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Working Paper

International health worker mobility and trade in services

WTO Staff Working Paper, No. ERSD-2019-13

Provided in Cooperation with:

World Trade Organization (WTO), Economic Research and Statistics Division, Geneva

Suggested Citation: Carzaniga, Antonia Giulia; Dhillon, Ibadat S.; Magdeleine, Joscelyn; Xu, Lihui (2019) : International health worker mobility and trade in services, WTO Staff Working Paper, No. ERSD-2019-13, World Trade Organization (WTO), Geneva, <https://doi.org/10.30875/9ba2dfed-en>

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World Trade Organization

Economic Research and Statistics Division

**INTERNATIONAL HEALTH WORKER MOBILITY
&
TRADE IN SERVICES**

WHO-WTO JOINT STAFF WORKING PAPER

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Manuscript date: 28 November 2019

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International health worker mobility and trade in services

WHO–WTO joint staff working paper¹

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Abstract:

Despite its substantial and increasing importance to health systems and inclusive economic growth, the relationship between international trade in services and health worker mobility 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 an important vehicle for health worker mobility. In this paper we analyse the commitments made in the context of the General Agreement on Trade in Services (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 more numerous and deeper in the regional and bilateral agreements than in the context of 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 the concerns of the health sector by ensuring that health worker mobility can respond to worldwide demand, while explicitly addressing health systems concerns across countries.

Keywords: health services, trade in services, health worker, worker mobility.

JELClassification: 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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Abbreviations

APEC	Asia-Pacific Economic Cooperation
CAFTA-DR	Dominican Republic-Central America-United States Free Trade Agreement
CPC	Central Product Classification
EEA	European Economic Area
ENT	economic needs test
EPA	economic partnership agreement
EU	European Union
GATS	General Agreement on Trade in Services
GDP	gross domestic product
I-TIP	Integrated Trade Intelligence Portal
JICA	Japan International Cooperation Agency
LDC	least developed country
MBBS	Bachelor of Medicine, Bachelor of Surgery (Latin: Medicinae Baccalaureus, Baccalaureus Chirurgiae)
MFN	most favoured nation
MRA	mutual recognition agreement
NAFTA	North American Free Trade Agreement
OECD	Organisation for Economic Co-operation and Development
RTA	regional trade agreement
UNECE	United Nations Economic Commission for Europe
WHO	World Health Organization
WTO	World Trade Organization

“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

Introduction

International trade in services is recognized as the most dynamic segment of world trade, growing faster than trade in goods and accounting for over 40 per cent of world trade today.² 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, with projections pointing to further acceleration. At the political level, new policy challenges are being created by the tension between the increasing need to recruit foreign health workers and the domestic discourse related to migration and mobility. An examination of the contemporary relationship between international trade in services and health worker mobility is urgently required to better understand and support the sustainable development of this important sector across its multiple dimensions, including access to education, employment, health services, inclusive economic growth and managed mobility.

Trade in services frameworks (global, regional, bilateral) are important vehicles for international health worker mobility, but are largely unrecognized. Sixty-one of World Trade Organization's (WTO) Members provide mode 4 market access with respect to health services under the General Agreement on Trade in Services (GATS). Our research indicates that international commitments inscribed in regional and bilateral trade agreements are more numerous and deeper in scope.

These 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. There is also potential for health stakeholders to strategically leverage trade dialogue and agreements to meet health system needs. In turn, trade representatives, by responding to expressed concerns of the health sector, can ensure continued global growth in trade in services with associated benefits to the world economy.

² Authors' calculation, based on Trade in Services by Modes of Supply (TiSMoS) experimental dataset. See https://www.wto.org/english/res_e/statistics_e/trade_datasets_e.htm#TISMOS.

This report specifically examines the relationship between the international trading system (global, regional and bilateral trade agreements) and the international mobility of health workers. To achieve this, we reviewed all commitments relevant to the movement of health service providers of WTO Members under the GATS. We additionally reviewed trade in services commitments as contained in regional trade agreements (RTAs) notified to the WTO as at January 2019.³ Textual and statistical analysis of the GATS and RTA commitments was further supplemented with a literature review to qualitatively describe selected RTAs.

The report begins with a description of the GATS, including health worker mobility-related commitments made by WTO Members. It adds to previous work in the area, where the GATS commitments of WTO Members related to the temporary cross-border flow of health professionals (“mode 4”) were analyzed (*1*). The report next describes commitments (and some domestic regulation disciplines) embedded in regional trade agreements. 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 a call for new research that could help to advance ethical health worker mobility and thus tangibly advance various aspects of sustainable development.

³ See <http://rtais.wto.org/UI/PublicMaintainRTAHome.aspx>. Detailed analysis was conducted on all 95 RTAs available in the I-TIP Services database (<http://i-tip.wto.org/services>).

1. International trade in services and health worker mobility

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 health care, without omitting the digital dimension of such trade (e-commerce). Services, in particular, have had increasing influence on the socioeconomic advancement of developing economies. Recent research reveals a strong correlation between services sector growth and overall growth of Gross Domestic Product (GDP). One important study showed that in 50 developing economies, growth in services was more closely correlated with poverty alleviation than growth in agriculture (2).

In the past 20 years, the growth of trade in services has come to outpace trade in goods. Today, trade in services accounts for more than 40 per cent of world trade⁴ – greater than manufacturing or agriculture. Despite this, trade in services often continues to be viewed by policy-makers as an issue of lower relevance than trade in goods.

In contrast to barriers imposed at the border that affect trade in goods, such as customs and tariffs, barriers to trade in services are often also 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 (3). As trade in services surges, it is important to make new efforts to strengthen mechanisms that 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 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 World Trade Organization (WTO) rules governing global trade in services.

Few 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 US\$ 8 billion would be generated through services performed abroad by Cuban health personnel (4).

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 US\$ 5.8 trillion per year (5). The number of jobs in the sector is growing. Across the countries of the Organisation for Economic Co-operation and Development (OECD), employment in health and social work grew by 48% between 2000 and 2014, while jobs in industry and agriculture declined. In 2017,

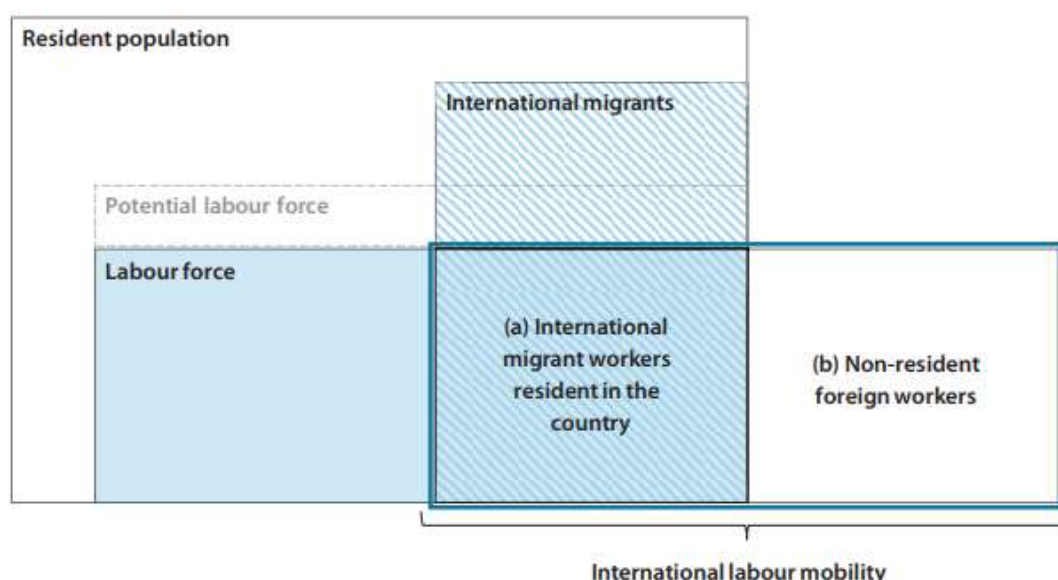
⁴ Considering trade in services as measured in the balance of payments (covering modes 1, 2 and 4), as well as sales of services of multinationals through their foreign affiliates (mode 3).

the health and social sector contributed to 11% of all employment in OECD countries. The global economy is projected to create an additional 40 million health worker jobs by 2030, primarily in middle- and high-income economies (5).

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% (6). The patterns of international health worker migration and mobility are also growing in complexity, with substantial intraregional, South–South, and North–South movement, alongside better understood movement of health workers from the global South to the global North (7).

As defined by the United Nations Economic Commission for Europe (UNECE), international labour mobility comprises all movement of natural persons from one economy to another for the purpose of employment or supply of services (Figure 1).

Figure 1. Relationship between usually resident population, international migration, labour force and labour mobility in an economy



Source: United Nations Economic Commission for Europe (8).

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 practising only in Ireland. 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 nurses (9). In the United States of America, in 2016, 10 500 physicians were employed on temporary visas (or H-1B visas), representing 1.4% of the total physician workforce (10). In 2012, more than 62 000 health workers from Cuba were deployed in 66 countries across the globe on a temporary basis (11). In Japan, a trainee visa programme was launched in 2019 to address labour shortages, with up to 60 000 nursing care workers expected to take temporary jobs (12). Similarly, within the

European Union, temporary provision of services in other economies by health professionals, like their occasional cross-border provision of services, is more flexibly regulated than for those seeking permanent migration (13).

Moreover, the supply of education for health professionals 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 programmes increased from 124 in 2005 to 17 600 in 2016 (14). 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 2016/2017.⁵ Economies 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 annually.⁶ The increased production across economies also stands alongside substantial unemployment of health workers, particularly in jurisdictions with limited fiscal and financial absorptive capacity.

Strong international collaboration related to health worker mobility is evident across multiple forums and stakeholders. Over 120 separate bilateral agreements have been notified to the World Health Organization (WHO) Secretariat as part of the national reporting on the WHO Global Code of Practice on the International Recruitment of Health Personnel (the Global Code).⁷

⁵ MBBS: Bachelor of Medicine, Bachelor of Surgery (Latin: *Medicinae Baccalaureus, Baccalaureus Chirurgiae*).

⁶ China, Ministry of Education: http://www.moe.gov.cn/srcsite/A20/moe_850/201805/t20180531_337897.html.

⁷ This paper has not analysed the compatibility of such agreements with the GATS most favoured nation (MFN) obligation.

2. Trade in services commitments:GATS

2.1 Overview of WTO and GATS

The World Trade Organization (WTO), which entered into force in 1995, 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 modes to supply services:

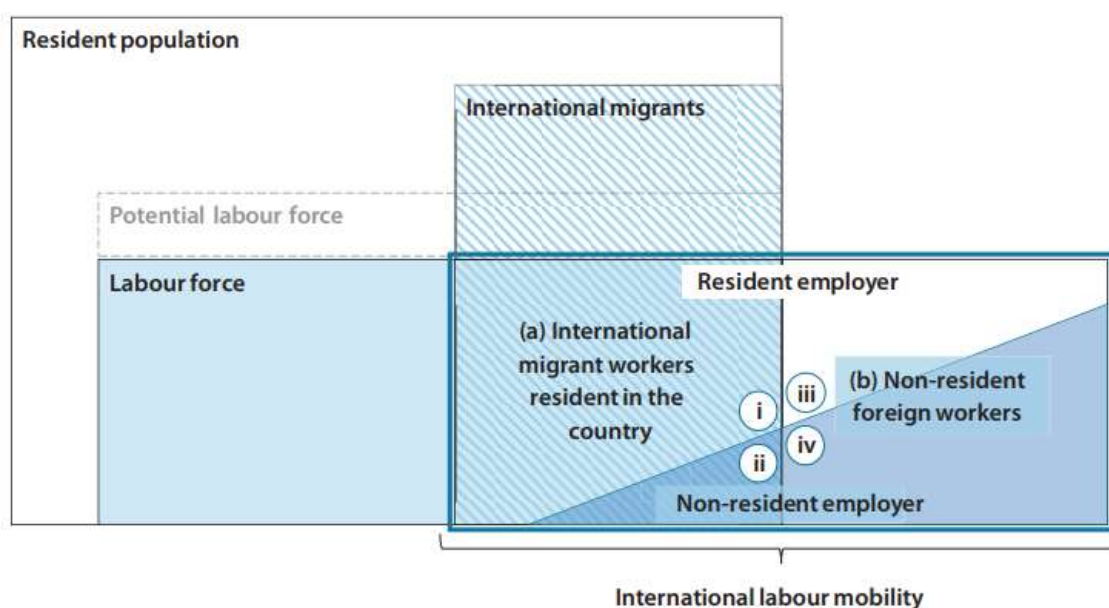
- mode 1: cross-border supply, without any movement on the part of either the supplier or the consumer, such as in telemedicine or e-health services;
- mode 2: consumption abroad, that is, the movement of consumers to another jurisdiction to consume services, for example in the case of health tourism;
- mode 3: commercial presence, such as the establishment of a foreign health institution, for example in the form of a branch, subsidiary, affiliate, or joint venture ;
- mode 4: movement of natural persons, which refers to the temporary cross-border presence of service providers, but not jobseekers or permanent migration to the receiving economy. For example, certain doctors and nurses practising in other jurisdictions.⁸

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 health care 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” (15).

Within the UNECE framework, as further detailed in Figure 2, from the perspective of the receiving economy, mode 4 would cover non-resident foreign health workers employed by a non-resident employer (or self-employed), providing services to residents (category (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)).

⁸ The examples 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.

Figure 2. Labour mobility and contractual relationship



Source: UNECE (8).

Commitments to open services markets are made sector by sector, and recorded in each Member's "schedule". It is important to note that the services markets of WTO Members 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 openings, including adjustment of domestic regulation and policy, that might not otherwise have been politically feasible.

Under the WTO agreements, such as GATS, Members are normally not allowed to discriminate between their trading partners. Pursuant to the so-called most favoured nation (MFN) principle, if a Member 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 GATS in 1995, or when they joined the WTO for more recent acceding Members.⁹ Members are also allowed to deviate from the MFN requirement in the context of RTAs.¹⁰ But a number of conditions need to be met for this to be possible, in particular that Members take commitments in RTAs covering the four modes of supply, providing for substantial sectoral coverage and eliminating substantially all discrimination. In other words, they should make more and deeper commitments than in the context of the multilateral GATS concessions.¹¹

⁹ Only four Members – Bulgaria, Cyprus, Dominican Republic and Jordan – have explicitly listed exemptions relating to health services. Other relevant exemptions were of more horizontal nature, affecting professional services or more generally mode 4.

¹⁰ Note that the term "regional trade agreements" also includes bilateral agreements.

¹¹ See Article V of GATS.

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 services sectors, except services supplied in the exercise of governmental authority, which are defined as those services that are supplied neither on a commercial basis nor in competition with other suppliers (16).¹² 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, subdivided into approximately 160 subsectors (17). The services categories relevant to the supply of health care services are “Health-related and social services”, and relevant professional services subsectors under “Business services”. 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 or 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. A structured approach to labour market analyses of the health sector provides the opportunity to address concerns of health system stakeholders in both jurisdictions of origin and destination. (Box 1).

Box 1. Economic needs tests and health labour market analysis

The economic needs test (ENT) or labour market test is a test that conditions market access upon the fulfilment 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 a significant barrier to trade, and there have been repeated calls by WTO Members for improved criteria, definition and transparency related to them, and for their removal .

With specific reference to the health sector, a structured analysis of the health labour market has the potential both to provide discipline for mode 4 health sector ENTs in the economy of destination and, if applied at the economy of origin, can also address concerns related to “brain drain”. Health labour market analysis uses harmonized approaches to assess labour market trends in the health sector, including attention to production, employment and migration. It analyses 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 health labour market analysis process in the design of a new generation of bilateral cooperation.

¹² Note that measures relating to air traffic rights are excluded from the scope of the agreement (see Annex on air transport services).

The approach takes explicit account of the labour market and health system needs in partner economies.
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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 training and licensing requirements that apply. 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 (see Box 2). Due to concerns that different types of behind-the-border non-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.

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 (15).

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 health care 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 licences and certification granted in some economies but not in others. This is an obvious derogation from the MFN principle 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 that would amount to discrimination between Members as regards the application of its criteria 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. A total of 137 RTAs include provisions concerning recognition of standards, education, experience obtained, or licences granted in certain jurisdictions. But only 44% are of a more binding nature than the permissive but not prescriptive treatment in GATS. Numerous agreements do not provide for automatic recognition of qualifications. In fact, the scope of the agreements varies significantly, from far-reaching provisions, for example within the European Union/European Economic Area (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 economies. 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 (for example within the EU/EEA, between the United States and Canada, and between Australia and New Zealand). Moreover, economies or regions with former colonial ties (Latin America and Spain, the Macao Special Administrative Region and Portugal, Australia and the United Kingdom) tend to conclude recognition agreements. Some non-OECD economies are part of the agreements between OECD countries, which are industry agreements or RTAs (for example, the Japan–Singapore Economic Partnership Agreement, Asia-Pacific Economic Cooperation (APEC), and the Agreement between New Zealand and Singapore on a Closer Economic Partnership).

Sources: OECD (18), World Bank (19).

2.2 WTO Member commitments under GATS

We first analyse the commitments made for (sub)sectors relevant in the context of health worker mobility:

- “Health-related and social services”, in particular "Hospital services" (CPC 9311) and "Other human health services" (CPC 9319, other than 93191); and
- health-related services under “Professional services”, which cover "Medical and dental services" (CPC 9312) and "Services provided by midwives, nurses, physiotherapists and para-medical personnel" (CPC 93191).

These categories refer to those of the Services Sectoral Classification List - MTN.GNS/W/120 (W120) which are pertinent in the context of the movement of health professionals.¹³

Of the 139 WTO Members’ schedules of commitments (EU 25 counted as one),¹⁴ 49 include commitments for the W120 subsector “Hospital services” and 25 for “Other human health services”. In addition, 52 have commitments on "Medical and dental services" , and 22 on "Services provided by midwives, nurses, physiotherapists and para-medical personnel". The total number of schedules that have at least one commitment relating to health services accounts for 69. Our research findings further indicate that 61 schedules provide mode 4 market access in relation to health services under GATS;¹⁵ 55 only have applicable mode 4 horizontal commitments; while 5 provide qualified sectoral mode 4 commitments in addition to the horizontal considerations. One (Trinidad and Tobago) indicates no limitation at the sector level (Figure 3).

¹³ This classification list is usually used by WTO Members to define the scope of their GATS commitments. CPC indicates the United Nations Central Product Classification codes for services.

¹⁴ European Union (EU) 25 covers Austria, Belgium, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Poland, Portugal, Spain, Slovak Republic, Slovenia, Sweden, and United Kingdom. It is the schedule in force for these WTO Members since March 2019.

¹⁵ Health-related services include those listed in the Services Sectoral Classification List, 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 (18).

Figure 3. WTO Member commitments to open health-related services under GATS



Table 1 provides an example of a schedule of commitments, 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 that 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.

When looking at mode 4 commitments, it is therefore important to review what is indicated in the “horizontal commitments” to assess what market access has actually been provided in scheduled sectors. The commitments of Saudi Arabia (Table 1) 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 (Box 3).

Table 1. GATS commitments: Saudi Arabia, medical and dental services

Member	Sector	Limitations on market access	Limitations on national treatment
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

Source: WTO I-TIP Services database.

Box 3. Saudi Arabia: excerpt from horizontal commitments under GATS

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 subsectors on business services:

....

Medical and 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 and dental services

(CPC 9312)

....

Source: WTO I-TIP Services database.

An additional five 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 (Boxes 4 and 5). 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 (Box 6).

Box 4. China: excerpt from medical and dental services GATS commitments

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** medical services in China after they obtain licences 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.

Box 5. Nepal: excerpt from hospital services GATS commitments

4) Unbound, except as indicated in the horizontal section.

Medical experts can work with the permission of Nepal Medical Council for **maximum of one year**.

Source: WTO I-TIP Services database.

Box 6. eSwatini: excerpt from 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 health care services to foreign service providers, under mode 4. For instance, Costa Rica provides conditions related to the availability of nationals (labour market test) (Box 7).

Box 7. Costa Rica: excerpt from 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 of foreign service suppliers to their health sectors. They are also used as a way to lock in reform, improve regulation for the benefit of the people, and promote 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 RTAs.

3. Trade in services commitments: regional trade agreements

3.1 Overview of RTAs

Regional trade agreements (RTAs) are trade agreements negotiated among two or more 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 services commitments can be categorized into those based on GATS, often termed a “positive list approach”; those based on a “negative list approach”, as in the case of the “old” North American Free Trade Agreement (NAFTA) involving the United States of America, Mexico and Canada; and RTAs with “other” forms (19).¹⁶

In a 2019 study covering 144 agreements notified to the WTO and containing services provisions, it was identified that a total of 115 RTAs include specific provisions on the presence of natural persons, generally in the form of a chapter or an annex (19). This was the case for 76% of the GATS-type agreements, 80% of the negative list-type agreements, and all of the other agreements. In particular, negative list -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.

3.2 RTA commitments on health services: status and excerpts from existing texts

3.2.1 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 and social services”, as described in section 2.2. There is significant variety among the nature and format of the commitments to provide for health

¹⁶ NAFTA was recently renegotiated into USMCA, but the latter is not yet in force.

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 commitments to opening services in regional and bilateral trade agreements than they do multilaterally, and they are often deeper in scope.¹⁷

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

Economy	RTA	GATS
Australia	4	2
Canada	4	0
Chile	4	0
China	2	1
Colombia	4	0
Costa Rica	4	1
Dominican Republic	4	3
El Salvador	4	0
European Union	4	4
Guatemala	4	0
Honduras	4	0
Hong Kong, China	2	0
India	3	1
Japan	1	0
Jordan	4	4
Malaysia	2	2
Mexico	4	4
Mongolia	3	0
Montenegro	4	4
Morocco	4	0
New Zealand	4	0
Nicaragua	4	0
Norway	2	2
Oman	3	2
Pakistan	3	2
Panama	4	1
Peru	4	0
Philippines	3	0
Republic of Korea	4	0

¹⁷ The RTA with most subsectors committed was selected for the comparison.

Economy	RTA	GATS
Rwanda	2	1
Saudi Arabia	3	3
Singapore	4	1
Chinese Taipei	4	2
Uganda	2	0
Ukraine	4	4
United Republic of Tanzania	2	0
United States of America	4	1
Viet Nam	2	2

Note: Subsectors covered are “Hospital services”; “Other human health services”; “Medical and dental services”; and “Midwives, nurses, physiotherapists and para-medical personnel”. 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.

* Economies identified as per WTO Membership.

Source: WTO I-TIP Services database.

Below we highlight some of the findings of the RTA review, referencing the United Nations Central Product Classification (CPC), provisional version, for the services 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 with the Chinese commitments in the RTA with Pakistan (note that the horizontal commitment is identical) (Box 8). In some agreements, although the sectoral entry is similar, the horizontal commitment may be wider in scope (for example China and 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 hospital services in the context of the China - Singapore Free Trade Agreement. Some economies have taken commitments for health services, to the extent that they are not related to “social services established or maintained for public purposes” (for example Canada, United States). Alternatively, some economies have taken deeper commitments for sectors they were already covering in their GATS schedule, for example Malaysia in its RTA with New Zealand (Box 9) with regard to “Specialized medical services” (CPC 93122).¹⁸

¹⁸ See I-TIP Services database.

Box 8. Comparison of China's commitments in Pakistan–China RTA and GATS schedules for medical and dental services

RTA: Pakistan–China 2010

Limitations on market access:

4) Unbound, except as indicated in horizontal commitments and as follows:

Foreign doctors with professional certificates issued by Pakistan shall be permitted to provide short-term medical services in China after they obtain licences from the Ministry of Public Health. The term of service is six months and may extend to one year.

GATS

Limitations on market access:

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 medical services in China after they obtain licences 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.

Box 9. Comparison of Malaysia's commitments in New Zealand–Malaysia RTA and GATS for medical specialty services

RTA: New Zealand–Malaysia 2009

Limitations on market access:

Unbound, except as indicated in 2 in the horizontal section.

Limitations on national treatment:

4) None other than:

- 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.

Additional commitments: The qualifying examination to determine the competence and ability to supply the service will be conducted in the English language.

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.

GATS

Limitations on market access:

4) Unbound except as indicated in 2 (a) in the horizontal section.

Limitations on national treatment:

4) None other than:

- 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.

The qualifying examination to determine the competence and ability to supply the service will be conducted in the English language.

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.

Source: WTO I-TIP Services database.

3.2.2 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 ENTs (or labour market tests, as ENTs are called in the case of mode 4), which limit entry of foreign workers in the absence of a demonstrated need for them. ENTs 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 (Boxes 10 and 11).

Box 10. Economic needs test 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 recognized 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 recognized as equivalent.

Source: WTO I-TIP Services database.

Box 11. Economic needs test of Panama in Panama–United States RTA, 2012

Professional services

Only a Panamanian may practise as a health care professional; agricultural science professional; barber; chemist; cosmetologist; customs agent; economist; journalist; library scientist; public relations specialist; real estate agent; social worker; sociologist; public translator; speech and language therapist; and veterinary doctor. **However, a foreign national may practise 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.

3.2.3 Licensing, qualifications and recognition

To facilitate immigration requirements, certain RTAs provide for the delivery of special and temporary licensing for foreign health care 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.¹⁹ CAFTA-DR – an agreement between the United States, the Dominican Republic, and the Central American countries of Costa Rica, El Salvador, Guatemala, Honduras and Nicaragua – provides for other conditions for mode 4 service delivery, with the example of Costa Rica presented in Box 12.

¹⁹ See I-TIP Services database.

Box 12. Conditional entry of foreign workers into Costa Rica in CAFTA-DR 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 given in Box 10, or the RTAs excerpted below (Boxes 13 and 14). The example of Costa Rican commitments in the context of CAFTA-DR (Box 14) 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 (see box 2). This is especially true in relation to health care, a sector that tends to be highly regulated in many economies. 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 or parties. For instance, the RTA between India and Singapore specifies that, in relation to services provided by midwives, nurses, physiotherapists, and para-medical personnel (CPC 93191), mode 4 market access is “unbound pending finalization of MRA”.²⁰

²⁰ See I-TIP Services database.

Box 13. Recognition of licensure by Panama in United States–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.

Box 14. Costa Rica professional association membership in CAFTA-DR 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.

3.3 Other health-related provisions

Finally, there are provisions related to health care services that are uncommon across RTAs but nonetheless worth noting. For instance, some RTAs provide for fully open market access for health care 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 (Box 15) in relation to mode 4 provision of medical and dental services (CPC 9812) and hospital services (CPC 9311).²¹ The mode 3 commitment is also reproduced because of the relationship to the mode 4 commitment relating to intracorporate transfers.

Box 15. 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% 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.

3.4 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 partnership agreements (EPAs) between Japan and the Philippines (JPEPA, 2009), Indonesia (IJEPA, 2008), and Viet Nam (JVEPA, 2008).²² In the case of JVEPA, the parties agreed to enter into negotiations about the possibility of accepting Vietnamese certified care workers in Japan. JVEPA articulates two commitments on the part of Japan: (a) the granting of entry for one to three years for a natural person of Viet Nam who has qualified under Japanese law by passing the *kangoshi* examination in Japanese; and (b) 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 (21).

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 first to learn the Japanese language 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

²¹ 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.

²² According to 2018 figures, 1118 nurses and 2740 care workers from the Philippines, Indonesia and Viet Nam entered Japan between 2008 and 2016 under the three EPAs (20).

Philippine Overseas Employment Administration and the Japan International Corporation of Welfare Services. The costs of recruitment, which are to be paid by the Japanese employers to the Philippine Overseas Employment Administration, amount to US\$ 435 as a processing fee, inclusive of contract guarantee, and US\$ 25 as a contribution to the Workers' 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 in Table 3.

It is of note that 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 Indonesia, the Philippines and Viet Nam (22). In the case of Indonesia, IJEPA included agreement for technical assistance and financial support through the multiyear 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, the National Agency for the Protection and Placement for International Migrants, the Ministry of Health, the Ministry of Foreign Affairs, and the Ministry of Education (23).

Table 3. Qualification requirements to take Japanese national nurses and caretakers examinations for Indonesian and Filipino applicants

Country	Conditions to take the national exams for (i) nurses and (ii) caretakers	Period of stay
Indonesia	(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) (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	Under the status of residence of "Designated activities" (EPA): 6 months, 1 year or 3 years per stay, and unlimited number of renewals of a permission of stay
Philippines	(i) Qualification as a nurse in the Philippines and professional experience of at least 3 years (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	Under the status of residence of "Medical services": 3 months, 1 year, 3 years or 5 years per stay, and unlimited number of renewals of a permission of stay

Source: WTO (24).

In the RTA between Japan and the Philippines, the relevant text related to qualifications for health professionals is presented in Box 16.

Box 16. 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.

4. Processes relevant to opening trade in health services

4.1 Continuing work at the WTO

Trade in services under GATS is meant to be progressively liberalized and, in fact, multilateral discussions began as far back as 2000 to this end, as mandated under GATS itself. They continued as part of the Doha round of multilateral trade negotiations, but there has been little progress and the request and offer process of negotiating new commitments is now on hold. Of close to 100 negotiating proposals and 20 plurilateral requests on sectors and modes of interest, none concerned health services. In addition, very few improvements have been offered for mode 4 delivery of health-related and social services (three new commitments, four improvements to existing commitments) or for relevant professional services (five new, five 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.²³

The WTO Council for Trade in Services is responsible for facilitating the operation of GATS; it is the locus in the WTO where issues related to trade in services are discussed, on the basis of Members' proposals. Given that the Doha round of talks, in relation to services as well as other trade topics, is 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 issues related to multilateral trade in services. For instance, a thematic seminar was held by the Council 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 the mobility of health professionals, has taken place thus far (25).

4.2 The WTO LDC Services Waiver

WTO Members agreed that special treatment should be accorded to least developed countries (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. During the Doha Development Agenda negotiations, at the Sixth WTO Ministerial Conference, Hong Kong, China, 13–18 December 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” (26).

In December 2011, it was agreed that, notwithstanding the MFN obligation, Members willing to do so could unilaterally grant preferential treatment to services and service suppliers from LDCs. The so-called LDC Services Waiver will expire in 2030. The preferences should be

²³ The impact of such discussions is difficult to assess, and will depend on the number of Members that adopt such disciplines, their extent, and their scope (only subsectors committed or all sectors).

targeted towards market access issues, but some other types of preferences (such as national treatment or 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 LDCs (27).

The resulting “collective request” submitted by LDCs in July 2014 sets forth a range of requests, both cross-cutting and in relation to specific services, that are of interest to the LDC group as a whole (28). 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 proposals in the collective request focus, to a large extent, on waivers for visas, 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, 24 Members (considering the European Union, including 28 Members, as one) have submitted preferential treatment notifications under the LDC Services Waiver. Examples of notifications in the area of health services are presented in Annex 1.

There are also some additional mode 4 horizontal preferences that have implications for existing health-related GATS commitments (for example in the cases of Norway and Turkey). Some Members also accorded preferences relating to facilitation of obtaining visas by nationals of LDCs (India and Turkey), or relating to technical assistance to service suppliers of LDCs (China, India and Turkey), or the establishment of dedicated contact points (Switzerland).

Given the extension of the LDC Services 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.

Conclusion

Despite its substantial and increasing importance to health systems and inclusive economic growth, the relationship between international trade in services and health worker mobility 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 long-standing concern related to the treatment of people as tradable commodities and the negative impact of the “brain drain” on developing economies.

Our examination of the relationship between trade in services and health worker mobility seeks to provide 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 of health worker mobility-related commitments in GATS and services RTAs has revealed the following.

- A variety of commitments to open mode 4 trade in health-related services do exist.
- The trade in services frameworks (global, regional and bilateral agreements) have resulted in the development of vehicles to facilitate and manage health worker mobility, and in specific cases have demonstrated the ability to bring together a range of national interests (education, foreign affairs, health, labour, migration and trade) related to health worker mobility.
- The trade in services frameworks has the 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 and destination economies, 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, with particular focus on the needs of developing economies and health systems. Our research on trade agreements points to areas of consistency with the ethical principles articulated in the WHO Global Code. These include provisions within RTAs that facilitate national treatment; circular mobility; education exchange and investment; skills exchange; filling of gaps in domestic skills in developing economies; 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. The application of health labour market analyses, in both sending and receiving economies, could serve to further clarify the economic needs tests or labour market tests of 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 the “brain drain”. It could provide

confidence at the national and subnational levels that liberalization of services provision benefits rather than harms socioeconomic 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 economies 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 and 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 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 socioeconomic 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 the expressed concerns of the health sector, can in turn ensure the continued global growth in trade in services with associated benefits to the world economy.

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Annex 1. Examples of notifications under the WTO LDC Services Waiver by Chile, European Union and 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 intracorporate transfers, business visitors, contractual service suppliers
European Union	
Intra-corporate transfers and business visitors (if no indication, means no limitation other than those provided in annex A and B of the notification dealing with commercial presence and cross-border supply – for business visitors only – commitments respectively)	
h) Medical (including psychologists) and Dental services (CPC 9312 and part of CPC 85201)	<p>In CZ, IT, SK: Residence requirement</p> <p>In CZ, EE, RO, SK: Authorisation by the competent authorities required for foreign natural persons.</p> <p>In BE, LU: For graduate trainees, authorisation by the competent authorities required for foreign natural persons</p> <p>In BG, CY, MT: Condition of nationality</p> <p>In DE: Condition of nationality which can be waived on an exceptional basis in cases of public health interest</p> <p>In DK: Limited authorisation to fulfil a specific function can be given for maximum 18 months and requires residence.</p> <p>In FR: Condition of nationality. However, access is possible within annually established quotas.</p> <p>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.</p> <p>In PL: Practice of medical profession by foreigners requires the permission. Foreign medical doctors have limited election rights within the professional chambers</p> <p>In PT: Residence requirement for psychologists.</p>
j) 1. Midwives services (part of CPC 93191)	<p>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</p> <p>In BE, LU: For graduate trainees, authorisation by the competent authorities required for foreign natural persons</p> <p>In CZ, CY, EE, RO, SK: Authorisation by the competent authorities required for foreign natural persons</p>

Services sector	Market access
	<p>In FR: Condition of nationality. However, access is possible within annually established quotas</p> <p>In CY, HU: Nationality condition</p> <p>In IT: Residence requirement</p> <p>In LV: Economic needs determined by the total number of midwives in the given region, authorized by local health authorities</p> <p>In PL: Nationality condition. Foreign persons may apply for permission to practise</p>
<p>j) 2. Services provided by Nurses, Physiotherapists and Paramedical Personnel (part of CPC 93191)</p>	<p>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 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>

Services sector	Market access
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 (part of CPC 93191)	<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>
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.

Note: AT Austria , BE Belgium, BG Bulgaria, CY Cyprus, CZ Czech Republic, DE Germany, DK Denmark, EE Estonia, EL Greece, ES Spain, FI Finland, FR France, HU Hungary, IE Ireland, IT Italy, LT Lithuania, LU Luxembourg, LV Latvia, MT Malta, NL The Netherlands, PL Poland, PT Portugal, RO Romania, SE Sweden, SI Slovenia, SK Slovak Republic, UK United Kingdom.