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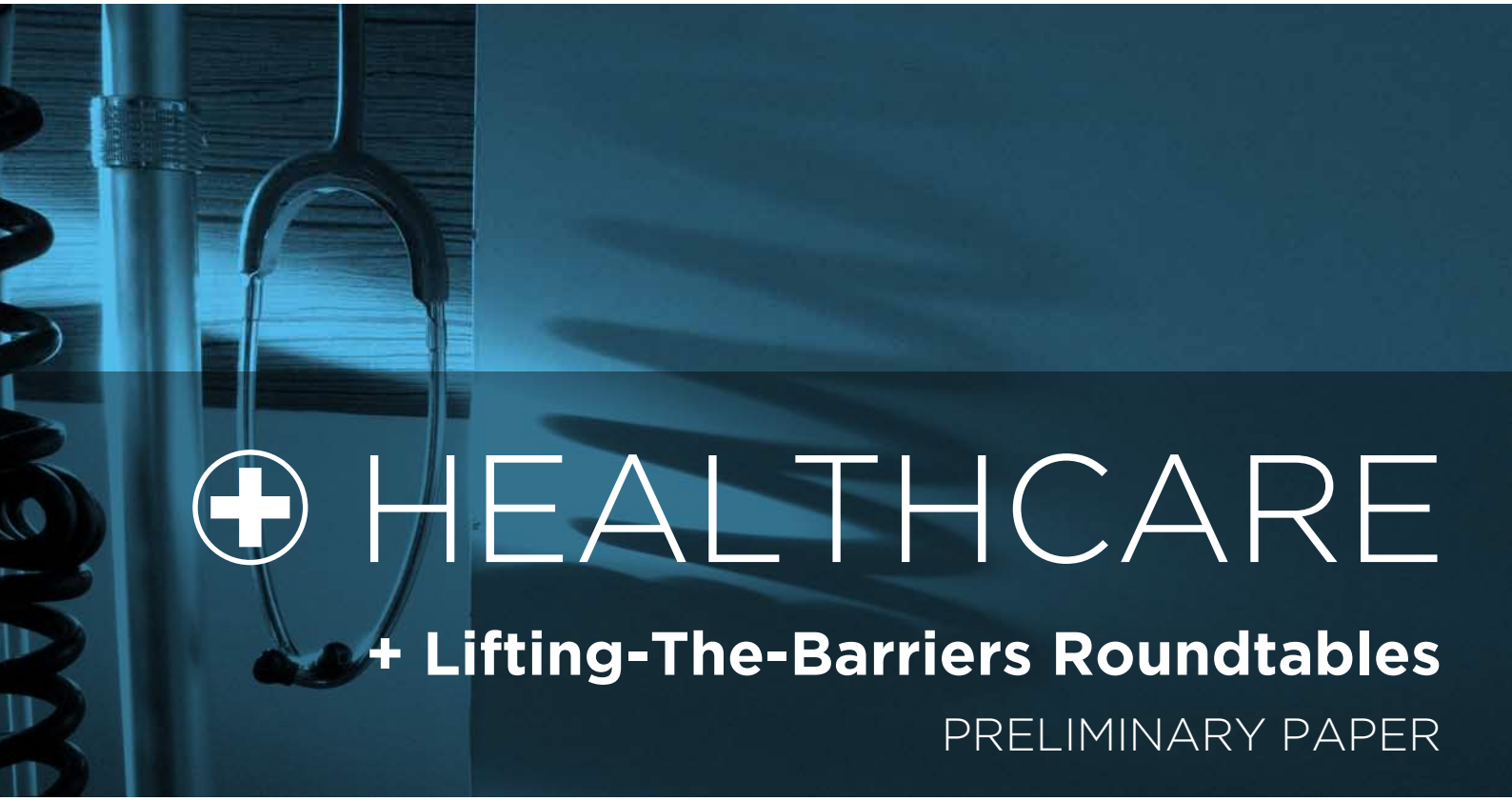

HEALTHCARE

+ Lifting-The-Barriers Roundtables

PRELIMINARY PAPER

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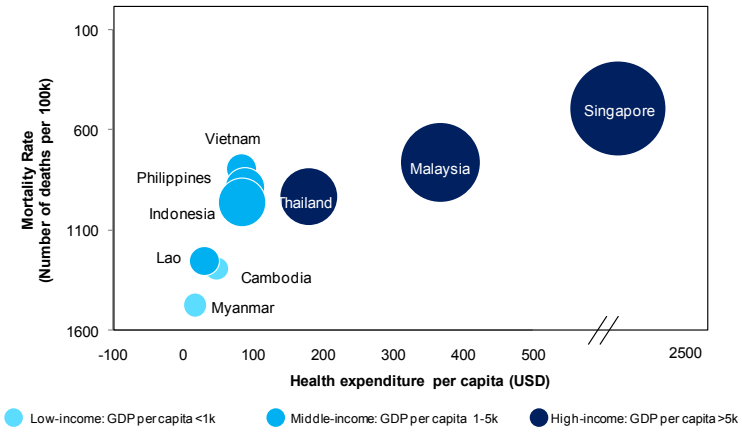
FIRST SECTION – ASEAN COUNTRIES OVERVIEW

- ASEAN is a very diverse region. It is composed of a group of countries with unique political, cultural, economic and social characteristics.
- From the perspective of healthcare, we see that member countries are at varying levels of development due mainly to significant differences in resources spent on health, access to healthcare, and healthcare supplies such as pharmaceuticals.
- Higher-income countries like Singapore, Malaysia and Thailand have healthier populations due to higher expenditures on healthcare while Lao People's Democratic Republic (PDR), Cambodia and Myanmar are grouped at the other end of the spectrum with higher mortality rates and lower per capita health spending (see Figure 1).

Figure 1.
Healthcare Spending and Health Profiles of ASEAN countries

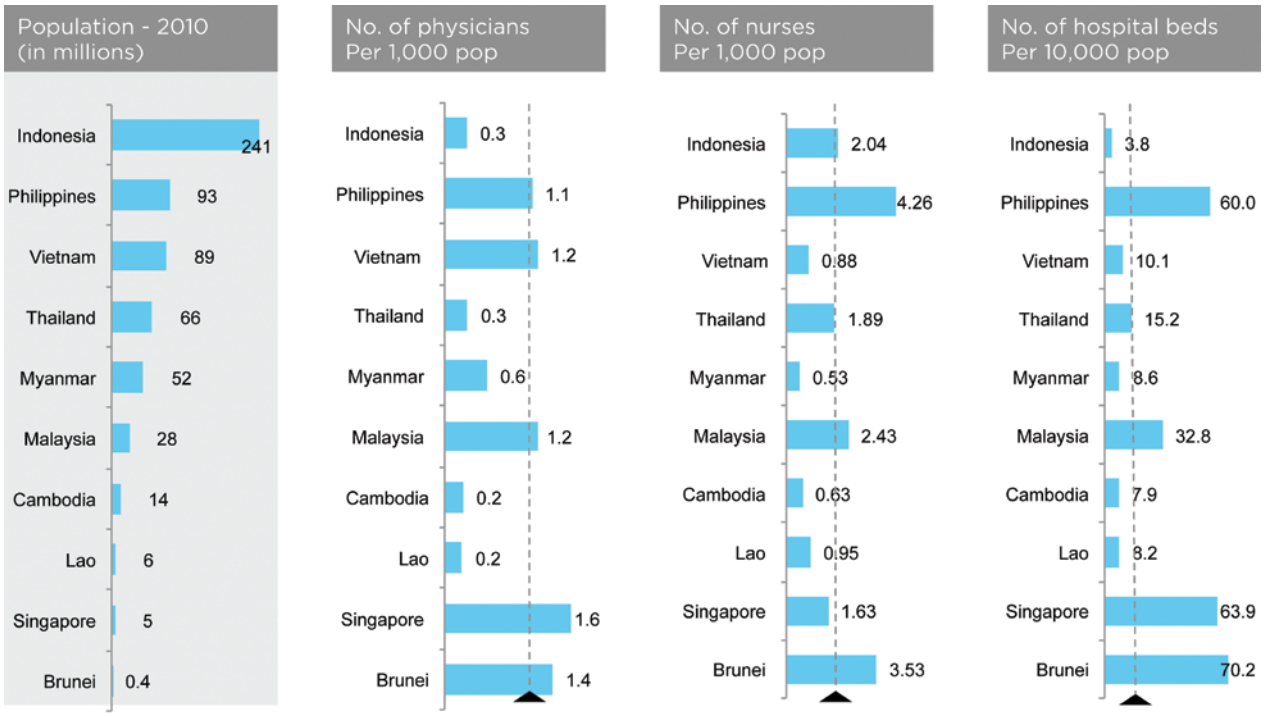


Source:
International Monetary Fund (IMF), World Economic Outlook Database April 2013; World Health Organization (WHO), World Health Statistics 2013

THE HAVES VS. THE HAVE-NOTS

- Not surprisingly, higher-income countries are well-ahead of the lower-income ones in terms of resource availability for health, healthcare coverage and quality of care (see Figure 2).

Figure 2.
Population and healthcare resource comparison across ASEAN



Source:
United Nations, Department of Economic and Social Affairs, Population Division (2013). World Population Prospects: The 2012 Revision, CD-ROM Edition.; OECD Health Data 2012; WHO Global Health Observatory Data Repository, national data sources; WHO World Health Statistics 2013
Note:
Figures for number of physicians, nurses and hospital beds reflect latest data available

- Singapore, Brunei and Malaysia, with their low population bases enjoy a surplus in healthcare resources with higher-than-average availability of medical personnel and facilities.

- Lao PDR, Cambodia and Myanmar suffer from severe resource deficits to respond to the healthcare needs of its citizens. For every 1,000 of its population, less than 1 doctor and nurse is available and less than 10 hospital beds for every 10,000 people is available.

- Middle-income economies such as Philippines, Vietnam and Indonesia have barely adequate healthcare resources to cover the health needs of its large population. Indonesia, for example, with more than 240 million people, sees a deficit in doctors and hospital beds. Vietnam, with 89 million people, has less than 1 nurse for every 1,000 people.

- Singapore, Malaysia, and Thailand have been able to leverage on the surplus of some of their resource bases to expand the coverage and develop the quality of their healthcare capabilities. These countries stand out as healthcare centers with results comparable with that of the US or UK. For instance, the number of births attended by skilled health personnel and immunization coverage of children for measles in these countries is equal if not higher than in the US and UK. Neonatal mortality rates for them are the lowest and case-detection rates for tuberculosis are the highest in the ASEAN region.

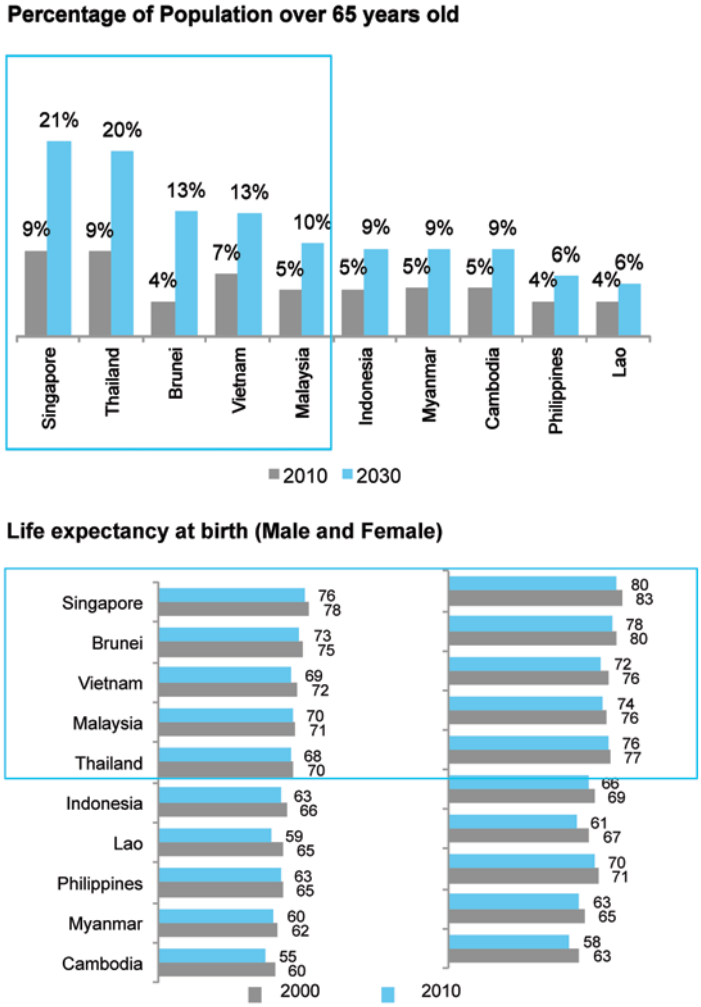
- In contrast, Lao PDR, Cambodia and Myanmar have the highest mortality rates at childbirth and poorest detection rates for tuberculosis indicating the shortfall in quality and coverage in healthcare services.

THE EVOLVING HEALTHCARE LANDSCAPE IN THE REGION

- **Increasing affluence.** As the level of income rises with economic development, the landscape for healthcare will evolve. At the broadest level, continued economic growth will cause a transition into more discretionary areas of healthcare spending. Between 2000 and 2010, healthcare spending by Southeast Asia's middle class grew over 9% of the annual compound rate. The Economist estimates that healthcare spending in Asia has risen from 14% of the global total in 2006 to 23% in 2012[1]. As some ASEAN populations become wealthier and more people join the middle class population, the region will witness more discretionary areas of healthcare spending although the gap between the haves and have-nots may grow wider.

- **Increasing aging population base.** Demographic shifts on population age structures will increase the burden of healthcare costs even for developed countries in ASEAN. Across the region, a demographic transition is set to occur in the next coming decades where the population of people aged more than 65 years old will double and comprise 10% of the population. Together with longer life expectancy, the total dependency ratio across ASEAN will jump to 23% by 2050 from 10% in 2015 and increase the burden of healthcare costs. This demographic shift will be more pronounced for well-developed nations with higher ageing populations and longer life expectancy rates (see Figure 3).

Figure 3.
Percentage of population over 65 years old and life expectancy across ASEAN

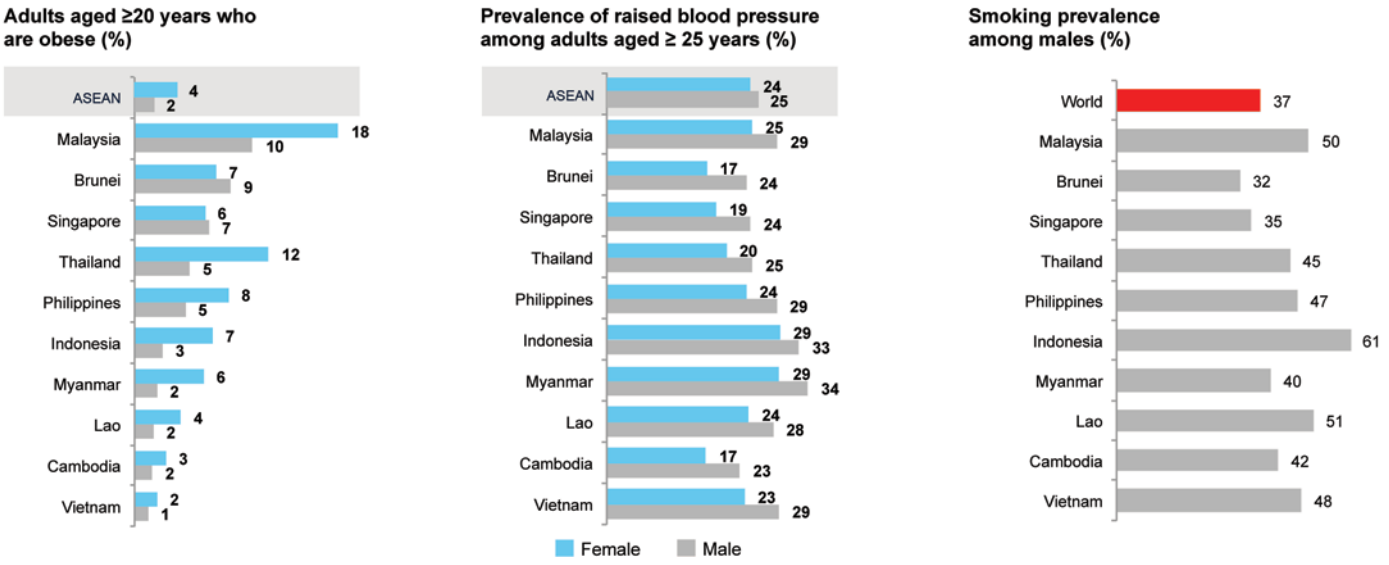


Source:
United Nations, Department of Economic and Social Affairs, Population Division (2013). World Population Prospects: The 2012 Revision, CD-ROM Edition; WHO World Health Statistics 2013

An ageing population leads to an increase in the demand for healthcare due to higher occurrence of non-communicable lifestyle diseases such as cardiovascular diseases as well as cancer and age related diseases such as arthritis and diabetes, among others; higher requirement for diagnosis and hospital-based inpatient and outpatient treatment; and longer duration of care.

- **Elevated health risk of ASEAN populations.** Relatively higher population growth rates and increased urbanization in the ASEAN region will increase overall health risk. Southeast Asia will add more than 131 million people in its cities, increasing the risk of communicable diseases from high-density urban life brought about by higher population density and poor living conditions. Along with urbanization comes socio-cultural developments that are detrimental to health conditions. Today, non-communicable diseases (NCDs) are top killers in ASEAN causing 7.9 million deaths annually. This is expected to increase by 21% over the next decade[2]. Much of NCDs are caused by lifestyle-related factors leading to hypertension, obesity, and respiratory diseases (see Figure 4).

Figure 4.
Indicators of lifestyle-related risk levels to health in ASEAN

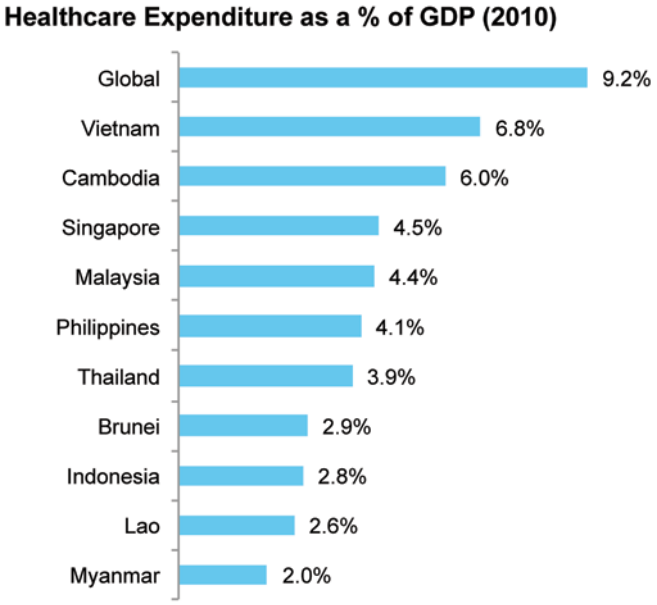


Source:
WHO World Health Statistics 2013

CAN ASEAN RESPOND TO THE CALL OF INCREASED HEALTHCARE DEMAND?

- **Funding for healthcare.** Meanwhile, the majority of ASEAN countries struggle to respond to the increasing healthcare demands due to their limited resources. Across ASEAN, healthcare spending remains low. The global average for health expenditure is at 9.2% of GDP. ASEAN countries spend way less than their global peers. On a per capita basis, Singapore spends the highest on healthcare, more than six times the amount that Malaysia spends and more than a hundred times that of Myanmar's health expenditure per capita (see Figure 5).

Figure 5.
ASEAN Healthcare expenditure as % of GDP



Country	Per capita expenditure on health at average exchange rate (US$)	
	2000	2010
Singapore	663	2005
Malaysia	125	368
Thailand	66	179
Philippines	34	89
Indonesia	15	84
Vietnam	21	83
Cambodia	19	48
Lao	11	30
Myanmar	3	17
US	4703	8233
UK	1765	3495

Source:
WHO World Health Statistics 2013

- **Most countries in ASEAN employ a mix of healthcare financing schemes.** Several have social health insurance schemes covering certain segments of the population, such as employees of public departments, workers from formal and informal sectors and their families, mostly covering sectors where premiums or contributions could be collected easily. There are efforts underway to expand the social health insurance schemes to achieve universal or near-universal coverage in some countries by combining social health insurance and direct subsidies or community-based financing coming from public revenue/funds but few have been successful so far[3].

  - Countries such as Thailand, Vietnam, Philippines and Indonesia have employed risk-pooling through social health insurance schemes. However, coverage remains low and thus still needs to be complemented with government revenues to become universal. Most schemes also cover mainly financial risk for hospital care and exclude other significant costs of health care such as transportation, medicines, follow-up consultations, etc.

  - Lao PDR and Cambodia, both being resource-poor countries, have mostly relied on donor-supported health equity funds to reach the poor, and reliable funding and appropriate identification of those eligible are two major challenges for nationwide expansion.

  - Malaysia and Singapore both use a mix of financing schemes involving compulsory saving schemes and provident funds[4].

- Funding aside, migratory patterns driven by a mix of push and pull factors are enabling access to, and the delivery of healthcare services in some countries much easier and more economical. In general, higher wages and better employment opportunities enable Singapore, Malaysia and Thailand to attract medical professionals and healthcare workers. Hence, high-income countries are already the preferred destination for quality healthcare by foreign patients due to the cost savings these countries can offer (see Figure 6).

Figure 6.
Average savings across a variety of specialties and procedures using US costs as a benchmark

Country	Average range of savings
Brazil	25-40%
Costa Rica	40-65%
India	65-90%
Korea	30-45%
Malaysia	65-80%
Mexico	40-65%
Singapore	30-45%
Taiwan	40-55%
Thailand	50-70%
Turkey	50-65%

Source:
Patients Beyond Borders Corporate Website, Medical Tourism Statistics and Facts. Available at http://www.patientsbeyondborders.com/medical-tourism-statistics-facts

- Significant focus by global healthcare players has been mainly in these advanced markets, where infrastructure, supply chain, regulation and operating models are very familiar. The impact of regional proportionate pricing and costing is a factor that has not been well understood outside of these markets

MEMBER STATE INITIATIVES TO IMPROVE NATIONAL HEALTH

- Individually, the member states have made progress in a number of specific areas to improve their healthcare industries in their respective jurisdictions.

  - SingaporeMedicine, an initiative between Singapore Tourism Board, Ministry of Health and Economic Development Board and IE Singapore is a collaborative effort to promote the Singapore brand overseas. Launched in 2003, SingaporeMedicine is committed to strengthening Singapore's position as Asia's leading medical hub, and promoting Singapore as a world-class destination for advanced patient care.

  - In Malaysia, the Malaysia Healthcare Travel Council (MHTC), a government agency under the Ministry of Health Malaysia has been set up to develop and promote the healthcare travel industry and to position Malaysia as the healthcare destination of choice in the region. MHTC is a focal point or a 'one-stop centre' for all matters related to healthcare travel, to facilitate enquiries on policies and programmes on healthcare travel development and promotion, and serve as a one-stop centre for solutions on matters related to healthcare travel. They are also the referral point to assist healthcare travellers and members in the healthcare travel industry in Malaysia.

  - Brunei has been stepping up efforts to leverage cross-country trainings through bilateral agreements. Brunei signed a series of memorandums of understanding (MOUs) on healthcare training and healthcare services with Singapore in the last 9 years and a MOU on healthcare services with Thailand in 2010. Thirteen doctors from Brunei have completed courses in various clinical expertise fields between 2010 and 2013[5].

  - Indonesia has laid down the framework towards providing universal health coverage for its population. The central government is preparing for the implementation of universal health coverage for all as mandated in the Social Security Providers (BPJS) Law and expects to have the law's executing body established and operational by January 2014. The commitment for universal health coverage is set by 2019[6].

- There is a move towards universal health coverage in the Philippines as well with the amendment of the National Health Insurance (NHIP) Law providing that all citizens of the Philippines, regardless of social and economic status, shall be covered by the national health insurance protection. However, enrolment in the NHIP shall not be made compulsory in certain provinces and cities until such a time that the Philippine Health Insurance Corporation shall be able to ensure that members in such localities have reasonable access to adequate and acceptable health care services[7].

SECOND SECTION – INTEGRATION EFFORTS

THE ASEAN ECONOMIC COMMUNITY

- The ASEAN Economic Community (AEC) aims to achieve economic integration through four pillars:

    1. Single market and production base - Liberalize and facilitate free flow of goods, services, investment, capital and skilled labor
    2. Competitive economic region - Foster fair competition, protect consumer rights and intellectual property rights
    3. Equitable economic development - Accelerate the economic integration of less developed member states by technical and development cooperation
    4. Integration into global economy - Make ASEAN a more dynamic and stronger segment of the global supply chain

- One of the AEC's key priority sectors is healthcare. The ASEAN Roadmap for Integration of the Healthcare Sector (Roadmap) covers five industries, four of which involve healthcare products: (1) pharmaceuticals, (2) cosmetics, (3) medical devices, (4) traditional medicines and health supplements.

AEC'S PROGRESS IN HEALTH CARE

- Relatively more progress has been made in lowering trade barriers for healthcare in the region. Most of the region's Common Effective Preferential Tariff (CEPT) rates were significantly lowered by 2003, and as of 2008, CEPT rates for most priority healthcare goods were at zero[8].

- ASEAN has also identified non-trade barriers such as harmonization of national standards with international standards, practices and guides; harmonization of mandatory technical requirements to ensure free movement of goods; and harmonization of conformity assessment procedures to save transaction time and to avoid high cost through multiple testing requirements as ways to respond to the challenge of addressing technical barriers to trade in ASEAN while at the same time ensuring that the aims of having a system of standards and conformance (which are to promote greater efficiency and enhance cost effectiveness in the production of intra-regional imports/exports) are realized.

- Collectively, developments are underway in completing regional initiatives that aim to establish an integrated ASEAN market in the identified healthcare goods – consisting of harmonized standards, registration and evaluation, an operable post-marketing surveillance mechanism, effective Mutual Recognition Agreements (MRA) – that would benefit consumers and economic growth:

    - Relative to the three other healthcare goods sectors, there is better progress in harmonizing standards for pharmaceuticals:

        - MRA on Good Manufacturing Practice was signed by all the ASEAN countries in 2009, which provides for the sharing of inspection and registration information and represents another recent step forward in the cooperation effort. The MRA became effective in 2011[9].

        - ASEAN Common Technical Dossier was also implemented in 2009, which gives information and format for the applications that will be submitted to ASEAN regulatory authorities for the registration of pharmaceuticals[10].

        - The MRA on the Post-Marketing Alert System (PMA) for pharmaceuticals has been set up and the system has been used initially by Brunei, Indonesia, Malaysia,

Singapore and Thailand. The PMA is an efficient and effective system of alert on post-marketing issues affecting the safety and quality of pharmaceutical products[11].

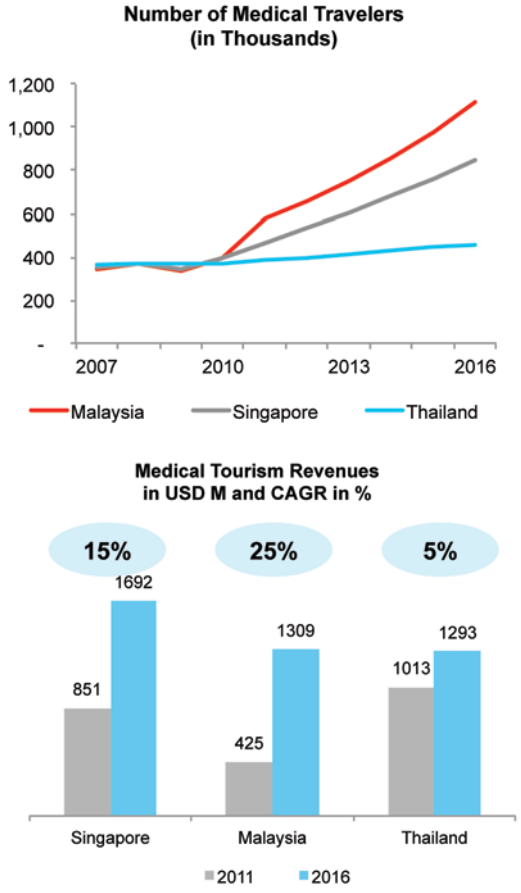
- The ASEAN Medical Device Directive (AMDD) -- came out in 2012, and implementation is expected by December 2014. The AMDD lays out basic requirements for a harmonized classification system, medical device safety and performance, conformity assessments and a Common Submission Dossier Template (CSDT). The AMDD sets up a risk-based classification system of medical devices into four categories. Classification determines fees, processing times and clinical requirements. Currently, these issues vary among ASEAN countries. Individual countries may set up their own expedited registration channels under the AMDD framework, and they will have final authority over any classification disputes that may arise during the registration process. However, it is expected that many ASEAN member countries will follow the lead of Singapore, which has already implemented many of the AMDD directives[12].

- The ASEAN Harmonized Cosmetic Regulatory Scheme, signed in 2003 is the flagship framework for regional cooperation in the field of standards and conformity assessment and in 2008, the ASEAN Cosmetics Directive came into effect.

- For the health supplement category, the expected output is the development of an ASEAN Regulatory Framework on Traditional Medicines and Health Supplements and transposition of the ASEAN Regulatory Framework into national laws of ASEAN Member States

- The healthcare services industry is the fifth segment of the healthcare priority sector. Healthcare services encompass a wide range of services and treatments provided by medical professionals and healthcare facilities such as hospitals, clinics, or laboratories. Trade in the ASEAN healthcare services industry is estimated to be smaller than trade in the four goods industries included in ASEAN's healthcare priority sector. For example, in 2007, the world (including ASEAN countries) imported US$7.1 billion of priority goods from Singapore; in comparison, Singapore's healthcare industry provided services to 348,000 patients, valued at S$1.7 billion (US$750 million). However, the designation of healthcare services in ASEAN's healthcare priority sector reflects the industry's economic potential (see Figure 7)

Figure 7.
Trends in medical tourism in Singapore, Malaysia and Thailand



Source:
Frost and Sullivan, "Independent Market Research on the Global Healthcare Services (HCS) Industry", 2012

- The ASEAN Open Skies agreement initiated by the transport ministers in 2005 to accelerate the liberalization of air travel has allowed regional budget airlines to enter the market and offer more flights between ASEAN destinations, such as Kuala Lumpur and Singapore or Kuala Lumpur and Rangoon (Burma). The increased capacity in interregional air transportation facilitated intra-ASEAN travel of medical purpose[13].

    - According to the MOH Vietnam, around 40,000 Vietnamese citizens spend about VND 20.7 trillion (US$ 1.1 billion) on medical treatment services overseas each year. Vietnam can therefore be considered as a medical travel source market[14].

    - It is a common practice for Indonesians to seek healthcare services in foreign countries such as Singapore and Malaysia for better quality healthcare. According to the Indonesian Medical Association, Indonesians spend more than 8.8 trillion Indonesian Rupiah (US$ 1.0 billion) per year on medical treatments overseas[15].

UNIDIRECTIONAL ACCESS TO HEALTH MIGRATION

- To date, Thailand, Singapore, and Malaysia are the ASEAN region's leading exporters of healthcare services. These three countries have developed a competitive advantage in healthcare with its ability to offer the same medical services at significantly lower price relative to developed countries and a reputation for high quality services. Thus, they are well-positioned to become healthcare hubs of the region, given the expected strong growth in medical tourism.

- Singapore, Malaysia, Brunei and Thailand are beneficiaries of migration patterns and are net labor recipients, i.e. they have greater stock of labor from ASEAN than they send to the rest of ASEAN. However, in an integrated market, increased mobility of healthcare professionals is exacerbating the shortage in medical talent in the rest of ASEAN. The region as a whole also faces stiffer competition for healthcare professionals. Countries such as Singapore and Malaysia become transit countries for those foreign nurses seeking further migration. Forecasts place the shortage of physicians in ASEAN at 1.6 million, the highest among regions in the world[16].

THIRD SECTION – IDENTIFICATION OF BARRIERS AND RECOMMENDATIONS

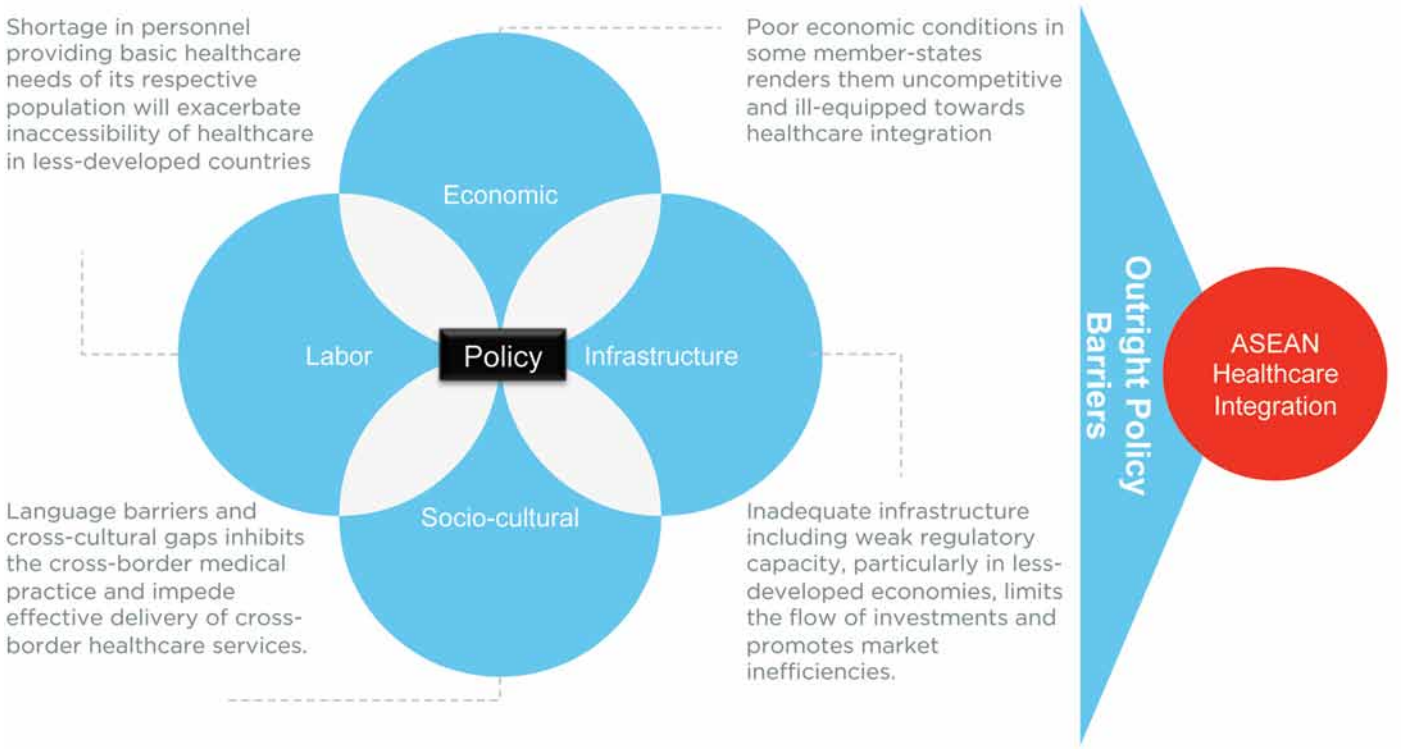
BARRIERS TO INTEGRATION

- At the highest level, outright non-trade policy barriers stand out as factors that impede healthcare integration in ASEAN. Most prominent are foreign ownership/equity limitations that inhibit the flow of capital into markets, restrictive laws or regulatory requirements that prohibit practice of medical profession across the borders or limiting the movement of patients within ASEAN.

- However, it is equally important to recognize that behind these policy barriers are interlinking core challenges that need to be addressed to achieve the objectives set by the AEC. Acceding to regional commitments and policy reforms to remove outright barriers are not sufficient to ensure that the region maximizes the benefits of an integrated healthcare sector. For instance, the opening up of healthcare markets does not necessarily lead to increased foreign investments as demonstrated in Lao PDR, Myanmar or Cambodia. Without accompanying developments in economic competitiveness, infrastructure, regulatory capacity or reforms in labor policies, access to healthcare remains limited.

- There are four interlinking critical areas of development where several barriers exist and hamper the success of integration efforts in healthcare (see Figure 8).

Figure 8.
Barriers to establishing an integrated healthcare sector in ASEAN



Source:
Accenture Analysis

POLICY BARRIERS

- As discussed in Section 2, ASEAN has made progress in harmonizing several regulatory gaps in healthcare. However, considerable effort remains to be done. Outright policy barriers in healthcare still exist:

    - **Foreign equity restrictions.** Only five out of the 10 member states have allowed full foreign ownership in their respective healthcare sectors. Malaysia, the Philippines, and Thailand only allow minority foreign ownership of 30%, 40% and 49%, respectively. Meanwhile, Indonesia's Ministry of Health states a 90% foreign ownership limit in contradiction to the 100% limit in the investment policy. Myanmar has recently revised its foreign investment law and provides an 80% cap on foreign ownership for hospitals and clinics.

    - **Other legal barriers.** In order to facilitate freer movement of foreign patients within ASEAN, certain laws need to be relaxed. Immigration laws and visa requirements across ASEAN do not provide preferential treatment for medical travellers. Visas are still required beyond the typical 30-day stay. Only Malaysia implements a "green lane" in its entry points and airports to facilitate easier travel for medical tourists. The absence of specific national laws also adds to the integration challenges. For instance, competition policy and law is integral to all four pillars of the AEC as it deals with various anticompetitive conducts, such as abuse of monopoly power, cartels among businesses, merger and acquisition which may affect market competition in a fully liberalized market. Of the 10 ASEAN member states, only five have national competition laws (Thailand, Indonesia, Singapore, Vietnam and Malaysia). The rest are in various stages of drafting their own laws.

    - **Regulatory gaps**. Gaps in various regulatory frameworks exist in healthcare. As discussed in the previous section, most of the ASEAN member states have yet to adopt and fully implement harmonized standards and MRAs that are critical to facilitating trade in health. For instance, MRAs in medical professionals employed is hampered by the language requirement in regulations of some member states. Requirements by registration authorities of proficiencies in local language prohibit the recognition of relevant training even if standards of clinical care are similar. For instance, medical professionals who want to practice in Thailand need to take the examinations in the local language.

- An equally if not greater challenge to healthcare integration are issues in areas of economic competitiveness, labor productivity and infrastructure including regulatory capacity development and cross-cultural integration. Meeting all policy and regulatory requirements may be accomplished on paper but preparations for the wider implications of a regional economy are lagging behind.

ECONOMIC BARRIERS

- One of the most urgent preparations relates to the economic sphere. Currently, ASEAN member states are in different stages of economic development. Less-developed countries in ASEAN are burdened with fiscal challenges that limit resources allocated to support healthcare. Despite employing a mix of financing schemes, the coverage of healthcare in the countries remains low and the populations are forced to shoulder the costs of medical care (see Figure 9).

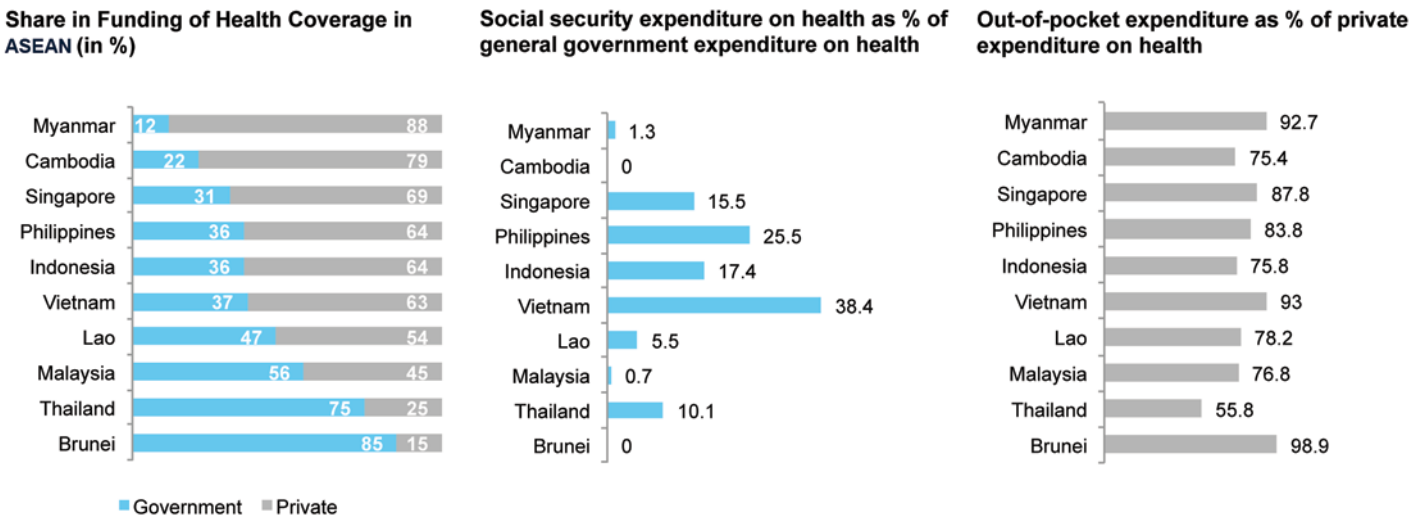
Figure 9.
Financing schemes and coverage (% of Population) in ASEAN

Country	General Policy	Financing Type	Coverage
Indonesia	ASKES	insurance scheme for civil servants	20% of population
	Jamsostek (C)	commercial insurance scheme (employer borne)	
	CBHI (V)	social safety net program	
Lao	CCS (C)	insurance scheme for civil servants	5% of population
	SSO (C)	social insurance scheme (coverage limited to pilot cities)	
	CBHI (V)	community-based insurance scheme	
Philippines	PhilHealth (C) (G)	social insurance scheme	75% of population*
Singapore	Medisave (C)	individual savings scheme	Universal
	Medishield (O)	insurance scheme	
	Medifund (G)	social safety net program(endowment fund)	
Thailand	SSS (C)	social insurance scheme	13%
	CSMBS	insurance scheme for civil servants	11%
	30 bahts Scheme	social safety net program	76%
Vietnam	VSS (C)	social insurance scheme	30% of population
	VSS (V)	social insurance scheme for informal sector	
	HCFP (scheme for the poor (G)	social safety net program	

Source:
World Health Organization, "Social Health Insurance: Selected Case Studies from Asia and the Pacific, 2005"and "Regional Overview of Social Health Insurance in South-East Asia", July 2004

- In Myanmar, where there is no national health insurance, all public hospitals offer a medical cost-sharing plan - first introduced in 1993 - where patients cover medicine and laboratory fees and the state pays doctors' fees[17]. In Cambodia, health costs financing by households are mainly out of pockets payments. It is estimated that 80% of Cambodians use savings, go into debt or sell assets[18]. Both Cambodia and Myanmar have the highest private share in funding healthcare and high out-of-pocket expenditures despite having high poverty levels (see Figure 10). Thus, the economic burden of healthcare lies on the individuals and contributes to even higher inequality and poverty.

Figure 10.
Distribution of healthcare funding in ASEAN



Source:
WHO World Health Statistics 2013

- Even with liberalized markets, the cost of healthcare in these countries will continue to be a burden given their low economic development. Poor economic climate directly impacts the affordability and availability of healthcare through inefficiencies and inadequacies of financing schemes. Entry of foreign providers is also unlikely to take place without significant economic reforms creating a viable healthcare market.

- Further, the perceived higher costs due to transportation and follow-up treatments and differences in the quality of care in foreign countries are major considerations that are likely to discourage these countries from taking advantage of cross-border healthcare services in the absence of financing schemes for healthcare[19].

- Increasing economic competitiveness that can attract entry by foreign healthcare players entails improvements in labor and infrastructure. However, challenges exist in these areas as well.

LABOUR BARRIERS

- **Labor shortage** is one of the critical challenges of regional integration. Even middle-income countries such as Indonesia and Thailand are suffering from a shortage in healthcare professionals. In addition to losing manpower to outbound migration opportunities, less-developed countries are also likely to experience internal brain drain as markets open up to foreign players. Foreign providers are most likely to set up businesses in high-density urban areas and cities. This can draw out health professionals away from rural areas attracted by higher compensation and opportunities.

- On the aspect of mobility of healthcare professionals across ASEAN, **discrepancies in standards and proficiency levels of personnel** are crucial barriers. For less-developed countries, the lack of access to training facilities with sophisticated technologies and advanced knowledge of specialized treatments are limitations to the country's ability to export health services and compete in the regional labor market.

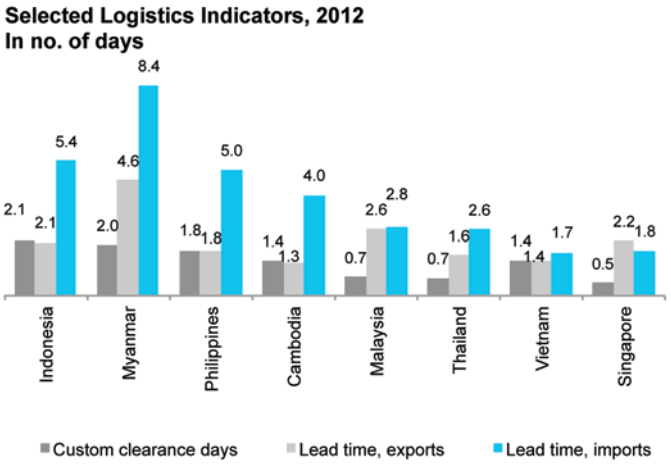
INFRASTRUCTURE BARRIERS

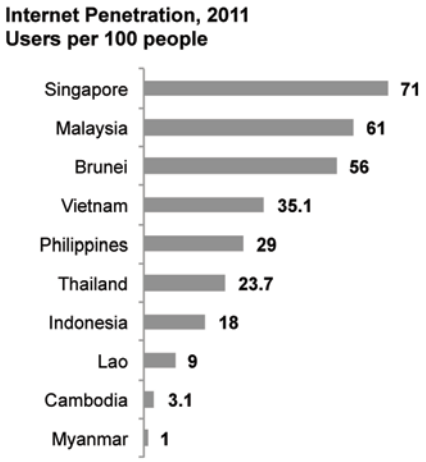
- Foreign direct investments in healthcare in less-developed countries are to remain low despite full liberalization if **infrastructure remains underdeveloped** and is not designed to handle the scale of global operations of providers. Both physical infrastructure such as well-developed network of roads, ports/airports; ICT infrastructure and supply chains and soft infrastructure such as digital penetration levels, regulatory capacity are requisites for critical factors that will determine the attractiveness of a country.

- There is a large imbalance in basic infrastructure existing among ASEAN member countries. For instance, only 14% of the total roads in Lao PDR are paved, compared to 57% in Indonesia and 80% in Malaysia[20]. Indonesia and Myanmar have the longest lead time in imports, 5.4 and 8.4 days respectively, reducing its attractiveness as a hub for foreign players with global operations. The high trade and logistics costs in these countries lead to economic stagnation and discourages entry of foreign players in their markets (see Figure 11).

- Low digital connectivity and limited access to information and communication technology restrict technology transfer and the flow of information associated with delivery of health services.

Figure 11.
Selected indicators on infrastructure development among ASEAN





Source:
World Bank, "Connecting to Compete 2010 - Trade Logistics in the Global Economy", 2010; World Bank Database

- **Weak regulatory capacity** also presents an important challenge to integration. The lack of resources to dedicate for personnel re-training, up skilling and enforcement creates challenges in effective management of cross-border regulations. Individually, some member states also struggle to enhance their administrative capacity, either due to low budgetary allocations or cultural challenges. For instance, a major challenge among those with social insurance schemes is accelerating and expanding coverage. Efforts are frequently hampered by poor administrative capacity[21].

CULTURAL BARRIERS

- **Cross-cultural gaps and mindset** are important factors slowing integration efforts. In labor, the difficulty of medical professionals to overcome language barriers, work around low health literacy among patients and embrace cultural practices in their host countries can impede effective delivery of cross-border health services. Conversely, patients' lack of understanding and information on proper healthcare coupled with cultural beliefs in death, suffering and sickness has an impact on their treatment preferences and providers. These barriers to accessibility of health services for foreign patients.

- The **lack of a regional mindset** among the ASEAN member states also feeds the low engagement levels by parties involved in the integration, ranging from patients, medical professionals, health providers and regulators. This partly stems from inadequate public awareness programs or information campaigns and mobilization activities for which resources at the national level are limited.

RECOMMENDATIONS

- Most policy barriers can be addressed by acceding to commitments made or working with the respective committees formed by the AEC to harmonize regulatory gaps in the various healthcare sectors. Other legal barriers require dedicated efforts from the various governments to speed-up the passage of relevant laws and drafting of new regulations to facilitate the integration of healthcare across the region. However, the removal of explicit trade barriers may be insufficient for foreign service providers to enter the domestic market. Often, trade can only take off if countries are competitive enough and regulatory systems are made compatible[22].

ECONOMIC BARRIERS

- Align the development of health financing schemes with structural shifts in the economy

    - Sustained economic growth is typically accompanied by increased urbanization and a growing pool of formal sector as the economy shifts from an agricultural economy towards a service-based economy. Leverage these shifts to increase health coverage by making participation to health financing schemes compulsory and subsequently target incremental increases in the coverage over time. This is particularly of high importance to less-developed economies where high out-of-pocket payments need to be reduced and government funds are limited. A study by the World Health Organization shows that all countries that have achieved the universal coverage have implemented necessary legislation to achieve compulsory participation.

- Improve the fiscal sustainability of healthcare funding through careful consideration of the costs and benefits of the design and structure of the financing schemes from an economic standpoint

    - Ensure the financial viability of social health insurance funds by carefully considering exemptions and exclusions. The inclusion of enterprises with high-paid workers will improve pooling between low-and high-paid earners, and also increase pressure on the funds towards improvement in the quality of benefits and transparency in management[23].

    - Evaluate the costs and benefits of merging public and private health financing schemes.

For instance, shifting from free care for civil servants to social health insurance coverage will free up government resources, facilitate flexibility of movement between public and private sector employment and between salaried and self-employed status but may lead to higher out-of-pocket payments for healthcare for low-salaried civil servants[24].

- Strengthen the ability to administer health funds by investing in the development of skills in the insurance administration and actuarial science at the level of the fund as well as in insurance regulation at the level of government

- Explore collaboration at the regional level to assist less-developed countries in establishing sustainable financing schemes for healthcare

  - Identify possible investment opportunities for more-developed countries in establishing healthcare systems of less-developed countries.

  - Share best practices for healthcare funding systems across ASEAN and leverage learnings to implementing social health insurance systems or other financing schemes, e.g. centralized provident funds, savings schemes, etc.

- Develop long-term human resource strategic plans at the national level to address labor shortages brought about by the regional integration

  - Mobilize labor ministries in cooperation with health ministries to draw up a comprehensive plan that will address the country's demand for healthcare professionals, factoring in external trends such as outbound migration, internal migration of healthcare workers due to entry of foreign health providers, and recent trends in medical education.

  - Increase the supply of medical professionals through subsidies. Given that the private sector is also a beneficiary of medical graduates, it makes sense that they also share some of the cost to alleviate the burden from the government. This may be done through the private participation in medical training or tuition refunds for medical graduates from public universities moving to the private sector.

  - Develop pay incentives, where labor shortage is severe. For instance, subsidize medical education of doctors in exchange for a fixed-term stay in rural areas to serve basic healthcare needs of the underprivileged or informal sector.

- Accelerate training programs to build productivity and competitiveness of medical professionals

  - Encourage foreign providers to bring in their specialists when establishing commercial presence in exchange of contributing their skills and knowledge to research programs or training programs in healthcare.

  - Enter into partnerships with foreign health institutions to institutionalize cross-country training initiatives or exchange programs for medical professionals, internship programs or joint development of curriculums.

  - Leverage technology to develop a more skilled workforce. The availability of tele-education or training provided remotely over the Internet can help improve healthcare workers' skills, allowing them to offer higher-quality, competitively priced healthcare services.

INFRASTRUCTURE BARRIERS

- Mobilize resources for upgrading infrastructure particularly in resource-strapped, less-developed countries in ASEAN by involving all available partners in the ecosystem, i.e. private sector, foreign donors and multilateral banks and financial markets

  - Leverage technical assistance from external sources such as multilateral development banks and foreign official development assistance (ODAs) to finance critical infrastructure projects.

  - Tap into the private sector as a source of private capital and expertise in developing sustainable infrastructure projects. In particular, public-private partnerships or PPPs represent an innovative way for the governments to work with the private sector in providing high-quality service delivery and in closing the gaps in fund requirements of the infrastructure sector

    - Access the banking market and capital market through bond issuance, bond rating and improved standing of public agencies as credible partners for the private sector.

- Build regulatory capacity in healthcare to support integration efforts

    - Strengthen regulatory systems by investing in capacity-building programs through increased collaboration with specialized international health agencies such as the World Health Organization and regulatory-focused organizations such as the Regulatory Affairs Professionals Society (RAPS)[26]

    - Augment human resource and expertise constraints by utilizing available and competent frameworks from external sources. For instance, Singapore relies on the result of the product assessment and approval of certain 'competent' drug regulatory agencies (DRAs) in other countries for its own evaluation. This mechanism helps save time and resources needed for reviewing technical documentation on the part of the regulatory agency.[27]

CULTURAL BARRIERS

- Promote deeper intra-ASEAN social and cultural understanding

    - Promote awareness about the AEC by engaging the public through educational campaigns and information dissemination on Southeast Asian studies and cultures. The inclusion of ASEAN cultures in national curriculums combined with exchange student programs to help foster greater understanding among ASEAN citizens[28].

    - To help medical professionals appreciate and deepen their knowledge of ASEAN cultures, regional publications or dossiers can be produced to aid attending physicians in removing cultural and communication barriers in delivering care to foreign patients.

- Facilitate a change in mindset from a national towards a regional identity

    - Develop a regional identity to be led by national governments who will commit to promote regionalism in the educational system, language, conflict resolution, etc. Standardize English as a second language across the region to eliminate communication barriers in a region where multitude of dialects exist.

- Undertake activities that promote unity and solidarity across ASEAN members. Engage the mainstream media in promoting, on a continuing basis, all ASEAN programs and projects. Promote ASEAN sporting events in the national and private media such as the SEA Games and PARA Games. Encourage the use of ASEAN Anthem and other ASEAN Symbols to raise ASEAN awareness[29].

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