GLOBAL SKILLS PARTNERSHIPS & HEALTH WORKFORCE MOBILITY: PURSUING A RACE TO THE BOTTOM?

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CONTENTS

EXECUTIVE SUMMARY

Global Skills Partnerships (GSP) are bilateral public-private partnerships to source skills from Low- and Middle-Income Countries in order to address the skills shortage in High-Income Countries. GSP have been included in the UN Global Compact for Safe, Orderly and Regular Migration with the aim to "Invest in skills development and facilitate mutual recognition of skills, qualifications and competence." Via this study Public Services International (PSI) critically assesses the skills partnership concept, its drivers and discourses as it might have an impact on health equity and health systems development in both source and destination countries. The study applied a scoping literature review and conducted actor interviews to provide a decent analysis of the potential and challenges of GSP in the health care sector. Using this critical discourse lens it is evident that foremost the economic development approach and indirectly a trade and health objective are pursued through these public-private skills development partnerships. The GSP seems to be a short-term cost-effective solution to address deficits in health care systems by sourcing skills transnationally. The investment case and economic benefits are considered to be sustainable and inclusive but both literature review and interviews do not provide evidence of this. The GSP concept as it currently stands doesn't provide a human rights-based approach to health development nor does it give much attention to health care services as a global public good. The involvement of trade unions in the governance of bilateral labour agreements that include skills mobility components protects the labour rights of those migrant health care workers involved and guarantees a form of sustainability. GSP should include references to, and respect, ethical international policy frameworks governing such partnerships. These could include WHO's Global Code of Practice and the on-going policy dialogue taking part in the International Platform on Health Worker Mobility, ILO's Decent Work Agenda, The Sustainable Development Goals, the UN Guiding principles on Business and Human Rights, and the Global Compact on Migration itself. While providing human capital gains and skills for some, it is unlikely that GSP will contribute to sustainable health systems development and reduce global health inequities on the long term, unless tightly designed, governed, financed and monitored by public oriented institutions, including national governments, civil society and trade unions.

Key policy messages:

- Global Skills Partnerships, in its current construction, will not lead to equitable and sustainable solutions from a global health workforce development, migration and social perspective. Multilateral organisations and governments must take a cautious approach engaging with these public –private partnerships.
- Trade unions should be involved when pursuing bilateral labour agreements that include skills partnerships. A tripartite dialogue between governments, employers and trade unions must be accomplished with the aim to design, govern and follow-up these agreements as to secure social protection and labour rights for health care workers involved and to pursue equitable health systems development in both source and destination countries.
- Regional, and perhaps a global, governance and public finance model would be required to mitigate the benefits and externalities of health personnel migration. This requires the implementation of ILO's Multilateral Framework on Labour Migration and WHO's Global Code of Practice on the International Recruitment of Health Personnel. The International Platform on Health Workforce Mobility co-governed by WHO, ILO and OECD is an important policy forum to engage with and deepen these governance requirements. These ethical policy guidelines must be respected as core principles when governments look into trade and investment treaties. ❑

1. INTRODUCTION

The concept of the Global Skills Partnerships (GSP) was introduced during the 2017 informal consultations in Geneva towards the development of a United Nations Global Compact on Migration (GCM). Michael Clemens from the Centre for Global Development then presented the GSP to the delegates of the UN member states.

The proposal received a high uptake among delegates of countries from both the global North and the global South. It appears that international institutions, such as the OECD and the World Bank, are promoting the GSP approach as a response to the global skills shortage in health care, which would be of benefit to high-income countries with ageing populations on one hand and low-income countries with funding challenges for expanding their health workforce, on the other. Developing countries, which are sending countries of migrant workers, are attracted to this concept. In light of this, the GSP is being marketed as a "mutual benefit" framework[1].

In a nutshell, the GSP are bilateral public-private partnerships to source skills from developing countries (countries of origin) in order to address the skills shortage in developed countries (countries of destination). There are many variations being modelled to distribute the benefits of GSPs between origin and destination countries and the workers, but the primary sector being identified for piloting is the health sector, with particular focus on nursing[1][2].

Public Services International (PSI), the global federation of public service trade unions, represents around 7 million workers in the medical, health and social services. Engaging with global labour migration policy debate is important for PSI as inadequate investments by governments in public services is a major push factor for labour migration. This trend reinforces a decline in capacity for improving public services in Low- and Middle Income Countries. PSI is concerned about the potential niche in high-income countries for unethical migration practices that contribute to a deepening of precarious working conditions in public health services.

PSI has a clear policy on migration and also runs a programme on migration in partnership with its health sector unions. PSI promotes the rights-based approach to migration, while defending universal access to quality public health services and decent work for health workers. GSP is being introduced as a new concept of skills mobility and labour migration, including in the GCM. Via this study, PSI aims to critically analyse this skills partnership concept, it drivers and discourses as it might have an impact on health equity and health systems development in both source and destination countries.

1 In the final draft (dated 11 July 2018) of the Global Compact for Safe, Orderly and Regular Migration it is proposed as 34 e: Build global skills partnerships amongst countries that 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; as action to OBJECTIVE 18: Invest in skills development and facilitate mutual recognition of skills, qualifications and competences (https://refugeesmigrants.un.org/sites/default/files/180711_final_draft_0.pdf)

2 See: www.world-psi.org/migration

2. AIM OF THIS STUDY

This research provides a general analysis and evidence-base for PSI and its health sector affiliates on the concept of Global Skills Partnerships (GSP), its discourse, governance and its implications for health systems development, health equity and human rights.

The analysis and recommendations from the research will equip the unions with the appropriate policy response as well as practical actions to support their work in collective bargaining, social dialogue and advocacy[3]. The GSP can be viewed as a new form of a labour migration scheme. However, if left outside the influence of trade unions, such scheme can potentially undermine the sustainability and balanced development of human resources for health (HRH), internationally and adversely impact on workers' rights. ❑

3 PSI's experience in the Germany-Philippines Bilateral Labour Agreement (BLA) on Nurses provides good examples on trade union involvement in the implementation and monitoring of a BLA. PSI unions, Ver.di (Germany) and PSLINK (Philippines) are officially part of the Joint Committee of the BLA.

3. METHODOLOGY

A critical discourse analytical framework has guided the methodology. This framework primarily studies the way "social power abuse, dominance, and inequality are enacted, reproduced and resisted. It takes explicit position, as it wants to understand, expose and overcome social inequality.[4]"

The GSP concept, related policies and collaborations must be seen as being part of value based 'frames' and approaches to international cooperation. Basically, these frames implicitly represent worldviews and embedded political priorities. Labonté & Gagnon have identified 6 'frames' to understand the position of health in foreign policy that can also be used as references to and benchmark for analysing GSP. These frames are security; development; global public goods; trade; human rights; and moral/ ethical reasons[5]. The review and discussion on GSPs will apply a critical discourse analysis, and will assess which of the 6 'frames' are prevalent and dominant in the literature and perceptions of GSP.

A rapid scoping review has been conducted that covers both academic as well as grey literature. The scoping review has focused on the broader notion of skills partnerships, and how they have been implemented in the health sector in a bilateral, regional or multilateral manner, whether between governments and/or non-state actors. The review was purposeful and hence provides a scoping overview on the topic. A targeted literature search, using references from sentinel articles, was used; focusing on the recognition of qualifications, certification and standardisation of diplomas, educational exchange programs, scholarships and professional training programs in the health sector. Specific attention was given to the contextual conditions, governance framework, drivers, political-economy of and actors involved in such partnerships, and to what extent workers' rights, collective bargaining agreements, social protection mechanisms and HRH sustainability are considered.

Several persons were purposefully contacted as to elicit their perspectives on GSP. These actors are policy officers and health sector representatives active in the trade unions affiliated with Public Services International. Besides these actors, academic experts as well as policy makers from international institutions relevant to the governance of labour migration in the health sector have been contacted.

A topics list was developed. This guided a semi-structured interview list. Interviews have been anonymised and informed consent was given. Interviews were digitally registered, transcribed and coded according to the topic covered. The outcome of the interviews are described in the results section and analysed according to the discourse analytical framework.

Both the literature review and analysis of the interviews are covered in the discussion part of the research report. The report finishes with a set of recommendations for PSI guiding a policy response on how to address GSP. The research took place in the months of July – October 2018. ❑

4. RESULTS

4.1 The UN Global Compact on Migration

The GCM is expected to be the first, intergovernmental negotiated agreement, prepared under the auspices of the United Nations, to cover all dimensions of international migration in a holistic and comprehensive manner. In the adoption of the 2016 New York Declaration for Refugees and Migrants, 193 UN Member states recognised the need for a comprehensive approach to human mobility and enhanced cooperation at the global level[6]. In this declaration it was also agreed to strengthen global governance of migration, including by bringing IOM into the UN family and through the development of a 'Global Compact for Safe, Orderly and Regular Migration'. Intergovernmental consultation and negotiations will culminate in the planned adoption of the GCM in Dec.2018. The aims of the GCM are to address all aspects of international migration, including humanitarian, developmental, human rights-related and other aspects. It sets a framework for international cooperation, global governance, and actionable commitments and is guided by the 2030 Agenda for Sustainable Development, The Addis Ababa Action Agenda and is informed by the declaration of the 2013 high-level dialogue on international Migration and Development[7].

BOX 1: Definition of a Global Skills Partnership:

A Global Skill Partnership is a form of, or could be part of a, bilateral agreement. It is a way for migrant destination countries and migrant origin countries to work together to maximize the potential contribution of skilled migrants and sensibly share the benefits of skilled migration. It is an exchange of finance and technology for training in the country of origin before migration of potential migrants in exchange for service at the destination. Well-designed partnerships would eliminate and even reverse fiscal drain from origin countries due to new migration, while preserving workers' mobility and providing needed skills at the destination. These partnerships take a dual economic opportunity and turn it into an engine of human capital creation for both origin countries and destination.

An example Global Skill Partnership could be a two-track technical school for nurses. Such a school would be a technical training institute in a developing country, where each student at entry must choose one of two tracks or courses of study. An 'away' track would train students to work abroad, in a developed country—permanently or temporarily. A 'home' track would train students to work in related jobs inside the country of training. Training for 'away' students could be financed either by destination-country employers or governments, or by graduates' future earnings through a form of migration-contingent student loan. This financing would contain a partial subsidy to the training of 'home' track students—a social training credit—fostering and financing a supply response to nurse mobility. (Clemens, 2017)

4.2 Global Skills Partnerships

GSP have been included in the to be adopted GCM in December 2018 under objective 18 with the aim to "*Invest in skills development and facilitate mutual recognition of skills, qualifications and competence." More precisely, as to 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.*"

These partnerships involve a focus on skills development, recognition, mobility and circulation, and professional exchange programs. A core underlying objective is to "enable mutually beneficial skills development opportunities for migrants, communities and participating partners."[8]

Conceptually, GSP have been shaped and put forward as a policy option by the labour economist and development policy researcher Michael Clemens from the Center for Global Development[7][8][9]. In his proposals GSP are an ex ante agreement between governments, employers, and should ideally also includetrade unions. Countries of migrant origin and destination agree ex ante how to bear the costs of training skilled migrants, and allow a small portion of the large economic gains from skill mobility to foster skill creation in origin countries. It is hence presented as a "triple win" for all parties involved (destination countries, origin countries and migrants).

Clemens argues that the GSP framework is highly flexible. It can and must be adapted to the highly specific settings of destination and origin countries, at the same time, he calls specifically for *bilateral* GSP and not for regional or multilateral agreements "a*s the needs of migrants and the needs of different origins and destinations are so different and highly specific*".[9]

GSPs in a broad sense

One could also argue that GSP, in a broader sense, are not new. There are very many examples of training partnerships between countries and institutions with the aim to provide capacity building and develop skills of health care workers. These are often rooted in development cooperation or bilateral exchange programs. Examples include the work by the Tropical Health and Education Trust (THET) from the UK that has been training health workers to build a world where everyone has access to affordable and quality health care. THET has been instrumental in implementing since 2010 the "Health Partnership Scheme" by the United Kingdom's Department for International Development (DFID). From 2011 to 2017 there were 139 partnerships in 32 countries. Volunteers from UK health and academic institutions worked during these years with

counterparts in low- and middle-income countries on health system strengthening by strengthening health worker capacity in terms of their skills, knowledge and confidence[10].

Another well-known example is the Latin American Medical School (ELAM) in Havana, Cuba. Cuba is well known for its 'medical diplomacy'. As an example, in the 2013 academic year, 19,550 students from 110 countries were reportedly enrolled at ELAM[11]. In a 2005 agreement with Venezuela, Cuba agreed to train 40,000 doctors and 5,000 healthcare workers in Venezuela and provide full medical scholarships to Cuban medical schools for 10,000 Venezuelan medical and nursing students. All these students are expected to work in their country of origin when graduating from ELAM. While the Cuban government provides scholarship to train students, it gets material goods (often oil) in return[12].

The difference between these, more traditional, training partnerships and the GSPs is that the former are mainly bilateral *publicly financed* cooperation programs that follow a development cooperation logic. Of course there are also many middle and high- income countries (e.g. China, Saudi- Arabia, Thailand) that provide public investments in scholarships for their professionals to study abroad, e.g. for postgraduate training, with the aim that they return afterwards to work in their country of origin. The difference with the GSP as now presented in the GCM is that it is presented as an *ex-ante Public-Private Partnership* scheme and investment in human capital by outsourcing education to a third country while expecting there will be a return of investment in the destination country for the government, employer, and migrant. A main question is what the return of investment will be in the country of training, and whether this will be re-invested in decent health employment and sustainable health systems development.

Skills Mobility Partnerships

OECD has also taken this investment approach in human capital and skills mobility forward by supporting the uptake of GSP as part of the GCM. Notably the OECD mentions that there are already a number of existing Skills Partnership Agreements such as development cooperation funded training programs in origin countries with the option for employment in a destination country (partnerships between Morocco & Spain and Italy & Moldova); seafarer training for the merchant industry; international students exchange in higher education; sectoral recruitment programs in nursing by destination country organisations and twinning arrangements between health institutions (e.g. with actors in Finland, Germany, Italy and Norway); vocational training in countries of origin or in the destination country. OECD does question to what extent graduates of such training will actually remain in the country of origin and whether any investment could lead to higher employability in domestic labour markets. Also when graduates receive training in destination countries there is a lack of opportunities to use new skills back home, which limits the incentives to return[13].

OECD has put forward the following typology and selected examples of Skills Mobility Partnerships[13](Fig 1)

As an example of existing GSP, including in the health care sector, OECD refers to the Australia Pacific Technical College Programme as well as training schemes abroad to enter the Italian labour market.

The OECD has also identified reasons why GSP have not yet been taken up widely (beyond pilot or niche programs). It identifies three obstacles. First is the ignoring of key participants, especially employers in both origin and destination countries. If employers don't see how it can benefit them, then the GSP will struggle to take off. Secondly, to be truly a 'partnership' it requires transfers of resources to the country of origin. These resources can come partly from employers – potentially even public-sector employers. However, public support may be needed, notably through development cooperation funding. The development impact of the program, by building up the skill base in the origin country, is key to ensure its sustainability. GSP have in a number of cases not

A typology and selected examples of Skills Mobility Partnerships

Training mainly paid by …	Objective - Addressing skills needs mostly at …	Training is taking place mainly in the country of … origin		Training is taking place mainly in the country of … destination	
		origin	destination	origin	destination
	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 agriculture 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 (e.g. 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)	

Fig 1: **OECD has put forward the following typology and selected examples of Skills Mobility Partnerships**

delivered on that promise because they did not lead to locally relevant skills and hence capacity. Moreover, skills acquired in the destination country were not always transferable to employment in the origin country. The OECD provides some recommendations for GSP to work; provide legal channels for medium-skilled workers (e.g. basic nurses, midwives) not only high-skilled workers; broaden definition of skills; apply training mechanisms in existing legal training channels; include employer requirements; ensure portability of pension and social rights and available decent work upon return; retain part of the workers in destination countries. OECD argues for a partnership-based structure, a global "clearing house" (intermediation, capacity building, evaluation and promotion) to facilitate GSP in the future.[13] PSI in contrast would argue for such a 'clearinghouse' to be governed by ILO as it has a legitimate multilateral mandate to do so. This observatory/ clearing house function can also be envisaged being integrated in the International Platform on Health Workforce Mobility (IPHWM) that is co- governed by WHO, ILO & OECD.

A 'success' story in health training partnerships, according to the OECD but also civil society, is the so called "Triple Win" project facilitated by the German Society for International Cooperation (GIZ) bilaterally with Philippines, Georgia, Vietnam and Tunisia. The partnership with Philippines, especially, requires attention[14].

In 2013 the German and Filipino governments signed their bilateral agreement to formalize the migration of nurses from the Philippines to Germany. (Box 2) Research has pointed to the lack of implementation of other agreements and follow-up mechanisms including the lack of multi-stakeholders' involvement. With the facilitation of ILO, eventually the trade unions from the Philippines as well as from Germany were invited to become members of the Joint Committee and to monitor the implementation of the bilateral agreement, which led to its success. Having social partners around the table facilitated the entire process, including the guidance of Filipino care workers by the trade unions upon arrival and the provision of specific advice with regard to labour law and working conditions from the works council. Despite this solid governance structure, however, 5 years later on,the actual contribution of the BLA on health workforce development and skills building in the Philippines remains to be seen[15].

Box 2. The Germany-Philippines Bilateral Labour Agreement on the Deployment of Filipino Nurses to Germany

The agreement is rich in details and following points should be taken into consideration;

- Clear regulation on the deployment of Filipino health care professionals
- Preservation, promotion, and development of Filipino workers' welfare. It includes coverage of all social protection entitlements.
- The agreement promotes exchange of ideas and information with the aim of improving and simplifying job placement procedures.
- The agreement stipulates the promotion of human resource development in the Philippines.
- The agreement also very importantly contains a section on the set up of a Joint Monitoring Committee (JMC), which inter alia has the task to monitor the implementation of the agreement. Members of the JMC are not only the signing parties but also relevant stakeholders, i.e. trade union representatives from the Philippines (PSLINK) and from Germany (ver.di).

See for details of the agreement: http://www.ilo.org/manila/info/public/pr/WCMS_173607/lang--en/index.htm

Clemens mentions in his articles several examples of bilateral agreements that included elements of a GSP but are not the comprehensive form of GSP as he has constructed it. These mostly include shared investment in skills both at the destination as well as the country of origin via a 'two-track' away and home structure and followed through over a longer time. There is hence at this moment not directly a 'blue-print' GSP model available that has proven to be effective, equitable and sustainable on the longer term. It would for this be relevant to look into existing bilateral agreements addressing health workforce mobility.

4.3 Bilateral agreements concerning health workforce mobility

The WHO Global Code of Practice on the International Recruitment of Health Professionals (Code of Practice) calls in paragraph 5.2 upon member states to "*use this Code as a guide when entering into bilateral, and/or regional and/or multilateral arrangements, to promote international cooperation and coordination on international recruitment of health personnel. Such arrangements should take into account the needs of developing countries and countries with economies in transition through the adoption of appropriate measures*". Access to specialised training, technology and skills transfers is mentioned in this regard. Developing bilateral agreements on health workforce mobility, and more specifically GSP is hence in line with, and following the principles of the Code of Practice[16].

Around the time that the Code of Practice was adopted in 2010, the Health Worker Migration Initiative, a partnership between the WHO, the Global Health Workforce Alliance, and Realizing Rights/Global Health & Development at The Aspen Institute, had produced a guidebook on bilateral agreements to address health worker migration. This guidebook provided the latest innovations in cooperation as how to develop such agreements, at the time[17]. This book made it clear that there is a significant variation in the types of bilateral agreements that governments enter into to manage the migratory flows of health workers. These include bilateral labour recruitment agreements, bilateral social security and welfare agreements, bilateral health cooperation agreements, and bilateral economic partnership/integration agreements. The GSP approach

can be considered to represent such a latter economic partnership agreement. It focuses on mutual recognition agreements, with respect to the recognition of health worker credentials, accreditation and skills. GSP are hence a *specific economic partnership* bilateral agreement but relatively narrow in scope and should be part of a broader bilateral agreement that also includes considerations of social rights and mutual health systems development.

'Innovative' models

Table 1 of this handbook provides a partial compilation of bilateral agreements and health workforce migration available at that moment. Interestingly the authors provided for 2 'innovative' models to construct bilateral agreements. The first one is a 'comprehensive' bilateral agreement model. It has provisions related to health worker recruitment and protection of migrant health workers, and also gets to the point of ensuring that the migration itself generates health benefits for those that remain behind in the source country. This is the model most of line with the Code of Practice and mostly related to managing temporary labour migration. The GSP approach must also be seen as part of such an approach.

The second model, is more focused on large-scale permanent migration in some Anglophone, settler countries, based on traditional 'quality-selective' and 'non-discriminatory' immigration policies.[17] Nevertheless, given political developments this outlook also changed over the recent years.

Given the broad range and scope of different bilateral agreements in the health care sector and beyond (trade and development cooperation) it is difficult to provide a general assessment and to provide a thorough overview. Some of these bilateral agreements on developing the health system contain skills development as a core focus, for others it has much less prominence. Nevertheless, the following observations can be made;

In the early 2000's much of the inter-state partnerships and bilateral agreements focused on diaspora engagement by supporting the transfer of knowledge, skills, technology and capacity building to benefit source countries. This was then conducted as a form of circular migration and promoted, analysed, developed amongst others by IOM in projects such as MoHPROF (Mobility of Health Professionals; global research project funded by the European Commission from 2008-2011) and the Migration for Development in Africa (MIDA) strategy. The MIDA Ghana Health Project (2008-2012) was the longest running health project under the MIDA programme. It linked migration more concretely to development and specifically "to the development of human resources in the health sector in Ghana". Over 30,000 students have benefitted from this program[18].

Bilateral agreements can be an important mechanism to protect the rights of migrant workers to mitigate the negative impacts of outward migration. The original Filipino – Bahraini agreement covers exchange of human resources for health (HRH) in recruitment, rights of workers, capacity building, sustainability of the development of HRH and mutual recognition agreements on qualifications. The agreement also covers scholarships, academic cooperation on HRH and technology cooperation[19].

Narrow or broad approach

Plotnovika provided an elaborated review and overview of the role of bilateral agreements in the regulation of health worker migration from a European perspective. She takes an alternative approach and questions what could be the several dimensions of such bilateral agreements including mobility partnerships with third countries outside the European Union. These dimensions could be of a narrow perspective, which looks largely at the economic impacts of agreements on the labour market or be a broader perspective on the political effects of such agreements in the arena of international relations, migration policies, development aid provision and regional integration. An alternative dimension to consider is the analysis of bilateral agreements from the perspective of source and destination countries.

The GSP approach can, also in this categorisation, then be regarded as a relative 'narrow' approach to economic investments and their impact on employability and the labour market. Plotnovika argues for a broader outlook to these bilateral agreements providing that they could potentially improve international relations, assist in the management of migration, provide means for the implementation of development policies in poor world regions, provide social protection of foreign labour abroad and facilitate regional integration between regions/countries. She points also to the weak points of bilateral agreements; such as the financial costs and organizational burden of management. Moreover, it should also be recognised that the labour market impact of bilateral agreements (in times of deregulation and 'flexibilisation' of health employment) is decreasing. Currently, the largest labour mobility between countries takes place outside the channel of bilateral agreements (through recruitment agencies, family links and social networks), and, in this sense, bilateral agreements could be considered to be old-fashioned instruments, she argues.

The exclusive labour market access based on nationality and profession might also not be consistent with WTO principles, which is based on the non-discriminatory principle of the "Most-Favoured Nations". Bilateral agreements hence may (legally) undermine WTO provisions that provide for a multilateral framework. Some cautious considerations could be made concerning bilateral agreements, including rather 'narrow' ones such as GSP, as follows:

A; The efficiency of bilateral labour agreements, as recruitment schemes, is much in doubt because such types of agreement are costly and are time-consuming.

B; Bilateral labour agreements face challenges and competition from the expanding global labour market, where the dominating role is taken by private agencies and individuals themselves.

C; While these bilateral agreements have less of an 'economic role' as recruitment tools they have their role in international diplomatic instruments promoting good relations between governments, as is for instance the case with the Triple Win projects between Germany and third countries.

Plotnovika mainly sees a role for bilateral agreements, including GSPs, for specific,

small-scale, temporary recruitment programmes between countries to target specific problems in the short term, not a larger scheme to address the growing differences between demand, needs and supply in health workforce employment across countries. It is best that such bilateral agreements are complemented by comprehensive regional or multilateral labour agreements with the latter governed by the ILO as the mandated UN institution.[20]

Two studies from the South-Eastern Asian region on bilateral and multilateral agreements are coherent with the European analysis described above. Te et al. looked at the impact of ASEAN economic integration on health worker mobility by conducting a scoping review[21]. From 2006 onwards Mutual Recognition Arrangements (MRA) in medicine, dentistry and nursing have been signed by Association of Southeast Asian Nations (ASEAN) Member States to facilitate the intra-regional mobility of health professionals for liberalization of healthcare services in the ASEAN Economic Community. The aim would be to eventually reduce barriers to labour migration as currently exists in the EU. This study indicates that, despite a number of programs being initiated, differences in the countries in the regions in language, qualifications standards and regulation framework so far have made it difficult to have labour mobility become sustainable and a long-term benefit for both host and destination countries.[21] This is confirmed in a study by Yeates and Pillinger who argue that there is much divergence in health systems development and wealth between the regions in the country. Seven countries in the region where health worker shortages are most critical have instituted MRA covering multiple health professionals. The Philippines stands out as a serial signatory of international agreements, with commitments through bilateral, regional and global instruments.

Yeates and Pillinger provide context to the international agreements signed by countries as they note that these cannot be separated from the multi-faceted inequalities that characterise the region or the wider issues of migration governance. They state:

"*These inequalities begin with the outcomes of past 'development' that position states differentially in global and regional hierarchies; they manifest in poorer countries servicing richer ones with significant health resources (skilled health professionals), and are institutionalised through the conclusion of inter-state agreements that facilitate health worker migration (whether through mutual recognition arrangements or fast-track visas and placement of migrants) but do not ensure compensating development returns to the sending countries.*"[22]

Bilateral agreements are supportive of temporary and circular migration 'solutions' to chronic problems of poorly resourced health services and an underfunded labour workforce. Only very few BLAs approximate good practice, one of which (the Filipino-Bahraini agreement) was actual not implemented and is currently renegotiated. The authors argue that neither the Code of Practice, nor international norms on social protection and labour standards, have provided enough sufficient weight to influence the design of regional health workforce agreements, nor alter their conditions of implementation.[22] This calls for a reflection on and advocacy for future BLAs to be grounded in international norms and labour standards, including the Code of Practice.

4.4 The global governance and policy environment

The Global compact on Migration

GSP must also be regarded as being part of broader policy and (global) governance environment. The GSP proposal is part of the GCM which is the first multilateral framework comprehensively addressing all aspects of migration. It sets definitions (a common understanding), shared responsibilities, aims as well as a cooperative framework to attain 23 objectives. The GCM is a non-binding multilateral framework, with countries maintaining their sovereign rights to govern migration according to national laws and legislation. Nevertheless, the GCM provides

a comprehensive framework of all elements required to govern safe, orderly and regular migration. Implementation and monitoring of the GCM need then also to be conducted in a coherent and accountable manner.[6] Any future development and implementation of a GSP needs to be assessed in line with this broader GCM framework.

Trade and Health Services

While global growth of merchandise (goods) trade has lost momentum, trade in commercial services is in contrast still growing. The Trade and Development 2018 report mainly refers to the biggest sector being maritime services and international tourism but care and educational services, especially digitally provided, are expanding as well[23].

Mode 4 of the World Trade organisation's (WTO) Global Agreement on Trade in Services (GATS) defines a policy framework regulating trade related possibilities for temporary cross border movement of service providers. In addition GATS Modes 1-3 are respectively about services across borders (without mobility), consumption abroad (cross-border care) and commercial presence of services abroad. The perceived insignificance of health care services in GATS-mode 4, as they have been partly excluded by countries from this trade framework, has led policy makers, academics and health advocates to focus on other aspects of the (multilateral) trade governance, such as intellectual property and regulation of food and beverage standards. Trade in health services is hence an under-researched and under-estimated policy terrain. Moreover qualifications and skills recognition across countries are normally addressed in a bilateral agreement between countries (in contrast to a multilateral agreement) albeit more and more countries do this in a regional matter. The EU is a clear example in this by having agreed on a framework for qualifications of the European higher Education area already in 2005[24].

Nevertheless, recent research by WHO has indicated that contrary to perceptions, countries have slowly opened up to liberalise their health services via commitments to GATS mode 4[25]. 87 out of 164 WTO members have opened health-related service commitments, which imply a willingness to open up their labour markets to health personnel from abroad. Although WTO- GATS negotiations have been 'frozen' since the Doha round in 2003 countries have deepened the trade commitment and framework in bilateral and regional trade agreements (RTAs). WTO has registered 144 of such RTA agreements that include services commitments, with about 2/3rd of them pertaining to Mode 4. Examples of RTAs with specific provisions on health worker mobility (e.g. in the field of nursing and dentistry) pertaining to the mutual agreement of qualification, include agreements between countries in the ASEAN region, with the Philippines leading by having several agreements with other countries. With progress slow in the Multilateral GATS negotiations, 23 WTO members started in 2013 negotiations on a pluri-lateral Trade in Services Agreement (TISA) with the aim to advance liberalisation of trade in services and secure commitments from participants that go beyond those in GATS. Due to political situation talks are on hold since November 2016 but TiSa could imply a deepening of services liberalisation. Although Least Developed Countries (at least until 2030) could make use of a "waiver" to get preferential treatment, there is a concern by public health community, trade unions and by civil society that the health workforce will be mainly seen as a "*tradable commodity*". [24]

If these Trade in Services governance agreements will further deepen at the regional or multilateral level it could imply that any GSP program has to be coherent with, and is subjected to, liberalisation of services agreements in trade modalities between two or more countries. A GSP program would then have to align with liberalisation of services modalities between two or more countries. While trade in service agreements might actually promote skills mobility such liberalisation could potentially also make it more difficult for countries to redress imbalances or instigate regulation to protect employment for the public health workforce in 'home countries'. This difficulty can arise as the liberalisation of services, normally agreed

upon via the reduction of barriers and seeking regulatory coherence, leads to countries having less policy tools to prioritise public over private services, the latter being backed by private foreign investment. The case of Dutch health insurance company Achmea to try and force the Slovak government to pay compensation for reversing health privatisation and liberalisation policies via an investment treaty has been a clear indicator about the public risks of trade liberalisation in the health care sector[26]. A main concern with such liberalisation of trade in health services across country borders is that it can put then pressure on labour rights, wages and might exacerbate inequalities in access to health care. PSI's position is to exempt public services from trade liberalisation.

Nevertheless WHO sees a possibility to align a flexible trade framework with ethical health worker mobility through applying and monitoring WHO's Global Code of Practice on the International Recruitment of Health personnel in a transparent manner. WHO would consider this seeming consistency between trade modalities and Code provisions generating a situation of mutual benefits for origin and destination countries. This could include provisions within GATS/RTAs to facilitate national treatment provision, circular mobility, education and skills exchange, filling of domestic gaps in developing countries, mobility for charitable purposes, reductions in recruitment fees, protection of health worker welfare etc.[24] A major question remains of course the governance framework and legal weight of the respective agreements while implementing. There is likely a possible dominance by the trade and investment approach over the ethical, sustainable development of health systems across countries according a public goods approach requiring shared responsibilities, including financial (redistribution) provisions. This resonates with what Missoni analysed on the impact of global trade liberalization on health systems pursuing Universal Health Coverage[27]. One of his conclusions is the following:

"*Global trade liberalization can have negative effects on health systems' capacity to ensure Universal Health Coverage. On the one side, trade can increase the burden of disease and cause higher demand; on the other hand, it can interfere with the interconnected functioning of health systems' building blocks. This is especially true in the current weakness, not to say absence, of governance mechanisms to ensure adequate health protection and promotion in international negotiations and policymak-*

ing fora, which often lie outside the control of agencies primarily responsible for public health."[27]

Human capital and fiscal space

GSPs must be placed in the economic policy discourse that is being promoted in the World Development Report 2019 (WDR 2019) the changing nature of work[28]. Skills development, enhanced mobility for employability, labour flexibility of and human capital investments are among core concepts promoted in the report. Interestingly, the ILO has explicit critique on some parts of the WDR 2019[29]. Firstly, ILO argues that there should be a life-long learning approach in the development of skills via the expansion of public funding to cover training. This problem is exacerbated with growing numbers of workers in the platform economy. It is doubtful whether GSPs create a long-term employment relation whereby health employers will invest in career development of externally recruited health workers. ILO argues that "*the WDR 2019 model stands to provide only low levels of employment and income security for the broad majority of the population... without a firm anchor in decent work which includes strong labour regulations and robust social protection the social contract proposed in the WDR will not lead to sustainable development ... The absence of serious consideration of gender inequality throughout the report misses a further opportunity to address one of the key challenges to inclusive growth.*"[29]

Over the years, a considerable number of LMICs have been imposed economic conditionalities, which have restricted fiscal expansion and investment in decent employment. An analysis of 16 West-African countries found that mandated IMF policy reforms between 1995-2015 reduced investments in health and limited staff expansion of doctors and nurses[30]. In light of GSP this would imply that there would be limited space to employ health personnel in 'home' countries if there is no coherent economic policy framework that is open to equitable health systems development.

It is good to consider that there is already a range of international normative and ethical policy framework that guides health labour development and mobility. These instruments include the "Working for Health" Five-year Action Plan for Health Employment and Inclusive Economic Growth (2017–2021)[31], WHO's Code of Practice, ILO's Decent Work Agenda, the UN Migrant Workers Convention and the ILO Conventions on Migrant Workers (C97 and C143)[32], The International Covenant on Economic, Social and Cultural Rights[33], as well as the Sustainable Development Goals itself[34]. This realisation is relevant in so far that there is not a shortage of frameworks or governance possibilities. Its potential for creating global public goods and cooperation is considerable. However, a main limitation with these policy directives is that they have limited teeth in enforcing practices by sovereign countries. These global social orientations end too often in gridlock during their implementation as economic integration arrangements and/ or FTA's legally overrule them.

4.5 Semi-structured interviews

As part of the study 6 key informants have been interviewed via a semi-structured questionnaire (See annex). 3 of the respondents work in (national and international) trade unions affiliated with PSI. 2 participants are academic experts and conduct research in the domain of trade, social policy, health care and migration. 1 respondent works for a multilateral organisation. Interviews were conducted in person, telephone or via online communication modalities and lasted in between 30 minutes and an hour. The transcribed answers from respondents are clustered and organised according to common themes in the interviews.

The GSP concept

The GSP concept was relatively new to most of the respondents, and they have as such not been working with it, or seeing it implemented in their work. It is being understood in the way that it has been proposed by Clemens; a flexible but technical

public –private partnership mechanism to enhance mobility of skills with some possibilities of the mutuality of benefits for parties involved. Participants have had in the past some experience with training elements of the proposal, while facilitating programs on the exchange of international skills and capacity, circular migration via the involvement of diaspora etc. Normally these were conducted via development cooperation funding or bilateral educational exchanges, and not via private financial channels.

The participant from the multilateral organisation stressed on the flexibility and openness of the concept, essentially saying that existing training and skills partnerships have been established in the past. "*GSPs should not be not a proprietary idea*."

A good practice of a form of GSP that was being referred to by this participant is the health workforce migration policy by Sudan that is built on the pillars of promoting health worker retention, development of bilateral agreements (e.g. between Sudan and Saudi Arabia; Sudan and Ireland), and the mobilization of diaspora to support Sudan's health system. According to the Sudanese government this could contribute to further regional integration of the health labour market via collaboration and skills recognition.

Interestingly, one of the participants (from a labour union) involved in the Triple Win project between Germany and the Philippines was adamant that this bilateral agreement should not be considered as a GSP. This contrast indicates that there is still confusion on how narrow or broad the scope is (should be) of a GSP. Its flexibility is considered an advantage but its multiple interpretations, and as a relative new concept, also hinders participants engagement with it.

Discourse

The main discourses mentioned by the participants (according to the Labonté & Gagnon framework) in relation to the GSP are the (economic) development and trade related frame. All participants understand the GSP is constructed as an approach to create a "win-win" situation, implying both economic growth and (sustainable) development outcomes. GSP must be seen as an investment case in human capital and employability as outlined in the World Bank report 2019. One participant explicitly stated that GSP is an outsourcing strategy (more than training) to invest in education outside the country and get in return a relatively cheap labour workforce, even more so at moments when health workers included in the partnership are still in training or residency. A participant appreciated the clear economic investment approach as this could be a way to incite countries governments to 'buy' into the concept but had much doubts about the public return on investment and actual development outcomes. Another participant mentioned that this public private partnership is part of a longer fiscal trend of privatisation of essential services, such as health services and education. It fits in this regard much in the 'partnership' and 'blended finance' approach as promoted by the SDGs. Also GSP should *not only* being considered to be mainly of interest for high-income countries. Countries from the south also want to facilitate mobility of personnel in *trade* relations. Countries like the Philippines and India have promoted this as a possibility to enhance human capital. Also UNCTAD has promoted this (provided under strict regulatory conditions). Facilitation of skills exchange is often done indirectly, not by facilitating mobility, but by mutual recognition of skills and qualifications.

The participants doubt that the other approaches being sufficiently addressed by the GSP approach. For instance, sustainability and a *global public goods approach* with shared public financing mechanisms and (global) regulation is missing. It is interesting that the *global health security* discourse is not being included in the GSP concept. None of the participants made the link between enhancing mobility of health professionals with the need for strengthening health systems to be more resilient and responsive to public health crisis. GSP seem hence more about mobility for health care functions rather than public health functions.

The human rights approach is not (direct-

ly) addressed by the GSP concept. Bilateral agreements are required to secure social provisions and labour rights. But that is of a broader notion than the GSP itself. Labour union representatives stressed on this link and the need for social tripartite dialogue to guarantee social rights for workers involved. Nevertheless, broader human rights considerations such as the Right to Health in both destination and source countries are not being included in the GSP as it is presently conceived. Some participants mentioned the GSP to have a potential to even violate human rights. "*This contributes to a race to the bottom and further privatisation of poverty.*" and "*There is no evidence that these public-private partnerships drive development on the long term.*" Lastly, regarding the *moral/ ethical elements* of the GSP, respondents mentioned the crucial role of the Code of Practice in relation to ethical recruitment and practices. All respondents saw a great need to align the GSP approach with principles of Code implementation including on transparency of practices and monitoring of these principles. Nevertheless, so far there has been no evidence of skill partnerships that took the code as a core or guiding priority.

Positive elements

One of the participants indicated a clear potential for the GSP as it addresses some elephants in the room and a potential to create benefits on both sides, by doing this through government-to-government involvement. If this approach is embedded in a bilateral agreement, with clear governance structures then, according to this participant, it is something that could be possibly supported from a trade union perspective. If so, skills partnerships must be backed by a regulatory framework and a public finance plan while not relying on loans, private finance or philanthropy. Also, if it is linked to the recognition of skills and qualifications, then an increased mobility could provide access to international labour markets and provide employment possibilities for health workers coming from places with relative unemployment, while stressing that this is often related to precarious working conditions and underinvestment in the public sector in the country of origin.

People have the right to be mobile to pursue decent socio-economic living conditions. Such labour market integration is what the EU has been developed effectively, albeit with many questions on equitable opportunities for the labour migrants themselves. This participant made the claim that If GSP are developed and monitored in a transparent and accountable way then they could, perhaps, support sustainable development outcomes in both the "home" and "away" tracks. One other participant referred to a positive project by Irish Aid that provides skills to medical doctors from Low- and Middle Income Countries that required post-graduate training. This program afterwards monitored how skills were being deployed in country of origin.

Negative impact

Sustainability of the GSP proposal is a major issue. Most participants agree that it is a short term "fix" for a much more complex issue on the nexus between globalisation, migration and social development, and how to govern this in a responsible, responsive manner. Also, as it is a public – private investment, the question is who will benefit from the outcomes. Where will participants in such a scheme actually be employed? Evidence shows that in health systems, the development impact in 'home countries' of such schemes is truly limited.

It is unlikely that countries, many of them having gone through austerity, will be putting a lot of public investment in GSP. If such a scheme is being complemented by private finance, then a financial return on investment is to be expected. In such approach there then is a risk of commodification of health care involved. Respondents argued that it is in a sense then a private investment that is being secured by public finance, which 'mitigates' the risk of a project failing, primarily on behalf of private for-profit interests.

Public finance would then have to "*bail-out*" potential indemnities like training costs, visa procedures, portability of social rights, and

a return trajectory to country of origin. A participant referred to experiences with the training and recruitment of international nurses for employment in the Netherlands about 20 years ago. The reflection indicated that, for several reasons, very little of this recruitment resulted in long-term employability of these foreign nurses. Initial investment and recruitment were not the main problem, but clarifying the regulatory framework and guaranteeing (financing) long-term social and labour protection by a host country government were the main challenges.

As there is fluctuation in the economics of labour markets many of these projects failed eventually as demand for employment dropped. Another major concern is that the GSP approach is a contra-incentive for countries to be self-sufficient in the production of their health workforce. The latter is seen as an important requirement to build sustainable and strong health systems. A last point is the temporality of such schemes whereby health workers are expected to return after several years to their country of origin. Without having access to social rights of those with a permanent citizenship status, or portability of social rights, these migrant health workers are then less secure, more precarious then fellow workers. This inequality and unfair situation undermines these schemes if no option or channel is opened to become a permanent labour migrant or even getting a citizen status.

Governance, bilateral agreements and trade relations

All participants agreed that GSP could only work if embedded in a clear governance framework. Bilateral treaties could potentially incorporate GSPs as they should not be "stand alone" partnerships. A clear bilateral government-to-government framework is promoted above unregulated private sector recruitment. Trade unions have an important role to play in the tripartite social dialogue of such schemes, as well as monitoring its implementation. The German – Philippines agreement could be seen as a good practice. Bilateral agreements would even be stronger if they can build on regional skills recognition and qualifications as is the case in the EU. The participants stressed on the explicit recognition of WHO's Code of Practice as well as ILO norms and standards, such as the labour conventions as well as tripartite negotiated guidelines, e.g. the ILO Guidelines on Fair Recruitment, the ILO Multilateral Framework on Labour Migration, as providing a normative policy guidance in BLA's on health labour mobility.

Nevertheless, to make it sustainable much more attention should be paid to global governance and multilateral mechanisms that function on the basis of shared responsibility and the financing of public goods for health. The rights-based and equity lens should be much more prominent. The trade and investment approach to complex issues leads more to a focus on short term solutions with less concern for the sustainable and long term health systems development requirements in practice. Although the WTO –GATS negotiations are frozen, Trade in Services is more and more included in RTA's such as between the EU and Canada (CETA) as well as the RTA currently under negotiation between EU with Japan. Moreover, extending loans by multilateral development banks to developing countries to finance Skills Development Partnerships raises questions about sustainability of these schemes and who actually benefits from the investment. A respondent made the statement that GSP is in essence about '*poaching nurses*'. It's part of a global "*Uberisation*" of labour, leading to more and more precarious jobs. A next risk could be that RTA's would allow transnational sub-contracting of health workers (via intermediate agencies, as is already practice in the EU), which could put further pressures on wages and social protection. There is here a main role for trade unions, civil society and governments to protect these social rights in trade agreements but at the moment there is, despite the normative frameworks like WHO's Code of Practice, limited regional or global governance mechanisms to protect social rights. This is legally the (exclusive) mandate of national governments, even within the EU. ❑

5. DISCUSSION

Both the literature review and interviews provide a rather coherent picture on how to assess GSP in relation to broader health systems development and the aim to attain equitable global health outcomes. Using the different frames as elaborated by Labonté & Gagnon[6], it is foremost the *economic development* approach and indirectly the *trade and health* angle that is being pursued through these public private skills development partnerships. In analysis, the GSP seems to be a short term cost-effective solution to address deficits in health care systems by sourcing skills transnationally and by ideally pursuing 'mutuality of benefits' for 'home' and 'away' countries, as well as the labour migrants involved. The investment case and economic benefits are considered to be 'sustainable' and 'inclusive' but both literature review and interviews do not provide evidence of this. Even more they raise critical questions about which actors eventually benefit from these schemes on the long term. Most of the envisaged skilled partnerships have a considerable proportion of private finances behind them, such as from health employers, private educational institutes or recruitment agencies which might benefit foremost from outsourcing skills development via a third country. The development component, building a sustainable skills base in the country of origin including a financial plan, is often poorly designed and implemented. The short-term investment outcome in the destination country is given priority over (inclusive) development objectives and the need to secure global public goods.

While *GSP* are not directly included in *trade modalities* it would facilitate the mobility of health professionals when mutual recognition of skills and qualification is recognised. Trade liberalisation should be fair and free, and if global health equity could be more central to the outcomes of trade then greater trade policy flexibility has to be given to poorer low-income countries as to protect the (social) policy space to guarantee access to essential health services and public goods for health in general. Nevertheless, given that global health equity is in general of low priority (or absent) in trade agreements much caution, or even opposition, is required in liberalising health services across borders.

"*There is evidence and argument that the pacing of such liberalization, alongside the provision of social safety nets and flexibilities that account for countries' different development levels and productive capacities, can help to offset the dislocations in domestic labour markets that inevitably follow openness to global competition.*"[35]

The GSP concept relates the financial demand to skills rather exclusively to (global) economic markets, and doesn't consider the workforce a *global public good*; neither has it given much attention to *health security*. In that sense, the GSP doesn't contribute to the respective targets in SDG3 "*Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States*" and "*Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks.*"

While bilateral agreements on health labour can include skills partnership and training elements, the actual social provisions they contain, including on labour rights, portability of social insurance etc. differ from one to the other. The German-Philippines provides a good example because it has also established a joint committee. This committee, based currently on a bipartite social dialogue, has designed and monitored the implementation of the agreement. However, within such agreements there is little to no reference to a broader international human rights framework, including the International Covenant on Economic, Social and Cultural Rights, and shared responsibilities from all parties involved to attain universal access to care in both origin and destination country. Unfortunately this aligns with research findings that current representations of the right to health in the SDGs are insufficient and superficial, because they do not explicitly link commitments or right to health discourse to binding treaty obligations for duty-bearing nation states or entitlements by people.[36]

GSP should include references to *ethical international policy frameworks* governing such partnerships. These could include WHOs Global Code of Practice and the on-going dialogue taking part in WHO's International Platform on Health Worker Mobility, ILO's Decent Work Agenda, The Sustainable Development Goals or the UN Guiding principles on Business and Human Rights[37] or even the GCM itself. While these guidelines provide legitimate policy frameworks, and its principles require monitoring in the implementation of partnerships, their legal reach is limited. In contrast, trade agreements as well as regional economic integration policies (like the advanced one in the EU) have deeper legal implications and might 'shape' the actual space and outcomes of these partnerships.

Yates and Pillinger provide the analysis that "*health worker migration is a global issue requiring a comprehensive multi-level set of responses. Yet while the need for coordinated and integrated responses at global, regional, national and sub-national levels is well understood, there seems to be far less progress in instituting such responses.*"[22] The authors argue that bilateral policy initiatives, like the GSP, are effectively postponing integrated and coherent responses that are so urgently required to attain international standards of social protection, universal health care and improved health outcomes. Rather, it is suggested to develop 'regional road maps" to develop self-sustainable health workforce policies, based on decent work and universal access to health care, including the required finance and shared responsibilities to pursue this transnationally. Efforts to build coordinated public policies across migration, health and social protection, and to strengthen global and regional alliances and networks are required. GSP mainly seem to provide a narrow, technical policy modality in skills development and exchanges, leading to short-term cost-efficiency gains and solutions through temporary migration schemes. While providing human capital gains and skills for some, it is unlikely that these will contribute to sustainable health systems development and reduce global health inequities on the long term, unless tightly designed, governed, financed and monitored by public oriented institutions, including national governments, trade unions and civil society. ❑

6. POLICY RECOMMENDATIONS FOR PSI AND OTHER ACTORS

In the first instance, PSI should best take a cautious approach to GSP and its program implementation. It doesn't necessarily have to reject the concept, but from an advocacy perspective at the international level, vis-à-vis multilateral organisations such as OECD, WHO and others, political leaders, and diplomatic missions it could outline the limitations, short-term economic frame, and risks that this public- private partnership bring. PSI should advocate that GSP, in current construction, will not lead to equitable and sustainable solutions from a global health workforce development, migration and social perspective angle.

When trade unions engage in bilateral programs or broader agreements that include skills partnerships they should then on an inclusive way be engaged in the design, monitoring and governance of such programs. This follows how trade unions engage in tripartite dialogue with the aim to secure social protection, labour rights, and equitable health systems development. PSI has much experience with these models, including in bilateral programs on professional mobility such as between Germany and Philippines. In existing, and new agreements, it would be relevant for trade unions and civil society to monitor developments and certain social indicators, trying to define a 'model' that

would be sustainable, respecting human rights provisions and equitable health systems development. Country based analysis of the skills partnership programs would be required including eliciting the experience of the migrant workers themselves as well as analysing the systematic effects on health systems development.

PSI and like-minded organisations, and users of services (the community) should analyse, and advocate, beyond the bilateral approach on the governance complexity of health labour migration. Regional, and perhaps a global, governance and public finance model would be required to mitigate the benefits and externalities of health personnel migration. There is a potential that the GCM, which is built on voluntary commitments and national sovereignty principles, 'locks in' future debates on global social policy integration. PSI should be encouraged to engage in 'parallel' processes, both at the regional and global level and via strengthening the capacity of ILO in labour migration governance. PSI could support the possibility of alternative models to govern health personnel mobility and health workforce development. A decent 'mapping' of this complexity and existing policies across several governance regimes would be a first step to engage in analysing potential for global social policy integration.

The International Platform on Health Workforce Mobility co-governed by WHO, ILO and OECD is an important policy forum to engage with this governance complexity. Using this platform to monitor these mobility partnerships, assess and discuss them in relation to implementation of the GMC, ILO's Decent Work Agenda, the SDG's as well as WHO's Global Code of Practice must remain a priority for PSI.

PSI champions gender equality. Monitoring GSP in an economic policy discourse as promoted in the WDR 2019 requires a gender perspective because the reasons for migrating and the impact on their migration experiences might differ between men and women. This might have implications for PSI's responses, too.

PSI and like-minded organisations could explore the development of skills partnerships that have a more explicit public service orientation and public goods approach. While traditionally these partnerships have been rooted in development cooperation programs between countries and institutions, it might be possible to envisage capacity development and skills recognition plus exchange in the domain of health care education from a regional perspective, e.g. in cooperation between the European Union and African regional integration bodies such as the Economic Community of West African States or the Southern African Development Community. Such cooperation would have to be truly mutual, sustainable, and rights-based and be rooted in a shared public finance model with clear outcomes and employment possibilities to be envisaged on both sides. ❑

ANNEX I

Semi-structured interview (taking +/- 30 minutes)

- What is your position and what are your responsibilities, line of work?
- Have you been working on the issue of health workforce labour mobility and/ or migration? If so, in which capacity and on what specific issue?
- Are you known with the concept (Global) Skills Partnerships in health care? If so, how would you describe it? Could you describe a skills-, training- or educational partnership that you think has been successful?
- (Explanation of how a GSP is defined)
- Have you been engaged in the implementation of international skills or training partnerships in the health sector?
- What could be benefits of such a GSP? What exactly, and for who?
- What could be the negative impact of a GSP? What exactly, and for who?
- Do you know about existing bilateral or regional agreements where GSP in the health sector have a role? How are obligations and responsibilities of parties involved (whether public or private) organised? What is your opinion of such an agreement? How could it be improved?
- How could the rights of health workers and students be guaranteed in such partnerships? What would be the role of labour unions in this?
- From a global health equity perspective, what would be required in the governance of these GSPs that support the equity goal, rather than undermining them?
- GSPs promote temporary labour migration? How to address the wish of skilled health employees employing for permanent labour status and consecutively citizenship?
- How to ensure sustainability and development of the health workforce in the country of origin? How could GSPs contribute to this?
- What kind of financial mechanism must accompany a GSP as to ensure equal benefits, shared responsibilities and sustainability?
- What would be alternative policies to deal with the impact on health workforce migration? Could you give an example of a policy that you think has been effective?
- (Mentioning to WHO Code, ILO regulations)
- Any comments, references or inputs you would like to share?

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