Several variations have been modelled to distribute the benefits of skills partnerships between origin and destination countries as well as the migrant workers themselves. These variations depend on the needs of which actors are targeted, who pays for the skills training, and where the skills training takes place. The OECD suggests a typology as shown in Figure 1.

The primary sector identified for implementing GSPs is the health sector, with a particular focus on nursing. Population ageing and the increasing prevalence of chronic diseases creates a growing need for long-term nursing in European countries (Clemens, 2017). Many countries face labour shortages and have difficulties retaining workers in the care sector. The CGD proposes a two-track technical school for nurses (Clemens, 2017). Such a technical training institute would be located in an LMIC; on admission every student would choose one of two tracks. An »away« track would train students to work abroad, in an HIC – permanently or temporarily. The »home« track would train students for work within the country of training. Training for »away« students could be financed either by destination-country employers or governments, or from future earnings (migration-contingent loan). This mode of financing would include a subsidy to the training of »home« track students in the form of a social training credit. This would foster and finance a domestic supply of health employment in response to nurse mobility. Whether such a GSP is sustainable and generates equitable and decent employment in the long term remains a major question. There are also issues over the design, role and responsibilities of the actors involved, including the private sector and trade unions.

Figure 1:
A typology and selected examples of Skills Mobility Partnerships.

		Training is taking place mainly in the country of ...			
		origin		destination	
	Objective – Addressing skills needs mostly at …	origin	destination	origin	destination
Training mainly paid by …	Migrant	(not applicable)	Privately funded education for migration	Self-financing international students	
	Employer in destination country	(not applicable)	Multinational firm global trainee schemes		
	Destination country	Australian Pacific Technical College prog. (AUS) Blue Bird Pilot Scheme (NLD)			
	Migrant – Employer in destination country		Seafarers Nurses (e.g. FIN, ITA, DEU)		Seasonal agricultural worker scheme with a training component
	Migrant – Destination country		Low-skilled workers with pre-departure training (e.g. KOR)	Scholarships and youth exchange programmes	
	Destination country – Employer in destination country	GIZ »triple win project« (with PHL, GEO, VNM, TUN) ITA (notably in the tourism sector)			Nurses (e.g. JPN) Trades (DEU, KOR) Traineeship prog. (e.g. CHE, JPN)
	Conditions for the programme to be beneficial to the origin country (beyond remittances)	1. Training for origin and destination needs according to common standards → perfect transferability of skills 2. Training enhances employability at origin 3. Some trainees either return or never migrate – and selection is random or protects against ›skimming‹		1. Return migration 2. Recognition of skills acquired abroad upon return 3. Demand for skills acquired abroad at origin 4. Indirect transfers (e.g. trade; technology)	

Reproduced from OECD. What would Make Global Skills Partnerships Work in Practice? 2018 https://www.oecd.org/els/mig/migration-policy-debate-15.pdf

3. WHY ARE GLOBAL SKILLS PARTNERSHIPS CURRENTLY RELEVANT?

GSPs are included in the GCM that was adopted by a majority of UN Member States at an intergovernmental conference in Marrakesh, Morocco, in December 2018 (UN, 2018). It is included in Objective 18 of the GCM: to *»invest in skills development and facilitate mutual recognition of skills, qualifications and competence«*. These partnerships cover skills development, recognition, mobility and circulation, and exchange programmes. This objective features also prominent in the WHO Code, where paragraph 5.2 encourages member states *»to engage in support for capacity building, in the development of appropriate regulatory frameworks, access to specialized training, technology and skills transfers«* in relation to labour migration in the health care sector (WHO, 2010).

The GSP approach is swiftly gaining interest among international institutions. The ILO, the International Organisation for Migration (IOM), the United Nations Educational, Scientific and Cultural Organisation (UNESCO), the International Employers Organization (IOE), and the International Trade Union Confederation (ITUC) are joining forces to forge GSPs. In a workshop in November 2019 they agreed that they were *»ready to play their role in fostering broader social dialogue on these issues. Skills partnerships should cover both national and international labour markets, and should be balanced and mutually beneficial for both origin and destination countries, and for the migrant workers themselves. Ensuring sustainability and equity in human resources for all countries, in all sectors involved, should be a priority for the Skills Partnership«* (ILO, 2020).

The OECD, the World Bank and development cooperation agencies like the British Department for International Development (DFID) and Germany's organisation for international cooperation GIZ are promoting GSPs as a response to the global skills shortage in health care (Clemens et al., 2019a; Anderson et al., 2019). And the European Commission appears very interested in the GSP approach to facilitate legal labour migration pathways between Africa and Europe (Clemens et al., 2019b).

The 2019/2020 review of the relevance and effectiveness of the WHO Code drew attention to new bilateral, multilateral and regional cooperative programmes for health worker mobility and exchange (WHO, 2019). For instance, in the context of trade liberalisation, Japan has signed economic partnership agreements allowing nurses and caregivers from South East Asian countries to practice in Japan temporarily (Buchan et al., 2019). Sudan has a bilateral agreement regulating the migration of physicians to Saudi Arabia (Gesmalla, 2018). Germany is involved in several partnership programmes. In the »Triple Win« project GIZ has facilitated the placements of nearly three thousand nurses from Serbia, Bosnia-Herzegovina, the Philippines and Tunisia. Germany also tested a destination-country training programme where Vietnamese care trainees received substantial vocational training upon arrival. GIZ has not to date

implemented any country-of-origin training programmes in the health care sector.

In 2013, Berlin and Manila signed a Bilateral Labour Migration Agreement (BLMA) to formalise the migration of nurses from the Philippines to Germany. A report by the CGD on GSPs (financially supported by the German Federal Ministry for Economic Cooperation and Development) presents a number of GIZ projects including this programme. Notably, the CGD frames German skills partnerships as a success story »maximizing shared benefits«, yet both CGD and GIZ acknowledge that the development benefits in the country of origin remain »unclear« even after five years (Clemens et al., 2019a).

All the mobility partnerships mentioned above lack a skills training and development component in the country of origin (although there have been a few pilots). The mobility partnership approaches adopted so far are bilateral labour migration agreements or other forms of country-to-country collaboration. Other policy options for countries to manage health labour migration include ethical recruitment practices, integration of foreign-trained/foreign-born professionals, facilitated returns and »circular migration« (Yeates and Pillinger, 2019).

The examples described above indicate that there is disagreement between different actors over which programmes can be considered GSPs. We argue that most BMLAs in the health care sector are not GSPs as defined in the GCM, because they lack an educational exchange element and an institutional capacity development component in the country of origin.

4. CAN GLOBAL SKILLS PARTNERSHIPS CONTRIBUTE TO HEALTH DEVELOPMENT?

The global health workforce gap has grown over recent decades. The WHO estimates that 4.45 health workers per 1,000 population are required to meet the health-related SDG targets. This represents a total global deficit of 17.6 million health workers relative to current supply, with a projected deficit of 13.6 million health workers in LMIC alone (Liu, 2017). Skills partnerships could potentially contribute to global health workforce development, if they properly balance and govern the interests of source countries, destination countries and migrant health workers – including economic and professional potentials for the migrant workers and their families, including through the remittances they send home. It would meet demand in high-income countries, where relative shortages exist in the chronic care sector, and could provide institutional investment for underfunded training and health institutions in low- and middle-income countries.

According to the OECD several factors facilitate GSPs. The development impact – building the skill base in the country of origin – is key to ensuring sustainability over and above economic viability. The OECD in 2018 recommended providing legal mobility channels for medium-skilled workers (for example nurses and midwives) as well as high-skilled workers like doctors; broadening the definition of skills development; applying training mechanisms in existing educational capacity exchange programmes; including clear employer requirements; ensuring portability of pension and social rights and guaranteeing the availability of decent work upon return; and retaining a proportion of the workers trained via the GSP in destination countries (Dempster and Smith, 2020).

Legally binding bilateral labour migration agreements, including GSP elements, could potentially offer relevant mechanisms to protect the rights of migrant workers, integrate a health systems development perspective and mitigate the negative impacts of excessive health worker mobility. However, the main role of bilateral agreements is to facilitate specific, small-scale, temporary recruitment programmes to address specific problems in the short term (Plotnovika, 2014). They are not a grand scheme to address growing international discrepancies between demand, need and supply in health workforce employment. Such bilateral agreements need to be complemented by comprehensive regional or multilateral labour agreements (the latter under the auspices of the ILO as the mandated UN institution) (Yeates and Pillinger, 2020).

Several international policy guidelines and governance mechanisms are relevant to the application of GSPs, including a range of normative and ethical policy frameworks that guide health labour development and mobility. The Sustainable Development Agenda, adopted in 2015, is the most relevant international policy framework for the development of health systems. It outlines a broad commitment to the notion of mutual interdependence and shared global responsibility. The agenda explicitly also includes considerations of social rights and mutual health systems development.

One important limitation of these policy commitments is that they are non-binding. There are no mechanisms to enforce their realisation by sovereign UN member states, partly also because a number of countries have not ratified international labour and human rights conventions. These global social policy aspects are often overruled by economic integration arrangements and/or free trade agreements (Yeates and Pillinger, 2020).

GSPs developed for the health care sector must fulfil certain criteria, including those articulated by the trade unions. This includes the core elements to be considered for GSPs identified by Public Services International (PSI), a major international trade union confederation for the public services sector. (Box 1)

Box 1:
PSI Perspective on Global Skills Partnerships – Core Considerations

- **Tripartism and social dialogue** – full engagement of trade unions to ensure protection of human and labour rights and mutual benefits for both countries involved.
- **Equity** – for both origin and destination countries, the migrant workers themselves and for the users of health services.
- **Sustainability** – GSPs must not undermine sustainability of the human resources for health of developing countries. GSPs must be accompanied by measures to support and sustain the human resource development plans of participating countries, not to replace or supersede them.
- **Full human and trade union rights** – The GSP must be fully grounded on international human rights norms and labour standards, in particular the UN and ILO Conventions on Migrant Workers. The WHO Global Code of Practice can provide guidance on the development of GSPs in the health sector, as well as the ILO Principles and Guidelines for Fair Recruitment. Under no circumstances could GSPs allow for the derogation of rights and standards, nor can they undermine clauses in collective agreements and labour laws and protections.
- **Access to permanent migration** – GSPs should allow for access to permanent migration or citizenship if the worker so chooses. They should not be used merely as an expansion of problematic temporary labour mobility schemes.
- **Sustainable and rights-based return and reintegration** – GSPs should take into account measures and policies for rights-based and sustainable return and reintegration, particularly into jobs in public health services, if the migrant worker chooses to return.
- **Regulation, accountability and transparency** – GSPs should be fully transparent, government-regulated and accountability is ensured throughout the whole chain of the partnership. Implementation should be through government-to-government agreements, carried out via a public-public partnership.

Source: PSI. Perspective on Global Skills Partnerships. Meeting of the International Platform on Health Worker Mobility. 13–14 September 2018, WHO. https://www.who.int/hrh/migration/E-PSI_Perspective-on-Global-Skills-Partnership.pdf?ua=1

5. CHALLENGES ASSOCIATED WITH GLOBAL SKILLS PARTNERSHIPS

GSP have not (yet) been widely adopted. The OECD report notes that to be a true »partnership« a GSP requires transfers of resources to the country of origin (OECD, 2018). These resources could come partly from employers, potentially even public-sector employers. However, additional public funding may be needed to make GSPs work, notably through development cooperation. However, public funding is often limited or absent. There is no evidence so far that GSPs have led to sustainable investment in health systems in countries of origin, whether from private or public funding sources, or that they have led to a significant impact creating health workforce employment in low- and middle-income countries. Moreover, where GSPs are constructed as public-private partnerships (PPPs), as recommended by CGD, there is a considerable risk that public finances may be subsidising commercial aims, rather than the other way around. A significant body of research suggests that in these kind of international (health) PPPs, the public sector covers the financial risks, while the profits go to the private partners and are not actually reinvested to make the partnership sustainable, equitable and compatible with labour rights (Romero 2018). This is why a trade union like PSI stresses governance principles to regulate GSPs (see Box 1).

Actors involved in certain existing skills mobility partnerships have in a number of cases failed to deliver on the development promise: partnerships have not generated in locally relevant skills and capacity. Moreover, skills acquired in the destination country have not always been transferable to employment in the country of origin. A lack of opportunity to use new skills back home limits the incentives to return. There are also questions concerning the extent to which recipients of such training will actually remain in the country of origin and whether other investment could lead to greater employability in domestic labour markets (OECD, 2018).

Fundamental ideas about managing health labour migration have actually changed very little since they were first articulated in the 1960s. At one end of the spectrum we have the aim of national self-sufficiency in health workforce development, including solidarity-driven financial restitution to mitigate workforce imbalances and inequities. At the other end are bilateral skills mobility schemes, including PPP-based GSPs, which have a short-term economic perspective where development and human rights are secondary considerations. Over the years the more socially progressive proposals for global redistribution and regulation seeking to strengthen universal (primary) health care and health systems (and workforces) have been largely replaced by market-oriented approaches such as bilateral skills mobility schemes. »*If these bilateral agreements are fully implemented they would at best leave existing international relations among 'partner' countries intact and at worst entrench short-termism at the expense of prioritizing long-term health systems sustainability*« (Yeates and Pillinger, 2019).

6. CONCLUSIONS

GSPs can potentially address deficits in health care systems by sourcing skills transnationally and ideally pursuing »mutuality of benefits« for »home« and »away« countries, as well as for the labour migrants involved. However, development components (such as building a sustainable skills base in the country of origin) are often poorly designed and implemented in existing skills mobility programmes in health care, such as those facilitated by GIZ. In fact, skills mobility programmes where this component is missing – meaning the majority – should not be considered GSPs under the GCM definition. In these, the short-term return on investment in the destination country is given priority over (inclusive) development objectives and the need to secure global public goods.

Any future GSPs should include references to, and seek coherence with, ethical international policy frameworks governing such partnerships. These could include the WHO's Global Code of Practice, the ILO's Decent Work Agenda, the SDGs, the UN Guiding Principles on Business and Human Rights, and the GCM itself. However, while these guidelines provide legitimate policy frameworks, their legal reach is limited and they require strict monitoring in implementation. The core principles for engagement with

GSPs, as outlined by PSI (Box 1), provide useful guidance on the requirements needed to make GSPs inclusive and sustainable. The ILO's recommendation that »*sustainability and equity in human resources for all countries, in all sectors involved, should be a priority for the Skills Partnership*« (Clemens 2017) should be followed.

If references to and coherence with global normative and frameworks are not sought, the risk is that bilateral policy initiatives like the GSPs will effectively delay the integrated global responses that are so urgently required to achieve international standards of social protection, universal health care and improved health outcomes – all the more so in the Covid-19 pandemic. In conclusion, while providing human capital gains and skills for some, it is unlikely that GSPs will contribute to sustainable health systems development or reduce global health inequities on the long term, unless tightly designed, governed, financed and monitored by all government stakeholders, employers' and workers' organisations, public institutions and civil society.

7. RECOMMENDATIONS

We advise policy makers to take a cautious approach vis-a-vis future GSPs and their implementation.

We advise policy-makers to involve trade unions when pursuing bilateral labour agreements that include GSPs. A tripartite dialogue between governments, employers and trade unions should design, govern and monitor these agreements so as to secure social protection and labour rights for the health care workers involved and to pursue equitable health systems development in both source and destination countries.

In existing and future agreements including GSPs, policy-makers, trade unions and civil society should monitor developments on the basis of certain social indicators, and seek to define a sustainable model that respects human rights provisions and ensures equitable health systems development. Country-based analysis of the skills partnership programmes would be required, including the experiences of the migrant workers themselves and analysis of the systematic effects on health systems development.

We recommend development of regional road maps, including in Europe, to develop self-sustaining health workforce policies based on decent work and universal access to health care. These should include the required funding and be based on a shared commitment to pursue universal health coverage transnationally. This will require efforts to build coordinated public policies across the migration, health and social protection sectors and to strengthen global and regional alliances and networks.

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ABOUT THE AUTHORS

Remco van de Pas is a public health doctor, academic lecturer and global health researcher. He is a research fellow at the Institute of Tropical Medicine, Antwerp and research associate at Netherlands Institute of International Relations Clingendael. He teaches on Global Health at Maastricht University.

Corinne Hinlopen holds an M.Sc. in Sociology and Development Studies and a Master's in Public Health and has extensive public health work experience, in the Netherlands as well as abroad. She currently works as global health advocate with Wemos Foundation where she focuses on human resources for health, health systems, the Sustainable Development Goals and 'leaving no one behind'.

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Friedrich-Ebert-Stiftung | Global Policy and Development
Hiroshimastr. 28 | 10785 Berlin | Germany

Responsible:
Felix Braunsdorf | Migration and Development
Tel.: +49-30-269-35-7462 | Fax: +49-30-269-35-9246

http://www.fes.de/GPol

Orders/Contact:
Christiane.Heun@fes.de

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GLOBAL SKILLS PARTNERSHIPS ON MIGRATION

Challenges and Risks for the Health Sector

With an expected global shortage of 18 million health workers by 2030, global competition for health workers can only increase. Global Skills Partnerships (GSPs) can contribute by funding training for health workers across the globe, and preparing them for the labour markets of all participating countries. Numerous skills mobility partnerships have already shown beneficial effects in countries of origin, countries of destination as well as on individual health workers.

Earlier projects were often rooted in development cooperation and funded through government-to-government schemes. By contrast, today's GSPs are designed as public-private partnerships aiming to *»invest in skills development and facilitate mutual recognition of skills, qualifications and competence«* and to generate a solid return on investment. The question is whether these returns are reinvested in decent employment, sustainable education and health systems development in the country of origin. Evidence to that effect is scarce to date.

With GSPs rapidly gaining popularity, it is essential that the interests of source countries, destination countries and migrant health workers are safeguarded: economic rewards (salary, remittances), professional gains (building knowledge and skills, career advancement), health labour market benefits (meeting demand in high-income countries), institutional strengthening for training and health institutions in low- and middle-income countries.

International policy guidelines, governance mechanisms, and normative and ethical policy frameworks can help design and govern health labour development and mobility partnerships. However, these are mostly non-binding in nature, so additional legally binding labour migration agreements would be required to ensure the rights of migrant workers, integrate a health systems development perspective and mitigate the negative impacts of excessive health worker mobility. Unless tightly designed, governed, financed and monitored by all government stakeholders, employers' and workers' organizations, public institutions and civil society, we fear that GSPs – in their current iteration – are unlikely to contribute to sustainable health systems development worldwide or reduce global health inequities.

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