

Trade in Health Services in the ASEAN Region

By Jutamas Arunanondchai and Carsten Fink^{*}

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Abstract

Promoting quality health services to large population segments is a key ingredient to human and economic development. At its core, healthcare policymaking involves complex trade-offs between promoting equitable and affordable access to a basic set of health services, creating incentives for efficiencies in the healthcare system, and managing constraints in government budgets. International trade in health services influences these trade-offs. It presents opportunities for cost savings and access to better quality care, but it also raises challenges in promoting equitable and affordable access. This paper offers a discussion of trade policy in health services for the ASEAN region. It reviews existing patterns of trade and identifies policy measures that could further harness the benefits from trade in health services and address potential pitfalls that deeper integration may bring about.

Key words: healthcare services; international trade; ASEAN economic integration; labor mobility

^{*} Jutamas Arunanondchai is a Senior Researcher at the Fiscal Policy Research Institute Foundation, Bangkok, Thailand. Carsten Fink is a Senior Economist at the World Bank Institute. This paper is based on a research project on trade in health services undertaken by the ASEAN Economic Forum research network and supported by the World Bank Institute. Comments by Rudolf Adlung, Nick Drager and Karin Timmermans are gratefully acknowledged. The views expressed in this paper are the authors' own and do not necessarily represent those of their respective institutions.

I. Introduction

The performance of a country's health sector is critical for the well-being of its citizens. Caring for sick workers preserves a country's stock of human capital, laying the foundation for sustained economic growth. The provision of health services also has important public good characteristics, in particular when it comes to containing the spread of infectious diseases such as HIV/AIDS, tuberculosis and malaria.

Given the centrality of health to human well-being, policy reform discussions in the health sector tend to be of a sensitive nature. Many countries have inscribed a basic right to healthcare in their constitutions, sometimes mandating the provision of services free of charge. Health services are not viewed as a tradable commodity that can be subject to global market forces.

Notwithstanding these sensitivities, healthcare policy does involve serious economic choices. Few countries can afford state-of-the-art healthcare for every citizen. Choices about what kind of health services are provided to which segments of the population have to be made—explicitly or implicitly. At their core, these choices involve complex trade-offs between promoting equitable and affordable access to a basic set of health services at minimum quality, creating incentives for efficiencies in the healthcare system, and managing constraints in central and state-level government budgets. International trade in health services influences these trade-offs. It can present opportunities for cost savings and access to better quality care, but it can also raise challenges in promoting equitable and affordable access.

Against this background this paper offers a discussion of trade policy in health services for the ASEAN region. It draws on a set of national research studies that were conducted by researchers of the ASEAN Economic Forum. These studies covered 7 of the 10 ASEAN countries: Cambodia, Indonesia, Laos, Malaysia, the Philippines, Thailand, and Vietnam.¹

Trade in health services is already an important phenomenon in the ASEAN region. To a large extent, this trade occurs outside the framework of existing trade agreements. At the same time, ASEAN governments have established a framework for progressively liberalizing trade in services and, in particular, have identified healthcare as a priority sector for region-wide integration. Therefore, a key aim of this paper is to identify policy measures that would harness the benefits from trade in health services and address potential pitfalls that deeper integration may bring about.

The paper is structured as follows. The next section will introduce the concept of international trade in health services and review the patterns of existing trade in the region. Section III will outline the gains that further trade liberalization could offer and also point to possible pitfalls that expanded trade may hold. Section IV discusses several policy implications and makes several recommendations for policy initiatives that ASEAN countries could pursue. The final section offers concluding remarks.

¹ See Chea (2005) for Cambodia, Leebouapao (2004) for Laos; Akhmad (2005); Abidin, Alavi, and Kamaruddin (2005) for Malaysia; Avila and Manzano (2005); Arunanondchai (2005) for Thailand; and Thang (2005) for Vietnam. In view of its economic importance, Singapore is also included in parts of this paper, drawing on information available from the seven country studies as well as publicly available data.

II. Current trade patterns in the ASEAN region

Trade discussions in services typically adopt a wide definition of what constitutes trade, involving the following four modes of supply:

- *Mode 1: cross-border supply.* This mode of supply is akin to traditional goods trade, whereby suppliers and consumers are located in different countries.
- *Mode 2: consumption abroad.* International trade also takes place when the consumer moves to the country of the supplier.
- *Mode 3: commercial presence.* This mode of supply describes the situation whereby producers, in the form of juridical persons (or companies), move to the country of the consumer.
- *Mode 4: movement of individual service providers.* Similar to Mode 3, this mode of supply describes the situation whereby the producer moves to the country of the consumer, but the producer takes the form of a natural person (or individual). Mode 4 trade typically captures the movement of service workers that is of a temporary nature and does not involve permanent migration.

Remarkably, current trade patterns of countries in the ASEAN region involve all four modes of supply.

Mode 1: cross-border supply

In the ASEAN region, the Philippines have started to export medical transcription services to the United States. The Philippine's comparative advantage in medical transcription is explained mainly by its pool of educated English-speaking workers. Transcriptionists are usually medical school college graduates who work part time while preparing for the Philippine's board exams. Interestingly, the majority of the 25 companies exporting these services in 2004 were owned by US investors. Indeed, the Philippine Government offers special incentives for foreign direct investment (FDI) in this sector. While exports are still small in absolute value (\$10 million in 2004 by a rough estimate), they hold substantial growth potential. For example, current exports to the United States still account for less than 1 percent of the \$13 billion spent on medical transcription in the United States per year.

Mode 2: consumption abroad

Several ASEAN countries have become significant exporters of "health tourism" services. These are chiefly Malaysia, Singapore, and Thailand. Table 1 presents information on export revenues and the number and origin of foreign patients for these countries. Thailand is the largest exporter in the region, followed by Malaysia and Singapore. Interestingly, in the case of Singapore and Malaysia, the majority of foreign patients come from other ASEAN countries (mainly Indonesia), whereas in the case of Thailand only 7 percent of foreign patients are from

the ASEAN region. For Thailand, Japanese nationals account for the largest share of foreign patients.

Table 1: Export of health tourism services

	Export revenues	Number of patients	Origin of patients
Malaysia (2003)	RM 150 million (\$40 million)	More than 100,000	60 percent from Indonesia, 10 percent from other ASEAN countries
Singapore (2002)	\$420 million	210,000	45 percent from Indonesia, 20 percent from Malaysia, 3 percent from other ASEAN countries
Thailand	Around 20 billion baht in 2003 (\$482 million)	470,000 (2001) 630,000 (2002)	42 percent from the Far East (mostly Japan), 7 percent from ASEAN countries

Sources: Singapore Tourism Board; Abidin, Alavi, and Kamaruddin (2005); Arunanondchai (2005).

The competitiveness of Malaysian, Singaporean, and Thai hospitals primarily stems from two factors. First, they can offer medical services at significantly lower price compared to developed countries (see Table 2.). Differences in labor costs are likely to account for much of the observed price differences. Second, hospitals in Malaysia, Singapore and Thailand have established a reputation for high quality services. In Thailand, service quality has been explicitly promoted by an accreditation system administered by a dedicated government agency. A related aspect is that Malaysian, Singaporean and Thai hospitals can offer specialized services not available in other, especially poorer, ASEAN countries.

Table 2: Price comparisons (US\$, 2001)

	Coronary by-pass graft surgery	Single private hospital room, per night
Malaysia	\$6,315	\$52
Singapore	\$10,417	\$229
Thailand	\$7,894	\$55
United Kingdom	\$19,700	n/a
United States	\$23,938	\$1,351

Source: Abidin, Alavi, and Kamaruddin (2005)

For a number of medical treatments, hospitals from Malaysia, Thailand, and Singapore directly compete with each other. The price comparisons in Table 8 suggest strong competition, in particular, between Thailand and Malaysia.

Interest in developing the health tourism industry has also emerged in the Philippines. The country benefits from a pool of well-qualified and English-speaking medical professionals. Hoping to build on these advantages, the Government included health tourism in its 2004 Investment Priorities Plan.

As for the low income ASEAN countries, Vietnam also exports some health services, mainly to neighboring Cambodia. Nonetheless, most Cambodian patients seeking treatment abroad choose hospitals in Thailand and Singapore. Several private hospitals in Cambodia make a business of facilitating treatment in foreign hospitals. Similar services are also provided by independent agents at Cambodia's borders.

Mode 3: commercial presence

There is limited foreign participation in the private sector healthcare segment in six of the seven ASEAN countries studied (Laos being the only exception). For example, in Indonesia foreign hospitals are estimated to account for only one percent of total hospital beds (Timmermans, 2002). In the Philippines, only 2 of 19 Health Maintenance Organizations (HMOs) are foreign-owned. In Thailand, foreign investment is estimated to account for only 3 percent of total investment in private hospitals in Thailand. Some foreign presence also exists in Cambodia and Vietnam, though no information is available on the market shares of foreign hospitals. Across all countries in the region, foreign-owned healthcare facilities cater to the middle and upper income population segments and are mostly found in urban areas.

Foreign investment appears to originate both from within and from outside the ASEAN region. In Cambodia, most foreign hospitals are of Chinese origin. Among ASEAN countries, Singapore and Thailand, in particular, have emerged as outward investors in the healthcare sector. For example, Parkway Group Healthcare, the biggest investment group in the healthcare sector in Singapore, has set up joint ventures with hospitals in India, Indonesia, Malaysia, Sri Lanka, and the United Kingdom. Bumrungrad Hospital in Thailand has entered into management contracts with hospitals in Bangladesh and Myanmar, and has formed a joint venture with a hospital in the Philippines. Bangkok Hospital has established twelve branches in Southeast and South Asia, locating primarily in tourist towns.

Mode 4: movement of individual service providers

The ASEAN region hosts two of the world's largest exporters of healthcare workers. The Philippines and Indonesia send large numbers of nurses and midwives to countries around the world. This form of trade is driven by a growing supply of well-educated professionals in these two countries and shortages of healthcare workers in richer economies. Demographic pressures and rapidly rising healthcare costs in developed countries are likely to increase the demand for healthcare professionals from lower wage economies in future.

In the case of the Philippines, the number of nurses working abroad is estimated to be around 87,000.² The main export destinations are outside the ASEAN region. They include Ireland, Kuwait, Libya, Saudi Arabia, the United Arab Emirates, the United Kingdom, and the United States. Hospitals and specialized recruitment agencies in these countries directly source their nurses from the Philippine's labor market. Over the past few years, there has been a sharp increase in the number of medical schools offering nursing degrees. Several of these schools have adapted their course curricula to the needs of foreign markets. So far, there have been few

² Unfortunately, no statistics are available on the number of returning nurses.

concerns about domestic shortages of nurses in the Philippines, as there has always been a sufficient supply of newly graduating nurses.

For Indonesia, the main export destinations are other Islamic countries, especially countries in the Middle East (Saudi Arabia, United Arab Emirates) but also Malaysia and Singapore. Language and cultural affinity account for this geographic export pattern. Concerns about exports leading to domestic shortages are more pronounced than in the Philippines, as Indonesia's healthcare system is chronically understaffed.

Within ASEAN, the main host economies for foreign healthcare workers are Malaysia and Singapore and, to a lesser extent, Thailand. Interestingly, Malaysia is both a recipient and a sender of healthcare workers, with Malaysian hospitals hiring mainly Indian and Filipino nurses, and Malaysian nurses working in Singapore and Saudi Arabia. In 2001, there was a net outflow of about 450 nurses, which represented less than 3 percent of total nurses employed. The same holds for medical doctors. Over the past decade, private and public hospitals have hired several hundred foreign doctors and medical specialists, partly to address a serious domestic shortage of doctors. At the same time, a significant number of Malaysian doctors have moved to higher wage countries—in particular, to Singapore.

III. The gains and pitfalls from trade in health services

As pointed out in the introduction, trade in health services creates both opportunities and risks. This section will review the key economic effects from greater openness in healthcare. Since these effects depend on the way in which services are supplied internationally, the discussion will proceed along the four modes of supply introduced in Section II.

Cross border trade and consumption abroad (modes 1 and 2)

Patients who seek medical treatment abroad and hospitals which outsource medical transcription to foreign service providers can realize significant cost savings. One recent study, for example, estimated that the United States would save \$1.4 billion annually if only one in ten patients were to go abroad for a limited set of low-risk treatments (Mattoo and Rathindran, 2005). Countries that export health services realize gains from specialization, allowing them to employ their capital and labor where they are most efficient and generating export revenues for the import of other goods and services.

A second important benefit from trade is greater choice. Patients from poorer ASEAN countries and elsewhere are able to undergo treatment for certain conditions not available in their home countries.

Notwithstanding these efficiency and choice gains, trade also has adverse effects. Any economic activity that experiences rapid growth due to export expansion will become dearer in the domestic economy. Even if economies as a whole gain, export expansion in the health sector may have important distributive consequences for domestic patients. In addition, the public

good characteristic of healthcare alluded to in the introduction raises the question of whether economies as a whole could even be worse off by rapidly expanding health tourism exports.

Distributive concerns are particularly relevant for Malaysia and Thailand. In Thailand, private hospitals that treat foreign patients do not participate in social health insurance schemes. Since they generate more revenue per patient, they can offer higher salaries to medical staff. This has diverted medical personnel away from public hospitals and private hospitals that serve Thai patients only (many of which participate in social health insurance schemes). By one estimate, an extra 100,000 patients seeking medical treatment in Thailand leads to an internal brain drain of between 240-700 medical doctors.³ This has exacerbated shortages of medical professionals in Thailand, especially in the public sector and in rural areas. A related concern is that tertiary medical education in Thailand is provided by the public sector. Private exporting hospitals hire from the same pool of doctors as public hospitals, yet they do not share the costs of medical education.

Similar concerns exist in Malaysia. The inflow of foreign medical professionals has not alleviated domestic shortages in medical personnel (partly because Malaysian doctors and nurses have gone abroad, too). Greater numbers of foreign patients seeking treatment in Malaysia would put further pressures on the domestic healthcare system.

Commercial presence (mode 3)

Foreign investment in hospital and related services can contribute in various ways to the reach and quality of health services. It may relax domestic capital constraints and alleviate supply shortages in the domestic healthcare system. Foreign hospitals may bring advanced medical knowledge and specialized equipment, offering new treatments to domestic patients. Foreign entrants may also transfer valuable organizational skills and managerial know how, gained through experience abroad. Being part of multinational hospital networks offers additional benefits. Bangkok Hospital, for example, cites increased bargaining power vis-à-vis suppliers of medical equipment and improved quality control mechanisms as key advantages of operating a large network of hospitals. The contribution of FDI could be especially important in the poorer ASEAN economies with underdeveloped health systems. This explains why Cambodia, Laos, and Vietnam impose few policy barriers to the establishment of foreign hospitals—though the small size of their healthcare market remains a binding constraint to attracting more FDI.

The more controversial aspect is to what extent foreign investment may exacerbate inequalities in the domestic healthcare system. As described above, foreign hospitals typically cater to middle and upper income patients and almost exclusively locate in urban areas. That also means they can offer the most attractive pay package to medical professionals, leading to the internal brain drain phenomenon discussed above. There is no evidence, however, whether such adverse effects have been important in the ASEAN economies studied. That may partly be because the extent of foreign participation in countries' healthcare sectors has so far been small. In addition, existing healthcare systems are often tilted towards more affluent patients who can afford private medical services. Foreign entry may thus, indeed, worsen inequality, but it would not

³ See Pannarunothai and Suknak (2004).

necessarily affect access to the health system by those patients who rely on public provision or public insurance schemes. A related consideration is that foreign entry may induce domestic patients who in the past sought medical treatment abroad to stay at home. Again, such an outcome would worsen inequitably in the national provision of healthcare, but it would not necessarily worsen inequality in the consumption of health services by domestic patients.

In the end, the net contribution of foreign investment to equity and access also depends on the type of foreign entry and accompanying policy choices. If entry takes the form of acquisition and domestic medical personnel is scarce, internal brain drain effects may be more pronounced. By contrast, if foreigners build new hospitals and bring along doctors and other medical staff, their investment may help alleviate pre-existing shortages.

Movement of healthcare workers (mode 4)

The movement of health workers from low wage countries to high wage countries can improve economic efficiency. For receiving countries, the benefit usually takes the form of alleviating shortages of domestic medical personnel—a growing problem in many middle and high income countries. For the sending countries, the welfare effects depend crucially on where foreign healthcare workers spend their income. If a significant share of earnings is remitted home—as is the case for Filipino nurses working abroad—the sending country is likely to benefit, too. Otherwise, the sending country will experience a net economic loss.

Another important question is how the outflow of healthcare workers affects the supply of medical personnel in the sending countries. As described in the previous section, the outflow of nurses from the Philippines has so far not led to any domestic shortages. By contrast, the net outflow of nurses from Indonesia and Malaysia seems to have exacerbated already existing shortages of nurses in the country.

Finally, a key consideration for the sending country is whether the movement of healthcare workers is of a temporary or permanent nature. If nurses and doctors return to their home countries after a number of years, concerns about domestic supply shortages may be less severe. Returning medical professionals may also bring back with them new skills and capital. If, by contrast, labor movement is permanent, there is the risk of substantial human capital losses with damaging long term effects on social and economic development.

IV. Policy implications

Trade policy in healthcare cannot be considered in isolation from domestic healthcare policy. The latter involves defining the roles of the public and private sectors in providing and financing healthcare. In doing so, governments face difficult choices. In some areas, trade reforms can be helpful in advancing objectives set by governments. In other areas, trade can make existing problems worse. Much also depends on how domestic policy reforms and trade policy reforms are sequenced. With these considerations in mind, what is the role of ASEAN in realizing the gains from deeper integration?

The ASEAN Framework Agreement in Services (AFAS) has so far not contributed to greater liberalization in the region. The four negotiating rounds under AFAS have not resulted in commitments in the health sector. Where ASEAN governments have opted for liberal trade policies, they have done so unilaterally. However, healthcare was identified as one of eleven priority sectors for integration at the 2003 Summit of ASEAN Economic Ministers in Bali.

Indeed, a regional forum may deliver quicker results for countries ready to commit to market opening in services, compared to the prolonged multilateral negotiating process at the WTO. In addition, if service providers from within the region are at an infant stage, regional market opening may, in theory, offer learning externalities that can enable these providers to become more efficient and eventually face global competition. But regional liberalization may also entail economic costs, mainly in the form of second-based service providers entering the domestic market.

There is little doubt that regional agreements can make an important contribution in the area of regulatory cooperation. While the ten ASEAN countries are not a homogenous group, there does appear to be scope for increased cooperation in the health sector—as is already happening in many other fields.

The national research studies for the seven ASEAN countries identified a number of specific areas for regulatory cooperation that could be pursued at the ASEAN level:

- *Promoting health tourism exports.* Notwithstanding the need for appropriate policy sequencing as outlined above, there are a number of initiatives that could expand trade within the region. First, an ASEAN-wide framework for the portability of health insurance could be developed, which would seek to address the concerns of public and private insurers in covering medical expenses occurred in other ASEAN countries. Second, the development of rules on the privacy and confidentiality of patient information would help assure patients that foreign hospitals treat such information responsibly. Third, while there is already an ASEAN initiative to promote visa-free travel among its member countries, there is scope to further minimize visa requirement for traveling patients—for example, for patients seeking treatments requiring a stay longer than the maximum number of days allowed in tourist visas. Fourth, an ASEAN-wide system for the accreditation of high quality hospitals could be developed. This could help hospitals overcome reputational barriers to greater health tourism exports.
- *Managing the movement of healthcare workers.* An ASEAN facility could be created that would monitor shortages and surpluses of medical personnel in different ASEAN countries. This could help policymakers evaluate where the movement of healthcare workers is warranted and where it exacerbates existing shortages. In addition, a special ASEAN visa—not necessarily limited to healthcare workers—could be developed that would be truly temporary in nature. Such a visa could address concerns in host countries that foreign workers will stay permanently and, at the same time, reduce negative brain drain effects in home countries. Where the movement of healthcare workers is considered desirable, it can be actively promoted through the harmonization of professional standards and the conclusion of agreements recognizing foreign

qualifications. The short term movement of medical specialists for individual treatments could be promoted by developing a framework for malpractice insurance of out-of-jurisdiction medical personnel.

- *Improving the quality of health services and medical training.* The transfer of medical knowledge could be advanced by encouraging exchanges of hospital staff within the ASEAN region. Skills transfers could also be promoted by region-wide training initiatives and the harmonization of course curricula, especially for new medical technologies. In the long term, cooperation on training could also contribute to increased mobility of medical personnel in the region. Finally, regulators could exchange best practices in developing and enforcing medical service standards, which could be of particular benefit to the poorer ASEAN countries.

Several of the proposed regulatory initiatives would require the direct involvement of the private sector and medical associations. The role of ASEAN governments in these cases would be to provide the forum and set the direction for cooperation among those entities. Developing regional frameworks for regulatory cooperation could help promote feasible cooperation at the bilateral level and ensure such cooperation could in the longer term be extended to other ASEAN members.

As part of ASEAN's effort to advance integration in the so-called priority sectors, the Government of Singapore has developed a Roadmap to advance the region-wide integration of the healthcare sector.⁴ This Roadmap was adopted by ASEAN Trade Ministers in November 2004 and incorporates many of the recommendations outlined above. Interestingly, the one area that has received relatively little attention in the Roadmap is the promotion of health tourism exports. In particular, while the streamlining of visa requirements for foreign patients is recognized, no measures are proposed to promote the portability of health insurance.

As a final note, for at least some countries in the region there are likely to be large pay-offs from pursuing such cooperation with countries outside the region. As described earlier in this paper, health services and healthcare workers are exported in large quantities to the United States, the United Kingdom, Japan, and countries in the Middle East.

V. Concluding remarks

ASEAN governments have set themselves the goal to progressively liberalize trade in health services in the region. From an economic perspective, opening healthcare markets promises substantial economic gains. Yet it may also intensify existing challenges in promoting equitable access to healthcare. In a way, trade may raise the stakes of domestic policy reforms. It may

⁴ The sectoral initiative in healthcare is not limited to the integration of service markets, but also encompasses the promotion of trade in healthcare goods (for example, medical equipment, pharmaceutical products) as well as cooperation on questions of technical standards, intellectual property protection.

help focus policymakers' minds and create new opportunities for improving affordable access. But it may also lead to outcomes from which only the better-off will benefit.

Pursuing integration regionally, rather than through unilateral liberalization, holds certain advantages for ASEAN countries. Each one has something to gain—whether the prospect of greater exports or the promise of regulatory capacity building. Still, delivering on the recently adopted ASEAN Roadmap on Healthcare will be no small feat. ASEAN's past experience in promoting deeper integration points to the difficulties posed by differences in regulatory regimes and levels of economic development. And for at least some countries in the region there are likely to be large pay-offs from pursuing deeper integration with countries outside the region.

Economic research on the effects of liberalizing trade in health services is still in its infancy. In particular, more studies are needed which empirically assess the impact of trade reforms on key healthcare performance indicators. Such research would improve policymakers' understanding on what works in which circumstances and could thereby contribute to improving the design of trade reforms.

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