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International Health Worker Mobility & Trade in Services

WHO-WTO Joint Staff Working Paper

Prepared for the 2nd Review of Relevance and Effectiveness of the
WHO Global Code of Practice on the International Recruitment of
Health Personnel

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INTERNATIONAL HEALTH WORKER MOBILITY & TRADE IN SERVICES

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¹ This is a working paper, and hence it represents research in progress. This paper contains the opinion of the authors, and is the product of professional research. It is not meant to represent the position or opinions of the organizations (or Members of the organizations) to which the authors are affiliated. We would like to particularly acknowledge Jennifer Brant whose research and guidance was fundamental to the report. We would also like to express our gratitude to the WHO and WTO colleagues who assisted in the process: Abbas El Akari, Cris Scotter and Tadyuki Tanimura.

Abstract

Despite substantial and increasing importance to health systems and inclusive economic growth, the relationship between international trade in services and health worker mobility is one that has been largely unexplored. However, international health worker mobility and trade in services have both been increasing rapidly, and at a growing pace in recent years. Trade in services frameworks (global, regional, bilateral) are important vehicles for health worker mobility. In this paper we analyse the commitments made in the context of the GATS and regional and bilateral trade agreements that cover services. Although there is room for more and deeper commitments, undertakings related to health worker mobility are already made in many trade agreements, with commitments often more numerous and deeper in the regional/bilateral agreements than in the context of the GATS. In addition, trade in services frameworks contain flexibility to strengthen and advance ethical health worker mobility, in accordance with the principles and recommendations of the WHO Global Code of Practice on the International Recruitment of Health Personnel. A strengthened collaboration between health and trade stakeholders could therefore serve to significantly expand sustainable development worldwide. There is potential for health stakeholders to strategically leverage trade dialogue and agreements to meet health system needs. Building on available tools, trade in services could help address concerns of the health sector, by ensuring that health worker mobility can respond to the worldwide demand, while keeping in mind the shortages witnessed by many countries.

JEL: F13: Trade Policy • International Trade Organization, F16: Trade and Labor Market Interactions, F22: International Migration, F66: Labor, I11: Analysis of Health Care Markets, J61: Geographic Labor Mobility • Immigrant Workers

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International Trade in Services & Health Worker Mobility

“One of the most pressing challenges with which the WTO is confronted today is how to reconcile free trade and sustainable development. The relationship between the two issues is complicated and sometimes seems incompatible. Yet the maintenance of free trade helps economic development on a sustainable basis if these two issues are put into a proper relationship.”

- Mistuo Matsushita, Founding Member of the WTO Appellate Body

Key Messages

- Two important phenomenon are taking place concurrently: accelerating growth in trade in services and in international health worker mobility.
- Growth in trade in services has been higher than trade in goods over the last two decades, with trade in services accounting for almost half of world trade today. The international mobility of health workers has similarly increased in scale and complexity, with projections pointing to further acceleration.
- Trade in services frameworks (global, regional, bilateral) are important vehicles for international health worker mobility, but largely unrecognized.
- Seventy-one of WTO's Members provide mode 4 market access with respect to health services under GATS. Our research indicates that international commitments inscribed in regional and bilateral trade agreements are more numerous and deeper in scope.
- Trade in services frameworks contain flexibility to strengthen and advance ethical health worker mobility, in accordance with the principles and recommendations of the WHO Global Code of Practice on the International Recruitment of Health Personnel.
- Strengthened collaboration between health and trade stakeholders can serve to significantly expand sustainable development worldwide.
 - Potential for health stakeholders to strategically leverage trade dialogue and agreements to meet health system needs.
 - In turn, trade representatives, by responding to express concerns of the health sector, can ensure continued global growth in trade in services with associated benefits to the world economy.

I. Introduction

International trade in services is recognized as the most dynamic segment of world trade, growing faster than trade in goods. The impact of the health sector on the global economy and employment has evidenced similar dynamism, with faster growth than other important sectors.

Concurrently, the international migration and mobility of health workers is accelerating. At the political level, the tension between the increasing need to recruit foreign health workers and the domestic discourse related to migration and mobility, is creating new policy challenges. An examination of the contemporary relationship between international trade in services and health worker mobility is urgently required to better understand and support sustainable development of this important sector across its multiple dimensions: e.g. access to education, employment, health services, inclusive economic growth, and managed mobility.

A. International Trade in Services and Health

Up to recent decades the global economy has been largely driven by trade in goods. Yet, services reflect some of the most dynamic components of the economy, from space transportation to telecommunications to entertainment to the provision of healthcare, without omitting the digital dimension of such trade (e-commerce). Services, in particular, have had increasing influence on the socio-economic advancement of developing economies. Recent research reveals a strong correlation between services sector growth and overall GDP growth. One important study showed that in 50 developing countries, growth in services was more closely correlated with poverty alleviation than growth in agriculture.²

In the past 20 years, growth in trade in services has come to outpace trade in goods. Today, trade in services accounts for almost half of world trade³ – greater than manufacturing or agriculture. Despite this, trade in services often continues to be viewed by policymakers as an issue of lower relevance than trade in goods.

In contrast to barriers imposed at the border, such as customs and tariffs, which can affect trade in goods, barriers to trade in services are often imposed behind the border, in the form of legal and regulatory policies that discriminate between foreign and domestic suppliers of services or place limits on market access for suppliers.⁴ As services trade surges, it is important to put new efforts to strengthen mechanisms to enable and support this growth, increase transparency, and remove unjustified barriers. At the time of writing this is not occurring at the multilateral level, but some recent bilateral, regional or plurilateral initiatives

² Services: New Frontier for Sustainable Development. UNCTAD. "Exploiting the Potential for Trade in Services for Development" Volume 2. (2014). Accessed at http://unctad.org/en/PublicationsLibrary/ditctncd2013d4_en.pdf.

³ Considering trade in services as measured in the balance of payments (covering modes 1, 2 and 4), as well as sales of services of multinationals through their foreign affiliates (mode 3).

⁴ Aid 4 Trade 2017 Report. World Trade Organization. "Chapter 4: Services Trade Policies and Their Contribution to Connectivity and Development." (2017) Accessed at: https://www.wto.org/english/res_e/booksp_e/aid4trade17_chap4_e.pdf

aim at reinforcing trade rules pertinent for services. For example, the Comprehensive and Progressive Agreement for Trans-Pacific Partnership, which entered into force in December 2018, builds upon the WTO rules governing global trade in services.⁵

Little statistics exist today on the weight of health services in international trade, due to the lack of reporting of detailed official statistics by many economies. Given the volume of temporary health worker mobility, as described below, the contribution from mode 4 related services is potentially significant. As one example, the Cuban government forecasted that in 2014 foreign earnings of \$8 billion would be generated through Cuban health personnel's professional services abroad.⁶

B. Trends in Health Worker Mobility

It is widely recognized that there can be no health without the health workforce. Less well recognized is the leading contribution of the health sector to employment and economic growth. The aggregate size of the world's health sector stands at over USD 5.8 trillion per year⁷. The number of jobs in the sector is growing. Across OECD countries, employment in health and social work grew by 48 per cent between 2000 and 2014, while jobs in industry and agriculture declined. In 2017, the health and social sector contributed to 11 per cent of all employment in OECD countries⁸. The global economy is projected to create an additional 40 million health worker jobs by 2030, primarily in middle- and high- income countries.⁹

Concurrently, the international mobility of health workers is accelerating. Over the last decade, the number of migrant doctors and nurses working within OECD countries has increased by 60 per cent.¹⁰ The patterns of international health worker migration and mobility are also growing in complexity, with substantial intra-regional, South-South, and North-to-South movement, alongside better understood movement of health workers from the Global South to the Global North.¹¹

As defined by United Nations Economic Commission for Europe (UNECE), International labour mobility comprises all movement of natural persons from one country to another for the purpose of employment or supply of services.

⁵ Information Technology & Innovation Foundation. "Crafting an Innovation-Enabling Trade in Services Agreement." (2016). Accessed at <http://www2.itif.org/2016-tisa-services.pdf>

⁶ <https://www.reuters.com/article/cuba-reform-healthcare/cuba-ups-healthcare-sector-pay-says-medical-export-earnings-to-rise-idUSL2N0MI0C920140321>

⁷ Report of the UN High-Level Commission on Health Employment and Economic Growth. World Health Organization. "Working for health and growth: investing in the health workforce." (2016). Accessed at <http://apps.who.int/iris/bitstream/handle/10665/250047/9789241511308-eng.pdf?sequence=1>

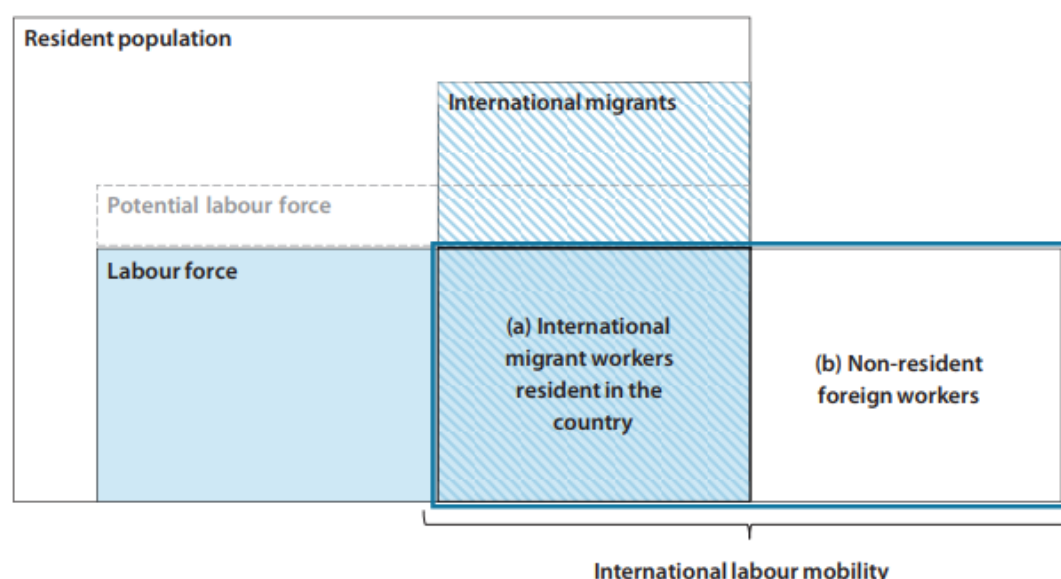
⁸ Id.

⁹ Id.

¹⁰ OECD, International Migration Outlook 2015 (2015). Accessed at https://www.oecd-ilibrary.org/social-issues-migration-health/international-migration-outlook-2015_migr_outlook-2015-en

¹¹ World Health Organization, "A dynamic understanding of health worker migration." (2017). Accessed at http://www.who.int/hrh/HWF17002_Brochure.pdf.

Graph 1: Relation of the concepts of usually resident population, international migration , labour force and labour mobility in a country



Source: UNECE¹²

International health worker mobility, including professional registration and employment or supply of services in multiple jurisdictions, is also becoming increasingly common. Of doctors who received their basic medical qualification in South Africa and are registered in Ireland, only one-fifth reported practicing only in Ireland.¹³ In Australia, between 2008 and 2016, the number of doctors and nurses granted work visas through temporary skilled worker schemes surpassed the number of permanent migrant doctors and nurses¹⁴. In the US, in 2016, 10,500 physicians were employed on temporary visas (H1B), representing 1.4 per cent of the total physician workforce¹⁵. In 2012, more than 62,000 health workers from Cuba were deployed in 66 countries across the globe on a temporary basis.¹⁶ In Japan, a trainee visa programme is to be launched in April 2019 to address labor shortages, with up to 60,000 nursing care workers expected to take temporary jobs.¹⁷ Similarly, within the EU, health professionals' temporary provision of services in other countries, like their occasional cross-border provision of services, is more flexibly regulated than those seeking permanent migration.¹⁸

¹² Measuring International Labour Mobility, UNECE (2019).

¹³ Id.

¹⁴ Hawthorne, Lesleyanne, "Health Workforce Mobility: Migration and Integration in Australia", Presentation at the WHO 4th Global Forum on Human Resources for Health (2017, Dublin). Accessed at: <http://www.who.int/hrh/Track-Health-workforce-mobility-Hawthorne-15Nov-15h30-17h.pdf>.

¹⁵ Kahn PA, Gardin TM. Distribution of Physicians With H-1B Visas By State and Sponsoring Employer. JAMA. 2017;317(21):2235–2237. doi:10.1001/jama.2017.4877

¹⁶ Msc. Olga Stolik Lipszyc et al. Exporting health services: concept elements, current situation and country experience. Revista Cubana de Ceconomia Internacional. Accessed: <https://www.who.int/trade/en/THpart2chap5.pdf?ua=1>.

¹⁷ <https://asia.nikkei.com/Spotlight/Japan-immigration/Japan-to-receive-60-000-nursing-helpers-in-new-visa-program>

¹⁸ <http://ec.europa.eu/growth/tools-databases/regprof/index.cfm>

Moreover, the supply of health professionals' education has both globalized and increased substantially over the last two decades. By way of example, in the state of Kerala, India, the number of seats available in nursing degree programs increased from 124 in 2005 to 17,600 in 2016¹⁹. Across India, the numbers of MBBS doctors produced annually has nearly doubled in a six-year period, from 37,192 in 2010/2011 to 63,985 in 2016/2017. Countries are also producing medical doctors specifically for the global labour market, as demonstrated by China's expansion of international medical education (English-medium), with as many as 3,500 international students enrolled in programmes annually²⁰. The increased production across countries also stands alongside substantial unemployment of health workers, particularly in countries with limited fiscal and financial absorptive capacity.

Strong international collaboration related to health worker mobility is evident across multiple fora and stakeholders. Over 120 separate bilateral agreements have been notified to the WHO Secretariat as part of the national reporting on the WHO Global Code of Practice on the International Recruitment of Health Personnel ("Code").²¹

C. Contribution of this Report

This report specifically examines the contemporary relationship between the international trading system (global, regional, and bilateral trade agreements) and the international mobility of health workers. The report begins with a description of the General Agreement on Trade in Services (GATS), including health worker mobility-related commitments made by WTO Members. It adds to previous understanding in the area, where WTO Members' GATS commitments related to the temporary cross-border flow of health professionals ("mode 4") have been described as "virtually non-existent".²² The report next describes the range of commitments embedded in regional trade agreements, identifying the ability of international trade negotiations to influence domestic regulations and behaviors. Current policy dialogues and innovations in trade, as potentially relevant to health worker mobility, are then discussed. The report concludes with a call for more strategic collaboration among health and trade stakeholders, including work to identify new research that could help to advance ethical health worker mobility and thus tangibly advance various aspects of sustainable development.

II. Methodology

The research team reviewed all commitments relevant to the movement of health service providers of WTO Members under the GATS regime, including on "Health and social services"; health-related services under "professional services". The team additionally

¹⁹ World Health Organization, "A dynamic understanding of health worker migration." (2017). Accessed at http://www.who.int/hrh/HWF17002_Brochure.pdf.

²⁰ http://www.moe.gov.cn/srcsite/A20/moe_850/201805/t20180531_337897.html

²¹ This paper has not analyzed the compatibility of such agreements with the GATS MFN obligation.

²² Adlung R., Carzaniga, A. (2006) Update on GATS Commitments and Negotiations: In Blouin C., Drager N., Smith, R. (Eds.). International Trade in Health Services and the GATS: Current Issues and Debates (pp. 87-99). Washington, DC: World Bank. Available at: <http://documents.worldbank.org/curated/en/405551468150322567/pdf/347700PAPER0In101OFFICIAL0USE0ONLY1.pdf>.

reviewed trade in services commitments as contained in 284 Regional Trade Agreements (RTAs) notified to the WTO as at January 2019. Detailed analysis was conducted on all 95 Regional Trade Agreements (RTAs) available in the I-TIP Services database.²³ Textual and statistical analysis of the GATS and RTA commitments was further supplemented with a literature review to qualitatively describe selected RTAs.

All errors and omissions in this Report are attributable to the research team/authors.

III. Trade in Services Commitments – WTO GATS

A. Overview of WTO and GATS

Created in 1995, the World Trade Organization administers several international agreements, that regulate international trade in goods and services. The WTO also administers a dispute settlement process to adjudicate claims by WTO Members that other Members have violated any of the WTO obligations and commitments made. The General Agreement on Trade in Services (GATS) establishes four major modes to trade in services, namely²⁴:

- Cross-border supply, without any movement on the part of either the supplier or the consumer, such as in telemedicine or e-health services (mode 1);
- Consumption abroad, i.e., the movement of consumers to another country to avail services (mode 2), e.g. health tourism;
- Commercial presence, e.g. the establishment of a health institution, e.g. in the form of a branch, subsidiary, affiliate, or joint venture and involves the movement of capital (mode 3); and
- Movement of natural persons, which refers to the temporary cross-border presence of service providers but not job seekers or permanent migration to the receiving country (mode 4).

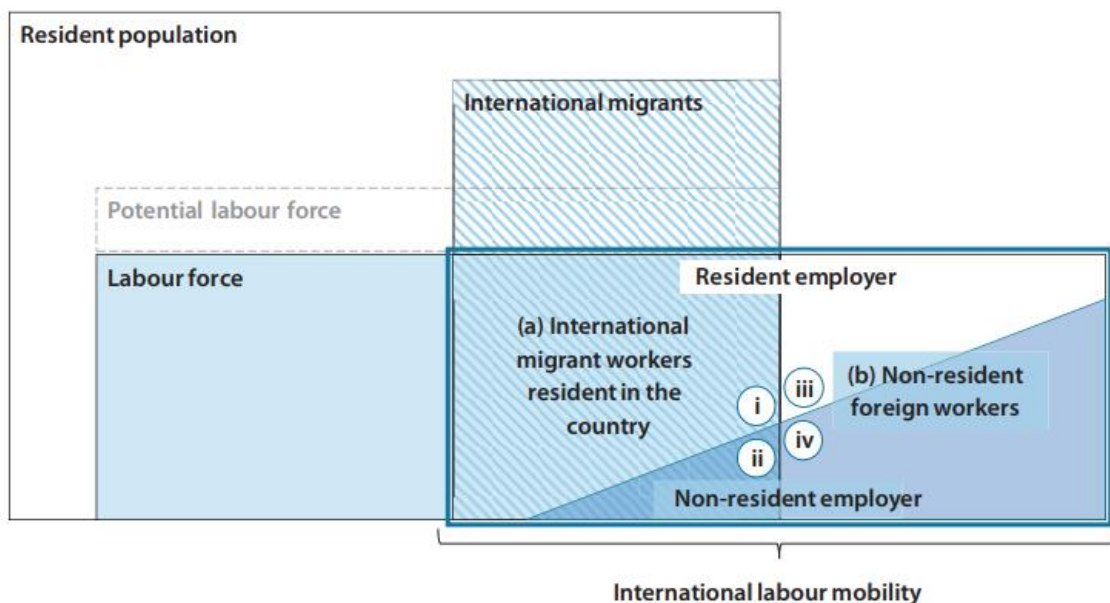
Of the “modes” identified above, mode 4 is most relevant to the movement of health workers, whether doctors, nurses, midwives, dentists, or other health workers. Mode 3, is indirectly relevant to health worker mobility. It can relate to establishment of a local office or subsidiary by a foreign health professional. Mode 4 relates to the temporary movement of individuals to deliver a service, for instance the temporary presence of nurses to staff a healthcare system abroad. Mode 4 covers individuals who are either service suppliers (such as independent professionals) or are employed by a foreign service supplier. GATS does not *“apply to measures affecting natural persons seeking access to the employment market of a Member, nor shall it apply to measures regarding citizenship, residence or employment on a permanent basis.”*²⁵

²³ The term « Regional trade agreements » encompasses bilateral trade agreements notified to WTO.

²⁴ The four modes identified are limited to health-related services. While the research is limited to health-related services, international health worker mobility is also linked to trade in educational services. The provision of on-the job training in the health sector in particular blurs the boundary between trade in health and education services.

²⁵ See GATS Annex on Movement of Natural Persons Supplying Services under the Agreement, at https://www.wto.org/english/tratop_e/serv_e/8-anmvnt_e.htm

Graph 2: Labour mobility and contractual relationship



Source: UNECE²⁶

Within the UNECE framework described above, from the perspective of the receiving country, mode 4 would cover non-resident foreign health workers employed by a non-resident employer (or self-employed), providing services to residents (categories iv), international migrant health workers employed by a non-resident employer and providing services to residents (ii), and those transferred within a transnational health institution (parts of (i) and (iii)).

Commitments to open services markets are made sector by sector, and recorded in each Member's "schedule". It is important to note that WTO Members' services markets are often more open than bound in GATS schedules; in other words, the applied regime is generally more open than that resulting from multilateral trade commitments. Nonetheless, the GATS commitments are important in that they set a baseline of liberalization that Members must respect, and they can spur opening, including adjustment of domestic regulation and policy, that might not otherwise have been politically feasible.

Under the WTO agreements, such as GATS, countries are normally not allowed to discriminate between their trading partners. Pursuant to the so-called most-favoured nation principle (MFN), if a country grants an advantage to another, it must extend it to all other WTO Members. Members were allowed to establish a one-off MFN exemptions list at the time of entry into force of the GATS in 1995, or when they joined WTO for more recent acceding Members.²⁷ Members are also allowed to deviate from the MFN requirement in the context of Regional Trade Agreements.²⁸ But a number of conditions need to be met for this to be possible, in particular that Members take commitments in RTAs covering the 4 modes of supply, providing for substantial sectoral coverage and eliminating substantially all

²⁶ Measuring International Labour Mobility, UNECE (2019).

²⁷ Only 4 Members, Bulgaria, Cyprus, Dominican Republic and Jordan, have explicitly listed exemptions relating to health services. Other relevant exemptions were more of horizontal nature, affecting professional services or more generally mode 4.

²⁸ Note that the terminology « Regional Trade Agreements » also includes bilateral agreements.

discrimination. In other words they should make more and deeper commitments than in the context of the multilateral GATS concessions.²⁹

The GATS applies to all WTO Members, as part of the basic package of obligations they sign up to when they join the WTO. GATS covers all service sectors, except services supplied in the exercise of governmental authority. The latter is defined as those services that are supplied neither on a commercial basis nor in competition with other suppliers.³⁰ The practice when undertaking market opening commitments is to define and classify services according to the Services Sectoral Classification List, which sets out 12 sectors, which are subdivided in approximately 160 subsectors.³¹ The service categories relevant to the supply of healthcare services are: “Health and social services” and relevant professional services subsectors under “Business services”. The GATS does not require privatization, liberalization, or deregulation of all services. Moreover, WTO Members can maintain public or private monopolies in any sector, subject to the MFN obligation and any commitments they have made.

Each Member’s schedule contains the list of sectors on which commitments are made, along with any remaining market access and national treatment limitations by mode of service supply. Market access is defined as the absence of six, mostly quota-type, restrictions, while national treatment requires Members to treat foreign and domestic service providers in the same way. However, with regard to both market access and national treatment, Members are not obliged to commit fully, provided they record any derogations/limitations in their schedules. For instance, Members retain the right in their schedules to apply “economic needs tests” (ENTs) before allowing market entry of foreign service providers. ENTs have been commonly recorded with respect to mode 4 and the health sector, often without underlying criteria for the application of the ENTs. The utilization of established Health Labour Market Analyses provides an important opportunity to simultaneously incorporate the needs of both labour markets and health systems through providing a more structured application of ENTs (see Box 1 below).

Applicable in principle to all sectors committed in their schedule, Members may also record “horizontal commitments” which, in the case of mode 4, generally cover the entry of specialized personnel, such as managers and senior staff. The horizontal commitments apply only to those sectors inscribed in a Member’s schedule, and should be read in conjunction with sector specific commitments.

Foreign service providers must meet domestic regulatory requirements to perform services. For instance, they must meet the licensing and training/qualifications that apply (see Box 3, below). Recognition of qualifications to perform a service, for instance to provide medical care in another jurisdiction, can be granted by one Member to qualifications obtained in certain countries. This is often granted bilaterally through an agreement or arrangement, but can also be done unilaterally. Given the tension with the MFN obligation, Members are allowed – but not required to – reach such agreements, provided that they do not entail substantive discrimination. Due to concerns that different types of behind-the-border non-

²⁹ See Article V of GATS.

³⁰ See https://www.wto.org/english/Tratop_e/serv_e/gatsqa_e.htm. Note that measures relating to air traffic rights are excluded from the scope of the agreement (see Annex on Air Transport services).

³¹ Document MTN.GNS/W/120, dated 10 July 1991.

discriminatory requirements can be excessively burdensome and thus undermine market access, including for domestic suppliers, multilateral services negotiations at the WTO have attempted to address such measures. In particular, emphasis has been on the need for transparency and good governance in rule-making. Efforts have not so far resulted in new disciplines.³²

The GATS Annex on the Movement of Natural Persons Supplying Services under the Agreement makes clear that the fact of applying differential visa requirements is not regarded as undermining commitments.³³

Box 1: Economic Needs Tests (ENTs)³⁴ and Health Labor Market Analysis (HLMA)

The “economic needs test” or “labour market test” is a test that conditions market access upon the fulfillment of certain economic or labour criteria. The term “economic needs test” is not defined in GATS and this limitation is often inscribed without indication of the criteria for its application. ENTs are most commonly recorded with respect to mode 4 and the health sector. ENTs are viewed as an important barrier for trade, and there have been repeated **calls by WTO Members for improved criteria, definition, transparency, and/or removal of them.**

In the health sector, the **standardized approach** to health labour market analysis has the potential to both provide discipline for mode 4 health sector ENTs and ensure health system sustainability. In particular, the health labour market analysis can improve the criteria, definition, and transparency of ENTs. HLMA uses harmonized approaches to assess labour market trends in the health sector, including attention to production, employment, and migration. It analyzes the key factors influencing the domestic supply of and demand for health workers, and strengthens the ability to forecast and plan for current and future health workforce needs.

WHO, working with its Member States, has introduced the HLMA process in the design of a new generation of bilateral cooperation. The approach takes explicit account of the labour market and health system needs in both partner countries. A first case example is to be launched in 2019.

B. WTO Member commitments under GATS

Of the 153 WTO Members’ schedules of commitments (EC-12 counted as one), 56 include commitments for the sub-sector “hospital services” and 28 for “other human health services. 62 have commitments on medical and dental services (CP 9312), and 28 on services provided by midwives, nurses, physiotherapists and others (CP 93191). The total number of schedules which have at least one commitment relating to health services therefore accounts for 79. Our research findings further indicate that 71 schedules provide mode 4 market access in relation to health services under GATS³⁵; 63 only have applicable mode 4 horizontal

³² Bridges Africa (2017). The WTO’s Buenos Aires Ministerial: What Is at Stake for Africa and LDCs?.

International Centre for Trade and Sustainable Development. Available at: <https://www.ictsd.org/bridges-news/bridges-africa/news/the-wto%E2%80%99s-buenos-aires-ministerial-what-is-at-stake-for-africa-and>.

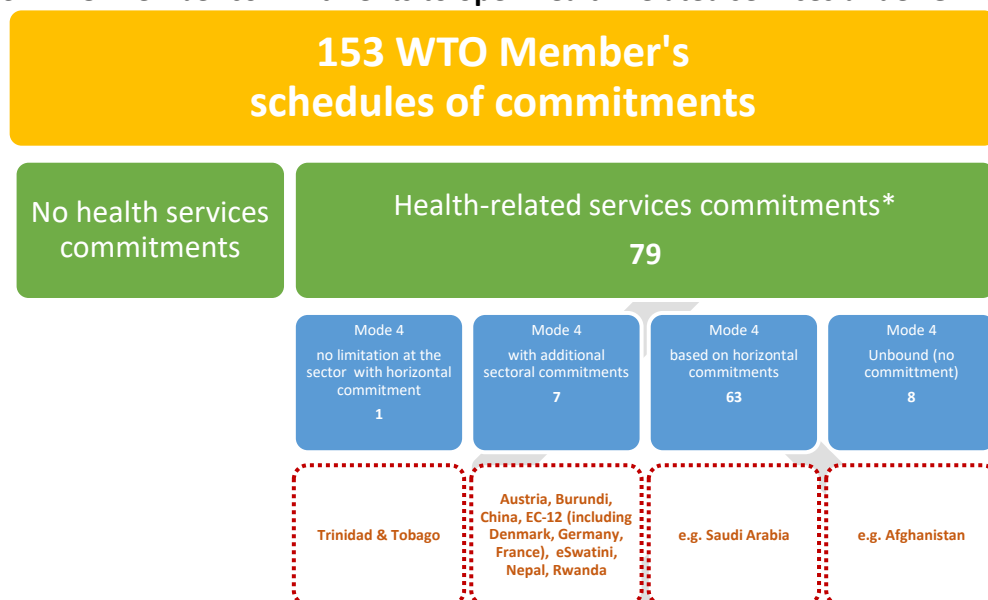
³³ See https://www.wto.org/english/tratop_e/serv_e/8-anmvnt_e.htm

³⁴ See https://www.wto.org/english/tratop_e/serv_e/mouvement_persons_e/mouvement_persons_e.htm

³⁵ Health-related services include Section 8 Health Related and Social Services and Section 1.A Professional Services (“medical and dental services” and “services provided by midwives, nurses, physiotherapists and para-medical personnel”), as per MTN.GNS/W/120.

commitments. 7 provide qualified sectoral mode 4 commitments in addition to the horizontal considerations. One (Trinidad and Tobago) indicates no limitation at the sector level (**Graph 3**).

Graph 3: WTO Member commitments to open health-related services under GATS



Below is an example of a commitment, for Saudi Arabia, as they relate to worker mobility and health-related services. Commitments are listed according to modes 1-4. Where the commitments are listed as “none” this means the Member commits to open that services sector completely (“no limitation”). Where commitments are listed as “unbound”, this indicates a lack of commitment. Finally, there are some commitments conditioned by limitations. As noted above, “horizontal commitments” apply to all services sectors which are listed in the schedule. Consequently, these should be read together with the commitment made at the sector level. However, where mode 4 service supply is “unbound” at the sector level, this means that health workers have no guaranteed access to the domestic services market even if there is a horizontal commitment.

Table 1: GATS commitments: Kingdom of Saudi Arabia, Medical and Dental Services

Member	Sector	Limitations on Market Access	Limitations on National treatment
Kingdom of Saudi Arabia	Medical and dental	Mode 1) None	Mode 1) None
		Mode 2) None	Mode 2) None
		Mode 3) Foreign equity limited to 75%	Mode 3) None
		Mode 4) Unbound except as indicated in the horizontal section	Mode 4) Unbound except as indicated

			in the horizontal section
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Source: WTO I-TIP Services Database

When looking at mode 4 commitments, it is therefore important to review what is indicated in the “horizontal commitments” in order to assess what market access has actually been provided in scheduled sectors. The commitments of Saudi Arabia, above, drive this point home. This Member has listed mode 4 as “unbound except as indicated in the horizontal section” and it is in its horizontal commitments that one finds what is specifically provided for in terms of market entry. Saudi Arabia has added sectoral specificity to its horizontal commitments by limiting access for certain mode 4 categories to given sectors, which include health professionals.

Figure 1: Kingdom of Saudi Arabia – Excerpt of Horizontal Commitments under GATS

<p>4) (iii)Contractual service suppliers Employees of contractual service suppliers, i.e. employees of juridical persons with no commercial presence in Saudi Arabia, who have obtained a service contract in Saudi Arabia requiring the presence of their employees in order to fulfil the contract. Entry and stay of such persons shall be for a period of no more than 180 days which would be renewable. Entry of such persons shall be allowed only for the following sub sectors on business services: Medical & dental services (CPC 9312) (iv)Independent Professionals Independent Professionals (i.e. natural persons) as part of a service contract with juridical person in Saudi Arabia for rendering professional services in which he/she possesses the necessary academic credentials and professional qualifications with three years experience in the same field. Their entry and stay shall be for a period of 180 days, which may be renewable [...] Medical & dental services (CPC 9312)</p>
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Source: WTO I-TIP Services Database

An additional seven WTO Members elaborate on the conditions for opening mode 4 supply of services in the relevant sectors, by inscribing “unbound except as indicated in the horizontal commitments”, plus additional sectoral considerations. The schedules of China and Nepal provide examples of this approach. The schedule of eSwatini (formerly Swaziland), which does not include any horizontal commitments, limits entry to specialist doctors, but with no additional market access or national treatment limitations.

Figure 2: China – Excerpt of Medical and Dental Services GATS commitments

<p>4) Unbound except as indicated in Horizontal Commitments and as follows: Foreign doctors with professional certificates issued by their home country shall be permitted to provide short-term</p>

medical services in China after they obtain licenses from the Ministry of Public Health. The term of service is **six months and may extend to one year**.

Source: WTO I-TIP Services Database

Figure 3: Nepal – Excerpt of Hospital Services GATS commitments

4) Unbound, except as indicated in the horizontal section.
Medical Experts can work with the permission of Nepal Medical Council **maximum of one year**.

Source: WTO I-TIP Services Database

Figure 4: eSwatini (formerly Swaziland) – Excerpt of Medical and Dental Services, and Hospital Services GATS commitments

4) Unbound except for **specialist doctors**

Source: WTO I-TIP Services Database

It is important to note that some Members also impose in their sector entry more specific conditions on the opening of their healthcare services to foreign service providers, under mode 4. For instance, Costa Rica provides conditions related to the availability of nationals (labour market test).

Figure 5: Costa Rica – Excerpt of Medical and Dental Services GATS commitments

4) Foreigners wishing to provide such services are required by law to be members of the Professional College. To this end they must fulfil the requirements of nationality and residence. In some cases, the recruitment of foreign professionals by State institutions is possible only when there **are no Costa Ricans ready to provide the service in the necessary conditions**.

Source: WTO I-TIP Services Database

The examples above demonstrate some of the variety and extent of strategies used by different WTO Members to guarantee access to their health sectors to foreign service suppliers. They are also used as a way to lock-in reform, improve regulation for the benefit of the people and development of the health sector. In general, commitments made by Members under GATS tend to be more conservative than those in bilateral or regional agreements. As we will see in the next section, commitments have been customized and liberalized to a greater extent under Regional Trade Agreements.

IV. Trade in Services Commitments – Regional Trade Agreements

A. Overview of RTAs

Regional Trade Agreements (RTAs) are trade agreements negotiated among two or a few economies. In recent years, the number of RTAs has risen significantly. This can be attributed to the fact that RTAs are relatively easier to conclude and targeted concessions can be traded more easily than in multilateral talks.

As explained in the previous section, GATS Article V allows WTO Members to deviate from MFN obligations in the context of RTAs; they may commit to open services markets to each other without having to offer the same concessions to all other WTO Members. As a matter of principle, RTAs generally contain deeper liberalization commitments than GATS.

Of the 284 RTAs notified to the WTO through January 2019, 149 had a services component. As services account for a growing share of GDP and an increasing share of global trade, the number of RTAs with a services component may be expected to rise over time. RTAs with service commitments can be categorized into those based on the GATS (often named « positive list approach»), those based on a « negative list approach » (such as NAFTA between the US, Mexico, and Canada) and RTAs with “other” forms.³⁶

One hundred fifteen RTAs include specific provisions on the presence of natural persons, generally in the form of a chapter or an annex.³⁷ In a 2018 study covering 144 agreements notified to the WTO and containing services provisions, this was the case for 76 per cent of the GATS-type agreements, 80 per cent of the NAFTA-type agreements, and all of the other agreements.³⁸ In particular, NAFTA-type agreements tend to include more disciplines than the GATS Annex on the movement of natural persons, especially with respect to transparency and procedures of admission.

Box 2: Recognition of Professional Qualifications of Service Providers in GATS and RTAs

Recognition of professional qualifications can be a critical factor affecting market access for service providers under mode 4. It is an especially relevant topic in relation to the provision of healthcare services, as the sector, for obvious reasons, is usually strongly regulated, and qualifications are at the cornerstone of the quality of the service and safety of patients.

GATS recognizes the right of Members to regulate, and to introduce new regulations, on the supply of services in order to meet national policy objectives. It does not impose on WTO Members the obligation to recognize professional qualifications of service suppliers of other WTO Members, nor does it encourage the conclusion of recognition agreements. Nonetheless, pursuant to GATS Article VII (Recognition), WTO Members may recognize education or experience obtained; requirements met; or licenses and certification granted in some countries but not in others. This is an obvious derogation from MFN as far as the procedural requirements are concerned, but does not allow for discrimination as far as the substantive conditions on the basis of which recognition is granted. However, in light of the significant regulatory variety on a global scale, a requirement to extend recognition to all would most probably erode the incentives to negotiate recognition agreements.

The most important obligation of GATS Article VII is that recognition should not be granted in a way which would amount to discrimination between countries as regards the application of its criteria

³⁶ Forthcoming World Bank dataset on PTA services provisions, prepared in co-operation with WTO.

³⁷ Id.

³⁸ Id.

for the authorization, licensing, or certification of service suppliers. Article VII also requires that WTO Members that conclude recognition arrangements must provide adequate opportunity to other Members to negotiate their accession to the agreement or to conclude a comparable agreement.

Several RTAs encourage the development of recognition agreements between the parties to facilitate trade in professional services. Frequently, these RTAs specify priority professions, while delegating the negotiation of such agreements to the relevant professional or industry bodies. 137 RTAs include provisions concerning recognition of standards, education, experience obtained, or licenses granted in certain jurisdictions. But only 44 percent are of a more binding nature than the permissive but not prescriptive treatment in the GATS. Numerous agreements do not provide for automatic recognition of qualifications. In fact, the scope of the agreements varies significantly: from far-reaching provisions (e.g. within the EU/EEA), to reduced requirements or procedures, to certain degrees of facilitation, and to what is nothing more than a broader form of cooperation or dialogue.

Mutual recognition agreements are generally reached between very similar countries. The majority of agreements exist between OECD countries, in particular as part of regional integration efforts or as a result of historical or cultural bonds (e.g. within the EU/EEA, between the US and Canada, Australia and New Zealand). Moreover, countries with former colonial ties (Latin America and Spain, Macau and Portugal, Australia and the UK) tend to conclude recognition agreements. Some non-OECD countries are part of the agreements between OECD countries, which are industry agreements or RTAs (e.g. Japan-Singapore New Age Economic Partnership Agreement, Asia Pacific Economic Cooperation forum or APEC, and New Zealand-Singapore Free Trade Agreement).

Source: Nielson 2004, Mattoo & Sauvé 2016; OECD; World Bank ³⁹

B. RTA Commitments on Health Services – Status and excerpts from Existing Texts

Scope of RTA commitments

To identify services commitments in RTAs that facilitate the temporary international mobility of health workers, we reviewed 95 services-related RTAs that have been notified to the WTO and that are included in the I-TIP Services database. We found that many RTAs had relevant provisions related to the international mobility of health workers. The review focused on services commitments made in relation to the WTO-established categories of health-related “professional services” and “health services”. There is significant variety among the nature and format of the commitments to provide for health worker mobility. As shown in table 2, a comparison of the mode 4 commitments for health-related services made by WTO Members in GATS with commitments in their (best) RTAs reveals that economies often take on more services opening commitments in regional and bilateral trade agreements than they do multilaterally, and they are often deeper in scope.

³⁹ Nielson, J. (2002). Service Providers on the Move: Mutual Recognition Agreements. Paris: OECD. Available at: [http://www.oecd.org/officialdocuments/publicdisplaydocumentpdf/?doclanguage=en&cote=td/tc/wp\(2002\)48/final](http://www.oecd.org/officialdocuments/publicdisplaydocumentpdf/?doclanguage=en&cote=td/tc/wp(2002)48/final)

Handbook of Deep Trade Agreements, World Bank, 2019

Table 2: Number of health-related services subsectors with mode 4 commitments, selected economies

	RTA	GATS		RTA	GATS
Australia	4	2	Montenegro	4	4
Canada	4	0	Morocco	4	0
Chile	4	0	New Zealand	4	0
China	4	1	Nicaragua⁴	4	0
Chinese Taipei	4	2	Norway	2	2
Colombia	4	0	Oman	4	2
Costa Rica	4	1	Pakistan	3	2
Dominican Rep.	4	3	Panama	4	1
El Salvador	4	0	Peru	4	0
European Union	4	4	Philippines	3	0
Guatemala	4	0	Rwanda	2	1
Honduras	4	0	Saudi Arabia	3	3
Hong Kong	2	0	Singapore	4	1
India	3	1	Switzerland	1	0
Japan	4	0	Tanzania	2	0
Jordan	4	4	Uganda	2	0
Korea, Rep. of	4	0	Ukraine	4	4
Malaysia	2	2	United States	4	1
Mexico	4	4	Viet Nam	2	2
Mongolia	3	0			

Note: Subsectors covered are hospital services; other human health services; medical and dental services; and midwives, nurses, physiotherapists and others. The RTA with most subsectors committed was selected for the comparison. For the European Union, the GATS commitments refer to the European Union 25 schedule.

Source: WTO I-TIP Services Database

Below we highlight some of the findings of the RTA review, referencing the UN Central Product Classification Provisional Version (CPC) for the service subsectors analysed. This analysis is conducted for mode 4. The text excerpts below illustrate the different approaches to services commitments in RTAs. Many of these could be replicated in other RTAs, whether integrated directly into the text or incorporated into the agreements via “side letters” outlining the arrangements, intentions and understandings of the Parties with regard to health worker mobility.

Some WTO Members merely replicate their GATS commitments in some RTAs in the relevant sectors, as is the case (below) with the Chinese commitments in the RTA with Pakistan (note that the horizontal commitment is identical). In some agreements, although the sectoral entry is similar, the horizontal commitment may be wider in scope (e.g. China-Switzerland, where an additional category, contractual service suppliers, is allowed to supply medical and dental services for up to one year). At the same time, many other WTO Members have used RTA negotiations to liberalize health-related services to a greater extent than under GATS, requesting and taking on deeper commitments within the regional or bilateral relationship. For instance, Singapore has taken new commitments for Hospitals services in the context of the Singapore-China free trade agreement. Some countries have taken commitments for

health services, to the extent they are not related to "social services established or maintained for public purposes" (e.g. Canada, United States). Alternatively, some countries have taken deeper commitments for sectors they were already covering in their GATS schedule, such as for Malaysia in its RTA with New Zealand, for Medical Specialty Services (CPC 93122).⁴⁰

Figure 6: Comparison of China's commitments in Pakistan/China RTA and GATS Schedules for Medical and Dental Services

RTA: Pakistan – China 2010	GATS
<p>Limitations on Market Access:</p> <p>4) Unbound, except as indicated in horizontal commitments and as follows:</p> <p>Foreign doctors with professional certificates issued by Pakistan shall be permitted to provide short-term medical services in China after they obtain licenses from the Ministry of Public Health. The term of service is six months and may extend to one year.</p>	<p>Limitations on Market Access:</p> <p>4) Unbound, except as indicated in Horizontal Commitments and as follows:</p> <p>Foreign doctors with professional certificates issued by their home country shall be permitted to provide short-term medical services in China after they obtain licenses from the Ministry of Public Health. The term of service is six months and may extend to one year.</p>

Source: WTO I-TIP Services Database

Figure 7: Comparison of Malaysia's commitments in New Zealand/Malaysia RTA and GATS for Medical Specialty Services

RTA: New Zealand – Malaysia 2009	GATS
<p>Limitations on Market Access:</p> <p>Unbound, except indicated in 2 in the horizontal section</p> <p>Limitations on National Treatment:</p> <p>4) None other than:</p> <ul style="list-style-type: none"> - practice only in private hospitals of at least 50 beds; - practice to be only at a specified location and a change of location requires approval; and - the setting up of individual or joint group practices is not permitted <p>Additional Commitments: The qualifying examination to determine the competence and ability to supply the service will be conducted in English language.</p>	<p>Limitations on Market Access:</p> <p>4) Unbound except as indicated in 2 a) in the horizontal section</p> <p>Limitations on National treatment:</p> <p>4) None other than:</p> <ul style="list-style-type: none"> practice only in private hospitals of at least 100 beds; practice to be only at a specified location and a change of location requires approval; and the setting up of individual or joint group practices is not permitted. <p>The qualifying examination to determine the competence and ability to supply the service will be conducted in the English language.</p>

⁴⁰ See <http://i-tip.wto.org/services/downloadfile.aspx?id=2246> and https://docs.wto.org/dol2fe/Pages/FE_Search/FE_S_S009-DP.aspx?language=E&CatalogueIdList=11649,35559,14911,8358&CurrentCatalogueIdIndex=3&FullTextHash=&HasEnglishRecord=True&HasFrenchRecord=True&HasSpanishRecord=True

<p>Horizontal Market Access Limitation: 2. Specialists or experts Persons who possess knowledge at an advanced level of continued expertise and subject to market test and the employment of Malaysians as counterparts and/or training of Malaysians through acceptable training programmes in the relevant services sector or subsector; The period of stay shall not exceed a total of 10 years.</p>	<p>Horizontal Market Access Limitation: 2. a) specialists or experts being persons who possess knowledge at an advanced level of continued expertise and who possess proprietary knowledge of the organizations' products and services subject to market test and the employment of Malaysians as counterparts and/or training of Malaysians through acceptable training programmes in the relevant services sector or subsector. [...] Entry and stay of natural persons [...] shall not exceed a total of five years</p>
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Source: WTO I-TIP Services Database

Quantitative restrictions

As indicated below, services liberalization related to movement of health workers under certain RTAs may be characterized by commitments with mode 4 quantitative limits such as quotas or the use of economic needs tests (or labour market tests, as economic needs tests are called in the case of mode 4), which limit entry of foreign workers in the absence of a demonstrated need for them. Economic needs tests can constitute an important barrier to services opening. They can take various forms, including, needs tests based on the commercial context in a given moment, or other conditions.

Figure 8: Economic Needs Tests of Switzerland in the RTA with Japan 2009

"The number of service suppliers admitted to practice on account of the compulsory medical and health insurance is limited per canton and per occupation (quantitative ceiling). **Cantons may exclude any further admission if the density of service suppliers in the canton is above the regional or the national average** (SR 832.10, Article 55a and SR 832.103, all Articles).

Swiss nationality is required to practice a medical profession independently. However, **a foreign natural person may exercise the medical profession in a practice provided the practice is located in a region where the number of professionals is proven to be insufficient (economic needs test), and if its diploma is recognised as equivalent and the foreign natural person speaks a national language.**

Moreover, a foreign natural person may be allowed to practice independently a medical profession in a specific hospital in the case where that person is allowed to teach within accredited course programmes in that hospital, and if his or her diploma is recognised as equivalent.

Source: WTO I-TIP Services Database

Figure 9: Economic Needs Test of Panama in Panama-US RTA 2012

Professional services

"Only a Panamanian may practice as a healthcare professional; agricultural science professional; barber; chemist; cosmetologist; customs agent; economist; journalist; library scientist; public

relations specialist; real state agent; social worker; sociologist; public translator; speech and language therapist; and veterinary doctor. **However a foreign national may practice in the following professions if the relevant professional council finds that no qualified Panamanian is available:** agricultural science professional; chemist; dietitian; medical doctor; medical radiology technician; nurse; nutritionist; odontologist; and veterinary doctor.

Source: WTO I-TIP Services Database

Licensing, qualifications and recognition

To facilitate immigration requirements, certain RTAs provide for the delivery or special and temporary licensing for foreign healthcare workers. An example is the RTA between Japan and the Philippines, under which the Philippines commits that “Special/temporary permit may be issued by Board of Nursing to foreign licensed” under certain conditions.⁴¹ The CAFTA Agreement between the US and Central America provides for other conditions for mode 4 service delivery, with the example of Costa Rica reprinted below.

Figure 10: Conditional Entry of Foreign Workers into Costa Rica in the CAFTA-DR-US RTA 2006

1.A Professional services

For greater certainty, subject to the conditions and terms included in the applicable legislation, **the following professional associations may provide temporary licenses to allow temporary professional practice in Costa Rica:** Biologists, Economists and Social Scientists, Political Scientists and International Relations Specialists, **Dental Surgeons, Pharmacists,** Physicists, Computer and Information Technology Professionals, Agronomical Engineers, Architects and Engineers, **Physicians and Surgeons,** Veterinarians, Journalists, Psychologists, Chemists and Chemical Engineers and Chiropractors.

For greater certainty, none of the measures listed in this Annex entry restricts enterprises in Costa Rica from otherwise employing foreign professionals in accordance with Costa Rican law in order to carry out contracts.

Source: WTO I-TIP Services Database

Approaches to the issue of qualifications and licensing can take many forms, including the text from the Switzerland-Japan RTA above, or the RTAs excerpted below. The example of Costa Rican commitments in the context of CAFTA (below) involves the conditions for membership in a relevant professional association.

The *recognition* of foreign qualifications for workers crossing borders is another critical issue for mode 4 service supply. This is especially true in relation to healthcare, a sector that tends to be highly regulated in many countries. Some RTAs explicitly state that mode 4 liberalization will be dependent upon conclusion of a Mutual Recognition Agreement (MRA) by which the parties explicitly provide for recognition of the credentials of health workers from the other party(ies). For instance, the RTA between India and Singapore specifies that, in relation to

⁴¹ See <http://i-tip.wto.org/services/default.aspx>

services provided by midwives, nurses, physiotherapists, and para-medical personnel (CPC 93191), mode 4 market access is “unbound pending finalization of MRA”.⁴²

Figure 11: Recognition of Licensure by Panama in US-Panama RTA 2012

1.A Professional services

Notwithstanding existing measures relating to requirements for the practice of professions referred to in this entry, the respective professional associations, institutions, or any other entity with authority to grant a license for the practice of the professions listed in the measures element of this entry (hereinafter referred to as the 'Authority') **will recognize the license granted by a jurisdiction in the United States, and allow the holder of that license to register with the Authority and to practice the profession in Panama, on a temporary basis, based on the license issued in a jurisdiction in the United States, in the following cases:**

- (a) no educational institution in Panama offers a course of study that would allow the practice of the profession in Panama;
- (b) the holder of the license is a recognized expert in the profession; or
- (c) allowing the professional to practice in Panama will, through training, demonstration, or other such opportunity, further the development of the profession in Panama."

Source: WTO I-TIP Services Database

Figure 12: Costa Rica Professional Association Membership in CAFTA-DR-US RTA 2006

1.A Professional services

To join the Professional Associations of Public Accountants, Pharmacists, Geologists, Physicians and Surgeons, Veterinarians, Lawyers (i.e., Notaries), **Dental Surgeons**, Optometrists, Journalists, **Nurses, Medical and Surgical Technicians and Medical Sciences Branches**, **all foreign professionals must prove that, in their home jurisdiction where they are allowed to practice, Costa Rican nationals can exercise their profession under like circumstances.**

To join the Professional Associations of Public Accountants, Pharmacists, Geologists, Agronomical Engineers (Forestry or Agriculture/Livestock Appraisers-Surveyors), Physicians and Surgeons, Veterinarians, Dental Surgeons, Journalists, Medical and Surgical Technicians and Medical Sciences Branches, Computer and Information Technology, Nurses and Official Translators and Interpreters, foreign professionals must have the migratory status of residents in Costa Rica at the time of applying for membership, as well as have a certain minimum number of years of residence.

The number of years varies from one Professional Association to another, but usually ranges between two to five years.

Source: WTO I-TIP Services Database

C. Other health-related provisions

Finally, there are provisions related to healthcare services that are uncommon across RTAs but nonetheless worth noting. For instance, some RTAs provide for fully open market access

⁴² See <http://i-tip.wto.org/services/downloadfile.aspx?id=1348>

for healthcare services delivered as part of charitable work, including free medical missions, while otherwise imposing conditions on market access and national treatment for foreign service providers and services supplied commercially. An example is provided by India's commitments in its RTA with Japan, below, in relation to mode 4 provision of medical and dental services (CPC 9812) and hospital services (CPC 9311).⁴³ The mode 3 commitment is also reproduced because of the relationship to the mode 4 commitment relating to intra-corporate transfers.

Figure 12: Liberalization of Access for Charitable Work by India in the India-Japan RTA 2011

Limitations on Market Access:

- 3) Only through incorporation with a foreign equity ceiling of 74 percent and subject to the condition that the latest technology for treatment will be brought in Publicly funded services may be available only to Indian citizens or may be supplied at differential prices to persons other than Indian citizens.
- 4) Unbound except as in the horizontal section. **None for charitable purposes.**

Source: WTO I-TIP Services Database

D. Examples of RTAs with Substantive Commitments on Health Worker Mobility

While it is not the norm, certain RTAs set out fairly detailed regimes regarding the movement of health workers. One noteworthy example is the Economic Partnerships Agreements (EPA) between Japan and the Philippines (JPEPA, 2009), Indonesia (IJEPA, 2008), and Viet Nam (JVEPA, 2008).⁴⁴ In the case of the JVEPA, the parties agreed to enter into negotiations about the possibility of accepting Vietnamese certified care-workers in Japan. The JVEPA articulates two commitments on the part of Japan: (i) the granting of entry for one to three years for a natural person of Viet Nam who has qualified under the Japanese law by passing the “kangoshi” examination in Japanese; and (ii) an undertaking to negotiate within two years from the entry into force of the agreement the possibility of accepting Vietnamese qualified nurses. Following an exchange of diplomatic notes on the “Entry and Temporary Stay of the Natural Persons of Viet Nam Who Engage in Supplying Services as Nurses or Certified Care Workers or Related Activities in Japan,” Japan began accepting Vietnamese candidates for nurses and care-workers as of 2014.⁴⁵

The relevant texts in the RTAs with the Philippines and Indonesia are almost identical, establishing a detailed and complex regime. Under these provisions, Japan grants access to qualified nurses and qualified care-workers selected and presented by the administration of their country of origin. The beneficiaries are required to first learn the Japanese language

⁴³ A designation of “none” in relation to limitations on market access and limitations on national treatment indicates that trade in services in that sector has been fully liberalized for the relevant mode.

⁴⁴ According to 2018 figures, 1,118 nurses and 2740 care-workers from the Philippines, Indonesia, and Vietnam entered Japan between 2008 and 2016, under the three EPAs. Japan International Cooperation of Welfare Service (JICWELS), Pamphlet on the Acceptance of Nurse and Care workers under EPA, 2017, p.39.

⁴⁵ See <https://www.japantimes.co.jp/news/2015/04/19/national/for-foreign-caregivers-role-remains-ambiguous/#.WyAvH2gvy70>

over a period of six months and subsequently to follow a training course within a designated Japanese medical institution to prepare for the Japanese examination for nurses or care-workers during a renewable period of one year. They can take the examinations up to three times and durations of stay are extendable accordingly. Their recruitment is allowed only by the Philippine Overseas Employment Administration (POEA) and Japan International Cooperation of Welfare Service (JICWELS). The costs of recruitment, which are to be paid by the Japanese employers to Philippine Overseas Employment Administration (POEA), amount to USD435 as a processing fee, inclusive of contract guarantee, and USD25 as contribution to the Worker's Welfare Fund per selected worker. Pursuant to the agreements, Japan is entitled to set annual quotas for the two categories of applicants to the examinations as well as global quotas. In addition, Japan can withdraw these quotas by invoking a mechanism similar to a safeguard. The Philippines also agreed new market opening for Japanese health services providers, as presented below in Figure 13.

Of note, provisions affording access to the Japanese labour market in the health sector are only a small portion of the more comprehensive EPAs. Negotiating access to the Japanese health labour market was a key trade priority for Philippines, Indonesia, and Vietnam.⁴⁶ In the case of Indonesia, **the IJEPA included agreement for technical assistance and financial support through the multi-year Japan International Cooperation Agency (JICA) project designed to enhance nursing competency through in-service training.** As an illustration, the negotiation of IJEPA was led by the Ministry of Trade and included participation from the Ministry of Manpower and Transmigration, National Agency for the Protection and Placement for International Migrants, the Ministry of Health, the Ministry of Foreign Affairs, and the Ministry of Education.⁴⁷

Box 3: Qualification requirements to take the Japanese national nurses/caretakers exams for Indonesian and Filipino applicants

Country	Conditions to take the national exams for (i) nurses and (ii) caretakers	Period of stay
Indonesia	<p>(i) Qualification as a nurse in Indonesia, professional experience of at least 2 years and some basic knowledge of Japanese language, equivalent to N5 (entry level)</p> <p>(ii) (a) Completion of studies at a higher educational institution and a qualification as a caretaker in Indonesia, or (b) completion of studies at a nursing school in Indonesia</p>	Under the status of residence of "Designated Activities (EPA)" 6 months/ 1 year/3 years per stay Unlimited number of renewals of a permission of stay

⁴⁶ Takahashi Kazu, Japan's Immigration Policy and the EPA between the Philippines and Japan, Yamagata University Faculty of Humanities & Social Sciences Annual Research Report, 15 (2018.3) 161—170

⁴⁷ Effendi F. et al, *IJEPA: Grey Area for Health Policy and International Nurse Migration*, Nursing Ethics, September 2015.

Philippines	<p>(i) Qualification as a nurse in the Philippines and professional experience of at least 3 years</p> <p>(ii) (a) Completion of 4 years of study at university and a qualification as a caretaker, or (b) completion of studies at a nursing school in the Philippines</p>	<p>Under the status of residence of "Medical Services"</p> <p>3 months/ 1 year/3 years/ 5 years per stay Unlimited number of renewals of a permission of stay</p>
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Source: WTO⁴⁸

In the RTA between Japan and the Philippines, the relevant text related to Health Professionals qualifications is:

Figure 13: Recognition of Health Professionals Nursing for Philippines in Japan-Philippines RTA

Philippines: 1.A Health Professionals Nursing

Limitations on National Treatment:

3 and 4) A. Foreigners may take the licensure exam if they are citizens or subjects of a country which permits Filipino nurses to practice within its territorial limits on the same basis as the subject or citizen of such country, provided that the requirements for the registration or licensing of nurses in said country are substantially the same as those prescribed in the Philippine Nursing Act (RA 9173).

B. A certificate of registration/ professional license may be issued without examination to nurses registered under the laws of a foreign state or country, provided that the requirements for registration or licensing of nurses in said country are substantially the same as those prescribed under the Philippine Nursing Act and the laws of such state or country grant the same privileges to registered nurses of the Philippines on the same basis as the subjects or citizens of such foreign state or country.

C. Special/temporary permit may be issued by Board of Nursing to foreign licensed nurses if they are:

- a. **Internationally well-known specialists/ outstanding experts in any nursing specialty;**
- b. **On free medical mission in particular hospital/center/ clinics; or**
- c. **Employed by nursing schools/ colleges as exchange professors in any nursing branch/specialty.**

4) As indicated in the horizontal section for Professional Services. Same as in 3)

Source: WTO I-TIP Services Database

V. Processes Relevant to Opening Trade in Health Services

A. Ongoing Work at the WTO

Trade in services under the GATS are meant to be progressively liberalized and, in fact, multilateral discussions began as far back as 2000 to this end, as mandated under the GATS itself. They continued as part of the Doha Round, but there has been little progress and the

⁴⁸ https://www.wto.org/english/tratop_e/tpr_e/s351_e.pdf

request/offer process of negotiating new commitments is now on hold. Of close to 100 negotiating proposals and of 20 plurilateral requests on sectors and modes of interest, none concerned health services. In addition very little improvements were offered for the sector mode 4 for health and social services (3 new commitments, 4 improvements to existing commitments), as well as for relevant professional services (5 new, 5 improvements).

At the time of writing there were renewed efforts by certain WTO Members to negotiate disciplines on domestic regulation which will eventually be beneficial to trade in health services if these discussions conclude successfully.⁴⁹

The WTO Council for Trade in Services is responsible for facilitating the operation of the GATS; it is the locus in the WTO where trade in services-related issues are discussed, on the basis of Members' proposals. Given that the Doha Round talks, in relation to services as well as other trade topics, are currently stalled, it is very unlikely that GATS commitments will be updated in the near future as part of multilateral trade negotiations. Nonetheless, the Council for Trade in Services provides an important forum for discussing multilateral trade in services issues. For instance, a thematic seminar was held by the Council on Trade and Services in 2018, on the temporary movement of natural persons across borders for the purpose of supplying services. However, no discussion related to health services generally, or on the mobility of health professionals has taken place thus far.⁵⁰

B. The WTO LDC Services Waiver

WTO Members agreed that special treatment should be accorded to LDCs in relation to trade in services negotiations. They committed to considering LDC interests when opening their services sectors in the context of the multilateral services talks. In the context of the Doha Development Agenda negotiations, at the Hong Kong Ministerial meeting in 2005, WTO Members agreed to “give priority to the sectors and modes of supply of export interest to LDCs, particularly with regard to movement of service providers under Mode 4”.⁵¹

In December 2011, it was agreed that, notwithstanding the MFN obligation, Members willing to do so could grant unilaterally preferential treatment to services and service suppliers from LDCs. The so-called LDC Services Waiver will expire in 2030. The preferences should be targeted towards market access issues, but some other types of preferences (e.g. national treatment, technical assistance) may be accorded if agreed by the Council for Trade in Services. LDCs were asked to identify their priorities for services sector liberalization in order to help WTO Members to target needs of services and suppliers originating from LDC countries.⁵²

The resulting “Collective Request” submitted by LDCs in July 2014 sets forth a range of demands, both cross-cutting and in relation to specific services, that are of interest to the LDC

⁴⁹ The impact of such discussions is difficult to assess, and will depend on the number of Members that adopt such disciplines, their extent, as well as their scope (only to subsectors committed or all sectors).

⁵⁰ https://www.wto.org/english/tratop_e/serv_e/mode_4_at_work_e/seminar_e.htm

⁵¹ See https://www.wto.org/english/thewto_e/minist_e/min05_e/final_text_e.htm

⁵² See document WT/L/918.

group as a whole.⁵³ Doctors, dentists, and medical technicians as well as Nurses, midwives, Physiotherapists, and Practitioners of traditional therapies are identified in the Collective Request as of particular interest. The asks in the request focus, to a large extent, on waivers for visa, residency permits and other administrative requirements of service provision, especially for individuals. The request calls for market opening concessions, as well as technical assistance and capacity-building. Following submission of the request, 51 Members have submitted preferential treatment notifications under the LDC Services Waiver.⁵⁴ Examples of notifications in the area of health services are presented in Annex 1.

There are also some additional mode 4 horizontal preferences, which also have implications on existing health related GATS commitments (e.g. Norway, Turkey). Some Members also accorded some preferences relating to the facilitation of obtention of visas by nationals of LDCs (India, Turkey), or relating to technical assistance to service suppliers of LDCs (India, China, Turkey) or the establishment of dedicated contact points(Switzerland).

Given the extension of the Waiver through 2030 there is time for additional WTO Members to notify concessions for LDCs and to provide capacity-building to help their service providers to take advantage of them.

VI. Discussion and Conclusion

Despite substantial and increasing importance to health systems and inclusive economic growth, the relationship between international trade in services and health worker mobility is one that has been largely unexplored. GATS mode 4 commitments in particular have been dismissed as insignificant. The interests of the trade and health communities, with respect to health worker mobility, have also generally been described in binary and adversarial terms. Within the health community, there is a longstanding concern related to the treatment of people as “tradeable commodities” and the negative impact of “brain drain” on developing countries.

Our examination of the relationship between trade in services and health worker mobility seeks to provides a deeper, more nuanced understanding, and one that evidences the potential of the international trading system to maximize benefits from health worker mobility while guarding against adverse effects. Notably, the analysis in this Report about health worker mobility-related commitments in GATS and services RTAs revealed that:

- First, a variety of commitments to open mode 4 trade in health-related services do exist;
- Second, the trade in services frameworks (global, regional, bilateral agreements) have resulted in the development of vehicles to facilitate and manage health worker mobility, and in specific cases has evidenced the ability to bring together the variety of national interests (education, foreign affairs, health, labour, migration and trade) related to health worker mobility ;

⁵³The Collective Request can be downloaded [here](#).

⁵⁴ See https://www.wto.org/english/news_e/news18_e/serv_02mar18_e.htm

- Third, the trade in services frameworks contain flexibility to strengthen and advance ethical health worker mobility, in accordance with the WHO Global Code of Practice on the International Recruitment of Health Personnel, with further analysis required on how best to leverage trade rules to meet the needs of sending countries, destination countries, and health workers.

The WHO Global Code of Practice on the International Recruitment of Health Personnel seeks to strengthen the legal and institutional framework in relation to international health worker mobility, including formulation and implementation of bilateral agreements, with particular focus on the needs of developing countries and health systems. Our research on trade agreements points to areas of consistency with the ethical principles articulated in the WHO Global Code. This includes provisions within RTAs which facilitate national treatment; circular mobility; education exchange and investment; skills exchange; filling of gaps in domestic skills in developing countries; mobility for charitable purposes; reductions in recruitment fees; and the protection of health worker welfare. Inclusion of development assistance in the Indonesia- Japan Economic Partnership Agreement, with focus on nursing education in Indonesia through JICA, stands as a particularly important example.

We believe that trade agreements and the WHO Global Code can be mutually reinforcing, with positive language from GATS and RTAs consistent with the WHO Global Code replicated in targeted bilateral agreements on health workers. The use of the recognized and harmonized “health labour market analysis”, in both sending and receiving countries, can serve to further clarify the “economic needs test/labour market tests” of the GATS and further liberalize trade in services, by better targeting demonstrated needs. The utilization of such analysis would also address and mitigate concerns related to “brain drain”. Use of economic needs tests in this way could provide confidence at the national, as well as sub-national, level that liberalization of services provision benefits rather than harms socio-economic advancement.

The potential to incorporate provisions to support international technical cooperation and financial assistance with respect to health personnel education in RTAs also holds important promise.

Some WTO Members have used the GATS commitments to attract the health skills and workers they require. Even though the multilateral WTO services negotiations are currently stalled, there could nonetheless be opportunities to leverage what already exists in terms of mode 4 market access for health services, while creating new mobility opportunities for qualified professionals from low income countries with excess production.

We consider that further research on the following topics could be useful: the relationship between GATS, RTA commitments and applied regimes for mode 4 delivery of health-related services; the extent to which behind-the-border measures as well as immigration-related requirements might affect mode 4 health trade in the real economy; the comparative advantage of trade dialogue to penetrate domestic regulation and policy; the extent to which potential deeper existing commitments in mode 4 delivery of health services could provide opportunities for greater temporary movement of qualified health workers; and the linkage between trade in educational services and international health worker mobility.

In closing, we hope the research presented in this Report will contribute to new collaboration and to the development of new tools that support the liberalization of trade in services and the movement of health workers in a manner that maximizes socio-economic development. We underscore, in particular, the significant overlap in the types of issues addressed by the health and trade communities in this sector. We also highlight the significant opportunity to ensure greater coherence across the education, health, labour, foreign affairs, immigration and trade sectors in order to create the conditions for increasing and transforming health workforce supply and strengthened health systems to meet people's needs.

Health officials and stakeholders in particular could more strategically leverage trade agreements and dialogue to meet the needs of their health systems. Trade representatives, by responding to express concerns of the health sector, in turn can ensure the continued global growth in trade in services with associated benefits to the world economy.

Annex 1: Examples of notifications under the WTO LDC Waiver by Chile, EU, Mexico

Services sector	Market access
Chile	
Midwifery, nursing, physiotherapeutic and paramedical services (CPC 93191)	(4) Unbound, except as indicated in the horizontal section Horizontal commitment covers intra-corporate transfers, business visitors, contractual service suppliers
EU	
Intra-corporate transfers, business visitors	If no indication, means No limitation
h) Medical (including psychologists) and Dental services (CPC 9312 and part of CPC 85201)	In CZ, IT, SK: Residence requirement In CZ, EE, RO, SK: Authorisation by the competent authorities required for foreign natural persons. In BE, LU: For graduate trainees, authorisation by the competent authorities required for foreign natural persons In BG, CY, MT: Condition of nationality In DE: Condition of nationality which can be waived on an exceptional basis in cases of public health interest In DK: Limited authorisation to fulfil a specific function can be given for maximum 18 months and requires residence. In FR: Condition of nationality. However, access is possible within annually established quotas. In LV: Practice of medical profession by foreigners requires the permission from local health authority, based on economic needs for medical doctors and dentists in a given region. In PL: Practice of medical profession by foreigners requires the permission. Foreign medical doctors have limited election rights within the professional chambers In PT: Residence requirement for psychologists.
j) 1. Midwives services (part of CPC 93191)	In AT: In order to establish a professional practice in Austria, the person concerned must have practised the profession in question at least three years preceding the setting up of that professional practice In BE, LU: For graduate trainees, authorisation by the competent authorities required for foreign natural persons In CZ, CY, EE, RO, SK: Authorisation by the competent authorities required for foreign natural persons In FR: Condition of nationality. However, access is possible within annually established quotas In CY, HU: Nationality condition In IT: Residence requirement In LV: Economic needs determined by the total number of midwives in the given region, authorized by local health authorities In PL: Nationality condition. Foreign persons may apply for permission to practise
j) 2. Services provided by Nurses, Physiotherapists	In AT: Foreign services suppliers are only allowed in the following activities: nurses, physiotherapists, occupational therapists, logotherapists, dieticians and nutricians. In order to establish a

and Paramedical Personnel (part of CPC 93191)	<p>professional practice in Austria, the person concerned must have practised the profession in question at least three years preceding the setting up of that professional practice</p> <p>In BE, FR, LU: For graduate trainees, authorisation by the competent authorities required for foreign natural persons</p> <p>In CY, CZ, EE, RO, SK: Authorisation by the competent authorities required for foreign natural persons.</p> <p>In CY, HU: Condition of nationality.</p> <p>In DK: Limited authorisation to fulfil a specific function can be given for maximum 18 months and requires residence.</p> <p>In CY, CZ, EL, IT: Subject to economic needs test: decision is subject to regional vacancies and shortages</p> <p>In LV: Economic needs determined by the total number of nurses in the given region, authorized by local health authorities</p>
<p>8. HEALTH SERVICES AND SOCIAL SERVICES (only privately funded services)</p> <p>A. Hospital Services (CPC 9311)</p> <p>B. Ambulance Services (CPC 93192)</p> <p>C. Residential health facilities other than hospital services (CPC 93193)</p> <p>E. Social Services (CPC 933)</p>	<p>In FR: The necessary authorisation for the access to management functions takes into consideration the availability of local managers</p> <p>In LV: Economic needs tests for doctors, dentists, midwives, nurses, physiotherapists and para-medical personnel.</p> <p>In PL: Practice of medical profession by foreigners requires permission. Foreign medical doctors have limited election rights within the professional chambers.</p>
Contractual service suppliers	
Medical (including psychologists) and dental services (CPC 9312 and part of CPC 85201)	<p>In SE: None.</p> <p>In BE, CZ, DE, DK, EE, ES, IE, IT, LU, MT, NL, PL, PT, RO, SI: Economic needs test.</p> <p>In AT: Unbound except for psychologists and dental services, where: Economic needs test.</p> <p>In BG, EL, FI, FR, HU, LT, LV, SK, UK: Unbound.</p> <p>In CY: Nationality condition</p>
Midwives services (part of CPC 93191)	<p>In SE: None.</p> <p>In AT, BE, CZ, DE, DK, EE, EL, ES, IE, IT, LT, LV, LU, MT, NL, PL, PT, RO, SI: Economic needs test.</p> <p>In BG, FI, FR, HU, SK, UK: Unbound.</p> <p>In CY: Nationality condition</p>
Services provided by nurses, physiotherapists and paramedical personnel	<p>In AT, BE, CZ, DE, DK, EE, EL, ES, IE, IT, LT, LV, LU, MT, NL, PL, PT, RO, SI, SE: Economic needs test.</p> <p>In BG, FI, FR, HU, SK, UK: Unbound.</p> <p>In CY: Nationality condition</p>

(part of CPC 93191)	
Mexico	
Medical and dental services(CPC 9312)	<p>(4) As indicated under horizontal measures</p> <p>Horizontal commitment covers intra-corporate transfers, business visitors, professionals</p>

Source: WTO documents S/C/N/821, 834, 840.

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