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Trade agreements and the risks for the nursing workforce, nursing practice and public health: A scoping review

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Abstract

Background

Trade agreements in the 21st century have evolved to include provisions that affect domestic public policy and public health in signatory countries. There are growing calls for health professionals and public health advocates to pursue an active advisory role in trade negotiations in order to anticipate and prevent negative outcomes for health services and public health.

Aim

This scoping review explored current literature to identify existing knowledge of the implications of trade agreements for the nursing workforce, nursing practice and public health using as an example the 2018 'Comprehensive and Progressive Agreement for Trans-Pacific Partnership'.

Design

Scoping review

Data Sources

Emerald Insight, Informit, Ovid MEDLINE, PubMed, ProQuest, Scopus, and a number of specialist Economics, International Trade and Business, and International Relations databases. Grey literature included national and international policy documents.

Review Method

Literature was selected according to extraction field criteria, supplemented by hand searching of relevant grey literature and snowballing references from the selected literature reference lists. Analysis was undertaken to identify key themes emerging from the literature.

Review results

Six key themes relevant to nursing workforce, nursing practice or public health were 1. Lack of consultation with public health and health professionals in trade negotiations; 2. Implications of strengthened intellectual property provisions for equitable access to medicines (including biologics) and medical devices; 3. Threats to government capacity to regulate domestic policy for public health and health services through 'Investor State Dispute Settlement' provisions 4. Threats to government capacity to regulate domestic policy for public health and health services through 'Regulatory Coherence' 5. Potential limited benefits to communities and increased health inequities 6. Potential implications of increased temporary migration. Gaps were identified in the literature for implications for nursing practice and the nursing workforce from regulatory and labour provisions of trade agreements.

Conclusions

The analysis of the literature reviewed is of international importance for the nursing workforce, nursing practice and public health. Policymakers must anticipate and respond to how the inclusion of labour or regulatory provisions in trade agreements will affect nursing practice and the nursing workforce, and how this may subsequently impact on the health of communities globally.

Keywords

Nursing, Nursing workforce, Public Health, Scoping review, Trade in services, Trade agreement, Health services.

What is already known about this topic?

- There is limited evidence in the international literature on the impact of trade in goods and services agreements on the nursing workforce, nursing practice and public health.
- Some prospective analyses and commentaries have, nonetheless, considered and described potential implications of trade in goods and services agreements for public health.
- There is evidence that concerns raised by health advocates have resulted in the suspension of some controversial provisions of the Comprehensive and Progressive Agreement for Trans-Pacific Partnership, although they have not been cancelled and may be reintroduced. Many of the suspended provision have now been introduced into the recent United States, Mexico, Canada Agreement (2018) while others such as 'Regulatory Coherence' have been expanded and strengthened.

What this paper adds?

- Provisions of trade in goods and services agreements have the capacity to adversely impact on the nursing workforce, nursing practice and public health.
- Gaps in the peer reviewed literature were identified for risks to the nursing workforce, nursing practice and public health from regulatory and labour provisions in the agreements.
- Further research into the potential benefits and challenges of each of these provisions in trade in goods and services agreements to the nursing workforce, nursing practice and public health is urgently required.
- Increased intrusions of trade agreement provisions into domestic public policy have risks for health services and public health. Health professionals, including nurses, and public health advocates must be afforded the same access to trade negotiators as traditional advisors in trade, finance and business law and that their subsequent advice is factored into trade agreements.

Trade agreements and the risks for the nursing workforce, nursing practice and public health: A scoping review

1. Introduction

The past two decades have seen a rapid increase in the number of trade agreements negotiated outside the World Trade Organization (WTO). Trade agreements in the 21st century have evolved to include provisions that affect domestic public policy and public health in signatory countries. Protections for health, which were established through the WTO, are being marginalised and new provisions place far greater constraint on domestic policy making (Gleeson & Labonté, 2020; Gleeson, Lexchin, Labonté, Townsend, Gagnon, Kohler, Forman & Shadlen, 2019). Issues such as intellectual property (patent) protections also continue to present a challenge to equitable global access to medicines (including biologics) and medical devices as pharmaceutical companies pursue new ways to extend product protection. Over the same period, there has been a growth in the power of markets to influence negotiation of these agreements. Trade agreements represent a point of potential conflict between public policy goals, the provisions of essential services and the profit motive of markets and trade.

These changes in trade agreements are occurring in the global context of increased demand for health services and the health workforce. At the same time, there is increased focus on the importance of the nursing workforce in the delivery of those services and in the achievement of the United Nations Sustainability Development Goals by 2030. For the nursing profession, these agreements have potential implications for nursing practice, the nursing workforce and workforce planning for sustainable and equitable health service delivery.

1.1 Brief History

The General Agreement on Tariffs and Trade, established in 1947, had both an economic and political purpose. Following the devastation of two world wars and the great depression in the early twentieth century, it was believed that increasing the wealth of countries and linking them through trade would promote peace and prosperity. The agreement led to a massive expansion of world trade which raised millions of people out of poverty (Johnston, 2019; Labonté, 2019; Schram, Townsend, Youde, & Friel, 2019). In 1995, the General Agreement on Tariffs and Trade became the WTO which now includes 164 member countries. The WTO oversees a number of international trade agreements, including the General Agreement on Trade in Services, the Agreement on Trade Related Intellectual Property Rights, and the Agreement on Trade Related Investment Measures.

The negotiations of agreements through the WTO were painfully slow and complex, requiring consensus across a large number of countries and economies at different stages of development. Countries struggled to agree on trade rules for such things as patent and data exclusivity protections for medicines and medical devices. Many countries have now turned away from the multilateral process toward bilateral or regional trade agreements and there has been a rapid increase in the number of these agreements in the past two decades (Johnston, 2019; McNeill, Birkbeck, Fukuda-Parr, Grover, Schrecker & Stuckler, 2017; Labonté et al. 2019, Bureau et al. 2019).

Trade agreements form a type of economic legal framework of rules and principles governing global trade. Some commentators believe that the forces influencing the development of those rules globally are increasingly dominated by private economic powers and very powerful countries (Schram et al. 2019). At the same time, there has been a strong growth in neoliberalism, which favours deregulation, reducing government spending, cutting taxes, competition and free markets. The International Monetary Fund has noted that this strong global trend to neoliberalism has led to increasing inequality rather than growth (Ostry, Loungani, & Furceri, 2016).

Traditionally, the policy areas of trade and health have operated separately (Gleeson & Labonté, 2020). However, these changes to trade agreements, coupled with increased cross-border flows in

goods, services, people and capital, affect public health and health services through a number of mechanisms (Smith, Blouin, &Drager, 2015). These mechanisms include the increased advertising and sale of unhealthy products, such as high sugar content foods and beverages, increased costs of medicines to health systems and consumers, ownership and capital investment by large international organizations in health infrastructure, and through impacts on key determinants of health such as employment, pollution and the environment (Smith, Blouin, & Drager, 2015; Gleeson & Labonté, 2020; Labonté et al. 2019; Schram et al. 2019).

The Comprehensive and Progressive Agreement for Trans-Pacific Partnership is one of the regional trade agreements negotiated outside of the WTO. The signatory countries are Australia, Brunei Darussalam, Canada, Chile, Japan, Malaysia, Mexico, Peru, New Zealand, Singapore and Vietnam. There is a broad range of economic development across these countries from advanced, high-income economies such as Japan, to developing, lower middle-income economies such as Vietnam.

Based on the Trans-Pacific Partnership (2016), which faltered after the withdrawal of the United States in 2017, the Comprehensive and Progressive Agreement for Trans-Pacific Partnership is fundamentally the same agreement with suspension of some of the more contentious provisions. These suspensions remain in place unless the signatory countries unanimously agree that they are reintroduced. The suspended provisions of relevance to this discussion relate primarily to provisions that would have strengthened patent and data exclusivity protections for pharmaceuticals (Box1). These articles and Annexe 26A would have added additional periods of protection for patent and data exclusivity for pharmaceuticals which would have delayed the introduction of generic products to the market and significantly increased the cost to health systems and consumers (Pusceddu, 2018).

Box 1. Relevant suspended provisions

Article 18.37	Requirement for patents to be made available for either new uses of known products, new methods of using a known product or new processes of using a known product and for inventions derived from plants.
18.46	Requirement for governments to adjust, upon request, a patent's term of protection to compensate the patent owner if there are unreasonable delays in a patent office's issuance of patents.
18.48	Requirement to adjust a pharmaceutical patent's term of protection to compensate the patent owner for unreasonable curtailment of the effective term of a patent as a result of the marketing approval process for a pharmaceutical product.
18.50	Requirement for five years protection for data and test data submitted to a regulatory authority for the purpose of obtaining regulatory approval to market a pharmaceutical product.
18.51	Requirement for five years of protection for test or other data submitted to a regulatory authority for the purposes of obtaining regulatory approval to market a biologic pharmaceutical product.
Annexe 26A	'Transparency and Procedural Fairness for Pharmaceutical Products and Medical Devices' relating to the listing and pricing of pharmaceutical products and medical devices which would have increased and enforced the influence of pharmaceutical companies in the decisions of national health care authorities.

157

158

159 Public health advocates and health professionals have warned that these provisions may be
160 reinstated in the current agreement or introduced into other trade agreements (Labonté et al. 2019;
161 Labonté, Schram & Ruckert, 2017; Tham & Ewing, 2016). Indeed, the recently signed Canada, Mexico
162 and United States Trade Agreement (2018) includes expansions of intellectual property rights and

new regulatory reforms, which introduce regulatory constraints that intrude into domestic public policy (Labonté et al. 2019).

Supporters of these trade agreements claim that they will expand and grow current markets, and create new markets, while supporting the establishment of best practice regulation across signatory countries. Proponents also claim that they have the capacity to improve labour standards and working conditions across the region through the incorporation of the International Labour Organization (1998) 'Declaration on Fundamental Principles and Rights at Work' (Government of the Commonwealth of Australia, Department of Foreign Affairs and Trade, 2018b; Foreign Affairs Defence and Trade References Committee, 2018; Joint Standing Committee on Treaties, 2018).

Researchers and scholars of public health, health systems, health policy and international law are concerned about the rapid growth in the number of trade agreements and the growing dominance of influence from markets in negotiations. These experts warn that provisions in these agreements have the potential to adversely affect access to medicines (including biologics) and medical devices, and that they will erode the capacity of governments to use regulation to address issues of public health such as highly refined foods or high sugar content beverages and foods (Crosbie, Sosa & Glantz, 2018; Crosbie & Thomson, 2018; Crosbie, Thomson, Freeman & Bialous, 2018; Gleeson & Friel, 2013; Gleeson, Lexchin, Lopert, & Kilic, 2018; Gleeson, Moir, & Lopert, 2015; Jarman, 2017; Gleeson, Lexchin, Labonté, Townsend, Gagnon, Kohler, Forman & Shadlen, 2019; Labonté et al. 2019; Labonté, Schram, & Ruckert, 2016; Schram & Labonté, 2017; Schram et al. 2019; Thow, Snowdon, Labonté, Gleeson, Stuckler, Hattersley & Friel, 2015; Thow, Jones, Hawkes, Ali & Labonté, 2017; Tienhaara, 2011). Other concerns have been raised by political scientists and researchers in global economic governance who consider that the broad scope of these agreements make them influential in shaping policy decisions that influence other determinants of health such as equity of

188 access to health services, employment, pollution and the environment (Jarman, 2017; McNeill et al.,
189 2017).
190
191 The majority of research to date in this rapidly evolving area of international trade has been through
192 prospective analyses undertaken by public health and international law scholars. There is a gap in
193 research of the potential implications particularly for the health workforce and public policy. Given
194 the essential nature of health services and the health workforce, urgent further research of these
195 issues is warranted. As health advocates, nurses have an important role in ensuring the
196 sustainability, accessibility and equity of health services. Health system sustainability is also
197 dependent on the health professionals that deliver health care to the community. The implications
198 for the nursing workforce, the largest group of healthcare providers, must also be considered in
199 order to anticipate and mitigate unintended consequences that may adversely affect health systems
200 and the health outcomes of populations.
201

202 **2. Method**
203

204 **2.1 Aim**

205 The aim of this review is to explore current literature and identify existing knowledge concerning the
206 implications of trade agreements relevant for the nursing workforce, nursing practice and public
207 health. The 2018 Comprehensive and Progressive Agreement for Trans-Pacific Partnership (2018)
208 will be used as an exemplar. A scoping review protocol was developed based on *The Joanna Briggs*
209 *Institute Reviewers' Manual 2015: Methodology for JBI Scoping Reviews* (Peters, Godfrey,
210 McInerney, Soares, Khalil, & Parker, 2015).
211

212 **2.2 Search Criteria**

213 The inclusion criteria for this review were English language, full-text, peer-reviewed journal articles,
214 as well as grey literature including national and international policy documents published between
215 2016 and 2019.

216

217 **2.3 Search strategy and outcomes**

218 Six databases were searched – Emerald Insight, Informit, Ovid-MEDLINE, ProQuest, PubMed, Scopus.
219 Search terms included 'trade in services agreements', 'free trade agreements', 'Trans-Pacific
220 Partnership' 'TPP-11' 'Trans-Pacific agreement', 'harmonisation of regulation', 'regulatory
221 coherence', Health*, Medic*, Nurs*, 'nurse migration', workers, 'workforce planning' and variations
222 of spelling in relation to these terms.

223

224 As shown in Figure 1, 872 abstracts were sourced from the databases, and 49 additional items were
225 sourced from grey literature using Google Scholar, hand searching and snowballing from reference
226 lists and peer referral. After the removal of duplicates, screening of titles and review of abstracts, 139
227 titles remained. Following full text review, a further 14 were discarded as being not relevant to context,
228 three were discarded as not related to concept and 10 were discarded as not related to population. A
229 total of 112 journal articles and items of grey literature were subsequently included in the review
230 (Table 1 – Supplementary data). Each document was reviewed thoroughly, using the six-step thematic
231 approach described by Braun & Clark (2006), in order to identify key themes relating to risks for the
232 nursing workforce, nursing practice and public health (Table 2).

233

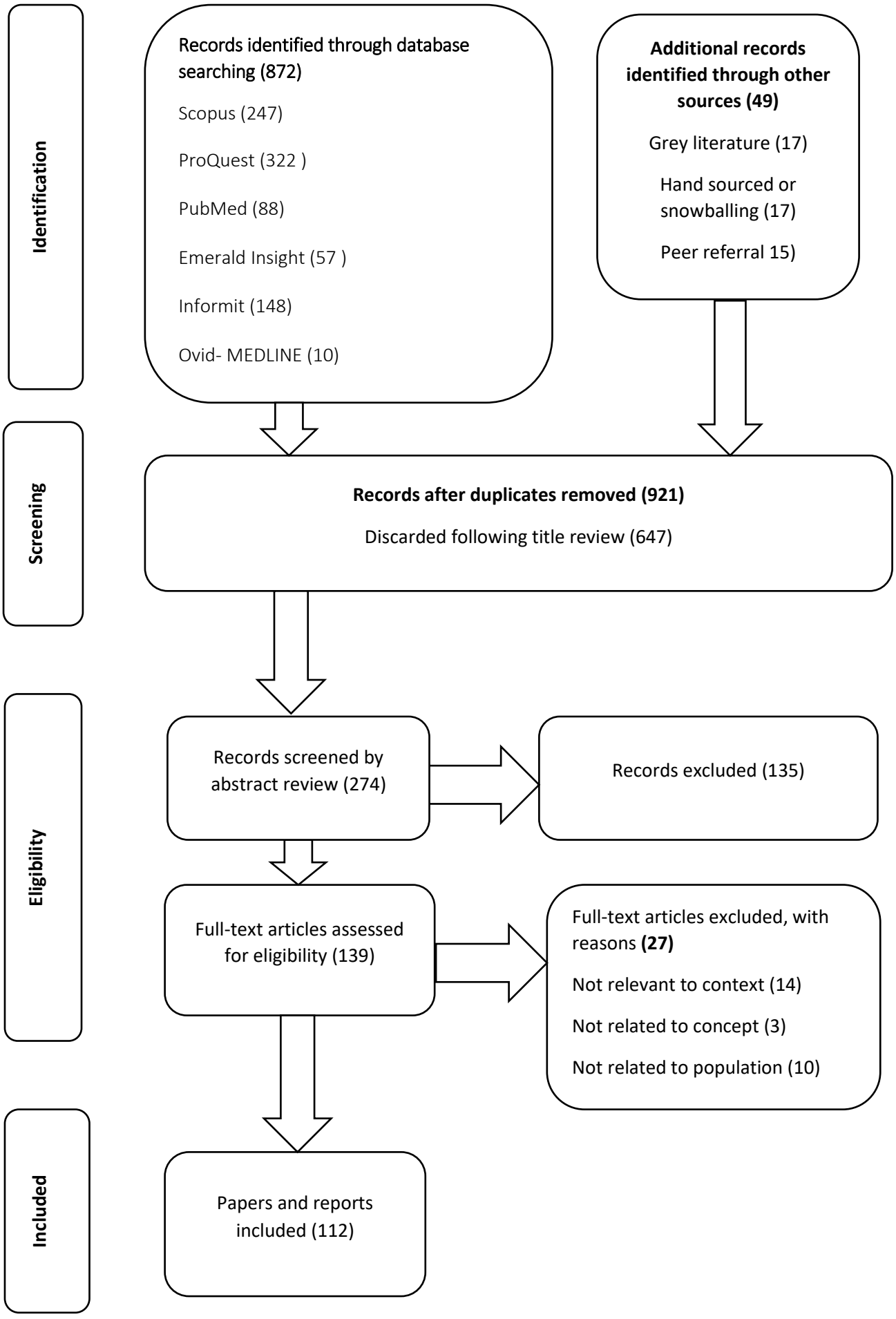

Figure 1. Literature search PRISMA flow diagram *n*

Table 2. Braun and Clarke's (2006) six-phase framework for 'reflexive thematic analysis'

Phase	Action
1.	Become familiar with the data
2.	Generate Initial Codes
3.	Search for themes
4.	Review themes
5.	Define themes
6.	Write up

3 Results

Six key themes were identified relating to risks for the nursing workforce, nursing practice and public health.

3.1. Lack of consultation with health professionals and public health advocates in trade negotiations

Trade agreements reflect the interests of those directly involved in the system (Schram et al, 2019). Trade negotiations are usually the responsibility of trade and finance or foreign affairs ministries of governments. Government trade negotiators are drawn from the experts in the areas of trade, finance, foreign affairs and international law rather than public health and health services (Jarman,2017). Access to trade negotiators is usually dominated by trade and finance interests. For example, the United States appointed approximately 600 corporate lobbyists as official advisors during the negotiations for the Trans-Pacific Partnership (Alcorn, 2016; Schram et al. 2019).

Health advocates argue that the essential nature of health services, and the critical importance to the community, differentiates them from traditional areas involved in trade negotiations. Any intended

policy change that may affect the provision of health services must, therefore, be analysed by experts in health service delivery to avoid unintended negative consequences for health systems (Alcorn, 2016; Jarman,2017; Joint Standing Committee on Treaties, 2018; Schram et al. 2019; Smith et al. 2009).

Currently, opportunities for health advocates to advise on trade agreements are limited and usually occur without access to the draft agreement until late in the negotiation stage or after the agreement has been drafted (Joint Standing Committee on Treaties, 2018). Because these agreements have significant potential to affect health system resources and policies, as well as the social determinants of health, there is an urgent need for consultation with health stakeholders including public health advocates and the health professions (Jarman,2017). Some commentators consider that trade negotiations provide an important opportunity to advance the health agenda. They urge public health advocates and the health professions to engage with the process and work toward greater inclusion in these negotiations (Alcorn, 2016; Schram et al. 2019).

As trade agreements evolve the potential for intrusion into domestic public policy increases the risks for public health and health services. There is a compelling need for health professions and public health advocates to have greater access to trade negotiators. Similarly, governments need to consult with and take advice from health professions and public health experts when negotiating trade agreements in order to anticipate and avoid negative unintended consequences for communities.

3.2 Implications of strengthened intellectual property provisions for equitable access to medicines (including biologics) and medical devices.

Pharmaceutical companies invent new medicines (including biologics) and medical devices that may take many years and significant investment to develop, trial and produce for the market. The Agreement on Trade-Related Aspects of Intellectual Property Rights (World Trade Organization,

1995) provides protections, through patents, which grant periods of 20 years monopoly rights to the inventing company. A registered patent provides the owner of the invention with the exclusive right to exploit it commercially for the life of the patent. During this time, no other company can produce a generic product for the market. This enables the company to recoup development costs and profit from the invention, thereby encouraging further investment and research.

However, at the same time as the WTO introduced the Agreement on Trade-Related Aspects of Intellectual Property Rights, the world was dealing with the unprecedented health crisis of the Acquired Immune Deficiency Syndrome (AIDS), caused by the Human Immunodeficiency Virus (HIV) (t' Hoen, 2016). Death rates from this disease were devastating for developing countries where millions of citizens were infected. The Agreement on Trade Related Intellectual Property created barriers to affordable, rapid and equitable access to cost-effective HIV medicines in many developing countries. As a result, a global campaign was launched by public health advocates, non-government organisations and health professionals, which succeeded in enabling the production of quality, generic HIV pharmaceuticals and access for millions of people to these lifesaving medicines (t' Hoen, 2016).

The WTO eventually agreed on the inclusion of protections for public health in trade negotiations and a framework of rules were established. The Doha Declaration on TRIPS (Trade-Related Aspects of Intellectual Property Rights) and Public Health in 2001, and the WTO 2005 Ministerial Declaration introduced Article. 31bis to the original agreement, creating 'compulsory licence' granting exemption for developing countries to produce and export generic pharmaceuticals for their own population, and other developing countries in a declared health crisis (Abbott, 2006; Pusceddu, 2018, t' Hoen, 2016).

Data exclusivity is a second type of protection for pharmaceutical companies, which relates to the process of developing new medicines (including biologics) or medical devices through clinical trials undertaken to establish that product is safe and effective. Data exclusivity refers to the period during which another pharmaceutical manufacturer cannot rely on the data generated by the inventing pharmaceutical company to gain marketing approval for their own generic products. This means that the generic manufacturer must wait until the period of data exclusivity expires or undertake their own clinical trials before they can begin manufacturing the product. When intellectual property protections expire, these products can be produced and sold as generic brands by other companies, usually at a much-reduced cost to the consumer.

Over the past two decades, pharmaceutical companies have pursued additional protections for products beyond those of the Trade-Related Aspects of Intellectual Property Rights, through the bilateral and regional trade agreements negotiated outside the WTO. The Comprehensive and Progressive Agreement for Trans-Pacific Partnership, and succeeding bilateral and regional agreements including the Comprehensive Economic and Trade Agreement (CETA) between the EU and Canada, and the United States-Mexico-Canada Agreement (USMCA), have included extended intellectual property protections. As indicated above, many of the provisions that would have enabled greater periods of exclusive patent to pharmaceutical companies were suspended in the Comprehensive and Progressive Agreement for Trans-Pacific Partnership. However, those provisions are extended and enforceable in the other trade agreements. These “TRIPSPlus” protections include such things as increases in the length of patent periods and periods of data exclusivity (Gleeson et al, 2019).

There are also other areas of these agreements that enhance these protections. These include provisions such as:

- Protections for investments through investor state dispute settlement provisions

- Procedural requirements for pharmaceutical pricing and reimbursement programs
- Provisions with implications for regulation of pharmaceutical marketing
- Regulatory requirements for assessment of safety, efficacy, and quality
- Reduction/elimination of tariffs on medicines or their ingredients
- Rules applying to government procurement of pharmaceuticals
- Rules applying to state-owned enterprises and designated monopolies
- Procedural requirements for customs administration and trade facilitation
- Rules applying to regulatory practices, cooperation and coherence (Gleeson et al, 2019).

Public health advocates and health professionals have expressed serious concerns about the implications of strengthened intellectual property protections in trade agreements for equity of access and cost of medicines (including biologics) and medical devices. The issue is extremely important for low and middle-income economies that rely on low cost generic medicines for the treatment of conditions such as Malaria, Tuberculosis and HIV. Any changes that further strengthen patent protections for medicines (including biologics) and medical devices put at risk the WTO Doha Declaration by creating barriers to affordable and equitable access to pharmaceuticals for communities globally (Crosbie, Sosa & Glantz 2018; Crosbie & Thomson, 2018; Crosbie, Thomson, Freeman & Bialous, 2018; Gleeson & Friel, 2013; Gleeson, Lexchin, Lopert, & Kilic, 2018; Gleeson, Moir, & Lopert, 2015; Gleeson et al, 2019; Jarman, 2017; Labonté et al. 2019; Labonté, Schram, & Ruckert, 2016; Pusceddu, 2018; Schram & Labonté, 2017; McNeill et al, 2017; Schram et al. 2019; Thow, Snowdon, Labonté, Gleeson, Stuckler, Hattersley & Friel, 2015; Thow, Jones, Hawkes, Ali & Labonté, 2017; Tienhaara, 2011).

From this literature review, it is clear that a conflict exists between the commercial perspective of pharmaceutical companies, the objectives of public health and public health services, and the basic human right to equitable access to medicines globally. Opinion also varies on what constitutes

appropriate remuneration for the investment and research involved in inventing new pharmaceuticals and the degree to which profits translate into further investment and research (Light & Lexchin, 2012). There can be no doubt that health professionals and public health advocates must remain vigilant in all trade negotiations to prevent the introduction of provisions that can effectively limit access to and raise the cost of medicines beyond the reach of the disadvantaged in our communities.

3.3 Threats to government capacity to regulate domestic public health policy from 'Investor State Dispute Settlement' provisions.

Governments control access to their country's markets and investments through various tariffs or quantitative restrictions on goods, and through domestic regulation. In the case of regulation, governments must balance the maintenance of domestic regulatory autonomy and liberalising access to markets and investment (Voon, 2017). Fifty years ago, an international system of arbitral jurisprudence was created to protect the rights of foreign investors from government policies and regulations that discriminate de facto against foreign goods, services or investors, or fail to meet other standards required by international economic law, such as the 'fair and equitable treatment' of foreign investors (Lencucha, 2017; Sheargold & Mitchell, 2016).

Many countries have given investors rights to arbitration through this system of international tribunals. Called 'Investor State Dispute Settlement', the system has developed rapidly in the 21st century through a vast network of bilateral and multilateral trade agreements. The tribunals are arbitrated by three lawyers, usually drawn from international business law. This has led to criticism that the tribunals favour business interests and are not qualified to adjudicate on matters related to challenges to public laws and sovereignty of countries in determining domestic policy for areas such as public health and health services (Jarman, 2019; Labonté et al., 2019; Schram et al. 2019; Puig &

409 Strezhnev, 2017). The system of arbitral jurisprudence has also been described as inconsistent,
410 particularly in relation to the sums of compensation being awarded. Compensation payments have
411 increased steadily from the beginning of the century to huge sums amounting to many billions of
412 dollars. In some cases, the compensation has been far in excess of the investment. For example,
413 Unión Fenosa Gas filed a claim against Egypt, which resulted in compensation awarded at USD 2.013
414 billion plus interest. This sum equated to 12 percent of the country's combined health and education
415 budget at that time (Bonnitcha & Brewin, 2019). Arbitration tribunals also operate outside the
416 national laws of the countries involved and have been described as undemocratic (Scram et al. 2019;
417 Puig & Strezhnev, 2017).
418
419 Health advocates have criticised Investor State Dispute Settlement provisions of trade agreements
420 as providing a mechanism by which companies can impede government efforts to regulate in the
421 national interest, particularly for health-related issues such as tobacco, high sugar content foods and
422 beverages, and alcohol labelling. There is growing concern that Investor State Dispute Settlement is
423 now increasingly encroaching on government autonomy and capacity to regulate both directly,
424 through a growing number of challenges in international courts, and through a phenomenon called
425 'Regulatory Chill' (Tienhaara, 2011; Lencucha, 2017; Crosbie & Thomson, 2018; Labonté et al. 2019;
426 Schram & Labonté, 2017; Schram et al. 2019.).
427
428 'Regulatory Chill' refers to the unwillingness of government to introduce regulation for fear of a
429 possible challenge under Investor State Dispute Settlement provisions. It has been argued that large
430 companies have the financial capacity to use the system as a deterrent to governments and to
431 dissuade regulation, even if they do not expect to 'win the case' (Lencucha, 2017). This creates a
432 hostile regulatory environment in which governments hesitate to enact regulations in the public
433 interest (Crosbie, Sosa & Glantz 2018; Crosbie & Thomson, 2018; Crosbie, Thomson, Freeman &
434 Bialous, 2018; Friel, Gleeson, Thow, Labonté, Stuckler, Kay & Snowdon, 2013, Gleeson & Friel, 2013;

Gleeson, Lexchin, Lopert, & Kilic, 2018; Gleeson, Moir, & Lopert, 2015; Labonté, Schram, & Ruckert, 2016; Labonté et al. 2019; Schram & Labonté, 2017; Schram et al. 2019; Thow, Snowdon, Labonté, Gleeson, Stuckler, Hattersley & Friel, 2015; Thow, Jones, Hawkes, Ali & Labonté, 2017; Tienhaara, 2011).

Investor State Dispute Settlement provisions of trade agreements provide investors with protections against exclusionary government practices or policies. They also have the potential to influence the ways in which governments regulate domestically for the public good. The most obvious areas of concern for public health advocates, including nurses, are such things as the capacity to regulate sugar content in food and beverages or tobacco and alcohol, the environment, and pollution. There are also many other potential areas of concern such as ownership of private acute, aged care and retirement health facilities, and education and training providers responsible for educating future health professionals.

3.4 Threats to government capacity to regulate domestic public health policy from 'Regulatory Coherence' provisions of trade agreements.

Regulatory coherence is a concept that was included for the first time in the Comprehensive and Progressive Agreement for Trans-Pacific Partnership, as a way of introducing 'best practice' regulations across signatory countries and reducing protectionist domestic regulation. In this agreement the provisions are not legally binding. Since then, however, the provisions of 'Regulatory Coherence' in the recently signed United States, Mexico, Canada Agreement (2018) are expanded and are also legally binding (Labonté et al. 2019; Trans-Pacific Partnership Agreement, 2018).

Regulatory coherence is another pathway through which markets can influence public policy and dissuade government regulation that impedes trade. When combined with the actual and deterrent

impact of Investor State Dispute Settlement provisions, there is a significant risk for the public sector and public policy from market forces and powerful countries in such areas as public health, health services, the environment and pollution (Labonté et al. 2019).

Regulation intersects with many aspects of the educational, professional and practice environment of nurses. The scope of these provisions has implications in areas including the regulation of investment in health and aged care services and the educational organisations that prepare health professionals for practice. Regulatory coherence is intended to reduce obstructive regulatory requirements that act as a barrier to trade. Regulation of the health care sector, including health service delivery, education of health professionals, and the regulation of nursing and other health professions is complex and has a primary purpose of protecting the public. The balance of opportunities and risks in the introduction of provisions that have the potential to affect health service regulation, is a key policy issue. Research into the benefits and potential unintended consequences of the introduction of regulatory coherence must be given high priority.

3.5 Potential limited benefits to communities and increased health inequities.

The labour provisions of the Comprehensive and Progressive Agreement for Trans Pacific Partnership have been described as “the most significant labour clause in a trade agreement concluded to date” (Tham & Ewing, 2016, p.2). The provisions address labour rights included in the ‘Declaration on Fundamental Principles and Rights at Work’ (International Labour Organization, 1998). They require signatory countries to have laws at the Federal level of government that enshrine the rights stated in the Declaration. Included are such important human rights as:

> *(a) freedom of association and the effective recognition of the right to collective bargaining; (b) the elimination of all forms of forced or compulsory labour; (c) the effective abolition of child labour and, for the purposes of this Agreement, a prohibition on the worst forms of*

child labour; and (d) the elimination of discrimination in respect of employment and occupation (International Labour Organization, 1998).

However, the obligations set out in Article 19.3 (Labour Rights) of the Comprehensive and Progressive Agreement for Trans-Pacific Partnership have been criticised for only including the International Labour Organization Declaration and not the more enforceable 'Fundamental Conventions' (International Labour Organization, 2002). These obligations are only enforceable where they affect trade or investment between signatory countries. Some commentators have questioned the level of adoption achievable of the labour clauses (Tham & Ewing, 2016). Others question whether access to these labour rights would be available to workers in insecure and unprotected employment, such as casual employment or working outside trade sectors directly included in the agreement. Workers in these positions could experience reduced benefits in actual health outcomes, and a decline in access to health services and health equity, relative to any material gain for the country's economy that they may experience (McNamara and Labonté,2017; Blouin, Chopra, & van der Hoeven, R, 2009). Although the conditions under which people live, work and die are a less direct and harder to assess social determinant of health than the impact of intellectual property protections and its consequences for equity of access to medicines, they are equally important (McNeill et al. 2017).

In summary, the Comprehensive and Progressive Agreement for Trans-Pacific Partnership includes the International Labour Organization (1998) 'Declaration on Fundamental Principles and Rights at Work' as part of its labour provisions. These provisions are not enforceable and sections of communities may see no benefit from the inclusions or may see a deterioration in their social determinants of health. Groups such as those in insecure or unprotected work, and those working outside industries directly included in the trade agreement fall within this category. The entitlement of all workers to fundamental rights, as outlined in the 'International Labour Organization

Declaration' (1998) and 'Fundamental Conventions' (2002), contribute to the social determinants of health and are of critical importance to ensuring health equity for communities.

3.6 Potential implications of increased temporary migration

Trade agreements include provisions for the temporary access of workers between countries. These provisions and the specific undertakings of each country form the requirements for workers, including nurses, to move between countries that are signatory to the agreement under temporary migrant status. Often governments include a requirement for employers to demonstrate their inability to fill the positions with domestic workers, called labour market testing or economic needs testing, before contracting workers outside the domestic workforce. In the Comprehensive and Progressive Agreement for Trans-Pacific Partnership, this requirement has been waived reciprocally for six of the signatory countries - Australia, Brunei Darussalam, Canada, Japan, Malaysia, Mexico and Vietnam.

In Australia, the waiver of the labour market testing requirement has caused significant concern. Many submissions to the parliamentary inquiries into the Comprehensive and Progressive Agreement for Trans-Pacific Partnership were about this issue. The Australian Nursing and Midwifery Federation expressed strong concerns for both the status and conditions of employment of temporary migrant nurses and other health workers, and the implications for the domestic nursing workforce. They asserted that, "acceptance of the need for temporary skilled migration is based on the view that appropriate policy and regulatory settings should discourage employers accessing offshore labour without first investing in training and undertaking genuine testing of the local labour market and must provide safeguards and protections for both local and overseas workers" (Australian Nursing and Midwifery Federation, 2018, p 6).

Australia, Canada and Japan, like other high income developed countries are facing increased demand for health services from a rapidly ageing population (Health Workforce Australia, 2014). In the recent past, Japan has managed increased demand for nurses through economic partnerships established with Indonesia (2008), the Philippines (2008) and Vietnam (2012) for nurses to work in the caregiving facilities in the aged care sector (Ford & Kawashima, 2016). These partnerships support the immigration of nurses for temporary contracts while making no change to permanent migration (Ford, & Kawashima, 2016). This has allowed the Japanese government to avoid labour challenges from a unionised workforce and negative community attitudes to immigration. A precedent has also been set for the use of trade agreements as a mechanism for management and regulation of labour flows leading to the normalisation of migrant labour as a tradable commodity (Ford, & Kawashima,2016; Hoekman, & OeZden, 2010; Jarman, & Greer, 2010; Jurje, & Lavenex, 2018; Labonté et al. 2019).

The capacity to employ temporary migrant nurses offers healthcare providers increased flexibility and nursing capacity in anticipation of significant predicted shortages of nurses (Health Workforce Australia, 2014), and in recruiting to high demand specialities such as aged care and to geographically remote and rural health settings. Some commentators consider the use of trade in services agreements to facilitate worker migration as having potential for significant gains for both partner countries and individuals (Barker, 2010). However, in countries that have not included a labour market testing requirement, this will potentially bring temporary visa nurses into competition with domestic nurses for employment opportunities. The implications of a potential increase in competition for nursing employment have yet to be explored. The availability of nurses through temporary migration may lead to downward pressure on wages for nurses, and increases in casualization and insecure employment of the nursing workforce (Mashayekhi, Julsaint, & Tuerk, 2006).

The advantages of the temporary emigration of nurses, for source countries, include the benefit to the economy of remittances from expatriate workers, and the exchange of knowledge and technology on their return. For individual nurses, temporary migration provides an opportunity to earn wages at a higher level, for better working conditions and for professional development (Ramasamy, Krishnan, Bedford, & Bedford, 2008). The disadvantages, however, can include the depletion of adequate workers within the source country to meet its own population health needs, particularly in the public sector and remote locations.

High levels of nurse emigration can also prove a significant financial burden on the country to educate and prepare nurses for both domestic and overseas demand. Outcomes depend greatly on whether the country has sufficient training capacity to educate enough nurses to support its own health care system and community as well as an emigrating population of nurses (Labonté et al., 2015; Li, Nie & Li, 2014; Liua, Goryakin, Maeda, Bruckner, & Scheffler, 2016; Manning, Sidorenko, 2007). Unfortunately, government health and trade portfolios are usually managed separately and there may not be harmony in policy decisions that can achieve both the health policy goals and the economic trade goal (Labonté et al., 2015; Li, Nie & Li, 2014; Liua, Goryakin, Maeda, Bruckner, & Scheffler, 2016; Manning, Sidorenko, 2007). In countries such as the Philippines, for example, the number of nurses being produced is adequate for the health system, but nurses qualify with the expectation of migrating to countries like Australia, Canada, Japan, the United Kingdom and the United States, and are supported by government policy to do so. Government health workforce strategies focused on export can frustrate efforts to ensure an adequate workforce of nurses for the home country (Yeates & Pillinger, 2018).

For the destination country, reliance on temporary workers may be an economical and immediate solution to nurse shortages. However, failure to address the factors contributing to domestic nurse shortages, such as recruitment to the profession, available education places and retention of nurses

591 in the profession is likely to lead to further long-term exacerbation of domestic shortages (Health
592 Workforce Australia, 2014; Australian Nursing and Midwifery Federation, 2018).
593
594 For individual nurses, migrating to work in another country's health system can also have negative
595 outcomes (Kurniati, Chen & Efendi, 2017). These can include difficulty in gaining recognition and
596 employment at the practice level attained in the home country, potential deskilling and loss of
597 employment opportunities on return home (Ford & Kawashima, 2016; Kurniati, Chen, Efendi, &
598 Ogawa, 2017). For example, Indonesian nurses recruited to work in Japan's aged care sector, under
599 the Japan-Indonesia Economic Partnership (2008), struggled to reenter nursing practice in Indonesia
600 at least at the level formerly achieved (Ford & Kawashima, 2016; Kurniati, Chen, Efendi, & Ogawa,
601 2017).
602
603 There are significant potential benefits and challenges from changes to the temporary migrant visa
604 provisions of the trade agreements including the Comprehensive and Progressive Agreement for
605 Trans-Pacific Partnership (Foreign Affairs Defence and Trade References Committee, 2018; Joint
606 Standing Committee on Treaties, 2018). However, little is known of how these changes may affect
607 the nursing workforce and the healthcare systems dependent upon nurses to function effectively.
608 Further research is urgently needed to address this gap in knowledge.
609
610 **3. Discussion**
611
612 The aim of this review was to explore current literature and identify existing knowledge of the
613 implications of trade agreements relevant to the nursing workforce, nursing practice and public
614 health, with a particular focus on the *Comprehensive and Progressive Agreement for Trans-Pacific*
615 *Partnership* (2018). Six themes were identified as having relevance for the nursing workforce,

nursing practice and public health. Each of these falls within the scope of the definition of nursing, defined as encompassing:

> *… autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles* (ICN, 2002).

The nursing profession can bring to trade negotiations the broad scope of expert knowledge and experience across all aspects of the health care environment, as well as an invaluable, multifaceted overview of a complex and interrelated system of service delivery, and environmental and social factors contributing to the health outcomes of the community. However, as has been discussed, opportunities for the health professions and public health advocates to contribute to trade agreements negotiations are currently limited (Schram et al.2019).

As trade and investment intrude further into the areas of public policy areas such as public health, health service delivery and the environment, advice from groups with expertise in these sectors will be essential to prevent unintended negative consequences and enhance positive outcomes. Nurses, other health professionals and public health advocates must make the case to governments for more direct access to government trade negotiations. Governments need to be fully aware of the potential unintended implications of trade provisions, how to include special protections for health and public policy, and how the terminology used in agreement texts can ensure those protections are enacted (Delany, Signal & Thomson, 2018).

4. Conclusion

The analysis of the literature reviewed is of international importance. The essential nature of the contribution of nursing to the effective provision of accessible and equitable health care adds a degree of urgency for research evidence which will support policy makers in anticipating and responding to labour and regulatory provisions in trade agreements that may impact on the nursing workforce, nursing practice and public health. A united approach by health professional and public health associations is also likely required to ensure the necessary protection for health systems and the health of communities.

Conflicts of interest

The authors declare no conflicts of interest.

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