

Overview of the South-East Asia Region

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The South-East Asia Region (SEARO) of the World Health Organization (WHO) consists of only 10 countries, and as such it could be considered the smallest of WHO Regions. However, its population amounts to one out of every four living human beings and between them, they unfortunately account for 40% of the burden of diseases worldwide.

Most of our 10 countries are members of the World Trade Organization (WTO), but some of them are still observers and there is one that is not yet involved in any capacity. The three main players that are members of the WTO and that are at the forefront of the issues of health and trade in the Region happen to be Indonesia, Thailand, and India. They have certain things in common in the health and trade field, therefore I will focus my discussion on those three countries, and consider them together.

MODES OF TRADE

Obviously, in South-East Asia there are the familiar four modes of trade. Due to its high costs, telemedicine by

and large is not very relevant. This is not to say that it does not exist, but it is not a major topic of interest right now. The three other modes are as follows. There is the commercial presence in foreign territory, with countries focusing on hospital services and trying to make use of the relative advantages that they may have. As has been noted by others, some countries in the region have qualified medical personnel, and since the wages, generally, are low, this creates some possibilities in mode 4. The only country, however, that has actually made a commitment to this mode is India. Yet, it is known that some of those that still have not made commitments are actually involved in the practice of providing health care personnel to foreign countries.

One of the comparative advantages in the Region might be the alternative forms of medicine. The best known example, but not the only one, is the Ayurvedic system of health care in India, for which there is an increasing interest among Western consumers. Accordingly, countries are trying to increase their competence in this particular area.

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Regarding the movement of patients in the Region, it is very much a two-way system. There is movement in and out of the countries. To give an example, patients from Nepal go to India to seek health care that is not available in Nepal but is known to be available in India. There is, on the other hand, a movement out of the Region. For instance, rich Indonesians have been known to seek health care in Australia, Singapore, and the United States because of a real or perceived better quality of services. At the same time, there is an inward movement. For example, India is receiving patients from other countries, including from developed countries, and so is Thailand. Patients from abroad are attracted by the cheaper, good quality care that is available in these countries. So, it is very much a two-way issue.

What most countries obviously are trying to do is to look for a win-win situation, where the rich patients, either foreign or national, can be offered cheaper care that is of good quality. Then, local health personnel could probably be offered better pay and greater job satisfaction from working with more sophisticated equipment. As for the rest of the local populations—the impact is not quite clear as yet. All governments in South-East Asia are aware of the equity issue and consider it important. But they are also aware that a solution will not come by itself and that some regulations are required to ensure more equitable access to services.

Different options are being tried, which may or may not work. This is still very much under investigation. What is becoming increasingly clear is that it will only work if there is good communication and coordination between sectors within countries and

maybe even between different countries. However, there might be some difficulty in this.

Often, when there is communication between a ministry of health and a ministry of trade, the ministry of health is talking about regulations to increase equitable access. The ministry of trade, on the other hand, is talking about trade liberalization. What the trade officials often pick up from the discussions or communications with health personnel is the word *regulation* and this word is perceived by them as going against trade liberalization. This makes them close the door immediately. To make a positive suggestion, maybe we, health personnel, should consider avoiding focusing on the word *regulation* and focus instead on the word *equity*. We could say something like “Look, we agree that we may have a comparative advantage in health services and we agree that maybe this could be put to use to achieve more development, but we see an issue. We are worried about equity.” It should be fairly easy to explain why to the trade officials and then maybe we could ask them: “OK, let’s sit down together and can you, from your point of view, and we, from our point of view, find a way to address this issue?” The regulation issue can thus be approached in a different way.

We should keep in mind that economic theory has its limitations; it is mainly about making efficient use of resources. Economic theory probably cannot give the answers to achieving an equitable sharing of benefits and maybe that is where trade and health need to sit together and have discussions to find ways and solutions.

Going back for a moment to the win-win situation, there are some

extreme situations to think over. It has been pointed out that the nonportability of health insurance could be a barrier to some of the countries realizing their potential in offering health care to foreigners. Let us now imagine a situation where unexpectedly, some of these barriers would disappear in a very short time and, all of a sudden, a number of developed countries would say “OK, we’ll allow it, find care anywhere.” We might witness a tidal wave of foreign patients coming into a health care system that would not be able to cope. The hospitals would not manage and there would definitely be a crowding out of the local patients.

Another extreme case might be that this does not happen at all, but that the countries continue to believe that they have a very good opportunity that they could gain from investing in hospitals or inviting foreign investments in these hospitals. Suppose then that the patients never materialize or that they come in very small numbers. This situation would probably trigger competition between hospitals and countries, with uncertain and worrisome results. It seems that the first losers would be the local health personnel, who might lose many of their benefits, have their wages cut, etc. Eventually, even the patients would lose, because there would be the risk of hospitals cutting corners in order to stay in the market. In that case, care would certainly be cheaper but, probably, not very good.

Now, a balance will have to be worked out between those two extreme situations—within the countries, at the regional levels, and maybe even at a wider level.

It is hard to envision what the solutions might be. We could think of different things, such as starting with

bilateral or regional agreements that would allow opening up one country to another. It depends on whether this would be allowed under world trade regulations. Another solution might be for countries to specialize in different kinds of care. Thailand is involved in the specific practice of short-stay patients. Maybe other countries would be interested in caring for longer-term patients. On the way to finding answers, we have to consider all the issues mentioned.

The last thing to come back to very briefly is mode 4, on the movement of health personnel. In the South-East Asia Region, the movement seems to be mainly outgoing. This outflow of personnel is seen by many as a brain drain that costs the countries a lot of money. On the other hand, others see it as a way for outgoing people to earn money, which is sent back home and represents a substantial inflow back into the country. This appears to be a comparison of unequal things, because the outflow relates to public sector resources, the public medical sector, and the educational sector. Perhaps, however, we should call it the ‘public social sector’, which had to pay for the education of medical personnel in the first place. The inflow that returns to the economy is there and it is, probably, substantial. But it is a different type of money. It comes as private earnings and people tend to spend it partly on what could be described as consumer goods; people build nice houses for themselves or they buy cars, as they well have the right to do.

As far as this money being invested in a productive way, part of it is not invested in the health care sector but in other sectors. Then, again, even the part invested in the health care sector

will (by definition) not be invested in the public sector but in the private sector. Even if the amount coming back into the country were larger than the

amount spent in the first place, there would still be a shift in resources. That is the issue to be addressed, rather than which amount is larger.
