Indonesian Journal of International Law

Volume 10 | Number 1 Article 7

10-31-2012

DIMENSIONS OF ASEAN COOPERATION IN HEALTH DEVELOPMENT OF SOUTHEAST ASIA

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Dimensions of ASEAN Cooperation in Health Development of Southeast Asia

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With respect to the conditions of the health sector of Southeast Asian countries, according to the WHO, Southeast Asia was a region accounting for nearly a third of maternal and child mortality globally. This region was also an epidemic area of the HIV/AIDS. Dengue Fever (DF) was also of concern to ASEAN health officials because the number of cases remained high. Through the Yogyakarta Declaration, signed on April 2002, Health Ministers of ASEAN countries declared HEALTHY ASEAN 2020. With this vision, ASEAN was about to make the Southeast Asian region as a center for health development in 2020 and to entirely ensure the creation of a physically and mentally healthy ASEAN community, living in harmony in an environment of safe Southeast Asia region.Today, 9 years after declared, an even distribution of health development in ASEAN region showed limited progress; instead, disparity was created. On the one hand, there were countries with highly dynamic level of health development; but, on the other hand, there were countries that were sluggish. On scrutiny, the problems were not overly different, the patterns of disease were also almost the same; but, why one country could be better in the handling compared to other Southeast Asian countries. In an effort to cultural binding and with respect to the economic growth gap among ASEAN member countries, the ASEAN Charter could be maximized as a bridge and inspiration to improve solidity and commitment to assist one another and to work together, not to be individualistic, but to be more open and mutually respectful and feel as part of the real ASEAN community (awareness on ASEAN).

Keywords: *ASEAN, cooperation, health, social and economic rights*

I. Introduction

With respect to the conditions of the health sector of Southeast Asian countries, according to the WHO,[1] Southeast Asia was a region accounting for nearly a third of maternal and child mortality globally. Maternal mortality rate in Southeast Asia remained relatively high. The WHO estimated that as many as 37 million births occurred in Southeast Asia every year, but the total maternal and newborn mortality in the region was estimated at 170 thousand to 1.3 million per year.

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[1] ANTARA, *Southeast Asia's Maternal Mortality Rate is the Highest in the World*, March 4, 2011.

This region was also an epidemic area of the HIV/AIDS. There were about 3.6 million people with HIV/AIDS and 260 thousand new cases each year. Thus, the region was considered highly vulnerable to transmission of HIV/AIDS infection and the second highest in the world.[2]

Dengue Fever (DF) was also of concern to ASEAN health officials because the number of cases remained high. Dengue Fever (DF) was one of infectious diseases remaining a serious threat to the ten member countries of the ASEAN.[3] The number of cases of dengue fever in Indonesia recorded the highest compared to other ASEAN countries. In 2009, it reached approximately 150 thousand cases. This figure was likely not to decline until 2010. Likewise, mortality rate from this disease did not changed significantly from 0.89 in 2009 to 0.87 in 2010. This meant that there were approximately 1,420 deaths from dengue in 2009 and about 1.317 for the next year.[4]

The high mortality rate from diseases in several countries in the region was due to the existing gaps of lower health care coverage,[5] limited health budget allocations and sub-optimal coordination and use of funds provided by donors.[6] The low allocation of state health budget compared to the percentage of private sector's capital involvement to the total health costs in some ASEAN member countries provided an indicator with a very pronounced effect of the creation of the health as an economic commodity rendering the cost of health luxurious and very expensive. As a result, health

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[2] Ibid.

[3] *Dengue fever case in Indonesia was the highest in ASEAN*, in http://health.kompas.com/read 2011/02/19/07163187/, accessed on October 3, 2011.

[4] *Indonesia the Champion of Dengue Fever in ASEAN*, in http://dinkeskotamobagu.blogspot.com/2011/03/, accessed on October 3, 2011.

[5] Indonesia ranked fifth of the number of TB patients in world with an estimated incidence of 430,000 new cases and 61,000 deaths per year. This was equivalent to a crash of one Boeing 737 every two days and killed all its passengers. This was a proof of the late provision of quality services for patients. See Adi Utarini, *Quality of Health Services in Indonesia, Responsive Regulation System*, Professorial Inauguration Speech at the Faculty of Medicine, Gadjah Mada University July 25, 2011.

[6] ANTARA, *Southeast Asia's Maternal Mortality Rate is the Highest in the World*, March 4, 2011.

services were difficult to access by the disadvantaged.[7]

In addition, there was still inequality in health insurance among ASEAN member countries. Participation coverage of Indonesia's population in compulsory social security programs of health sector was still low at around 15%. This figure was still lower than Vietnam with 55%, the Philippines 76%, Thailand 56%, and Taiwan 96%. The low participation coverage in health insurance programs led to inefficiencies in the delivery of health services.[8]

The low number of people obtaining health insurance indicated a need for an insurance system capable of covering all levels of the people. Both the high-income and no-income people should get the same insurances.[9]

Through the Yogyakarta Declaration, signed on April 2002, Health Ministers of ASEAN countries declared HEALTHY ASEAN 2020. With this vision, ASEAN was about to make the Southeast Asian region as a center for health development in 2020 and to entirely ensure the creation of a physically and mentally healthy ASEAN community, living in harmony in an environment of safe Southeast Asia region.

Today, 9 years after declared, an even distribution of health development in ASEAN region showed limited progress; instead, disparity was created. On the one hand, there were countries with highly dynamic level of health development; but, on the other hand, there were countries that were sluggish. On scrutiny, the problems were not overly different, the patterns of disease were also almost the same; but, why one country could be better in the handling

[7] Indonesian government's budget for health sector was only 5.1% with the percentage of private sector's capital to the total health costs of 64.1%, Myanmar 2.5% with the private capital of 80.6%, the Philippines 5.9% with the private capital of 56.3 %, Laos 6.2% with the private capital of 61.5%, and Vietnam 5.6% with the private capital of 72.2% (WHO Health Report, 2006). In terms of life expectancy, Indonesia was the lowest with 68 years compared to other ASEAN countries. The ratio of bed to the total population was also lower at 0.6 per 1,000. The causes of death in Indonesia proved to be the diseases that have actually been known the diagnosis and therapy, namely respiratory infections (15.15%) and tuberculosis (11.5%). Meanwhile, in the neighboring countries, the main causes of death were cancer or cardiovascular events, which were ones that were more difficult to cure.

[8] Wendy Hutahahean, in redaksi@wartaekonomi.com, accessed on October 4, 2011.

[9] *Indonesia still Lose to Vietnam in Health Insurance*, in http://www.kebijakankesehatanindonesia.net/?q-content/, accessed on October 4, 2011.

compared to other Southeast Asian countries.

Admittedly, there was indeed a difference and inequality in economic and wealth distribution that became one of the causes contributing to the increase in gap of health development among ASEAN member countries. However, the politically- and sociologically-linked Southeast Asia countries should be expected to mutually share and provide input one another in the search for solutions, especially if it was constructed in the framework of ASEAN cooperation and solidarity.

II. Basis of ASEAN Health Cooperation and Program Implementation

In 1997, in Kuala Lumpur, the countries in Southeast Asia who were members of the ASEAN regional organization committed to establish the ASEAN Community. In order to realize the aspiration, it was signed the *ASEAN Vision 2020*, which was a noble aspiration to develop ASEAN region as an integrated area within an open, peaceful, stable and prosperous community of Southeast Asian countries, united by ties of dynamic development partnership in a mutual caring society.

Those expectations were then confirmed again in 2003 at the 9th ASEAN Summit in Bali by approving the establishment of an ASEAN Community that was passed in the *ASEAN Concord II*.

The ASEAN community intensified after ASEAN Leaders, at the 12th ASEAN Summit in Cebu, Philippines on January 13, 2007, signed the "*Cebu Declaration on the Acceleration of the Establishment of an ASEAN Community by 2015*." At the summit, a commitment to realize the vision of ASEAN Community was accelerated from the year 2020 to 2015. The goal was to further deepen ASEAN integration in order to deal with the developments of international political constellation. The ASEAN was fully aware that it needed to adjust his perspective in order to be more open in dealing with internal and external issues.[10]

[10] Dian Triansyah Djani, *ASEAN at a Glance*, Directorate General of ASEAN Coop-

One of the issues internal to the ASEAN region was the strategic one of achieving national health development goals and Millennium Development Goals (MDGs).

At the age of 41 the ASEAN has engraved many achievements for its member countries. Among the most important achievements and contributions of ASEAN was the establishment of peaceful and stable Southeast Asia. The central issue was how about the health development.

During the four decades of its existence, ASEAN as a regional organization has undergone many changes as well as significant and positive developments leading to its maturation. ASEAN Cooperation toward the stage is now a new, more integrative and forward-looking vision to realize the ASEAN Community in 2015.

The ASEAN Community was built over three pillars of ASEAN Security Community (ASC), ASEAN Economic Community (AEC) and ASEAN Socio-Cultural Community (ASCC).

At the 10th ASEAN Summit in Vientiane, Laos, in 2004 the concept of an ASEAN Community progressed with the approval of the three Plans of Action (PoA) for the respective pillars, which were long-term programs for realizing the concept of an ASEAN Community. The 10th ASEAN Summit also integrated those three Plans of Action for the ASEAN Community into the Vientiane Action Program (VAP) as the basis for short-to-medium–term programs for the period 2004-2010.[11]

ASEAN's cooperation and action programs grew steadily due to the hard work of the Eminent Persons Group and then followed by the High-Level Task Force that sought to realize the ASEAN Community to be able to have its own constitution. This effort finally succeeded in giving birth the draft of ASEAN Charter which was then, at the 13th ASEAN Summit in Singapore in 2007, produced the ASEAN Charter that altered it from a loose association to be a rule-based organization and having a legal personality.

Currently, ASEAN cooperation was more responsive, progressive, integrative and forward-looking. Therefore, ASEAN

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eration, Jakarta, 2008, *p.* 9.

[11] Dian Triansyah Djani, Op cit, *p.* 9.

countries recognized the need for increased solidarity, cohesiveness and effectiveness of cooperation. Cooperative activities in ASEAN were not merely focused on cooperation to bring peace and stability of regional security but also supported by other cooperation in the economic and socio-cultural sectors. For example, the cooperation was focused on alleviating poverty and narrowing the development gap in ASEAN region through mutual help and cooperation as stated by the sixth goal of the ASEAN Charter.

The Blueprint for the ASEAN Economic Community (AEC Blueprint) that would be used as the roadmap was expected to transform ASEAN into a single market and production base, which was competitive and integrated with the global economy. Through AEC Blueprint ASEAN region was expected to become the more stable, prosperous and highly competitive, allowing free traffic of goods, services, investments and capital flows. In addition, it would be pursued an equality of economic development as well as alleviation of poverty and socio-economic disparities by 2015.

Establishment of the ASEAN Free Trade Area (AFTA) has provided implications of reduction and elimination of tariffs, removal of non-tariff barriers, and the improvement of trade-facilitating policies.

In the process, the AFTA was not merely focused on liberalizing trade of goods, but also of services and investments. Of the twelve priority sectors in the vision of realizing the ASEAN Economic Community (MEA 2015), there were four service sectors that since 1995 were gradually liberalized and targeted to achieve full liberalization in 2010; they were tourism, health, aviation services, and e-ASEAN.

Negotiation on liberalization of health service sector was conducted through alleviating barriers in the context of the four mode of service supply from service providers to service users. Those four modes of services supply were (i) provision of remote health services, (ii) health tourism, (iii) presence of foreign service domestically, and (iv) export of medical personnel.

According to the Trade Minister of Republic of Indonesia Mari Elka Pangestu the health sector was increasingly prepared to face ASEAN

single market. Currently, there were standards in the health sector commonly understood by ASEAN countries, namely the professional standards of dental assistants and nurses. The compatibility of standards enabled Indonesian physicians or nurses to practice in other ASEAN countries, and vice versa. In addition, standards of cosmetic products have also been agreed. With the compatible standard cosmetic products could move freely among ASEAN countries.

Harmonization of standards of nursing care, competence, educational curricula, and training as well as developing nurses' capacity in providing nursing care towards a global standard has been signed through the ASEAN Mutual Recognition Arrangement on Nursing Services in December 2006. Currently, it has been carried out gradually.[12]

For traditional medicines and health supplements, ASEAN member countries actually have devised a roadmap for the integration of that sector. However, the implementation was delayed due to the lack of supporting scientific data. Finalization of the ASEAN Model for Traditional Medicine and Health Supplement (TMHS) was expected to be completed on December 31, 2010 with Indonesia as chairman of the project.[13]

By the time Indonesia was entrusted to be chairman of ASEAN's health sector in 2011, the Ministry of Health had 3 (three) main agendas: official launch of the ASEAN dengue day, the third conference on traditional medicine and the 19th meeting of ASEAN Task Force on AIDS (ATFOA).

Those activities were motivated by several concerns.[14] The first was ASEAN Health Ministers' concerns that dengue has affected millions of people around the world and Southeast Asia region was most seriously affected.

ASEAN Health Ministers also recognized that increasing public awareness was one of the main strategies to reduce the risk of dengue

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[12] *Readiness of Indonesian Nurses in Facing Globalization of Health Sector in ASEAN*, in www.depkes.go.id, accessed on October 4, 2011.

[13] Wendy S. Hutahaean and Jati Andrianto, *Welcome ASEAN Countries*, in redaksi@wartaekonomi.com, accessed on October 4, 2011.

[14] "*ASEAN Community in a Global Community of Nations*" Bakohumas Meeting, May 26, 2011 at Hotel Bidakara.

transmission. Therefore, they supported the ASEAN Dengue Day as an annual advocacy campaign for the prevention and control of dengue fever in ASEAN region and nationally.

For that purpose, ASEAN Health Ministers were committed to supporting and promoting the official launch of ASEAN Dengue Day. This campaign was executed on June 15, 2011 and would be commemorated annually. The resulting output was the Jakarta Call for Action on Combating Dengue that was a document of dengue control advocacy by all ASEAN member countries and the Jakarta Recommendations for Management of Dengue Fever in Indonesia.

The second activity was the 3rd ASEAN traditional medicine conference with the theme "The utilization of evidence-based traditional medicine in the health care facilities." The conference produced *Tawangmangu statement of achievements* and identification of areas of cooperation.

The final activity was the 19th Meeting of ASEAN Task Force on AIDS (ATFOA). The theme was HIV among migrants & improved access to affordable ARVs, OI drugs, and diagnostics. Participants who would attend were ASEAN member countries (the focal point of ATFOA), ASEAN Secretariat, ASEAN partners, Ministries of Health, and Indonesian experts.

In the field of research, the ASEAN Science and Technology Commission had six flagship programs. ASEAN Committee on Science and Technology (ASEAN COST) has formulated six flagship programs of ASEAN Plan of Action in Science and Technology (APAST) containing plans of action in the field of science and technology cooperation among ASEAN countries. One of the flagship programs in question was in health sector that was led by Singapore.

III.Impacts of the Gap in Economic Growth on Health Development

ASEAN countries had a lot of comparative advantages as modalities of economic development. Southeast Asia was so abundant of natural

resources that it became fertile grounds for foreign investments. In addition, a large population of 580 million people could be relied upon as a huge potential market for the producing countries, not to mention their relatively high purchasing powers with GDP of Rp 1.1 trillion.[15] Furthermore, the region was a strategic location. The Malacca Strait proved it. Advantageous geographical conditions made the Malacca Strait the most crowded route in the world. Twenty percent of the total value of world trade used this route. There were 50,000 tankers passing the route annually to meet the global oil supplies.[16] The strait was a shipping lane for crude oils shipped from the Middle East to Japan for industrial fuels. Thus, for the sake of Japan's trade alone, 80% of Japan's energy supply was transported through the route. This was not inclusive of cargo ships loading commodities for shipments to Japan and the world.[17] Malaccan Strait was so vital that it was considered very important for economic security of Japan and internationally.

Advantages possessed by ASEAN countries made ASEAN an important priority of foreign policy for countries of the world. ASEAN was expected to become Single Market and Single Production Base. Therefore, ASEAN has now become economic partners in international trade and investment cooperation. Currently, ASEAN has developed an active and intensive cooperation with Dialogue Partner Countries. ASEAN not only had 10 dialogue partner countries (Australia, New Zealand, the United States, Canada, European Union, India, China, Japan, Republic of Korea, Russia), but also had cooperation frameworks of ASEAN East Asia Summit (EAS) and ASEAN Plus Three (APT) as well as Sectoral Dialogue Partners. Partnership of ASEAN and Dialogue Partner countries was reflected through cooperative programs focused

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[15] Djafar Zainuddin, *the ASEAN Charter, Legality of the New Milestones Towards Regional Integrity*, in Indonesia Journal of International Law, Institute for International Legal Studies, Law Faculty of University of Indonesia, Vol. 6 No. January 2, 2009, *p.* 208.

[16] Syamsul Hadi, *Japan and Some Issues in International Relations in the Asia Pacific region*, in the Nihon Shakai Bunka Kenyu, Centre for Japanese Studies, National University, Vol. 1 No. May 1, 2008, *p.* 43.

[17] Syamsul Hadi, *Japan's checkbook diplomacy in relations with ASEAN: Relevance and Challenges for Indonesia*, Indonesia Journal of International Law, Research Institute for International Law, Law Faculty of University of Indonesia, Vol. 6 No.2, January 2009, *p.* 227.

on strengthening the ASEAN Community by 2015.[18]

However, the success of ASEAN in realizing economic development has not been able to distribute income and employment equally. There is country that listen carefully in catching business opportunity because supported by technology domination and human resource that professional but on the other hand there is slowgoing country in studying technology and human resource insuffiency with quality, not to mention made bussy with internal problems home affairs that enough cleanse energy and financial, like corruption, political condition and unstable security and also high cost economy.

Range from to economy Difference ASEAN country is caused also because state majority ASEAN still relied on exporting performance pass by products raw materials, and although move in same framework area economy, competition continues happened range from to state ASEAN community. Products with quality high ASEAN country not has the character of complementary, until degrade commerce potency intra area, commerce percentage intra-ASEAN still smaller compared to extra-trade ASEAN. [19] Economic disparities among ASEAN countries gave birth to problems internal to the organization.

Consequence of various of factors above then ASEAN countries can for become 4 state groups base progress sequence that is:[20]

1. Brunei Darussalam and Singapore
2. Malaysia and Thailand
3. Indonesia, Vietnam and the Philippines
4. Laos, Myanmar and Cambodia

Indonesia was on the same level with the Philippines and Vietnam categorized as countries with improved conditions but did not progress as fast as Thailand and Malaysia. Therefore, the biggest challenge for ASEAN was to minimize the gaps among its members.

It takes a teamwork and solid commitment from all the members.

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[18] *Implementation of the ASEAN Charter*, in http://www.muslimah.web.id/implementasi-piagam-asean, accessed on October 4, 2011.

[19] Zainuddin Djafar, *Rethinking the Indonesia Crisis*, Reader Jaya, Jakarta, 2006, *p.* 37-63.

[20] Endang L. Achadi, Talkshow on *the Launching of The Lancet special ASEAN Health Edition*, at Hotel Bidakara, Wednesday, June 22, 2011.

Economically strong countries were expected to assist the weaker ones. However, according to Zanudin Djafar,[21] ASEAN has not been capable of dealing with the shortfall or assisting the economy of the 'weak' countries as with the EU. Furthermore, toward the end of 2007, the strong ASEAN member countries were getting stronger, and those of weaker ones were 'stagnant.'

The gap in economic growth among ASEAN member countries had a significant impact on the creation of health development gap among them. It was directly proportional to health care disparities and uneven distribution of physicians, especially specialists; it represented difficult obstacles to overcome by relatively weak countries in the region.

Therefore, there were several ASEAN member countries that were deemed to be delayed in achieving the Millennium Development Goals (MDGs). The condition was visible from the high maternal mortality, the low quality of sanitation and clean water, an increasingly uncontrolled rate of HIV/AIDS transmission, and the rising foreign debt burdens. Clearly, these sectors had an impact on the quality of human life.

The ranking of Indonesia itself was increasingly declining in the Human Development Growth Index of 2010. According to the Progress Report in Asia & the Pacific published by the UNESCAP,[22] in 2006 Indonesia ranked 107; in 2008 it ranked 109 and in 2009 up to 2010 it still ranked 111 or a difference of 9 ranking with the Palestinians (West Bank & Gaza Strip) at 101.

The number of physicians in Indonesia was far from ideal. According to Indonesia Physician Association (IDI),[23] in 2005 the number of new physicians in Indonesia reached 46,926 people, while the number of hospitals was 1,300 units. Meanwhile, the number of specialists was 14,261, including 1,580 internists, 1,882 pediatricians, and 1,608 gynecologists and obstetricians.

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[21] Zainuddin Djafar, *Indonesia, ASEAN & the Dynamics of East Asia*, Pustaka Jaya Jakarta, 2008, *p.* 37-63.

[22] *Indonesian Still Lagged in Some MDG Sectors*, in http://dinkesbanggai.wordpress.com, accessed on October 4, 2011.

[23] *Applying Referral System, Foreign Physician would be Competitors*, in http://www.idijakbar.com/ February 4, 2008, accessed on February 12, 2011.

From 2007 up to 2010 Indonesia still lacked health personnel since there were only approximately 26,000 general practitioners, 8,000 medical specialists, 14,000 dentists, 63,000 nurses, and 97,000 midwives.[24]

In addition, their distribution was uneven. The Indonesian Pediatric Association (IDAI)[25] indicated that the number of pediatricians in Jakarta in 2005 was 443 (5.29 per 100,000 population), while in Papua there was only 7 (0.32 per 100,000 population).

So far, the ratio of physicians in Indonesia was still one in 5000 citizens. Compared to Malaysia, it was one in 700 citizens so that patients could be served well there.

The health development gap among ASEAN countries impacted on the heightened public interest in the ASEAN countries seeking access to more quality and affordable health care in other ASEAN countries considered as having complete health facilities and infrastructures as well as well-established health development. This bias could be seen from the quite high public interest to seek treatment outside Indonesia. IDI Chairman declared[26] that the nearly 1 million Indonesians sought treatment abroad per year with the money spent abroad for the treatment reached Rp 20 trillion. This at least showed that there was still health development gap in the region.

It would be better for a moment to look at the portrait of health services in Thailand and Malaysia. For public health services, the Thai government implemented the "30-Baht Policy." This country was not much richer than Indonesia but it was able to make "pro-people" health policies. With the 30-Baht Policy (equivalent to Rp 6,000), the government guaranteed the entire population to be able to obtain the required health care. Civil servants or private employees were guaranteed through a social security system, while

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[24] *Indonesia Lacks of Medical Personnel*, in http://www.bataviase.co.id/, December 8, 2010, accessed on February 12, 2011.

[25] *Prospects of Telemedicine in the 3G Era*, in http://www.id-id.connect.facebook.com, September 4, 2010, accessed on February 12, 2011.

[26] *Foreign vs. Local Physicians*, in http://umum.kompasiana.com, May 27, 2009, accessed on February 12, 2011.

the informal sectors only paid 30 baht for a single treatment or hospitalization. Although a resident had to be signed in ICU one week, he or she only paid 30 baht (in Indonesia, the patient had to pay Rp 10 million or so). It included physician services, lab fees, x-rays, surgery, or medication.[27]

In Malaysia the system was slightly different. Physicians practicing at state hospitals worked full-time and must not practice privately, both at the same hospital and private hospitals. Hence, physicians were always available at all times. The entire cost of hospitals and physician salaries was financed by the budget of Malaysian Ministry of Health. Although not too great, a physician there got decent salaries, enough to meet daily needs and pay house and car installments.[28]

Each patient requiring treatment in Malaysian state hospitals only paid RM 3 per day (equivalent to Rp 6,500). The rate to be paid by the patient did not depend on the type of services received since it was inclusive of all the cost of care in the ICU, surgery, or drugs. The service quality could be considered good, not markedly different from the services provided by private hospitals there. Meanwhile, in Malaysian private hospitals there was a fee-for-service rate for each type of service. Patients of private hospitals were also not to be disappointed because the physicians were practicing at other hospitals or the charges were prohibitive. Physicians in private hospitals also worked full-time so that they were always available to patients in need. The Malaysian Physician Association along with the Malaysian Ministry of Health have made a list of the maximum rate. Thus, private physicians and hospitals could not arbitrarily set the rates. There was no difference in physician services between VIP class and the third class as with Indonesia. The cost of cardiac surgery in Malaysia was much lower than in Indonesia both in state and private hospitals since there was a rate cap. The cost of cardiac surgery in Kuala Lumpur was about Rp 40-50 million (an average of RM 22,000), whereas in other hospitals was about Rp 60 million In Jakarta, a cardiac surgery cost Rp 150 million. However,

[27] *Different Strategies of Thailand and Malaysia*, Economic News magazine No. 17, the 21st year.
[28] *Ibid.*

Malaysian citizens requiring cardiac surgery at the hospitals there only paid RM 10 for a single day care. This was an example of a healthy system of hospital care for the people.[29]

According to PriceWaterhouse Coopers' survey, Indonesia spent U.S. $ 19.1 per capita per year for health care or about 1.7% of the gross domestic product (GDP). Just compare it with Malaysia (U.S. $ 97.3 or 2.4% of GDP), Thailand (U.S. $ 108.5 or 4.3% of GDP), Singapore (U.S. $ 667 or 3.5% of GDP), and Taiwan (U.S. $ 623.8 or 4.8% of GDP). Indonesia's GDP per capita was calculated at U.S. $ 1,080.[30]

Socio-economic gap among ASEAN countries still existed today. This was because in ASEAN region there was still an unlevel playing field capable of hindering realization of economic integration. Until that, according to Priatna that, vision playing field in ASEAN compromy must direct concerning aspects of economy life, which during the time looked into too eat time to alter someone chance. No doubt again that awaited from ASEAN progress is ability develops protect for its citizen in order to get good and cheap education, acceptable health facility, get job and production competent, and guaranteed human standing its.

IV. Conclusion

Momentum of Yogyakarta Declaration on HEALTHY ASEAN 2020, signed in April 2002 by ASEAN Health Ministers with the vision of making the Southeast Asian region as a center for health development in 2020 and totally ensuring the creation of a physically and mentally healthy ASEAN community living in harmony in the safe Southeast Asia environment, was a milestone that remained to be tested.

Advancement of economic cooperation among ASEAN countries and with partner countries remained causing gap in distribution of income and employment, leading to disparity in health development.

Apart from a variety of challenges faced by the ASEAN countries, they should be able to realize an integrated region in a community of

29 *Ibid.*
30 *Ibid.*

Southeast Asian countries in dynamic partnership and development relations as mutual caring societies.

In doing so, ASEAN community needed to integrate in a holistic manner, especially in order to improve its cultural unity so that the sensitivity image of ASEAN identity could be strength and part of its identity to be able to serve as a regional problem solving.

In an effort to cultural binding and with respect to the economic growth gap among ASEAN member countries, the ASEAN Charter could be maximized as a bridge and inspiration to improve solidity and commitment to assist one another and to work together, not to be individualistic, but to be more open and mutually respectful and feel as part of the real ASEAN community (awareness on ASEAN).

Local government especially in border regions must can create excellent idea in employment relation equal to entangle all importance elementary bodies (stake holder) include society in both region so that can race growth of area economics or technological transfer and knowledge in education sector, health, culture, tourism and environment, for example in program sister city or sister province.

Finally of course required political will from all government of ASEAN member countries to share, each other opened, and each other learn from experience base difficulty, resistance and challenge and existing difference at each member state. Strong ASEAN Member state must haves help and will each other share to help weak member until difference of health development can be minimized. For that then, this condition must programmed well and must evaluated continually till created healthy and dynamic quality of ASEAN society life.

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