MRAs for health professionals in ASEAN – Initial movements for future freer flow of health professionals in ASEAN?

Developed by

Ms. Cha-aim Pachanee
Dr. Suwit Wibulpolprasert
Ministry of Public Health, Thailand

For the International Council of Nurses

May 2008

1. The ASEAN Framework Agreement on Services (AFAS) and the free trade on health services

The Association of Southeast Asian Nations (ASEAN) was established, initially with 6 member countries, on 8 August 1967. At present, ASEAN consists of 10 members, including Brunei Darussalam, Cambodia, Indonesia, Lao PDR, Malaysia, Myanmar, Philippines, Singapore, Thailand, and Vietnam. One of its aims is to accelerate economic growth, social progress and cultural development in the region. Under the final goal of ASEAN economic integration, the ASEAN Vision 2020 was agreed upon in 1997 and encompasses the ASEAN Economic Community as a goal for free flow of goods, services, and investments within the region.

To enable the economic integration of services, the *ASEAN Framework Agreement on Services (AFAS)* was signed by the ASEAN Economic Ministers on 15 December 1995 with an aim to achieve a free trade area in services by the year 2020. The AFAS also encourages ASEAN members to enter into agreements or arrangements to recognise education or experience requirements, or licenses that are granted, met or obtained in another ASEAN country.

Under the AFAS, negotiations for trade in services are conducted through the Coordinating Committee on Services (CCS) which was established in January 1996. The CCS encompasses several sectoral working groups responsible for trade negotiations, including health care. Although health care is one of the 11 priority service areas for negotiation, the Healthcare Services Sectoral Working Group was not established until the AFAS third round of negotiations in July 2003; seven years after the establishment of the CCS.

At the Seventh ASEAN Summit in Brunei Darussalam in November 2001, ASEAN leaders mandated the start of negotiations on Mutual Recognition Arrangements (MRAs) to facilitate the flow of professional services under AFAS. However, it was not until after the

signing of the Declaration of ASEAN Concord II (Bali Concord II)[1] in Bali, Indonesia in October 2003, that a High-Level Task Force was established to complete the negotiation on Mutual Recognition Arrangements (MRAs) for major professional services. This was aimed at assisting the freer movement of professionals, skilled labourers and talent by 2008, through the establishment of a "*Professional Exchange*" mechanism. This is part of the movement towards the free flow of goods and services by 2020 as stated by Bali Concord II.

MRAs for professional services could be concluded under the 'ASEAN minus X' formula[2] whereby member countries not ready for implementation are able to participate at a later stage.

Member countries in the region do have different interests in different modes of trade in health services. However, the 6th meeting of the Healthcare Services Sectoral Working Group, held on 29 March - 1 April 2005 in Malaysia, concluded that the target for commitment on trade in heath services among ASEAN countries for *Mode 1* (*Cross border supply)* and *Mode 2* (*Consumption abroad)* would be "none"; i.e. free flow. Furthermore, *Mode 3 (Commercial presence)* and *Mode 4 (Movement of natural persons)* should be liberalised progressively to achieve free or freer flow of trade in services by 2010.

The AFAS was agreed upon more than 10 years ago and several areas of trade liberalization were completed and implemented. An assessment of the progress, conducted by Thanh and Bartlett (2006), found an increase in commitments by ASEAN members from 795 sub-sectors in GATS to 1,255 sub-sectors in AFAS. This represented a 58% increase in the coverage.

[1] See details of Declaration of ASEAN Concord II at http://www.aseansec.org/15159.htm

[2] ASEAN minus X formula was adopted by ASEAN Economic Ministers during the retreat in Malaysia in 2002 to be applied for service negotiation. Under this principle, two or more countries may proceed with the agreed service sector liberalisation without having to extend the concessions to non-participating countries. Others may join at a later stage or whenever ready.

The depth of liberalization also increased from 1,915 in GATS to 2,777 in AFAS; an increase of 45%. However, the unbound components also increased from 1,265 in GATS to 1,883 in AFAS, representing an increase of 49% (Table 1). It can be concluded that, *after 10 years of negotiation, the progress of liberalization of trade in services under AFAS was slow and not very impressive.*

Table 1 Comparison of sectoral coverage and depth of commitment in GATS and AFAS

Country	Sectoral Coverage			Depth of Commitment					
				Liberalisation (None + Partial)			Unbound		
	GATS	GATS + AFAS 1-4	% increase	GATS	GATS + AFAS 1-4	% increase	GATS	GATS + AFAS 1-4	% increase
Brunei	26	88	238	63	154	144	41	198	383
Cambodia	146	177	21	343	415	21	241	293	22
Indonesia	61	95	56	119	276	132	125	104	-17
Lao PDR	-	90	-	-	-	-	-	-	-
Malaysia	122	154	26	275	314	14	213	302	42
Myanmar	36	108	200	72	216	200	72	216	200
Philippines	36	109	203	126	313	148	18	123	583
Singapore	102	111	9	288	310	8	120	134	12
Thailand	127	172	35	334	498	49	174	190	9
Vietnam	139	151	9	295	281	-5	261	323	24
Total	**795**	**1255**	**58**	**1915**	**2777**	**45**	**1265**	**1883**	**49**

Source: Analysed from Thanh, V.T. and Bartlett, P. 2006.
Note: Lao PDR is not a member of the WTO

2. Other motivations for free trade in health services

Apart from the political commitments for freer trade under AFAS as mentioned above, health sectors of ASEAN members are also interested in liberalisation of trade in health services. Within ASEAN there are countries interested in export and import of health services, including health professionals, as shown in Table 2 (Pachanee and Wiblpolprasert 2007). Furthermore, some ASEAN members have better competitive

advantages in health services as shown in Table 3 (Private Hospital Association and Business Council of Thailand 2004).

Table 2 Interests of ASEAN countries on different modes of health service trade

Mode	Export	Import
1. Cross border supply	- Thailand	- Singapore
2. Consumption abroad	- Singapore - Malaysia - Thailand - Philippines	- all ASEAN members
3. Commercial presence	- Singapore - Malaysia - Thailand	- Thailand - Indonesia - Philippines - Vietnam - Laos - Cambodia - Malaysia
4. Movement of natural person	- Philippines - Indonesia - Myanmar	- Singapore - Brunei - Thailand

Table 3 Competitive Advantage of health facilities in Asian countries providing health care services to foreign patients

Competitive Advantage	Thai	Singapore	Malaysia	India#	Hong Kong#
Service & Hospitality	*****	***	**	**	**
Hi-technological Hardware	****	****	***	***	****
HR Quality	****	****	***	***	***
International Accredited Hospital	**	**	*	*	*
Pre-emptive Move	***	***	*	*	*
Synergy/Strategic Partner	**	**	*	*	*
Accessibility/Market Channel	***	***	**	*	**
Reasonable Cost	****	**	***	*****	**

Source: modified from Private Hospital Association and Business Council of Thailand, 2004
Note: # not ASEAN member

Singapore, one of the popular destinations for medical tourism (Mode 2), needs more health professionals from other countries to provide services to increasing numbers of foreign patients (Mode 4). Therefore, as of 2007, the country has started to recognise some medical schools in Myanmar and Thailand. It also has outsourced radiological images to be read by certified Indian radiologists (Mode 1). Moreover, Singapore and Thailand have invested in private hospitals in other ASEAN countries (Mode 3).

Clearly, approaches vary. Brunei Darussalam depends mainly on foreign health professionals for its health care systems (mode 4) but Thailand does not. With more than 2 millions foreign patients per year (Mode 2), Thailand is facing a shortage of health professionals in rural public health facilities, but is relying on production of health professionals within the country.

Some ASEAN members have produced more health professionals than they can employ, resulting in their aggressive exportation (Mode 4). For example, the Philippines has 30 medical schools and more than 350 nursing colleges, mostly private, producing more than 2,000 medical doctors and 15,000 nurses per year (Ronquillo et al 2005). The exodus of Philippine doctors and nurses to Western countries is well known. The Philippines also has recently adopted a bilateral agreement with Japan to facilitate the movement of Philippine nurses to Japan. Another example is Indonesia which produces around 18,000 - 20,000 nurses per year but can absorb less than 6,000 graduates. The remainder, with strong government support, need to apply for work in other countries. (Suwandono et al 2005).

At present, standards of education and qualifications, as well as language inadequacy, are major barriers to external movement from and among ASEAN countries. Although ASEAN members may not be the prime host countries, future progress on the ASEAN MRAs for health professionals may make these countries more attractive.

3. MRA negotiations for nursing services

The draft MRA on Nursing Services was proposed for negotiation in the 4th meeting of the Healthcare Services Sectoral Working Group in 2004. The draft MRA for medical practitioners and the one for dental practitioners were proposed and considered for negotiation in 2005 and 2006, respectively.

In the beginning of MRA negotiations, members of the Health Sectoral Working Groups were usually represented by officials from the Ministry of Commerce who did not have enough knowledge on health care services. Once this was clear, there was more participation from personnel of the Ministry of Health or independent professional bodies such as nursing councils. However, not all ASEAN members have yet established such independent professional bodies.

ASEAN members are at varied stages of socioeconomic development. Therefore, they also have different levels of health professional education and service standards. In addition, representatives from professional councils of most countries are quite cautious about (though not against) MRAs due to concerns about different levels of education quality and standards. Consequently, MRA content is negotiated in the direction that is most beneficial for their countries, rather than to really facilitate the freer flow of health workers.

Several barriers that affect the negotiation for MRAs and freer flow of health workers include:

- Different standards of curriculum and education institutes
- Different professional definitions and scopes of practice
- Different levels of education to enter into professional education programmes
- Different standards of regulatory systems and licenses to practice
- Differences in continuing education and training
- Professional conservatism and protectionism

- Language barriers
- Cultural sensitivity.

With these barriers and concerns from negotiators, it took two years for the first MRA (on Nursing Services) to be agreed upon and signed in December 2006 (Pachanee and Wibulpolprasert 2007). The MRAs on Medical Practitioners and Dental Practitioners are still under negotiation.

Moreover, according to the agreed texts, *the MRAs do not truly facilitate the movement of health professionals.* Doctors, dentists and nurses from the original countries *still need to comply with the requirements of the domestic laws and regulations of host countries which may include, for example, permanent residence and licensing examinations in the local language.* In addition, there are *other requirements which may increase difficulty for movement*, such as the requirement of at least three years' work experience in the country of origin for the MRA on Nursing Services (ASEAN Secretariat 2007) and five years for the draft MRAs on Medical and Dental Services (Healthcare Services Sectoral Working Group 2008). This is in spite of the fact that there is no such requirement in the current medical, dental and nursing service regulations within member countries. Therefore, only experienced health professionals can move to work in other member countries. This may reflect the intention of negotiators in accepting only experienced health professionals. This slow progress in freer flow of health professional is not an extraordinary situation, as the progress in other commitments under AFAS is also slow as shown in Table 1.

4. The current situation of MRA negotiations

The economic ministers of 10 ASEAN members signed the MRA on Nursing Services on 8 December 2006 at the ASEAN Summit in the Philippines. Although the first health professional MRA was signed more than one year ago and with no real commitment in mutual recognition, not all countries are ready to implement it. Four out of the ten ASEAN

members (including Cambodia, Lao PDR, Myanmar and Vietnam) have submitted their deferral. Under the 'ASEAN minus X' mechanism, members that deferred can start implementation whenever they are ready, but not later than 1 January 2010. The MRAs for Medical Professionals and for Dental Professionals are expected to be finalised and signed in the near future.

It can be concluded that the major movement to commit to more liberalisation of trade in health services under AFAS is progressing slower than the agreed targets. The negotiations for health professionals, particularly nurses, medical doctors and dentists, seem to show concrete movement. Nevertheless, some members did not wait for the commitments under AFAS to have real regional effects. They are moving unilaterally or bilaterally towards freer trade to fulfil their own interests. As noted earlier, Singapore is addressing its shortage of health professionals through unilaterally recognizing qualified health professionals from some schools in Myanmar and Thailand. As well, it allows radiological services through telemedicine by certified Indian radiologists. Countries such as Indonesia and the Philippines are also aggressively negotiating bilaterally to facilitate the external movements of their health professionals. These unilateral and bilateral arrangements are ongoing irrespective of the Mutual Recognition Agreements.

5. Future Direction

Considering the differences and barriers mentioned above, if future MRAs are to be effectively implemented in a manner like the MRA in the European Union, ASEAN members need to start improving and harmonising standards of health professional education and licensing. Knowledge management and sharing, capacity building and networking - including extensive upgrading of educational institutions in many countries - need to be accomplished. A Joint Coordinating Committee on nursing services was established under the nursing MRA and the same mechanisms are being proposed for the

medical and dental professions. These mechanisms will help facilitate the implementation, as well as further improvement, of standards among member countries in order to achieve better mutual recognition in the future. There is also a mandate to revise the MRAs through these mechanisms every 5 years.

It is still too early to assess the effectiveness and impacts of the MRAs for health professionals as the first MRA on Nursing Services was signed merely one year ago, while the other two are still in process. Nevertheless, with the commitment of ASEAN leaders, the intention of negotiators to reach the ASEAN Vision 2020, and the establishment of the Joint Coordinating Committees, the MRAs will be important starting tools for freer flow of health professionals and health services within ASEAN in the future.

References

1. ASEAN Secretariat, *Association of Southeast Asian Nations (ASEAN)*, http://www.aseansec.org
2. ASEAN Secretariat (2007), *Mutual Recognition Arrangement on Nursing Services*, http://www.aseansec.org/19211.htm
3. Healthcare Services Sectoral Working Group (2008), *The Report of the 17th Meeting of the Healthcare Services Sectoral Working Group*, 19-20 February 2008, Siem Reap, Cambodia.
4. Pachanee C, Wibulpolprasert S (2007), Trade in Health Services in the ASEAN Context. In: Blouin C, Heymann J, and Drager N, editors. *Trade and Health: Seeking Common Ground*. Montreal: McGill-Queen's University Press.
5. Private Hospital Association and Business Council of Thailand (2004), *Competitive Advantage of private health facilities in Southeast Asia* (The presentation).
6. Ronquillo K, Elegado-Lorenzo F, Nodora R (2005), *Human Resources for Health Migration in the Philippines: A Case Study and Policy Directions*. Philippines country paper presented at the Workshop on "Asian Action Learning Network on Human Resources for Health" 3-5 August 2005, Bangkok, Thailand.
7. Suwandono A, Muharso, Achadi A, Aryastami K (2005), *Human Resources for Health for Foreign Countries: a case of nurse "surplus" in Indonesia*. A country paper presented at the Workshop on "Asian Action Learning Network on Human Resources for Health" 3-5 August 2005, Bangkok, Thailand.
8. Thanh VT, Bartlett P (2006), *Ten Years of ASEAN Framework Agreement on Services (AFAS): An Assessment*. Regional Economic Policy Support Facility (REPSF) Project No. 05/004. Jakarta: ASEAN Secretariat.

Authors' Biography

Ms. Cha-aim Pachanee

Ms. Pachanee has been working at the Bureau of International Health, Thai Ministry of Public Health since 2000. Previously, she was a research assistant at Thailand Environment Institute. She holds a Bachelor degree in Applied Science (Environmental Health) and Masters degree in International Health. Currently, she is pursuing a PhD in Epidemiology and Population Health at the Australian National University.

She is interested in the areas of international health, international trade in health services, human resources for health, health systems and health policies. Ms. Pachanee has been involving in research in these areas and has been invited to present her works in a number of international forums. Some of her works are published internationally.

Contact details: Bureau of International Health
3rd Floor, Building 2 Office of Permanent Secretary
Ministry of Public Health,
Tivanond Road, Nonthaburi 11000 Thailand
Email: chaaim@health.moph.go.th

Dr. Suwit Wibulpolprasert, M.D.

Dr. Wibulpolprasert is a general practitioner, public health specialist, administrator and policy advocator. His main interests are in health policy and planning, and international health. He has been extensively involved in research and development in the areas of human resources for health; health economics and health care financing; international trade and health; health promotion; health information; and pharmaceuticals and has published more than 100 papers, reports and books locally and internationally.

As parts of his international involvements, he represents Thailand in many international health forums and the World Health Assembly. At present, Dr. Suwit chairs the Steering Committee of the Asia Partnership on Avian Influenza Research and the Steering Committee of the Asia-Pacific Action Alliance on HRH. He is also a member and Chair of the Program Coordinating Board of UNAIDS, and member and Chair of the Program and Policy Committee of the Board of the Global Health Workforce Alliance.

Dr. Suwit served as Deputy Permanent Secretary of the Thai Ministry of Public Health in 2000-2003. Currently, he serves at the highest rank of government official (PC11) as a Senior Advisor in Disease Control, after serving as a Senior Advisor in Health Economics during 2003-2006. He is also responsible for the health policy and international health work of the ministry.

Contact details: Office of Permanent Secretary
(5th Floor, Building 1)
Ministry of Public Health,
Tivanond Road, Nonthaburi 11000 Thailand
Email: suwit@health.moph.go.th