Healthcare Sector in ASEAN: "Who will care for the caregivers?" Implication of Regional Economic Integration to Trade Union Organizing in the Health Care Sector

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Introduction

The Association of South East Asian Nations (ASEAN) was formed in 1967 to advance regional co-operation in South East Asia, including the promotion of peace, freedom and prosperity for its peoples. During its first 25 years, the ASEAN was focused on issues of regional peace and security but by the 1990s it began to actively pursue economic integration objectives, as member countries began to liberalize their economies to cohere with the rules of the World Trade Organization (WTO). In October 2003, ASEAN leaders declared that the ASEAN Economic Community should "be a goal of intensified regionalization processes by 2020".[1] Towards realising this, healthcare was one of the priority sectors identified for accelerated economic integration.[2] This meant eliminating barriers to trade in the healthcare sector, including the movement of health professional services across countries in the region. The new commitment was meant, for one, to reverse negligible trading activities in the health/social services, which for a long time had lagged behind in the liberalization of services, together with distribution services, educational services, environmental services, and recreational, cultural & sporting services.[3]

This study is part of a research project that seeks to analyze the actual and potential impact of ASEAN economic agreements on workers and unions in Southeast in four sectors, namely telecommunications, construction, healthcare, and finance. The study was commissioned by global union federations (GUFs) that have organized the ASEAN Service Employees Trade Union Council (ASETUC) and by the Friedrich Ebert Stiftung (FES), a solidarity support organization.

Admittedly, this report on the healthcare industry is a preliminary one which is challenged by a lack of data. Its aim is to stimulate further research interest in an economic sector that is undergoing rapid liberalization as the ASEAN intensifies regional trade relations. It is a sector where workers' rights and securities are being threatened by this changing scenario.

The paper first draws attention to the larger concern of healthcare financing in an attempt to explore surface tensions between two perspectives on the healthcare system, namely, as a development / public good concern and/or as a market / private exchange concern. It then

[1] ASEAN Secretariat. (2009). *Roadmap for an Asean Community 2009- 2015*, p. 21. Retrived from < http://www.aseansec.org/publications/RoadmapASEANCommunity.pdf>
[2] *Ibid*, p. 30.
[3] Manning, Chris and Pradip Bhatnagar. (2004). *Liberalizing and Facilitating the Movement of Individual Service Providers under AFAS: Implication for Labour and Immigration Policies in the ASEAN.* RESPF Project 02/04. Jakarta: ASEAN Secretariat, p. 27.

proceeds to provide a tentative landscape of key players in the lucrative healthcare market. Part three discusses the key ASEAN policy agreements that impact on the development of the market and the final section raises some challenges for trade union organizing and proposals for policy reforms that may lead to the protection of workers and the pursuit of healthcare management that is development-friendly.

PART ONE: Who Pays For Healthcare? : Tensions Between Trade & Development

Traditionally, health has been tackled as a social development issue, not an economic issue, much less a trade sector concern. That is why the health sector contains some of the most contentious issues within the trade liberalization regime. Given the global commitment to the Millennium Development Goals (MDGs), and in light of recent indicators pointing to the lack of marked improvement in global health conditions worldwide – with several low income high-disease burden countries in the developing world showing the most dismal results[4] – concerns are high regarding securing sound health policy in light of global trade intensification in the healthcare industry.

Aggregate financing flows and expenditure trends reveal the existence of both publicly-provided and privately accessible health services in most countries worldwide. Relying on National Health Accounts (NHA) data between 2000 and 2006, which was made available by the World Health Organization (WHO),, the immense role of the private sector in the provision of health services stand out in the ASEAN region.[5] To wit:

- Total expenditure on health comprises the funds mobilized by the system, being the sum of general government and private expenditure on health. The average regional expenditure on health spent by ASEAN Member States between 2000 and 2006 was 3.66 percent of Gross Domestic Product (GDP), and did not change very much from year to year over the duration. Cambodia had the highest total expenditure in the region, and this averaged 6.3 percent of its GDP. This expenditure was followed closely by the expenses incurred in Viet Nam and Malaysia which stood at 5.7 percent and 4 percent respectively. Brunei, Mynamar and Indonesia had the lowest allocations averaging 2.31 percent, 2.2 percent and 1.99 percent respectively. It is noteworthy that expenditure on healthcare slightly increased in all Member States between 2003 – 2006, except in Brunei and Cambodia where it declined. (See Annex 1 for complete table)

- Within the region, statistics show that on average over the 6 years, governments were the single institution with the highest percentage of the total health expenditure. This was, however, below 50 percent of the total health expenditure which was covered by the private sector and other funders or sources. The World Health Organization (WHO) defines the **general government expenditure on health (GGHE)** as the sum of outlays for health maintenance, restoration or enhancement paid for in cash or supplied in kind by government entities, such as the Ministry of Health, other ministries, parastatal organizations or social security agencies (without double

[4] Sampiao, Jorge. (2007) *Global answers to global problems: health as a global public good.* Retrieved from < http://www.coleurop.be/file/content/studyprogrammes/ird/research/pdf/EDP%201-2007%20Sampaio.pdf >
[5] *World Health Organisation. (2009)* WHO Statistical Information System. Retrieved from <http://www.who.int/whosis/indicators/compendium/2008/3exo/en/>

counting government transfers to social security and extra budgetary funds). The GGHE includes transfer payments to households to offset medical care costs and extra budgetary funds to finance health services and goods. The revenue base of these entities may comprise multiple sources, including external funds.[5] A country by country analysis shows only three governments had expenditures that constituted on average over 50 percent of the total expenditure on health. They are Brunei (79.41 percent), Thailand (62.23 percent) and Malaysia (51.43 percent). The lowest government expenditures posted as percentages of total health expenditure were by the governments of Cambodia (28.66 percent), Laos (27.31 percent) and Mynamar (13.01 percent). (See Annex 2 for complete table)

- The general government expenditure on health only forms a small percentage of the total government expenditure. Averaged at 6.32 percent for the years between 2000 and 2006, this is fairly low. While we noted above that the government health expenditure of Cambodia as a percentage of the *total health expenditure* was very low (see graph 2), in graph 3 we realize that in the region, the government of Cambodia had the highest allocation of expenditure on health as a percentage of the total government expenditure. Only the government expenditures of Cambodia and Thailand are above 10 percent, standing at 11.66 percent and 10.84 percent respectively on average over the six years. It is noteworthy that, of its total government expenditure, only 1.33 percent was spent on health in Myanmar. The average amount allocated to healthcare by the governments has slowly increased since 2000. It is also evident that there was a steep increase in the government allocation to healthcare by Member States in 2003. This was in response to the *2003* outbreak of the Severe Acute Respiratory Syndrome (SARS) which was contained largely through traditional public health interventions. (See Annex 3 for complete table)

- Also shown is the private expenditure on health as a percentage of the total health expenditure in Member States for the period 2000-2006. This expenditure is the sum of outlays for health by private entities, such as commercial or mutual health insurance providers, non-profit institutions serving households, resident corporations and quasi-corporations not controlled by government with a health services delivery or financing, and direct household out-of-pocket payments.[6] It is clear that the role of private healthcare in the region is great, as their participation constitutes on average over 50 percent of healthcare expenditure in the ASEAN region. Over the 6 years, the expenditure of private healthcare players was consistently highest in Myanmar, where the government expenditure as a percentage of the total health expenditure, as well as the total government expenditure, was very low. It is noteworthy that in half of the countries, the expenditures of private players constituted over two thirds of the total expenditure on average over the 6 years. (See Annex 4 for complete table)

- Private expenditure includes out-of-pocket expenditure[7], which on average between 2000 and 2006, was exceptionally high throughout the region. Estimates have it that

[5] World Health Organisation. (2009*) WHO Statistical Information System*. Retrieved from <http://www.who.int/whosis/indicators/compendium/2008/3exo/en/>

[6] *World Health Organisation. (2009)* WHO Statistical Information System. Retrieved from <http://www.who.int/whosis/indicators/compendium/2008/3exo/en/>

[7] Out-of-pocket spending by private households (OOPs) is the direct outlay of households, including gratuities and payments in kind, made to health practitioners and suppliers of pharmaceuticals, therapeutic appliances and other goods and services, whose primary intent is to contribute to the restoration or to the enhancement of the

there are at least 130 million Asians who have a disposable income and can afford private services, mainly the wealthy and the middle class in Asia.[8] (See Annex 6 for complete Table)

- Another component that forms a percentage of the private expenditure is the **Prepaid and risk-pooling plans**. These are the expenditure on health by private insurance institutions. Private insurance enrolment may be contractual or voluntary, and conditions and benefits, or basket of benefits, are agreed on a voluntary basis between the insurance agent and the beneficiaries. Thus they are not controlled by government units for the purpose of providing social benefits to members.[9] Thailand, Malaysia and the Philippines had the highest expenditures incurred through the private prepaid plans (14.97 percent, 14.47 percent, 10.87 percent respectively). It is interesting to note that there was no expenditure in this area in Mynamar and Cambodia, while expenditure was almost negligent in the Lao People's Democratic Republic (0.4 percent). It is also noteworthy that between 2000 and 2002 there was no prepaid plans expenditure in Singapore, as this was only first incurred in 2003 at 2.8 percent of total healthcare expenditure.

- **External resources**, also referred to as "rest of the world funds", are the sum of resources channeled towards healthcare by all non-resident institutional units that enter into transactions with resident units, or have other economic links with resident units, whether explicitly labeled for health or not, to be used to pay for health goods and services by financing agents in the government or private sectors. They include donations and loans, as both cash and in-kind resources.[10] This amount is exceptionally low in most states, and does not constitute more than 5 percent of the total budget in 7 of the 10 countries. An exception to this are the Member States of Cambodia and The Lao People's Democratic Republic where the external resources constitute 21 percent and 16 percent respectively. (See Annex 7 for complete table)

PART TWO: Asian Healthcare Market – Key Players

Estimates have it that by 2010, the Asian healthcare market will be valued at US$600 billion, with Japan's spending share at US$422 billion. Other Asian countries are projected to spend at least US$190 billion by 2013.[11] Overall, global healthcare spending is expected to contribute to 15 percent of the global Gross Domestic Product (GDP) by 2015, with Asia getting a significant percentage of this increase.[12] Multinational corporations engaged in the

health status of individuals or population groups. It includes household payments to public services, non-profit institutions and nongovernmental organizations. It includes non-reimbursable cost sharing, deductibles, co-payments and fee-for-service, but excludes payments made by companies that deliver medical and paramedical benefits, whether required by law or not, to their employees. It also excludes payments for overseas treatment. http://www.who.int/whosis/indicators/compendium/2008/3exo/en/

[8] Dacanay, Jovi and Maria Cherry Lyn Rodolofo. (2005). *Challenges in Health Services Trade: Philippine Case*. Discussion Paper Series Number 2005-30. Manila: Philippines Institute for Development Studies, p. 7

[9] World Health Organisation. (2009) WHO Statistical Information System. Retrieved from <http://www.who.int/whosis/indicators/compendium/2008/3exo/en/>

[10] *Ibid*

[11] Dacanay, Jovi and Maria Cherry Lyn Rodolofo. (2005). *Challenges in Health Services Trade: Philippine Case*. Discussion Paper Series Number 2005-30. Manila: Philippines Institute for Development Studies , p. 4

[12] Press Release. (2007) *Philips Healthcare CEO Urges Asian Leaders to Double Efforts to Solve Growing Healthcare Challenges.* Retrieved from <http://www.thaipr.net/nc/readnews.aspx?newsid=7081BE6EC8AD710AB0EA30B7FAC6F1AE>

production and supply of healthcare goods and services, in particular, giant pharmaceutical and health insurance companies, continue to operate profitably in the ASEAN healthcare market.

Healthcare was one of the priority sectors identified for accelerated economic integration toward a single ASEAN market.[13] In November 2004, the ASEAN Trade Ministers adopted a Roadmap which was significantly concerned with promoting trade in healthcare goods, such as pharmaceuticals and medical equipment. In addition, two service sub-sectors in the healthcare industry have been specifically targeted for progressive liberalization, namely, (a) the services of medical professionals, including medical and dental professionals, midwives, nurses, physiotherapists and paramedical personnel; and (b) health services, covering hospital services (including psychiatric hospitals) and the services of medical laboratories, ambulances, and residential health care other than hospitals.[14] This huge consumption value has attracted multinational corporations to engage in the production and supply of various healthcare goods and services in the Asian market.

- ***Healthcare goods***. The giant pharmaceutical companies that operate in the sub-region include Pfizer (USA), Johnson and Johnson (USA), GlaxoSmithKline (UK), Bayer (Germany), Roche (Switzerland), Sanofi-Aventis (France), Novartis (Switzerland), Astra-Zeneca (UK/Sweden), Abbott (USA) and Merck & Company (USA). (See Annex 8 for full listing) The same listing shows that the drug industry is a huge market, with the multinational companies gaining net incomes in billions of US dollars and employing sizable workforces. The market is expected to remain big, since all members of the ASEAN are net importers of pharmaceuticals and all, save for Singapore, do not have research and development capability for drugs.[15] In the case of Singapore, its health authority is aiming for the country to become a centre of excellence in ASEAN for biologics and biotechnological products.[16]

- ***HMOs***. There are also Health Medical Organizations (HMOs), and medical care equipment or technology suppliers, such as Philips Healthcare. The HMOs include health insurance companies, such as AON AIG/AIU, CIGNA, and AXA. The first three have their mother companies in the United States of America while AXA's mother company is located in France. (See Annex 9 for listing)

- ***Medical professional services***. Cross-border trade in medical professional services predominantly happens through Mode 4, the movement of natural persons. This mode of trans-border movement is overwhelmingly made up of individual professionals, mostly female nurses and midwives that are hired as temporary migrant workers by firms in another country. To a lesser degree, it also involves the movement of medical employees to a country where their firms have set up overseas operations. Recruitment of medical professionals for overseas work is a lucrative business, and it takes place either through a government placement agency, private

[13] ASEAN Secretariat. (2009). *Roadmap for an Asean Community 2009- 2015*, p. 30. Retrived from < http://www.aseansec.org/publications/RoadmapASEANCommunity.pdf>

[14]Dee, Phillippa. (2009) *Services Liberalization Toward the ASEAN Economic Community* Retrieved from <http://www.eria.org/pdf/research/y2008/no1/DEI-Ch02.pdf >

[15] Ratanwijitrasin, Sauwakon. (2009) *Drug Regulation and Incentives for Innovation: The case of ASEAN.* Retrieved from <http://www.who.int/intellectualproperty/studies/Drugregulationincentives.pdf>

[16]Lätzel, Ruth. (2007) *Development of the ASEAN Pharmaceutical Harmonisation Scheme: An Example of Regional Integration,* Retrieved from <http://www.dgra.de/studiengang/pdf/master_laetzel_r.pdf>

recruiting firms or via direct hiring by foreign hospitals. As a result of the increased deployment of female nurses and care-givers, the number of Filipino women working overseas had exponentially increased to account for up to 70 percent of all overseas contract workers deployed in a single year.[17] Two of the largest source countries of healthcare professionals who are deployed as temporary overseas workers in the world are the Philippines and Indonesia, while the main destinations for these individual professionals are the richer countries, including the relatively more wealthy ASEAN countries of Singapore, Malaysia (which is also a source country), Thailand, and to a lesser extent, Brunei,[18]

- ***Health services***. These are primarily facilities-based services that cross borders through foreign-investment in hospitals and other health facilities and medical services. Within the ASEAN, Singapore and Thailand have led other countries in setting up joint ventures with hospitals. The key players are the Parkway Group Healthcare (Singapore) and two Thai companies, namely, Bumrungrad Hospital and Bangkok Hospital.[19] ASEAN governments try to attract foreign investment in hospitals and other healthcare facilities as a strategy linked to their health tourism plan, which is meant to attract the upper and middle class individuals from other countries, or from richer ASEAN countries, to utilise health services in their countries. The medical tourism industry in Asia is being catalyzed by the Medical Tourism Association (MTA), a US based non-profit organization that is aiming to set global standards for this industry. Health services tourism has become big in Singapore, Thailand and Malaysia.[20] This has also motivated lower income countries, such as, Cambodia, the Lao People's Democratic Republic, and Vietnam, to be relatively lax in allowing foreign hospitals to operate in their countries. Medical transcription services firms have also begun to spring up. As of 2004, there were 25 firms owned by US investors in the Philippines, where medical college graduates waiting to take their board examinations, provide medical transcriptions to foreign clients.[21]

- ***Medical, Dental & Nursing Schools***. An allied development has been the rapid development of medical, dental and nursing schools throughout the region, which provides training for health professionals.[22] Some of those who had taken up nursing degrees and left to work overseas as nurses were actually licensed Filipino doctors who could not find good pay in their home country.[23] This phenomenon of "nurse-

[17] Encinas-Franco, Jean. (2007) "The Gender Dimension of Health Professional Migration from the Philippines," in *3rd Report on the Advancement of Women in the ASEAN: Dimensions of Globalization and Economic Integration.* Retrieved from <http://www.aseansec.org/5187-7.pdf>.
[18] ASEAN – ANU Migration Research Team. (2005) *Movement of workers in ASEAN: Health Care and IT Sectors*, REPSF Project No. 04/007. Retrieved from < http://www.aseansec.org/aadcp/repsf/docs/04-007-FinalMainReport.pdf >
[19] *Ibid*.
[20] Arunanondchai, Jutamas and Carstern Fink. (2005) *Trade in Health Services in the ASEAN Region*. Retrieved from < http://ictsd.org/downloads/2008/06/arunanondchai_fink.pdf>
[21] Arunanondchai, Jutamas and Carstern Fink. (2005) *Trade in Health Services in the ASEAN Region*. Retrieved from < http://ictsd.org/downloads/2008/06/arunanondchai_fink.pdf>
[22] Wikipedia. (n.d.) *List of Medical Schools.* Retrieved from <http://en.wikipedia.org/wiki/List of Medical Schools>
[23] Encinas-Franco, Jean. (2007) "The Gender Dimension of Health Professional Migration from the Philippines," in *3rd Report on the Advancement of Women in the ASEAN: Dimensions of Globalization and Economic Integration.* Retrieved from <http://www.aseansec.org/5187-7.pdf>.

medics" needs to be further investigated and may not only be taking place in the Philippines.

PART THREE: Policy Reforms Toward Removing Barriers to Market Access

There are two areas covered by the ASEAN economic integration agreements and regulations that, among others, directly affect the healthcare industry or market. These are the liberalization of services, and standards and conformance.

Liberalization of Services. When it comes to regional economic integration, the healthcare sector is prominently featured in ASEAN agreements, declarations and technical reports falling under the domain of service liberalization. The ASEAN Framework Agreement on Services (AFAS), signed in Thailand in December 1995, is the key ASEAN document that set the stage for the elimination of restrictions to trade in services within and outside ASEAN countries.[24] The follow-up document, entitled "ASEAN Framework Agreement on the Integration of Priority Sectors" ("Framework Agreement"), listed healthcare as one of eleven priority sectors for integration. [26] The *ASEAN Framework (Amendment) Agreement on the Integration of Priority Sectors* further makes significant improvements to the "Framework Agreement", all aimed at enabling the progressive, expeditious and systematic integration of the priority sectors, including healthcare in ASEAN. [27] Significant are the amendments on Article 5 of the Framework Agreement that were found in Article 3 of the "Framework (Amendment) Agreement." These are as follows:

"Member States shall accelerate the liberalisation of trade in priority services sectors by 2010. This could be achieved through:

a. "elimination of all limitations in Mode 1 (cross-border supply) and Mode 2 (consumption abroad) by **31 December 2008**, otherwise due reasons shall be provided;
b. allowing for Mode 3 (commercial presence) foreign equity participation targets, with flexibility, by **31 December 2010**, in conformity with the relevant decisions of the ASEAN Economic Ministers Meeting (AEM);
c. setting clear targets for liberalising other Mode 3 limitations, by **31 December 2007**;
d. improving Mode 4 commitments in line with the results of each ASEAN Framework Agreement on Services (AFAS) Round Negotiations;
e. accelerating the development and finalisation of Mutual Recognition Arrangements (hereinafter referred to as "MRAs"), as identified, by **31 December 2008**; *(underscoring supplied)*
f. applying the ASEAN-X formula; and

[24] ASEAN Secretariat. (1995) *ASEAN Framework Agreement on Services.* Retrieved from <http://www.aseansec.org/6628.htm>
[26] ASEAN Secretariat. (2004) *ASEAN Framework Agreement on the Intergration of Priority Sectors.* Retrived from <http://www.aseansec.org/AIPS%20-%20Framework.doc>
[27] ASEAN Secretariat. (2006) *ASEAN Framework (Amendment) Agreement on the Integration of Priority Sectors*. Signed in Cebu, the Philippines, December 2006 <Retrieved from http://www.aseansec.org/19200.htm>

g. promoting joint ventures and cooperation, including third country markets beginning 2007."[25]

Healthcare services continue to be listed as one of the twelve priority sectors found integrated to the "Economic Community Blueprint" of the "Roadmap for an ASEAN Community 2009-2015" (henceforth, "Roadmap"), they were also identified as one of four priority services sectors where the removal of restrictions on trade in services was fast-tracked to 2010.

In addition, the other actions identified under "A.2. Free flow of Services" of the "Roadmap" that are relevant to the healthcare sector, are as follows:[26]

"iii. Undertake liberalization through consecutive rounds of every two years until 2015;[27]
v. Schedule packages of commitments for every round according to the following parameters:

- No restriction for Modes 1 and 2 with exceptions due to bona fide regulatory reasons (such as public safety) which are subject to agreement by all Member Countries on a case-by-case basis;
- Allow for foreign (ASEAN) equity participation of not less than 51 percent by 2008 and 70 percent by 2010 for the four priority areas (…); and
- Progressively remove other Mode 3 market access limitations by 2015;

vi. Set the parameters of liberalization for national treatment limitations, Mode 4 and limitations in the horizontal commitments for each round by 2009;
vii. Schedule commitments according to agreed parameters for national treatment limitations, Mode 4 and limitations in the horizontal commitments for each round by 2009;
viii. Complete the compilation of an inventory of barriers to services by August 2008;

ix. Allow(ing) for overall flexibilities … liberalization through ASEAN Minus X Formula;
x. Complete mutual recognition agreements (MRA) currently under negotiation, i.e. … medical practitioners by 2008, and dental practitioners by 2009; *(as of this writing, the ASEAN Mutual Recognition Arrangements on Nursing Services[28], Medical Practitioners[29], and Dental Practitioners[30], have been signed)*
xi. Implement the MRAs expeditiously according to the provisions of each respective MRA;

[25] ASEAN Secretariat. (2006) *ASEAN Framework (Amendment) Agreement on the Integration of Priority Sectors*. Signed in Cebu, the Philippines, December 2006 <Retrieved from http://www.aseansec.org/19200.htm>
[26] ASEAN Secretariat. (2009). *Roadmap for an Asean Community 2009- 2015*, p. 26. Retrived from <http://www.aseansec.org/publications/RoadmapASEANCommunity.pdf>
[27] As mentioned above, in the case of the healthcare sector, liberalization is fast tracked to 2010.
[28] ASEAN Secretariat. (2006). *ASEAN Mutual Recognition Arrangement on Nursing Services*. Retrieved from <http://www.aseansec.org/19210.htm>
[29] ASEAN Secretariat (2009). *ASEAN Mutual Recognition Arrangement on Medical Practitioners*. Retrieved from <http://www.aseansec.org/22231.htm>
[30] ASEAN Secretariat (2009). *ASEAN Mutual Recognition Arrangement on Dental Practitioners*. Retrieved from <http://www.aseansec.org/22228.htm>

> xiii. Strengthen human resources development and capacity building in area of services."[31]

All provisions found in "A.5 Free Flow of Skilled Labor" of the "Roadmap" are also relevant to the healthcare sector.[32]

The current interest in the trade in healthcare services may be traced to four global and regional disparities that reveal structural imbalances in health care systems across countries. These are: (1) demographic structure (aging populations) in the developed countries; (2) shortage of health professionals in the developed countries (but also in some developing countries; (3) high cost of healthcare in the developed countries; and (4) poor access to health care facilities and services in the developing countries.[33]

While the trans-border movement of low-skilled workers takes place with regularity and, in some cases, even increases, Southeast Asian governments remain reluctant to recognize these workers, and elect to only focus on the movement of professional workers.[34] A long-standing call for serious attention to be given to the protection of the rights and welfare of low- and semi-skilled, as well as unskilled workers, remains unheeded.

Standards and Conformance Another important element in economic integration is the adoption of harmonized systems of standards, technical regulations and conformity assessment procedures. Variations in national standards are one source of technical barriers to trade. An example of a standardized conformity assessment approach are mutual recognition agreements (MRAs) covering nursing, medical or dental professionals that were mentioned above, in the section on the liberalization of trade in services.

The implementation of an ASEAN Common Technical Dossiers (ACTD) for Pharmaceuticals and Medical Device is an ongoing process. The ACTD was established as a result of the process of harmonizing national level standards. In 1997, the Pharmaceutical Product Working Group (PPWG) was established under the ASEAN Consultative Committee on Standards and Quality (ACCSO). The PPWG determined that the topics selected for harmonizing national standards would be divided into Safety, Quality and Efficacy, to reflect the three criteria which formed the basis for approving medicinal products.[35]

Multinational corporations and global regulators are now applying pressure on the ASEAN to align its ACTD with the standards being put in place by the International Conference on Harmonisation of Technical Requirements for Registration of Pharmaceuticals for Human Use (ICH). The ICH is a project that brings together the regulatory authorities of the three richest economies – Europe, Japan and the United States – and experts from the pharmaceutical industry in the three regions to discuss scientific and technical aspects of product registration.[36] Once the ASEAN aligns with the ICH, this would mean implementing

[31] ASEAN Secretariat. (2009). *Roadmap for an Asean Community 2009- 2015*, p. 26. Retrieved from <http://www.aseansec.org/publications/RoadmapASEANCommunity.pdf>
[32] *Ibid*, p. 30
[33] PIDS Discussion Paper Series Number 2005-30, p. 4
[34] ASEAN Secretariat. (2009). *Roadmap for an Asean Community 2009- 2015*, p. 210. Retrieved from <http://www.aseansec.org/publications/RoadmapASEANCommunity.pdf>
[35] Lätzel, Ruth. (2007) *Development of the ASEAN Pharmaceutical Harmonisation Scheme: An Example of Regional Integration*, Retrieved from <http://www.dgra.de/studiengang/pdf/master_laetzel_r.pdf>
[36] ICH Secretariat. (n.d). *Official Web Page for ICH.* Retrieved from <http://www.ich.org/cache/compo/276-254-1.html>

a mutual recognition of pharmaceutical registrations. If this happens, one possible effect might be indigenous Asian, mainly Chinese and Indian, pharmaceutical companies many of which specialize in herbal medicines and generic drugs, will not be able to compete with bigger, more established foreign pharmaceutical companies from the developed countries.

PART FOUR: Implications to Workers in the Healthcare Services Sector and Initial Proposals

Challenges for trade union organizing. The privatization of public health facilities, including hospitals, is leading to the disappearance of large sections of public sector workers. Moreover, the changing employment conditions of medical professionals, who now move across borders or find themselves under foreign management, provide both a challenge and opportunity for trade union organizing. There are also the persistent issues of low standards of living and working conditions for migrant workers both professionals and non-professionals, exploitative recruitment, occupational health hazards, and various forms of discrimination and violence against women that need to be vigorously monitored and addressed.

Need for classification system for workers in the healthcare industries. The changes in the terrain of the healthcare industries brought about by new services activities have generated at the global level much confusion in the classification and identification of workers.[37] Without a clear classification system, statistics on employment and working conditions, including wages, of specific health workers cannot be obtained, and an overall analysis of the labour market in the health sector cannot be carried out.

Health protection & development for migrant sending countries. The extremely high proportion of medical professionals who leave the country each year – most of whom are female nurses and midwives – have created a "care deficit" health system in the Philippines.[38] This health deficit cuts across the public and private, national and local, institutional and informal.

Need for transparency and accountability in domestic regulation. There is a need to have a more transparent regulatory regime, in terms of having wider consultation before regulatory decisions are made and wider dissemination of those decisions after they are made.[39]

Initial Proposals. In light of the findings, the following are being put forward for workers' protection and empowerment, and the pursuit of publicly accessible quality healthcare development. These are as follows:

- The current framework of the mobility of healthcare service providers in the ASEAN is limited to professional healthcare workers. As a newly emerging category of

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[37] See Hoffmann, Eivind. (2003) *Comparisons between OECD'S definitions of the scope of 'Human Resources in Health' and those emerging from informal discussions between ILO and WHO officials.* Retrieved from <http://unstats.un.org/unsd/class/intercop/expertgroup/2003/AC94-Bk3.PDF >

[38] Encinas-Franco, Jean. (2007) "The Gender Dimension of Health Professional Migration from the Philippines," in *3rd Report on the Advancement of Women in the ASEAN: Dimensions of Globalization and Economic Integration.* Retrieved from <http://www.aseansec.org/5187-7.pdf>.

[39] Dee, Philippa. (2009) *Services Liberalization Toward the ASEAN Economic Community.*

workers, migrant professional workers in the health sector can be unionized, so that they can protect and promote their interests. In so doing, women workers, who comprise a significant proportion of professional healthcare service providers, must be empowered to lead.

- Low- and semi-skilled migrant workers, many of whom are also women, need to be supported in organizing themselves into trade unions, so that they can push for their welfare needs and be able to actively provide input to their employee-employer relationships.

- ASEAN must have strong regulatory powers over the drug companies and resist pressures to align with global regulatory regimes that are dominated by the big economies and powerful transnational corporations. The ASEAN must continue to promote small and medium-sized companies that will produce healthcare goods and services for the consumption of the poorer segments of the population.

- ASEAN should continue with its certification of generic and herbal medicines in order to ensure that workers and other vulnerable groups are able to access affordable medicines.

- The ASEAN, especially the Economic Ministers, should invite trade union representatives to their meetings, as social dialogue partners.

- Technical requirements such as standards, assessments and procedures should be accessible to associations of small- and medium-sized businesses and firms.

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Annex 1

Total expenditure on health as percentage of gross domestic product								
	2000	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**Mean**
Indonesia	1.7	1.8	1.8	2.2	2.1	2.1	2.2	**1.99**
Myanmar	2.1	2.1	2.3	2.2	2.2	2.2	2.3	**2.20**
Thailand	3.4	3.3	3.7	3.9	3.5	3.5	3.5	**3.54**
Brunei Darussalam	2.5	2.6	2.6	2.5	2.2	2	1.8	**2.31**
Cambodia	5.8	6.2	6.3	6.8	6.6	6.4	6	**6.30**
Lao People's Democratic Republic	3.2	3.3	3.3	4.4	3.9	3.6	3.6	**3.61**
Malaysia	3.3	3.5	3.5	4.7	4.5	4.2	4.3	**4.00**
Philippines	3.5	3.2	3	3.3	3.3	3.2	3.3	**3.26**
Singapore	3.4	3.7	3.7	4.2	3.7	3.5	3.4	**3.66**
Viet Nam	5.4	5.7	5.2	5.3	5.7	6	6.6	**5.70**
Mean	**3.43**	**3.43**	**3.54**	**3.54**	**3.95**	**3.77**	**3.67**	**3.66**

Annex 2

General Government Expenditure On Health As Percentage Of Total Expenditure On Health								
	2000	2001	2002	2003	2004	2005	2006	**Mean**
Indonesia	38.5	42.2	41.2	42	40.1	46.6	50.4	**43.00**
Myanmar	13.4	11.8	14.4	11.2	12.9	10.6	16.8	**13.01**
Thailand	56.1	56.4	63.5	66.6	64.7	63.9	64.4	**62.23**
Brunei Darussalam	83.3	76.9	78.4	79.9	78.1	79.6	79.7	**79.41**
Cambodia	22.5	29	31.9	37.2	29.7	24.2	26.1	**28.66**
Lao People's Democratic Republic	32.6	33.6	32.6	30.8	20.2	20.6	20.8	**27.31**
Malaysia	52.4	55.8	55.4	56.4	50	44.8	45.2	**51.43**

Philippines	47.6	44.2	40	38.2	38	36.6	39.6	**40.60**
Singapore	36.8	33.9	30.1	34	30	31.9	33.6	**32.90**
Viet Nam	30.1	31	30	31.4	26.9	25.7	32.4	**29.64**
Mean	**41.33**	**41.48**	**41.75**	**42.77**	**39.06**	**38.45**	**40.90**	**40.82**

Annex 3

General Government Expenditure On Health As Percentage Of Total Government Expenditure								
	2000	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**Mean**
Indonesia	3.8	3.6	4.2	4.8	4.5	5.1	5.3	**4.47**
Myanmar	1.2	1.1	1.5	1.2	1.4	1.1	1.8	**1.33**
Thailand	10	9	9.3	13.5	11.5	11.3	11.3	**10.84**
Brunei Darussalam	5	5.2	4.4	5.8	4.8	5.1	5.1	**5.06**
Cambodia	8.7	10.6	10.8	14.8	14	12	10.7	**11.66**
Lao People's Democratic Republic	5.2	5.6	6	6.9	5.2	4.1	4.1	**5.30**
Malaysia	6.2	6.3	6.5	8.6	7.9	7	7	**7.07**
Philippines	7	6.2	5	5.4	5.7	5.5	6.4	**5.89**
Singapore	6	5.2	5.2	6.8	5.3	5.6	5.4	**5.64**
Viet Nam	6.4	6.9	6.1	5.5	4.7	5.1	6.8	**5.93**
Mean	**5.95**	**5.97**	**5.9**	**7.33**	**6.5**	**6.19**	**6.39**	**6.32**

Annex 4

Private expenditure on health as percentage of total expenditure on health								
	2000	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**Mean**
Indonesia	61.5	57.8	58.8	58	59.9	53.4	49.6	**57.00**
Myanmar	86.6	88.2	85.6	88.8	87.1	89.4	83.2	**86.99**
Thailand	43.9	43.6	36.5	33.4	35.3	36.1	35.6	**37.77**
Brunei Darussalam	16.7	23.1	21.6	20.1	21.9	20.4	20.3	**20.59**
Cambodia	77.5	71	68.1	62.8	70.3	75.8	73.9	**71.34**
Lao People's Democratic Republic	67.4	66.4	67.4	69.2	79.8	79.4	79.2	**72.69**
Malaysia	47.6	44.2	44.6	43.6	50	55.2	54.8	**48.57**
Philippines	52.4	55.8	60	61.8	62	63.4	60.4	**59.40**

Singapore	63.2	66.1	69.9	66	70	68.1	66.4	**67.10**
Viet Nam	69.9	69	70	68.6	73.1	74.3	67.6	**70.36**
Mean	**58.67**	**58.52**	**58.25**	**57.23**	**60.94**	**61.55**	**59.1**	59.18

Annex 5

Out-of-pocket expenditure as percentage of private expenditure on health								
	2000	2001	2002	2003	2004	2005	2006	**Mean**
Indonesia	63.3	66.1	65.8	69.7	69.2	66.4	66.3	**66.69**
Myanmar	99.2	99.2	99.3	99.4	99.4	99.4	99.4	**99.33**
Thailand	76.9	75.8	74.8	74.5	74.7	76.6	76.6	**75.70**
Brunei Darussalam	98.8	99.1	99.1	98.9	98.9	98.9	98.9	**98.94**
Cambodia	97.1	94.3	93.8	90	84.3	79.3	84.4	**89.03**
Lao People's Democratic Republic	91.8	91.1	89.5	92.2	90.3	92.7	93.5	**91.59**
Malaysia	75.4	73.5	73.6	72.4	75.1	75.7	73.3	**74.14**
Philippines	77.2	78.6	78	78.4	78.6	80.3	80.2	**78.76**
Singapore	97	96.8	96.8	94.1	93.9	93.8	94	**95.20**
Viet Nam	91	89.3	86.5	86.1	86.1	86.1	89.5	**87.80**
Mean	**86.77**	**86.38**	**85.72**	**85.57**	**85.05**	**84.92**	**85.61**	**85.72**

Annex 6

Private prepaid plans as percentage of private expenditure on health, 2006								
	2000	2001	2002	2003	2004	2005	2006	Mean
Indonesia	8.4	7.1	9.2	9.1	8.7	9.7	9.7	**8.84**
Myanmar	0	0	0	0	0	0	0	**0.00**
Thailand	12.8	13.6	15	15.7	16.5	15.6	15.6	**14.97**
Brunei Darussalam	0.6	0.4	0.5	0.5	0.5	0.5	0.5	**0.50**
Cambodia	0	0	0	0	0	0	0	**0.00**
Lao People's Democratic Republic	0	0.2	0.6	0.5	0.5	0.5	0.5	**0.40**
Malaysia	11.9	14.1	14.2	16.4	15.3	14.6	14.8	**14.47**
Philippines	11.1	10.1	10.7	11.8	11.3	10.5	10.6	**10.87**
Singapore	0	0	0	2.8	3.1	3.1	2.9	**1.70**
Viet Nam	4.1	2.2	2.3	3.2	2.8	2.5	2.5	**2.80**
Mean	**4.9**	**4.8**	**5.3**	**6.0**	**5.9**	**5.7**	**5.7**	**5.5**

Annex 7

External resources for health as percentage of total expenditure on health								
	2000	2001	2002	2003	2004	2005	2006	**mean**
Indonesia	10.8	4.4	3.3	3.5	3	4.6	2.3	**4.56**
Myanmar	1.1	6.1	6.9	6.1	11.2	10.9	13.9	**8.03**
Thailand	0	0.1	0.3	0.4	0.3	0.2	0.3	**0.23**
Brunei Darussalam								
Cambodia	9.4	18.7	19.4	28.4	26.7	25.7	22.3	**21.51**
Lao People's Democratic Republic	30.3	12.6	15	20	10.3	11.3	14.1	**16.23**
Malaysia	0.6	0.6	0.6	0	0	0	0	**0.26**
Philippines	3.5	3.7	2.8	3.4	4	5.1	3.3	**3.69**
Singapore	0	0	0	0	0	0	0	**0.00**
Viet Nam	2.6	2.7	3.4	2.7	1.9	2	2.2	**2.50**
Mean	**6.48**	**5.43**	**5.74**	**7.17**	**6.38**	**6.64**	**6.49**	**6.33**

Annex 8: List of Transnational Pharmaceutical Companies in Southeast Asia (With Net Income and Number of Employees 2008)

Company	Sites (Southeast Asia)	Net Income (2008/ USD millions)	Employees (2008)
Pfizer	US (Mother Company) Asia Pacific Malaysia/Singapore; Philippines; Thailand	14,111	137,127
Johnson & Johnson	US (Mother Company) Philippines; Thailand; Vietnam; Indonesia	10,576	119,200
GlaxoSmithKline	UK (Mother Company) Cambodia; Indonesia; Malaysia; Myanmar; Philippines; Singapore; Thailand; Vietnam	10,432	103,483
Bayer	Germany (Mother Company) Singapore; Indonesia; Malaysia; Philippines; Brunei	6,448	108,600
Roche	Switzerland (Mother Company) Philippines; Thailand; Vietnam; Cambodia; Malaysia; Indonesia; Myanmar; Singapore	8,135	78,604
Sanofi-Aventis	France (Mother Company) Thailand; Vietnam; Singapore; Malaysia; Philippines; Indonesia	7,204	99,495
Novartis	Switzerland (Mother Company) Philippines; Vietnam; Thailand; Indonesia; Malaysia; Singapore	11,946	98,200
Astra-Zeneca	UK/Sweden (Mother Company) Indonesia; Malaysia; Singapore; Thailand; Philippines; Vietnam	5,959	67,400
Abbott Laboratories	US (Mother Company) Indonesia; Malaysia; Philippines; Singapore; Thailand; Vietnam	4,880	68,697

Merck & Co.	US (Mother Company) Malaysia; Philippines; Singapore	7,808	74,372

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Annex 9: Partial List of Health Insurance Companies in Southeast Asia

Company	Sites (Southeast Asia)
AON (USA Mother Company)	Malaysia; Philippines; Singapore; Thailand; Vietnam
AIG/AIU (USA Mother Company)	Malaysia; Philippines; Singapore; Thailand; Vietnam
CIGNA (USA Mother Company)	Singapore; Indonesia; Thailand
AXA (France Mother Company)	Indonesia; Malaysia; Singapore; Philippines; Thailand

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