JMAJ

Japan Medical Association Journal

Special Feature:
The 29th CMAAO General Assembly and 50th Council Meeting
Manila, the Philippines, September 24-26, 2014

Conferences and Lectures

The 29th CMAAO General Assembly and 50th Council Meeting

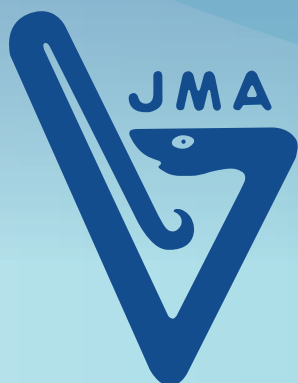Inaugural Address

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From the Editor's Desk

JAPAN MEDICAL ASSOCIATION

JMAJ

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The present issue of the JMAJ features the 29th Confederation of Medical Associations in Asia and Oceania (CMAAO) General Assembly and 50th Council Meeting held on September 24-26, 2014, in Manila, the Philippines, hosted by the Philippine Medical Association.

Of the 18 National Medical Associations (NMAs) of the CMAAO, 13 medical associations (Bangladesh, Hong Kong, India, Indonesia, Japan, Korea, Malaysia, Myanmar, Nepal, Philippines, Singapore, Taiwan, Thailand) took part in the meetings. The total number of participants in the General Assembly was about 70. Dr. Margaret Mungherera, President of the World Medical Association (WMA) and Dr. Robert Wah, President of the American Medical Association were invited as international guests.

At the 12th Taro Takemi Memorial Oration, Dr. Jaime C. Montoya, Professor V, Department of Medicine, University of the Philippines College of Medicine; Executive Director of the Philippine Council for Health Research and Development, gave a speech titled "Building a Regional Health Research and Innovation Network in ASEAN." In a symposium which followed the Takemi Oration, each NMA delivered a presentation under the theme of "Health Database in an Information Society." All of the participating NMAs gave their annual Country Report which followed the symposium.

At this General Assembly, there was no application for a new member to join the CMAAO.

New CMAAO President and Officers

Dr. Jose Asa Sabili (former President of the Philippine Medical Association) was installed as the 32nd President of CMAAO and received a Presidential medal from his predecessor, Dr. Vinay Aggarwal (former President of the Indian Medical Association). Dr. Rai Mra (President of the Myanmar Medical Association) was elected as President-Elect, and Dr. Prasert Sarnvivad (Medical Association of Thailand) was elected as the 1st Vice President. Dr. Dong Chun Shin (Korean Medical Association), Dr. Yeh Woei Chong (Singapore Medical Association) and Dr. Masami Ishii retained the posts of Chair, Vice-Chair of Council and Secretary General, respectively.

Officers, Councilors, Secretary General and Advisors of CMAAO (2014-2015/6)

President:
Jose Asa Sabili (Philippines)

President-Elect:
Rai Mra (Myanmar)

Immediate Past President:
Vinay Aggarwal (India)

1st Vice President:
Prasert Sarnvivad (Thailand)

2nd Vice President:
—   (—)

Chair of Council:
Dong Chun Shin (Korea)

Vice-Chair of Council:
Yeh Woei Chong (Singapore)

Treasurer:
Yee Shing Chan (Hong Kong)

Secretary General:
Masami Ishii (Japan)

Assistant Secretary General:
Hisashi Tsuruoka (Japan)

Councilors:
Steve Hambleton (Australia)
Mahmud Hasan (Bangladesh)
Saint Saly (Cambodia)
Yee Shing Chan (Hong Kong)
Vinay Aggarwal (India)
Ihsan Oetama (Indonesia)
Yoshitake Yokokura (Japan)
Dong Chun Shin (Korea)
Nai Chi Chan (Macau)
Krishna Kumar (Malaysia)
Rai Mra (Myanmar)
Anjani Kumar Jha (Nepal)
Mark Peterson (New Zealand)
Maria Minerva P. Calimag (Philippines)
Yng Yng Bertha Woon (Singapore)
—   (Sri Lanka)
Ching-Chuan Su (Taiwan)
Prasert Sarnvivad (Thailand)

Advisors:
Tai Joon Moon (Korea)
Yung Tung Wu (Taiwan)
Wonchat Subhachaturas (Thailand)
Shinichi Murata (Japan)

From right: Dr. Wah, Dr. Calimag, Dr. Chan, Dr. Mungherera, Dr. Sabili, Dr. Ishii, Dr. Aggarwal, and Dr. Shin

Program

DAY 1: Wednesday, September 24, 2014

11:00-	**Registration**
11:30-12:30	**Committee Meetings** (if necessary)
13:30-14:30	**Opening Ceremony and Inauguration of the new President of CMAAO**

      1. Opening   Dr. Dong Chun Shin

      2. Roll Call   Dr. Masami Ishii

      3. Welcome Remarks   Dr. Minerva P. Calimag

      4. Opening Address   Dr. Vinay Aggarwal

      5. Inspirational Messages   Dr. Margaret Mungherera

                                                   Dr. Robert Wah

      6. Installation of the 32nd President of CMAAO 2014-2015

      7. Inaugural Address by New President   Dr. Jose Asa Sabili

      8. Presidential Award to the Outgoing President   Dr. Vinay Aggarwal

      9. Group Photo

    10. Adjournment

14:30-15:00	Coffee Break
15:00-17:30	**Council Meeting chaired by Dr. Shin**

      1. Roll Call by Dr. Masami Ishii, Secretary General

      2. Opening Remarks

      3. Report of Secretary General

      4. Approval of Minutes of the 28th CMAAO General Assembly and 49th Council Meeting

      5. Report of the Treasurer by Dr. Alvin Chan, Treasurer

      6. Venue and Dates of the 30th CMAAO General Assembly and 51st Council Meeting

      7. Membership Application (if any)

      8. Report of the Committees (if any)

      9. Other Business

    10. Adjournment

19:00	**Welcome Reception hosted by the Philippine Medical Association**

DAY 2: Thursday, September 25, 2014

09:00-09:45	**The 12th Taro Takemi Memorial Oration: Chaired by JMA Officer**

Orator: Dr. Jaime C. Montoya

        Professor V, Department of Medicine, University of the Philippines College of Medicine

        Executive Director of the Philippine Council for Health Research and Development

      1. Introduction of Orator

      2. Memorial Oration titled "Building and Sustaining a Regional Network for Health Research and Innovation in South-East Asia"

      3. Presentation of Plaque to the Orator

      4. Adjournment

09:45 -10:00   Coffee Break

10:00-12:30   **Symposium: Health Database in an Information Society**
   10:00-10:20   **Keynote speech 1 by Dr. Margaret Mungerhera, President of WMA**
   10:20-10:40   **Keynote speech 2 by Dr. Robert Wah, President of AMA**
   10:40-12:30   **Presentations from the NMAs**

12:30-14:00   Lunch Break

14:00-14:45   **Panel Discussion on Health Database**

14:45-15:30   Coffee Break
               Develop a draft of the resolution committee on health database in an information society

15:30-17:30   **Country Report of the NMAs**

19:00   **Dinner hosted by the Philippine Medical Association**

DAY 3: Friday, September 26, 2014

09:00-12:00   **Plenary Session chaired by President**
   1. Approval of Minutes of the 28th CMAAO General Assembly held in New Delhi, India
   2. Report of the Council Meeting by Chair
   3. Approval of the Report of the Treasurer
   4. Approval of the Report of the Committees
   5. Discussion and adoption of the proposed CMAAO resolution on health database
   6. Appointment of the CMAAO Officers for 2014-2015
      6.1 President-elect . . . to be appointed by the host NMA in 2015
      6.2 Two Vice Presidents . . .1st Vice-President from the host NMA in 2016
                    2nd Vice-President, optional
   7. Venue and Dates of the 30th CMAAO General Assembly and 51st Council Meeting 2015
   8. Venue and Dates of the 31st CMAAO General Assembly and 52nd Council Meeting 2016
   9. Membership Applications (if any)
   10. Other Business: Theme of the symposium for the CMAAO General Assembly in 2015
   11. Closing Remarks
   12. Adjournment

12:00-13:00   Lunch Break

14:00-18:00   **City Tour hosted by the Philippine Medical Association**

19:00   **Farewell Dinner hosted by the Philippine Medical Association**

CMAAO

The Confederation of Medical Associations in Asia and Oceania

(Established since 1956)

Official Homepage   http://www.cmaao.org/

Current membership: 18 national medical associations

(As of December, 2014)

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Inaugural Address[*1]

It gives me immense pride to take the leadership of National Medical Associations of the CMAAO. It is a huge and challenging task to take the road of fulfilling the dreams of our past leaders to attain the highest possible practice of medicine in respective countries by sharing information and expertise.

CMAAO has become an integral part of the WMA. It has produced several WMA Presidents and served as venue of its General Assemblies and meetings. Though, faced with many challenges, CMAAO, through its Symposiums, has tackled several issues like health care insurance and reform system, infectious and social related diseases, traditional medicine, longevity, suicide prevention, child abuse, and health database and information technology. Through the Takemi Memorial Oration, the best speakers and themes from each country were presented and highlighted giving importance to topics which is attuned to prevailing situations. The Committee on Resolution, collated all the proposals and presented to the body. At the end of the discussions and deliberations during plenary session, resolutions were formulated pertaining to issues vital to existing conditions and problems within the region. The resolution serves as a guide for all NMA's on how to deal with the government and the medical practitioners in different countries.

CMAAO has played a tremendous role on the life of every medical practitioners in Asia and Oceania, realizing its mission and vision to promote cooperation and support in terms of knowledge, information technology, principle, cultural exchange and fellowship, and provide essential materials and moral support during calamities and disasters.

During my term, I will continue to promote camaraderie and professional partnership among physicians in member countries and to further strengthen linkages and collaboration within the National Medical Associations. There's a lot to be done and shared upon with regards to several areas of concerns like ethics and professionalism, physicians autonomy and patients privacy, emerging onset of new virus that affects the region, the different approach in private and public healthcare partnership and the prevalence of different communicable and non-communicable diseases. With our hands joined together, we can achieve our goals and purpose.

Allow me to thank our Secretary General, Dr. Masami Ishii and the leadership of the Japan Medical Association for efficiently hosting our Secretariat, Council Chair Prof. Dr. Dong Chun Shin, Treasurer Dr. Alvin Chan, my predecessor Dr. Vinay Aggarwal, Advisors Dr. Yung Tung Wu, Dr. Wonchat Subhachaturas, Dr. Tai Jai Moon, and Mr. Shinichi Murata for providing support on my leadership. Lastly, I would like to thank the leadership of the Philippine Medical Association through President Dr. Maria Minerva Calimag for giving me full trust and confidence, to my family, PMA staff and friends for the assistance and support.

Thank you very much and my warmest regards to everybody.

I love you all !

Jose Asa SABILI, M.D.
President, CMAAO, 2014-2015

Building and Sustaining a Regional Health Research and Innovation Network in Southeast Asia[*1]

Jaime C. MONTOYA[1]

The Association of Southeast Asian Nations (ASEAN) has a continuum of member nations at different stages of economic and health development, with the majority of the countries belonging to the middle- and low-income categories. While there are ASEAN member states that are more advanced in terms of health systems and programs, the majority still suffer from communicable and non-communicable diseases. With 8.6% of the share of the world's total population, the region contributes 27% of the global burden of infectious and parasitic diseases (WHO, 2007). There is clearly a link between economic capacity as reflected by GDP per capita and the status of health of the population across the ASEAN member states.

Based on national poverty lines, Cambodia, Lao PDR, Myanmar and the Philippines have more than 25% of their population living below the national poverty lines. On the other hand, Malaysia and Thailand had less than 10% of their populations living below national poverty lines in 2007 while in Viet Nam, the latest estimate in 2007 was 14.8%. Overall, all countries have showed consistent improvement in poverty reduction.

Infectious tropical diseases also continue to be a challenge to the health sector despite developments in health research and development (R&D) and medical technology. There is widespread concern about the emergence and reemergence of some infectious diseases such as tuberculosis, Severe Acute Respiratory Syndrome (SARS), avian influenza, and Chikungunya. These tropical infectious diseases form part of the neglected tropical diseases (NTDs) alluded to by international organizations. These diseases include infections that have shown low economic returns for investments in health products R&D. However, from a human capital perspective, these so-called NTDs not only place a significant burden on the health system, but they also adversely affect productivity and efficiency of human capital in their respective societies.

Budgetary limitations for health research also cause difficulty in pursuing R&D initiatives. With scarce resources for health research, efforts to pursue health research activities in many of the ASEAN nations are limited.

In terms of human resources, the ratio of R&D personnel to the population varies across the ASEAN nations with countries including Singapore, Malaysia, and Thailand having more R&D personnel than the rest of the ASEAN nations. The proportion of researchers to population is also much higher in the more developed nations in the ASEAN (e.g., Singapore and Malaysia) compared to those which are less economically developed. It is apparent that many of the ASEAN nations fall below the ratio of researchers to population recommended by the United Nations Educational, Scientific and Cultural Organization (UNESCO). This significantly reduces R&D productivity in the region.

Considering all of these public health challenges and hindrances to providing better quality of health in the ASEAN, activities towards the establishment of a regional health innovation network were initiated with the goal of enhancing product discovery and providing a sustain-
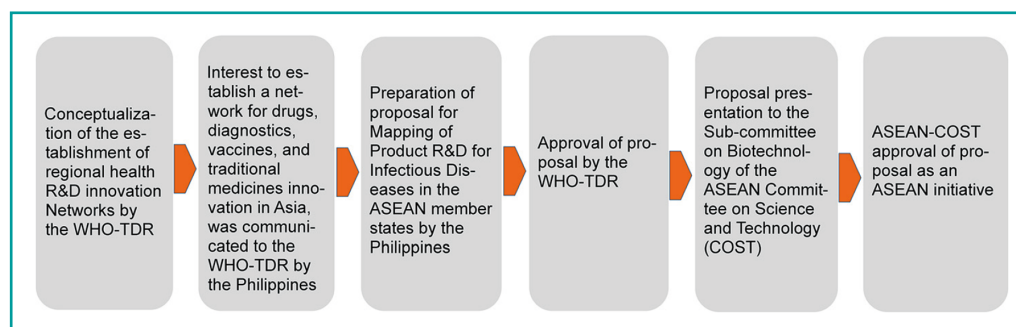
Fig. 1   First stage of the establishment of the ASEAN-NDI
Following the establishment of the ANDI, interest to establish a similar health R&D innovation network, the ASEAN-NDI, was communicated by the Philippines to the WHO-TDR through PCHRD-DOST. With funding support from the WHO-TDR, the activities of the Network were started, including the ASEAN health R&D landscape mapping.

able essential health R&D through intraregional collaboration—a framework suggested by the World Health Assembly (WHA) Resolution 61.21, Global Strategy and Plan of Action on Public Health, Innovation, and Intellectual Property (GSPA-PHI).

The ASEAN Network for Drugs, Diagnostics, Vaccines, and Traditional Medicines Innovation (ASEAN-NDI) was founded in 2009 in line with the objectives of the GSPA-PHI, which include promotion of R&D, development of North-South and South-South partnerships to support capacity building, and establishment of strategic research networks to facilitate better coordination of stakeholders. It was conceptualized to parallel the African Network for Drugs and Diagnostics Innovation (ANDI), a network championed by the World Health Organization Special Programme for Research and Training in Tropical Diseases (WHO-TDR), which started the idea of establishing regional innovation networks.

The ASEAN-NDI is a regional innovation network composed of the ASEAN member states, namely: Brunei Darussalam, Cambodia, Indonesia, Lao PDR, Malaysia, Myanmar, Philippines, Singapore, Thailand, and Vietnam. Its concept was proposed by the Philippines to the ASEAN and was first discussed among the ASEAN member states during the 40th Meeting of the ASEAN Sub-Committee on Biotechnology (SCB) in Bali, Indonesia on 25-26 May 2009, and was later adopted by the ASEAN Committee on Science and Technology (COST) as its own initiative. The ASEAN, through the COST, approved

the creation of the ASEAN-NDI in 2009. Start-up funds to support the establishment of the Network were provided by the WHO-TDR. The Philippine Council for Health Research and Development (PCHRD) of the Department of Science and Technology (DOST) served as the secretariat of the ASEAN-NDI, with Dr. Jaime C. Montoya as the overall coordinator (**Fig. 1**).

The ASEAN-NDI was established to ensure that health technology development and the capacity of member states are appropriately maximized and managed according to regional health needs. It aims to build a sustainable partnership among the ten ASEAN countries to rapidly build the needed human resource, technology, and financing for health development and security.

The enhancement of public R&D capacity to prioritize the public good elements of innovative policy tools and harness the private sector is one strategy most relevant to the 61st WHA framework. The aim was to build developing countries' leadership and capability in addressing major endemic health issues, as well as issues concerning access to health products by the poor. One of the critical elements of the framework was setting up R&D networks in disease endemic countries.

To lay the groundwork towards this initiative, the ASEAN SCB endorsed a mapping activity to be carried out in order to assess the product R&D landscape for the triple burden of disease in the region, including infectious tropical diseases, non-communicable diseases, and prevent-

Table 1   Number of articles and ranking of the ASEAN member States with biomedical articles, 2005-2009

Country	Number of biomedical articles	Rank	Number of articles on infectious diseases	Rank
Thailand	12,568	1	2,698	1
Singapore	12,405	2	578	2
Malaysia	7,071	3	509	3
Indonesia	1,324	4	335	4
Cambodia	318	6	204	5
Philippines	574	5	154	6
Laos	168	7	80	7
Myanmar	103	9	50	8
Brunei Darussalam	163	8	25	9
Vietnam	86	10	25	9

able diseases due to accidents and traumas.

"Mapping of Product R&D Landscape for Infectious Tropical Diseases in ASEAN Member States" was conceptualized with the aim of mapping out the capabilities of the ASEAN member countries on drugs, diagnostics, vaccines, and traditional medicine innovation on infectious tropical diseases; identifying gaps and opportunities in the ASEAN; creating a database of institutions, networks, and initiatives with capacities for innovation; and providing the template for the establishment of an ASEAN regional network for innovation in product R&D.

The planned mapping activity was further refined during the first organizational meeting held in Manila, Philippines on 21 October 2009. Attended by delegates from the ASEAN who were identified through the assistance of the SCB members and the ASEAN Secretariat, participants agreed to focus the mapping exercise on infectious diseases such as malaria, tuberculosis, schistosomiasis, dengue, leishmaniasis, lymphatic filariasis, and helminthiases, as well as on other diseases of public health importance.

The mapping activity was conducted from December 2009 to November 2010, through survey and key informant interviews among researchers and institutions, and a review of Elsevier's Scopus database. The mapping activity gathered records on institutional data of R&D institutions across the ASEAN region.

The exercise showed that there is keen interest among the ASEAN institutions in each country to pursue health R&D. While some countries such as Brunei Darussalam and Cambodia are still in their infancy, others such as Singapore, Malaysia, and Thailand are far advanced in R&D.

One measure for this is the number of biomedical and infectious disease articles that these three countries produced from 2005-2009 as compared to the other member states (**Table 1**).

The ASEAN region has substantial human resources and institutions that can support the pursuit of R&D on drugs, diagnostics, vaccines, and traditional medicine.

There are major institutions located in the different ASEAN nations that can be tapped for future collaboration. The ASEAN also has a number of institutions that have the capacity to produce drugs, diagnostics, vaccines, and traditional medicine.

One of the challenges that arises from the disparity across the ASEAN countries is that a number of countries work on the same disease and for the same product (i.e., drugs, vaccines, etc.), which results in duplication and wastes time and resources. This shows that although collaborating ventures may have limitations imposed by funding/sponsoring partners, the ASEAN member states need to explore and expand collaborative engagements with other ASEAN member states with the end goal of enhancing capacity in the region and minimizing duplication of efforts.

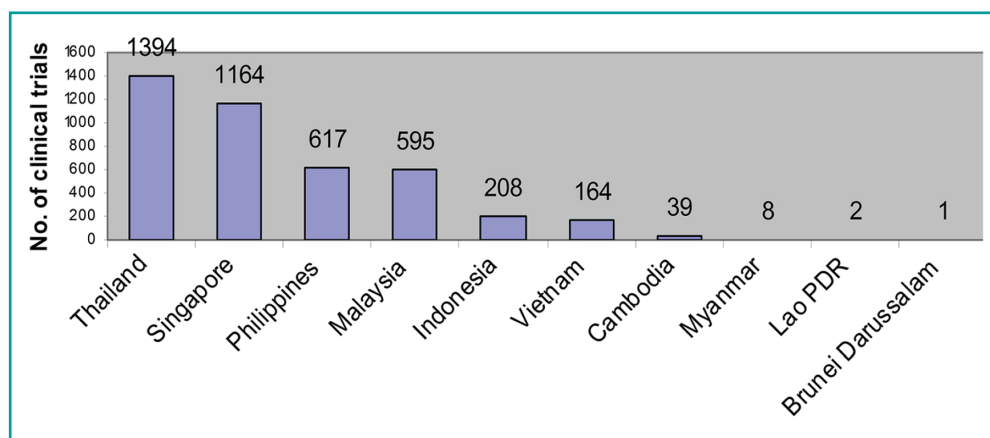Asia, including the ASEAN, is a major player

Fig. 2 Number of Clinical Trials conducted per country in Southeast Asia
Countries in the ASEAN region have been recently identified as an emerging potential in the field of clinical trials. In order to assess the focus of current clinical trials in the region, absolute numbers of clinical trials were obtained from the Clinicaltrials.gov database (as of July 2010). It was found that most clinical trials reported are focused on maladies and conditions such as neoplasms and cancers.

in the future of pharmaceuticals. The recent slow-down in major Western countries has led to the outsourcing of developmental work in developing countries including the ASEAN (**Fig. 2**). The growing presence of clinical research organizations in the region and the increasing number of clinical trials being conducted are testimonies to the presence of capable human resources and growing importance of the region in the future of the pharmaceutical industry.

The disparity across the ASEAN member states indicates some gaps that need to be addressed. There is a problem of reduced coordination among clusters of researchers and innovators. There is also a problem of infrastructure and resources in some countries, which can be addressed by implementing working arrangements among the ASEAN member states, and by sharing resources and expertise. Concerns such as funding and logistics support, and ethical considerations need to be addressed by their respective countries and by the ASEAN as a whole. Intellectual property concerns, which may arise from collaborative ventures, are issues that need to be laid down and agreed upon at the onset.

The extensive collaboration among the ASEAN member states and with other major research centers in the world indicates that the ASEAN countries have the capacity to pursue collaborative R&D activities on health products development (**Figs. 3 and 4**). These are illustrated by collaborations in the area of diagnostics and the area of vaccines development.

The ASEAN has been used in several free trade agreements and harmonization initiatives. Hence, embarking on an ASEAN initiative that will strengthen the scientific ties to address neglected diseases will not be difficult. The ASEAN member states can facilitate the exchange of expertise, resources, and health products as they have been working in other initiatives to improve the region. Under the ASEAN umbrella where harmonization and collaboration are the key elements, these arrangements can be easily addressed.

The results of the mapping were presented and discussed during the second organizational meeting held in Manila, Philippines on 6 December 2010. A website, www.asean-ndi.org, was created to serve as a repository of the mapping exercise-related information.

The conclusions from the mapping activity triggered the call for the preparation of a Strategic Business Plan (SBP) and the creation of a Task Force (TF) that will serve as an ad hoc group who will guide the development of the plan. The SBP will:
· Assess and recommend how ASEAN member states can come together to establish a center
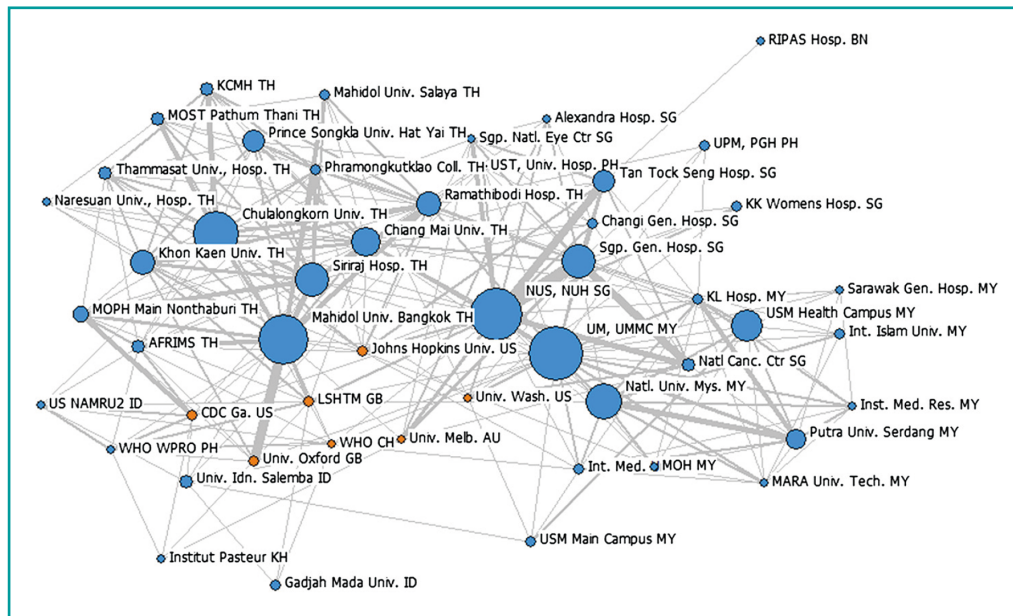
Fig. 3 Networks for diagnostics research collaborations among the top 50 most productive institutions (within and outside the ASEAN) based on articles on diagnostics

Size of the nodes indicates relative number of articles. Thicker links indicate more instances of collaboration between the two institutions. Blue nodes are institutions in the ASEAN, while orange nodes represent institutions outside the ASEAN. Thai, Singaporean, and Malaysian universities and research centers have most of the collaborations on publications on diagnostics compared with the other ASEAN countries. Most of the collaborations are with the ASEAN member states but there are some collaborations with research centers in the United States, Great Britain, Australia, and Switzerland.

for drugs, diagnostics, vaccines, and traditional medicine innovation to address public health threats in ASEAN.

· Provide plans for an inter-governmental, collaborative response to the lack of access of poor countries and people to health products.

· Create public research and development (R&D) capacity while harnessing the strengths and potential contributions (technical and financial) of the stakeholders including the private sector.

On 20 October 2011, the first ASEAN-NDI Task Force meeting was held in Manila, Philippines where the initial outline of the draft SBP and timelines were discussed.

The ASEAN-NDI is envisioned to become Asia's premier facilitator for collaborative innovation in R&D for health products, benefiting primarily the ASEAN but more open to global markets. As a network involving the ten ASEAN member countries, the ASEAN-NDI will build the needed human resources, technological capacity, and financing to ensure sustainable

health, development, and security. These inputs will be translated into research and eventually into the production of innovative health products and services that will be made available within and even outside the ASEAN.

The R&D and delivery value chain structure that underlines the ASEAN-NDI's business model is spelled out in the aggregate—specifically for the core partners in R&D, multilateral partners, and donors, which the ASEAN-NDI shall tap for research in priority diseases. The stress on the entire value chain will result to R&D being viewed from a perspective beyond bricks and mortars, management issues, and knowledge and information systems.

The ASEAN-NDI value chain is patterned from Michael Porter's business management concept, which defines the chain of activities that result in the production of the desired delivered final products/services. This concept was likewise reflected in the ANDI business plan where there is a value chain scoped for core diseases,
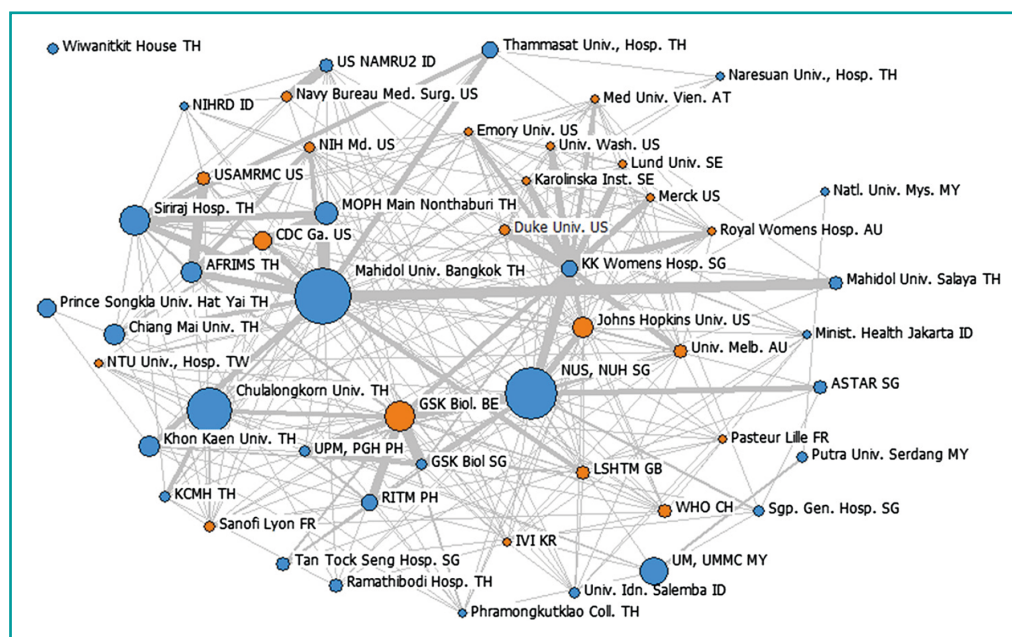
Fig. 4 Network for vaccine research collaborations among the top 50 most productive institutions (within and outside the ASEAN) based on articles on vaccines

Thai, Malaysian, and Singapore-based research centers dominate the scene with their networks in vaccine development. The collaborations are not only within the ASEAN but also with other countries such as the USA, Australia, Belgium, Austria, France, South Korea, Taiwan, Sweden, and Switzerland. GSK Belgium was a dominant collaborating partner in the ASEAN with respect to vaccine-related articles.

traditional medicine, and immediate druggable compounds.

The major activities of the R&D and delivery value chain include: (1) basic research, (2) assay/model development, (3) compound/candidate screening, (4) lead generation/optimization, (5) pre-clinical trials, (6) clinical trials, and (7) manufacturing and delivery/access. It is regional and even global in extent, involving private enterprises, public sector institutions and governments, non-profit organizations, and donor agencies, which may have done related work on the priority disease areas in the past, and may be willing to collaborate.

The governance structure comprise a policy-making and strategic direction setting by a 14-person Governing Council and a four-person Executive Committee. The ASEAN-NDI is designed to operate in a hub-and-spokes model, in contrast to the hierarchical models where initiatives emanate only from the top. The National Coordinators relate to their respective country R&D hubs independent of the system

of other members, but relate to the overall ASEAN-NDI network hub in the Philippines.

Innovation Communities (IC) will also be established. The most important outcome of the ICs will be the coordinated and cooperative strategy that the stakeholders develop through the sharing of best practices, and R&D knowledge to meet the common challenge at hand.

Details regarding the SBP were presented during the First ASEAN-NDI Stakeholders Meeting in Manila on 5 June 2013. Future plans for the ASEAN-NDI, including the proposed collaborative activities, were also discussed, taking advantage of the presence of representatives from the WHO, and the Africa and China NDIs. These activities include holding joint regional consultations on the development of demonstration projects, collaborating in setting up a global health R&D observatory, and forming a wider network composed of the regional innovation networks.

One innovative technology that has revolutionized the healthcare sector in the region is

ICT. The advantages of using ICT in health are very much apparent and clear in developing various reforms to answer the unique challenges that the ASEAN region will be facing. It is paramount that the region harness this technology in order to further the gains of an innovation network such as ASEAN-NDI.

At this juncture, I would like to share with you the Philippine experience on how we are exploiting ICT in developing products and services that will improve health care delivery in the country.

The Philippine eHealth Strategic Framework and Plan recognizes two pervasive challenges that remain to be the major stumbling blocks in the delivery of quality health care in the Philippines, namely;

At the moment, close to 60% of tertiary hospitals are located in urban areas and that 87% of health professionals are found in urban areas. However, because 70% of Filipinos live in rural areas, access to health professionals and quality health facilities is very limited.

With regards to decision making, our policy makers have difficulty creating relevant and timely policies because they do not have access to the most relevant and newest health information. Currently, consolidation of health data in the Philippines can sometimes take 2 years. This puts a dent in the decision-making process because of delay in the availability of much needed health statistics.

These challenges led the national government to push for initiatives to utilize ICT for health. The Philippines first attempted to utilize ICT for health in the year 1987 with the development of Field Health Services and Information System or FHSIS of the country's Department of Health (DOH), which was a database for barangay health centers and rural health units. At the time, the infrastructure to properly utilize ICT for health was still immature and that majority of Filipinos have no to very limited access to a computer.

In 1998, with the objectives to develop information resources in the form of specialty databases, electronic journals, health advisory, and directories; while at the same time, provide a forum for online discussions on health concerns of Filipinos, the Philippine Council for Health Research and Development of the Department of Science and Technology (PCHRD-DOST)

launched the electronic Health Information Village or eHealth Village.

Following the eHealth Village, PCHRD spearheaded the development databases and Internet resources on surgery, biomedical devices, tuberculosis, reproductive health, medicinal plants, managed health care, and malaria in the country. This initiatives, later on became the foundation of our presently ongoing work of HERDIN (Health Research Development Information Network), a comprehensive national database on health researches.

PCHRD developed databases for various health research initiatives such as the Health Research and Development Information Network or HERDIN database which serves as the national repository of health researches in the Philippines with more than 50,000 citations and bibliographic information, to date and the Philippine Health Research Registry or PHRR which is a publicly available database of ongoing health and health-related researches from 2011 onwards. Both of these registries will be replicated as regional registries to capture the depth and breadth of research in ASEAN region, as well.

In cooperation with other agencies, PCHRD-DOST also supported efforts to develop more databases such as the ASEAN-NDI and the Philippine Traditional Knowledge Digital Library —Health or TKDL which provides information on traditional knowledge in health including ethnobotanical studies, traditional healing practices and rituals as well as current researches being conducted in selected ethnolinguistic groups in the Philippines.

The region, through a recent meeting of experts and researchers on traditional medicine have also identified the need for a similar regional database for ASEAN which will document the traditional medicine knowledge in the different ethnic communities and serve as a basis for local and international research collaboration for the development of potential drug candidates.

The PCHRD is also very active in pursuing the national government's initiative to transform the health care delivery system in the Philippines through the eHealth program.

The PCHRD is at forefront of the country's initiative to adopt ICT as a strategic tool to help address the challenges and demands of

making health care services more efficient and effective in order to ensure equitable access to quality health services for every Filipino, primarily through the Philippine Health Information Exchange.

Staying true to the concepts of ICT of connecting people, PCHRD hopes to reinforce our "connection" with stakeholders, especially the Philippine Medical Association and all the doctors in the country, to make our dreams come true. This will be facilitated also by the development of key databases such as patients, health care providers and health facility registries.

It is this same convergent strategy that we hope to replicate in Southeast Asia through the ASEAN-NDI in order to facilitate the research gains in the health sector that will redound to better quality of life for all the people of ASEAN.

The global contribution of the ASEAN-NDI will be significant. The ASEAN-NDI will improve health R&D by driving innovation through collaboration not only among the ASEAN member states but with other networks and health R&D institutions. Engagement of non-ASEAN stakeholders is also vital considering that infectious diseases and NTDs are emerging in European countries and other Western states.

In a recent study by Hotez and Papageorgiou (2013), it was deduced that one way to address NTDs and infections of poverty is to establish a center for fundamental and translational research in which product development activities including R&D on drugs, diagnostics, and vaccines are conducted. This is the main thrust of the ASEAN-NDI, and with many countries sharing the same health challenges, the Network may be the link to providing solutions not only in the ASEAN but in other regions as well.

The ASEAN-NDI will coordinate research by partnering with research networks, developing capacity-building initiatives, supporting R&D infrastructural improvement, advocating for more research investment, and enhancing regional access to health products.

ASEAN-NDI will start by enhancing collaboration among the ASEAN member states to address the specific health needs of the ASEAN, but collaboration with other countries will soon follow. This is consistent with the GSPA-PHI goal of making a network of networks wherein the ASEAN-NDI can partner up with other NDIs (ANDI, China-NDI, India-NDI, etc.) that have been established and form the nucleus for South-South collaboration.

With a number of NTDs and vector-borne diseases which affect both the African and Asian regions, network collaboration will be helpful in developing and conducting R&D projects which result in programs and policies which address such public health threats. Likewise, with their expertise in traditional medicine development, the India and China NDIs can also help the ASEAN-NDI form its strategies in advancing the ASEAN's own traditional medicine.

Through regional network collaboration, global health problems will be addressed by properly channeling resources and partnering on projects according to collective needs. This will capacitate the different regions to contribute to the advancement of global health R&D while providing solutions for their own health challenges.

To close my talk on the establishment of an ASEAN innovation network, let me quote India's first Prime Minister, Jawaharlal Nehru, a true visionary, who said that: "I see no way out of our vicious cycle of poverty except through the means that science and technology has placed at our disposal." Adding further that "…because we are poor, we cannot afford not to do research."

Very much like how Dr. Takemi envisioned to use his knowledge for the greater good of mankind, I hope that this event will help us have a very fruitful exchange of ideas and strategies in order for us to deliver the utmost service to mankind.

We are doctors and we are in the best position to change the lives of the people who seek our help. Let us continue moving forward not as individual countries but as one ASEAN community committed to health for all.

The African Health Systems and the Information Society[*1]

Margaret MUNGHERERA[1]

THE AFRICAN HEALTH SYSTEMS AND THE INFORMATION SOCIETY

Dr. Margaret Mungherera
World Medical Association President
2013-2014

SELF INTRODUCTION

- Medical Doctor for 30 years
- Psychiatrist for 22 years
- MBChB – Makerere University, Kampala, Uganda
- Diploma in Tropical Medicine and Hygiene - London School of Tropical Medicine and Hygiene, U.K.
- Masters of Medicine – Makerere University, Kampala, Uganda
- Clinical Training in Forensic Psychiatry – Keel University, U.K.
- Senior Consultant Psychiatrist - Mulago National Referral Hospital, Kampala, Uganda
- Past President, Uganda Medical Association
- Past Vice-President for Eastern, Central and Southern Africa, Commonwealth Medical Association
- Past Treasurer, Commonwealth Medical Association
- President, World Medical Association (2013-2014)

HEALTH SITUATION IN AFRICA

Africa's greatest asset is its one billion people.

Yet Africa has a huge disease burden.

Africa is 11% World's population but has:

- 45% World's women dying from childbirth related complications
- 50% World's children dying before age of 5 years
- 62% World's HIV/AIDS patients

HEALTH SITUATION IN AFRICA

60% – Infectious Diseases
- Malaria
- HIV/AIDS
- TB
- Diarrheal diseases

40% - Non Communicable Diseases (NCDs)
Increasing prevalence, nearing epidemic proportions

Common:
- Hypertension
- Cardiac diseases
- Cancer
- Depression.

WHY HUGE BURDEN OF DISEASE IN AFRICA?

1. Natural disasters

2. Political instability – wars, undemocratic governance

3. Social Determinants of Health - LIFESTYLES (alcohol, tobacco, exercise) education, employment, communication, transport, housing, Violence against Women, Climate Change, etc)

4. Weak health systems

HUGE DISEASE BURDEN IN AFRICA?

4. Weak health systems in terms of:
- Equitable distribution
- Efficiency
- Effectiveness
- Patient centred care
- Patient safety
- Ethical care
- Health worker safety

Health workers:
- Acute shortage (external, internal brain drain)
- Inequitable distribution (More than 90% population in rural areas yet less than 5% health workers)
- Poor access to CPD.

HEALTH SYSTEMS

- Limited research data – socioeconomic determinants, impact of policies and services

- Inequitably distributed sources of health information for the general public (Health Literacy)

- Health databases – underdeveloped, poor dissemination, unprotected

HEALTH SYSTEMS

- No African country has achieved UNIVERSAL HEALTH COVERAGE.

- PRIMARY HEALTH CARE SERVICES are generally weak.

- Limited integration of MENTAL HEALTH into general health services.

- 82% Africans seek health care from TRADITIONAL PRACTITIONERS but no country has INTEGRATED traditional medicine into national health system.

- Integration of COMMUNITY HEALTH WORKERS into formal health system – Only a few countries eg. Ethiopia.

- Inadequate financing – 20-40% wastage, inadequate budgetary allocation, few countries with public health insurance schemes

POST 2015 AGENDA FOR HEALTH IN AFRICA

Growing consensus in Africa:
1. Continue with MDGs
- improve maternal health
- reduce child mortality
- prevent and treat HIV/AIDS, TB and Malaria.

2. Intensify efforts on NCDs

3. Social Determinants of Health

4. Universal Health Coverage

THE INFORMATION SOCIETY IN AFRICA

- Mid 1990s – Economic Commission of Africa (ECA) started efforts to build the Information Society in Africa.

Emphasis placed on countries to develop:
- National Information and Communication Infrastructural Development Strategies

- ICT Development Plans in all government sectors including Health.

- Training of personnel in the various sectors.

- Development of physical infrastructure – computer, mobile phone, etc

INFORMATION SOCIETY

Success?

Yes, Africa is gradually moving into the Information Era.

There has been growth and expansion in harnessing of ICT for:

1. Trade and Industry
2. Agriculture
3. Economic development
4. Education

INFORMATION SOCIETY

Contribution of Health Sector to building Information Society in Africa:

✓ Research and Documentation
✓ Telemedicine – still underdeveloped
✓ M-health – Some good practices but limited -
✓ Development of ICT based Health databases

HEALTH DATABASES

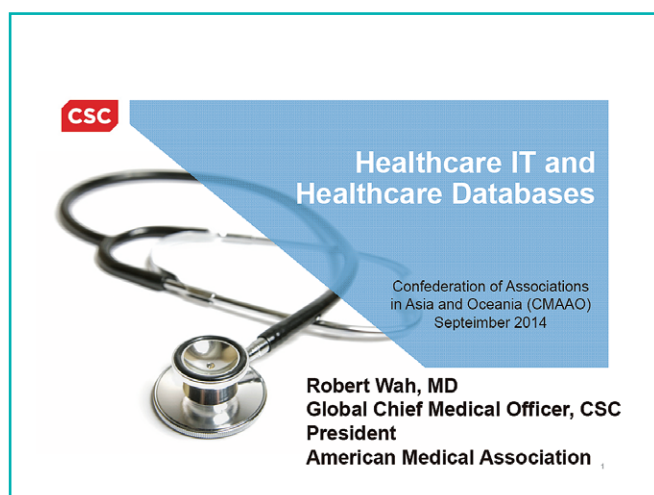Growth with development of ICT but slow because:

1. Legal framework and Policies
2. Perceptions
4. Limited awareness of relevance
5. Cost of ICT infrastructure
6. Lack of skills

THANK YOU FOR LISTENING
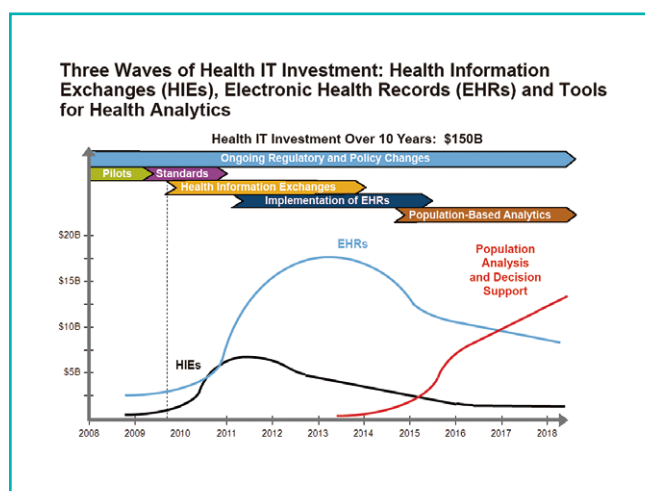
Healthcare IT and Healthcare Databases[*1]

Robert WAH[1]

The Way Forward – Coordinated Care

Care Coordination

Transitions of Care
- Integration and Edge Adapter Services
- HIE capabilities for Data Exchange

CDR

Population Health/Care Mgmt
- Collaboration and Communication Bridge
- Rules based surveillance
  ✓ Chronic Disease Mgt
  ✓ Coordination of Care Mgt
  ✓ Disease Specific Dashboards
- Care Coordinator Workspace

Patient Engagement
- TeleHealth, TeleCoaching
- In-Home Device Integration and Monitoring
- Video Conferencing
- Encounter Documentation

Analytics

BI/DW
- Enterprise Data Warehouse
- BI Tools Reporting
- Descriptive Analytics

Big Data
- Advanced Alerts and Care Coordination
- Near-Real time Patient Surveillance
- Predictive Analytics
- BIG Data Analytics
- Advanced Rules Engine

CSC Health Services Strategy   Competition Sensitive   9/24/2014 10:46 AM   5

Organizational Alignment

Services Provided

People Assets

Care and Business Processes

Patients

Locations

Care Delivery Operating System

Operations Policies

Technology Choices

Organizational Alignment

LEVEL 5: PREDICTIVE COORDINATION
- Patient and provider behavior change achieved
- Outcomes improved
- Big data and predictive analytics

LEVEL 4: COORDINATION
- Outcomes impacted
- Communication and collaboration bridges adopted
- Coordinated Care Program matured, part of organizational DNA
- Workflows socialized
- Patients engaged in their health
- Analytics impacting outcomes

LEVEL 3: COLLABORATION
- Robust coordinated care program — care coordination workflow/workspace established
- Coordinated Care record
- Increased patient engagement (teleservices)

LEVEL 2: COMMUNICATION
- Provider workflow (care transitions and notifications)
- Message and data exchange (DIRECT, CCD)
- Basic reporting program initiated

LEVEL 1: INFRASTRUCTURE
- Technical infrastructure
- Data ingestion
- Information exchange
- Base lifetime EHR
- Begin workflow process changes
- Program planning
- Organizational alignment
- Governance

CURRENT STATE
- Traditional approaches to case and disease management

BIG DATA

Predictive

Analytics

Business Intelligence

Reporting

CSC Health Services Strategy   Comp   2014 10:46 AM   6

Intersection of Health IT, Cloud Computing and Cybersecurity with the Patient in the Center

Cloud Computing

Cyber

Health IT

Desktop | Windows 7 | Virtual Desktop | Desktop Management | Bring Your Own Device | Application Management
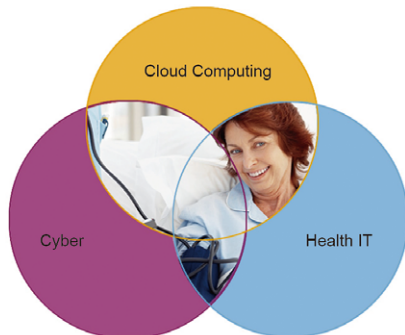
Access functionality from Any Place, Any Time and Any Device

Stop thinking of the mobile as a device, and begin thinking of it as a means to __Access a Service__

At home

At Aunt Edna's

In the office

In the hotel or at the airport

On the move

As you move between devices and/or locations, your functionality is always available

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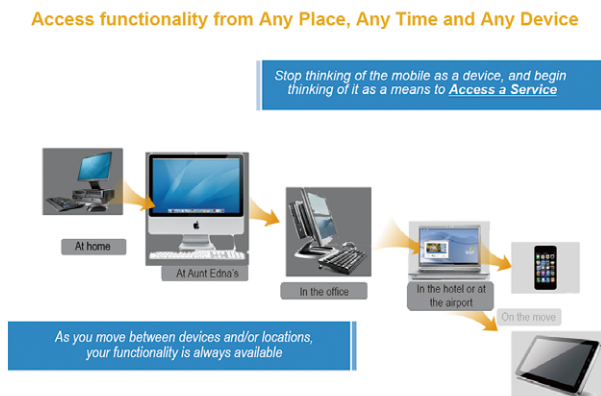
Medical Data Breaches Cost Billions

- *71 percent of health care organizations suffered a data breach in the last year*
- Data breaches in US alone Cost between $4.2 billion and $8.1 billion a year, or an average of $6.5 billion
- Most breaches were the result of employees losing or having their IT devices stolen or other unintentional, but ill-advised, employee action according to 49 and 41 percent of respondents
- Shoddy security from partners and providers, including business associates, according to 46 percent of participants, was another significant reason
- Once a breach is discovered, 83 percent of hospitals reported it taking one to two months to notify affected patients. Nearly a third, or 29 percent, admitted that breaches lead to cases of identity theft, up 26 percent from the previous year

Graphic Courtesy World Privacy Forum, Aug. 2011, Based Upon Information from the U.S. Federal Trade Commission.
Source, Dec. 2011, Second Annual Benchmark Study on Patient Privacy and Data Security conducted by the Ponemon Institute and sponsored by ID Experts.

Health Care Industry Is A Primary Target for Thieves and Regulators

- Represents one of the largest global repositories of sensitive personal information
- All services targeted
  - Health Care Providers
  - Health Services
  - Life Sciences
  - Health Insurance
- Regulators require
  - Controlling access to patient medical and personal data
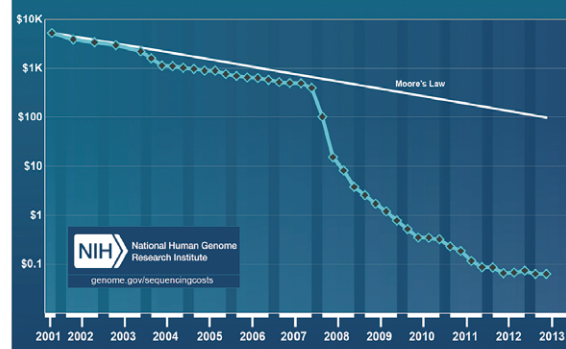 - Transaction accountability

WMA Workgroup on Healthcare Databases and Bio-banks

- Updating 2002 Declaration
- Make distinction between ongoing Clinical use and Research use of information and bio materials
- Hold Patient's rights and Physician's Duty of Confidentiality paramount
- Cite the essential role for Research Committees
- Need for governance in use of data and tissue
- Important to have physician engagement and leadership in this important area

CSC Health Services Strategy   Competition Sensitive   9/24/2014 10:46 AM   17

AMA Policy on Genetic and Genomics

- D-460.971 Genome Analysis and Variant Identification Our AMA: (1) encourages payers, regulators and providers to make clinical variant data and their interpretation publicly available through a system that assures patient and provider privacy protection; and (2) encourages laboratories to place all clinical variants and the clinical data that was used to assess the clinical significance of these results, into the public domain which would allow appropriate interpretation and surveillance for these variations that can impact the public's health. (Res. 519, A-13)
- H-65.969 Genetic Discrimination and the Genetic Information Nondiscrimination Act Our AMA: (1) strongly opposes discrimination based on an individual's genetic information; (2) will pursue and support legislation intended to provide robust and comprehensive protections against genetic discrimination and misuse of genetic information; and (3) supports education for health care providers and patients on the protections against genetic discrimination currently afforded by federal and state laws. (CSAPH Rep. 7, A-13)

AMA Policy (Continued)

- H-460.905 Clinical Application of Next Generation Genomic Sequencing 1. Our AMA recognizes the utility of next-generation sequencing (NGS)-based technologies as tools to assist in diagnosis, prognosis, and management, and acknowledges their potential to improve health outcomes. 2. Our AMA encourages the development of standards for appropriate clinical use of NGS-based technologies and best practices for laboratories performing such tests. 3. Our AMA will monitor research on and implementation of NGS-based technologies in clinical care, and will work to inform and educate physicians and physicians-in-training on the clinical uses of such technologies. 4. Our AMA will support regulatory policy that protects patient rights and confidentiality, and enables physicians to access and use diagnostic tools, such as NGS-based technologies, that they believe are clinically appropriate. 5. Our AMA will continue to enhance its process for development of CPT codes for evolving molecular diagnostic services, such as those that are based on NGS; serve as a convener of stakeholders; and maintain its transparent, independent, and evidence-based process. (CSAPH Rep. 4, I-12)

The Future
Interconnected, Private, Secure Health Information Exchange
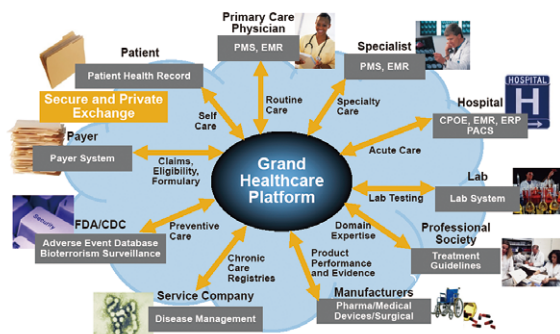
Questions?

Thank You!

Robert Wah, MD

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@RobertWahMD

CSC BUSINESS SOLUTIONS
TECHNOLOGY
OUTSOURCING

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[Bangladesh]

Health Databases in an Information Society— Bangladesh Perspective[*1]

Jamal Uddin CHOWDHURY[1]

Health Databases in an
Information Technology Society
Bangladesh Perspective

Presented by
Dr. Jamal Uddin Chowdhury
Member, Central Executive Committee
Bangladesh Medical Association

- Bangladesh is a populous country of the world with a population size of 156.06 million in an area of 147,570 sq.km only
- The government is working hard to carry the country into the middle income group having at present annual per capita income of nearly 1200 US Dollars only

COUNTRY DATA
GDP growth (annual %)

Bangladesh South Asia

Data from World Bank
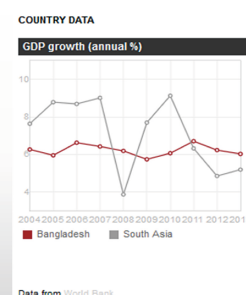
- The present government of Bangladesh seems to have understood the importance of information technology in boosting up the GDP growth
- As such has set up the independent Ministry of Information Technology

- The government has expanded its work in accordance with its pledge to digitize the country in true sense
- Now **3G telecommunication** system is in operation and **4G is coming soon**
- A huge web portal namely ***Bangladesh National Portal***comprising of 25 thousand websites has been launched recently by the government to facilitate the activities of the government
- Ministry of Health has brought all relevant information about its employees of all categories under an electronic database system

- We can find health databases in the field of
  - Vital statistics
  - Medical journals
  - Research publications
  - Human resources
  - Drugs
  - Improved healthcare waste management
  - Information about healthcare providers
  - Blood donors

- Directorate General of Health Services has prepared a database of 98 million rural people having their basic health records which will make the foundation of future lifetime shared health records
- An initiative has also been taken to register and track the people specially pregnant women and under-5 children using 11 indicators as suggested by the Commission on Information and Accountablity (COIA) of the United Nations
- To develop an integrated health system Electronic Medical Records are kept in some hospitals as pilot project

11 COIA Indicators for Maternal and Child Health

1. Maternal mortality ratio (deaths per 100,000 livebirths)
2. Under-five child mortality, with the proportion of newborn deaths (deaths per 1,000 livebirths)
3. Under-five children who are stunted (percentage of children below five years of age whose height-for-age is below minus two standard deviations from the median of the WHO Child Growth Standards)
4. Met need for contraception (proportion of women aged 15-49 years, who are married or in union and who have met their need for family planning, i.e. who do not want any more children or want to wait at least two years before having a baby, and are using contraception)
5. Antenatal care coverage (percentage of women aged 15–49 years, with a livebirth, who received antenatal care from a skilled healthcare provider at least four times during pregnancy)
6. Antiretroviral prophylaxis among HIV-positive pregnant women to prevent vertical transmission of HIV, and antiretroviral therapy for women who are treatment-eligible
7. Skilled attendance at birth (percentage of livebirths attended by skilled health personnel)
8. Postnatal care for mothers and babies (percentage of mothers and babies who received postnatal care visit within two days after childbirth)
9. Exclusive breastfeeding for six months [percentage of infants aged 0–5 month(s) who are exclusively breastfed]
10. Three doses of the combined diphtheria/pertussis/tetanus vaccine (percentage of infants aged 12–23 months, who received three doses of diphtheria/pertussis/tetanus vaccine)
11. Antibiotic treatment for pneumonia [percentage of children aged 0–59 month(s) with suspected pneumonia receiving antibiotics]

- An initiative for creating an archive of health databases has been taken by ICDDRB,DGHS and Ministry of Science and Technology jointly
- Bangladesh Medical and Dental Council has introduced a database which includes registration numbers and other details of the doctors registered with it

- An Integrated National eHealth Enterprise Architecture(eHEA) is being developed to combine
  - Individual records of all citizens
  - Registries of organizations
  - Information on public health programs(DHIS 2.12)
  - Hospital information system(open MRS)
  - Health workforce registry(HRIS)
  - Inventory system for major equipments

  to virtually function as one system through a data exchange mechanism

- All hospitals both public and private will be able to post the records of the patients to the national data warehouse through eHEA
- The first usable version of this is expected to be ready for use within the next year

Figure 17.2. Proposed design of the eHealth Enterprise Architecture which is being developed with technical assistance from DHD
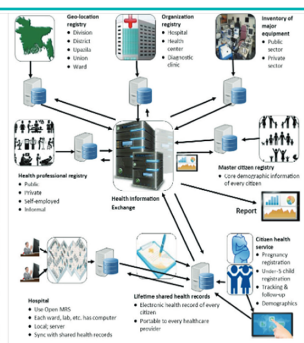
To collect data from grassroots level, community healthcare providers and community health workers have been provided with laptop computers and netbook computers

- An archival system has been developed in 2007 namely *BanglaJOL*
- It is a project supported by the International Network For The Availability of Scientific Publication(INASP)
- It uses the Open Journals System created by the Public Knowledge Project based in Canada
- Bangla JOL includes 65 medical journals accredited and published in Bangladesh
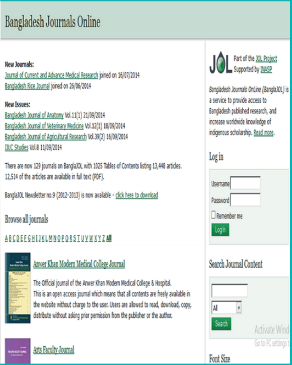
- Bangladesh is on the right track
- We will pursue the relevant authorities to speed up their work
- Meanwhile i would like to request our development partners and international community to support us wholeheartedly

THANK YOU

[Hong Kong]

Health Database in Hong Kong*1

Alvin Yee Shing CHAN[1]

Present Progress of IT in the Health Care Area in Hong Kong

A. For healthcare professionals
B. For the public, including public education
C. E-Health record sharing
D. Primary care directory
E. Health database for subsidy programmes
    (1) Elderly Healthcare Voucher Pilot Scheme
    (2) Vaccination Subsidy Schemes
F. For research and development

For healthcare professionals

(1) Information access
(2) News access
(3) CME

For the public

(1) Information access
(2) Press release
(3) Public education

E-Health record sharing

(1) Food and Health Bureau—Steering Committee on eHealth Record Sharing (eHR sharing)
• Working group on e-HR partnership
• Working group on institutional arrangements
• Working group on legal, privacy and security issues
• Working group on eHealth record and information standards
  ·Coordinating group on eHR and information standards
   - eHR domain group on drug record
   - Domain group on person mater index
   - eHR domain group on immunization record
   - eHR domain group on provider index
   - eHR domain group on laboratory record
   - Technical task force
(2) eHR Sharing System Bill (eHRSS Bill)/Electronic Record Sharing System Bill
- drafted
- security and privacy issues→safe deposit box
- future "Commissioner for the Electronic Health Record (eHRC)" to define data retention policy
- patient information notice
- consent, PIN, sharable data
(3) The Hong Kong Medical Association TaoYuan Project (桃園計劃)—Clinic Management System (CMS) 3.0
The CMS 3.0 is an open-source clinical management system project jointly implemented by the Hong Kong Medical Association (HKMA) and the Information and Software Industry Association (ISIA), with funding support from the Office of the Government Chief Information Officer (OGCIO).
    Now undergoing further enhancement—upgrade existing system so that it would connect to the eHR Sharing System via the eHR viewer; repack it as CME 4.0 (Wenchang project) (文昌計劃).
        (http://cms3.hkma.org/pages/index.asp)
(4) New requirements from government regarding uploaded information
- Person Master Index for personal identification
- Encounter with dates of attendance when patients consult private medical practitioners
- Medication dispensed during healthcare process

Primary care directory

- Web-based system containing personal and practice-based information of different primary care providers
- Public can use the search function to choose the primary care providers who most suit them
- Consists of sub-directories for different healthcare professionals providing primary care. In the initial stage, we have established the sub-directories of doctors and dentists. Sub-directories

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for other professionals, like Chinese medicine practitioners, nurses and allied health professionals will be developed in a later stage

Health database for subsidy programmes

(1) Elderly Health Care Voucher Pilot Scheme (www.hcv.gov.hk)

Purposes:
- Encourage elders to seek consultation
- Establish a closer relationship with private doctors who are familiar with their health conditions
- Promote the concept of family doctor

Developments:
- 2009: 5 vouchers of $50 each were provided to each elder aged 70 or above annually.
- 2012: increased the annual voucher amount from $250 to $500.
- 2013: further increased the annual voucher amount to $1,000.
- 2014: further increased the annual voucher amount to $2,000. Unspent vouchers would be carried forward and accumulated by an eligible elder, subject to a ceiling of $4,000.

Highlights:
- Vouchers will be issued and used through the eHealth System. They will not be issued in paper form separately.
- Voucher Recipients need not pre-collect the health care vouchers.
- Voucher Recipients need not carry the health care vouchers.
- "Money follows Patient"—Voucher Recipients can choose freely on private primary healthcare services in the local community.

(2) Vaccination Subsidy Schemes
- Childhood Immunisation Programme
- Government Vaccination Programme
- Childhood Influenza Vaccination Subsidy Scheme
- Childhood Vaccination Subsidy Scheme (PCV13 booster)
- Elderly Vaccination Subsidy Scheme
- Pneumococcal Vaccination
- Residential Care Home Vaccination Programme

For research and development

- Faculty of Medicine of 2 Universities:
  - The University of Hong Kong
  - Chinese University of Hong Kong

- Other institutions

Current Status of Privacy Protection and Personal Information Protection, Including Handling of Gene Information

- The Office of the Privacy Commissioner for Personal Data ("PCPD")
  - an independent statutory body set up to oversee the enforcement of the Personal Data (Privacy) Ordinance (Cap. 486) ("the Ordinance") which came into force on 20th December, 1996.
- The University of Hong Kong Privacy Policy Statement (http://www.hku.hk/privacy_policy/)

Use of the Citizen Numbering System

- Hong Kong Identity Card (http://en.wikipedia.org/wiki/Hong_Kong_Identity_Card)

Merits and Demerits of Health Care Supported by IT

Merits
(i) Huge storage of database in limited space
(ii) Efficient/Fast
(iii) Able to cater different needs
(iv) Based on a "need-to-know" basis, information readily available anywhere anytime to facilitate assessment and decision

Demerits
(i) Security concerns
(ii) Protection of patients' privacy and respect of patients' choice of not to disclose one's own sensitive health record to unrelated healthcare providers
(iii) Might need to set up a system separately storing patients' sensitive data with security access control over it
(iv) The hiding of certain data might lead to diagnosis errors or wrong treatment and influence patients' care
(v) The existence of a separate system might create stigmatization and labeling effect on patients, thus hampering the trust between doctors and patients

[India]

Health Database in an Information Society

Jitendra B. PATEL,[1] Narendra SAINI[2]

Twenty first century is the age of informatics. India reports that all of the listed actions to promote an enabling environment for information and communication technologies (ICT) in the health sector have been taken and are rated from slightly to moderately effective. National mechanisms such as an information policy, an e-Strategy, and an e-Health policy have been put in place between 2000 and 2002 to promote the use of ICT. Specific health sector mechanisms, such as public-private partnerships, procurement policies, public and private funding and e-health standards have been successfully introduced since 1998.

ICT in the health sector:

a) enactment of the Information Technology Act 2000, providing a legal basis for all digitally related information actions and privacy issues;

b) comprehensive guidelines and recommendations for IT infrastructure in health (2003);

c) creation of a task force on the topic of tele-medicine (2005).

A national policy to reduce the costs of ICT infrastructure for the health sector will be implemented over the next few years. India highlights the launch in 2007 of Health statistics, which is likely to strengthen specific health planning & network communications. Among the most effective actions so far in building ICT infrastructure for the health sector has been the creation of more than one hundred pilot projects in telemedicine with connectivity and funding support from the Indian Space Research Organization. The Ministry of Finance has mandated that 3% of the budget of all government spending will go to ICT, which has created a culture of ICT usage in government.

India reports that efforts in providing health information to the citizen are undertaken by disease control program (for Example—Nikshay in TB control program), which provide prevention and control-related information. Currently all major associations of health professionals are developing web-based information sources. The Ministry of Communication and Information Technology took the lead in promoting action on standards and guidelines for ICT initiatives, and ICT issues are also high on the Ministry of Health's agenda.

India has started talking about adoption of Electronic Medical Records (EMRs) which is a good sign. It was Confucius who once remarked "a journey of a thousand miles begins with the first step." The concept of EMR is gathering steam, with several health care & insurance providers. The development of a common strategy and roadmap for e-health standards development, to support interoperability and the adoption of electronic patient records is crucial.

With the exponential increase in mobile telephony and the imminent deployment of 3G, it is imperative that broad band wireless technology be exploited and used to develop m-Health.

Indian Medical Association (IMA) started database of the all the members with their specialties. The strength of the directory technology is its fast look up capabilities.

Mobile App to collect epidemiology data on Vector Borne Infectious diseases: The objective is to set up an infrastructure to collect epidemiological data of the diseases, by developing a simple app on the smart mobile phones.

IMA to spearhead and establish a process of collecting epidemiological data.

In this global information society, this user oriented services of health care information can

achieve effective horizontal integration of networked information services, which will have an impact on the quality care of the patient. The current vision comprises affordable wireless access to health care services, for all the citizens, thus making medical expertise a shared resource, whenever and wherever needed.

Coordination with other inter-departments still remains a challenge.

Provision of Internet access in rural areas (where approximately 65% of the total population dwell) and the great diversity of languages across regions are listed as the most significant challenges in this field. India's healthcare information technology market is expected to hit US\$1.45 billion in 2018, more than three times the US\$381.3 million reached in 2012, according to a report by Frost and Sullivan.

Keeping confidentiality & sensitive issues information is still a challenge.

[Indonesia]

The Health Database in an Information Society[*1]

Ihsan OETAMA[1]

*1 This article is base on a presentation made at the Symposium "Health Database in an Information Society" held at the 29th CMAAO General Assembly and 50th Council Meeting, Manila, the Philippines, on September 24-26, 2014.

1 International Relations, Indonesian Medical Association, Jakarta, Indonesia (dr.ihsanoetama@idionline.org).

CURRENT SITUATION

In progress
- National Health Data Dictionary
- eHealth road map
- Legal and regulatory about health data
- ITC infrastructures
- Telemedicine

2,362 hospitals

Database physician
- Indonesia Medical Asscosiation
- Indonesia medical Council

115.000 physicians

INTERNET PENETRATION

INDONESIA NETIZEN SURVEY 2013: WHAT EVERY MARKETER SHOULD KNOW ABOUT INDONESIAN INTERNET USERS

Internet Penetration (Mio)
Base: Indonesia Population

100 millions

In million	2010	2011	2012	2013
Urban Population	121.16	123.24	123.57	133.73
Urban Family	30.29	30.81	31.61	34.72
Urban Internet User	37.56	50.53	56.38	62.19
Internet User	42.16	55.23	61.08	74.57

42.2 (2010) 55.2 (2011) 61.1 (2012) 74.6 (2013)

Source: Indonesia Netizen Survey 2013 by MarkPlus Insight, Marketeers Magazine November 2013

2006 2007 2008 **2009** 2010 2011 2012 2013 2014 **2015**

IMPLEMENTATION OF MULTI APLICATIONS HIS IN NUSA TENGGARA TIMUR PROVINCE WITH 23 DISTRICTS

INFORMATION (Graph & Tabel)

INFORMATION (Graph & Tabel)

Web Aplication

4 Web Aplication

Monthly recapitulation

- Pregnancy risk monitoring
- Diseases registry

DISTRICT
DATABASE DIGITAL

5 SMS gateway aplication

Daily recapitulation

Selected data

Registry Book (Database manual)

Batch entry

2 Stand Alone Aplication

3 Multi Clients Aplication

1 Manual Aplication

297 Health centers | 61 Health centers | 4 Health centers | 1 Health center

U n i f o r m   M i n i m u m   B a s i c   D a t a   S e t

IMPLEMENTATION HIS IN NTT PROVINCE

1 2 3 4 Goal 5 6 7 8

National

Goal
Information
Information
Decision making

DB
PROVINCE DATABASE

Feedback
Minimum basic data set
One door policy
One databse

Goal
Information
Decision making

DB
DISTRICT DATABASE

Information
Feedback

Goal
Information
Decision making

DB
SUBDISTRICT DATABASE (personal data)

Feedback

Health provider

Data | Data | Data
COMMUNITY

NATIONAL SOCIAL HEALTH INSURANCE

JKN
Jaminan Kesehatan Nasional

- Start in 1 January 2014 with target 121.000.000 for the first year and will achieve the whole population by the year 2019. **Recently members have registered are 127 millions**
- Mandatory, Government pay fees of poor families
- **National single identity number** is used as unique member identification
- ± 17.000 Point of Care (Health centers, private clinics), payment method by capitation
- ± 1400 hospitals, payment method by INA-CBGs
- All the Point of Care have to install the Primary Care Information System provided by BPJS (National Social Health Insurance), and send reports by online.

ITC IS CHANGING OUR SOCIETY
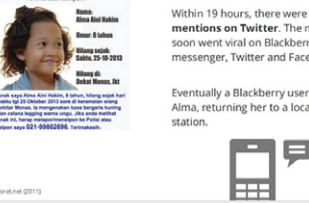
"The phone and smartphone is not just convenience or indulgence, but actually it's a big part of a day-to-day necessity

At first there was an instant messaging craze, then came social networking,

Instant messaging has become a multi-faceted platform - where people can **chat, play games and buy things** - all in one place.

Now there's instant messaging 2.0

[Japan]

Health Database in an Information Society*1

Hiromi ISHIKAWA[1]

There is a movement in Japan to take advantage of databases to improve healthcare quality and strengthen research foundations. I would like to introduce health databases that are representative of Japan and report the framework for a privacy protection and national identification number system in the age of Big Data.

The National Database (NDB) was established based on the Act on Assurance of Medical Care for Elderly People to develop optimization plans for national healthcare expenditures. This database includes the health insurance payment claim data and the records from specific health check-ups and health guidance in electronic form. About 6.9 billion cases of health insurance claims and 90 million cases of specific health check-ups are stored. The information is processed for de-identification when collected.

The government review board discussed the framework for the utilization of the National Database, and the trial period for third-party use began in 2011. The database is now available for academic research of significant public interest.

However, it is still underutilized in academic research because exploratory studies are carefully investigated. There are also strict information security requirements for users, and the data are difficult to analyze in terms of specifications.

To understand medical and pharmaceutical product safety information, healthcare information databases have been established in 10 core hospitals. The 5-year project that started in 2011 links databases across the nation to cover 10 million people. The Pharmaceuticals and Medical Devices Agency (PMDA) established a system for the cooperating medical institutions, built an analysis system within PMDA, and is exploring ways to proactively utilize the linked databases.

The test run of the healthcare information database system will be completed in the future.

In order to implement medical and pharmaceutical product safety measures using the data, PMDA will promote the enhancement of data utilization methods with an epidemiological approach and verify the accuracy and reliability of the information extracted from healthcare information databases.

The operation of large-scale healthcare databases has begun already, and it is time to evaluate the framework for privacy protection and the national identification number system.

It has been almost 10 years since the Act on the Protection of Personal Information was legislated in 2005, and it is now inadequate to handle highly sensitive healthcare information. Japan Medical Association (JMA) prepared guidelines for patient privacy protection, but it remains a work in progress for those involved.

This act regulates private businesses that handle more than 5,000 cases of personal information. Its flaw, however, lies in the fact that different hospitals a patient visits may be subject to different laws. Small-scale medical institutions are exempt from this act.

Penalties for violators are minor. Individually, doctors have the duty of confidentiality by the Penal Code, but hospital staff are not legally bound by it.

The exchange of genetic information will become very common in future generations. Breaches of personal information risk affecting family members and may extend to their human rights. However, the current law does not provide sufficient protection.

The national identification number system has been debated as a possible means to link various types of information about an individual. The My Number System was legislated in May 2014. For the time being, its application is limited to taxes, social security, and disaster manage-

ment. The healthcare areas subject to this law are limited to insurance benefits provision and insurance premium collection. Healthcare information such as medical records is exempt from the system. This was decided due to sensitive issues such as healthcare information privacy.

Thanks to the development of IT and Big Data technology, we can now collect and analyze a vast amount of information of various kinds. However, the inappropriate use or breach of information has brought serious damages.

This year alone, a railroad company sold 43 million cases of train ticket data purchased by smart cards including boarding records, gender information, and dates, after removing identifiable information such as names and phone numbers. The company provided little explanation or announcement in advance.

A company in the education industry leaked up to 20.7 million cases of customer information, including the names of children and their guardians, addresses, telephone numbers, gender information, and dates of birth. The offender who leaked the information was arrested not under the Act on the Protection of Personal Information but under a different law called the Unfair Competition Prevention Act that controls industrial espionage.

In the age of Big Data, breach of personal information means enormous damage, and there is a risk that even de-identified data can become identifiable. The damage from healthcare information, which is highly sensitive in nature, cannot be undone once it is leaked. The risk will become even higher if it is linked to all-inclusive and unique personal numbers.

The Act on the Protection of Personal Information is currently being revised in order to promote the active utilization of personal data accumulated with Big Data. The government's general principle emphasizes the active utilization of the data, and JMA is requesting the government to generously protect people's privacy and healthcare information.

The analysis of health databases may advance medical research and healthcare policies. Nevertheless, we should consider cases in other countries and discuss separate legislation that aims to protect genetic information in advanced medicine and highly sensitive healthcare information.

JMA will continue to provide policy recommendations to the government in the interest of the Japanese citizens, while carefully balancing active utilization of healthcare information and privacy protection in the Big Data age.

CMAAO Symposium
The Health Database in an Information Society

Hiromi Ishikawa, MD
Executive Board Member
Japan Medical Association

Database for Health Insurance Claim Information & Specific Health Check-up Information : 1 (National Database, NDB)

Source: Ministry of Health, Labour and Welfare

Database for Health Insurance Claim Information & Specific Health Check-up Information : 2 (National Database, NDB)

▸ **Data included (as of December 2013):**
- **Approx. 6.9 billion cases of health insurance claims**
  (covers medical examinations performed from Apr 2009 to Sept 2013)
- * Japan has a universal health insurance system, and more than 95% of health insurance payment claims are digitized. Therefore, almost all citizens' data are accumulated in the NDB.
- **Approx. 90 million cases of specific health check-ups and health guidance**
  (covers those performed from FY 2008 to FY2011)

▸ **The reasons for underutilization in the area of academic research**
- Exploratory research and studies that involve data extraction of an extensive number of categories or high volume are carefully investigated
- Information security requirements for users are very strict
- Specification of the data is made difficult for analytic use

3

Healthcare Information Database Foundation Preparation Project

Purpose: Promotion of safety measures for medical and pharmaceutical products using a pharmaco-epidemiological approach by utilizing the healthcare information database (DB)
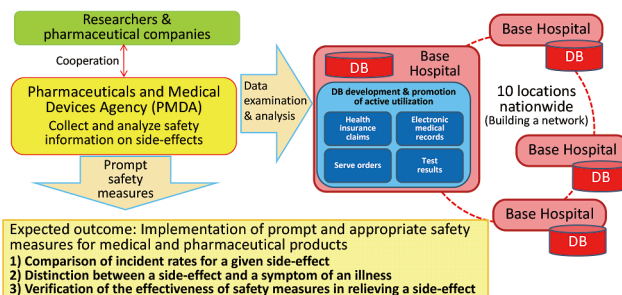
4

Source: **Ministry of Health, Labour and Welfare**

Privacy Protection Laws in Japan

Act on the Protection of Personal Information
(Privacy Protection Act, PPA)

→ **Approved in May 2003, enforced from April 2005**

→ **Problems of the existing act**
- Insufficient to protect highly sensitive personal medical info.
  Medical institutions use guidelines prepared by MHLW or JMA to provide proper privacy protection.
- Different privacy protection laws exist for different types of medical institutions
  Private hospitals = PPA
  National hospitals = PPA for Administrative Organs
  Municipal hospitals = ordinance for privacy protection
- Private hospitals with <5,000 cases of patients are exempt

5

Privacy Protection Laws in Japan (cont.)

→ **Problems of the existing act (cont.)**
- The penalty imposed for violations is minor
  Medical professionals are legally bound by the duty of confidentiality, but hospital staff are not.
- Sharing genetic information not only affect the human rights of the patient but also his/her family members and/or offspring

6

Privacy Protection Laws in Japan (cont.)

"My Number Law" stipulates the use of identification number in administrative procedures

→ **Approved in May 2014, expected to be enforced from January 2016**

→ **In what areas will it be used?**
- Social security (inquiry/provision of pension)
- Taxes (forms & legal reports)
- Disaster Management
- Healthcare
  Only for "the provision of insurance benefits and collection of insurance premiums"
  Healthcare information (incl. medical records) are exempt

7

Personal Information Leakage in the Big Data Age: 1

▸ Selling of the boarding history data from train tickets purchased by smart cards without notice

In September 2013, the JR East Japan sold 43 million cases of train ticket data purchased by smart cards to Hitachi, Ltd. The data sold included boarding records, gender, and dates; identifiable information such as names and phone numbers had been removed. The company provided little explanation or announcement in advance.

8
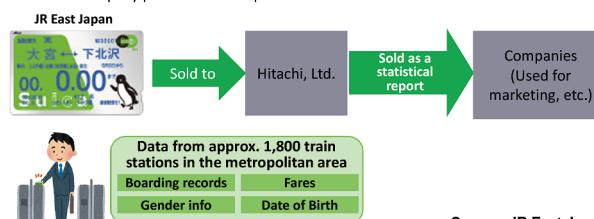
Source: JR East Japan

Personal Information Leakage in the Big Data Age: 2

▸ Personal information leakage at a company in the education industry

In July 2014, Benesse Holdings, Inc., a company in the education industry, leaked up to 20.7 million cases of customer information, including the names of children and their guardians, addresses, telephone numbers, gender information, and dates of birth. The offender who leaked the information was arrested not under the Act on the Protection of Personal Information, but under a different law called the Unfair Competition Prevention Act, which controls industrial espionage.

Obtained the info

Benesse

Suspect

A mailing list supplier in Chiyoda City, Tokyo

Mailing list suppliers in Tokyo

Mailing list suppliers in Shinjuku City

Scheme of data proliferation
(Based on interviews with the Metropolitan Police Department and others)

Bunkensha

Users

Companies in the education industry
Tutoring school
Kimono stores

English conversation schools
IT companies

Source: The Asahi Shimbun Company
(July 22, 2014; Partially modified)
http://www.asahi.com/articles/ASG7Q5J38G7QULFA01T.html?google_editors_picks=true

9

Personal Information Leakage in the Big Data Age: 3

▸ **Leakage of personal information means:**

1. The damage is enormous once leaked.

2. Even the de-identified data can become identifiable by cross-referencing with other data.

3. If highly sensitive healthcare information is leaked, the damage cannot be undone.
   The risk will become even higher if healthcare information is linked to all-inclusive and unique personal numbers.

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Thoughts for the Future

▸ The revision of the Act on the Protection of Personal Information is underway in order to promote the active utilization of personal data accumulated in the Big Data.

▸ The general principle of the government is to emphasize the active utilization of data.

▸ In order to utilize the healthcare database safely, JMA request the government to:

1. Generously protect the people's privacy and healthcare information.

2. Carefully discuss the linking of healthcare information to unique and all-inclusive personal numbers, considering the enormous damage brought by the leakage of such information.

3. Examine cases in other countries and discuss possible solutions, including separate and specific legislation that aims to protect genetic information in advanced medicine, and highly sensitive healthcare information.
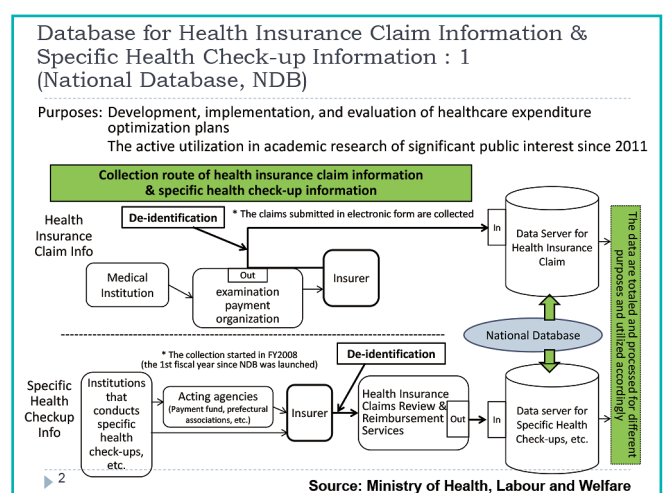
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Thank you for your attention.

12

[Korea]

ICT and Healthcare in Korea: Present and Prospect[*1]

Dong Chun SHIN[1]

Korea's health care is characterized by its well-developed ICT (Information-Communication Technology) infrastructure. In response to the Asian financial crisis in 1997, the Korean government prepared for the future by developing the ICT industry. ICT combined with medicine has created many advances in Korea.

ICT has not always been a positive influence on medicine. The ease of information processing increased the risk of privacy information being leaked. Also, greater protection of medical information such as genetic information and medical records is needed. Accordingly, the Korean government implemented the Personal Information Protection Act in 2009 and the medical field started to encrypt resident registration numbers of subjects with personal identification numbers so that the resident registration number would not be exposed when research data is provided. All information originating from a subject including not just genes but also blood and body fluids is defined as "human-derived material" and placed under extremely strict control by the IRB.

The government has announced that it plans to promote U-healthcare and develop it as the next generation medical service and corporations are also preparing for another wave of growth for the ICT industry. On the other hand, the medical field holds its reservations due to potential issues such as patient safety, clinical efficacy, liability of misdiagnosis, and the implication that ICT would bring to practice of physicians. This presentation will introduce the current status and future outlook of ICT in health care in Korea and discuss relevant issues.

ICT and Healthcare in Korea, Present and Perspectives

Dong Chun Shin, MD, PhD

Professor, Dept. of Preventive Medicine
Yonsei University College of Medicine
Chair, Executive Committee of International Relations
Korean Medical Association
Council Chair, CMAAO
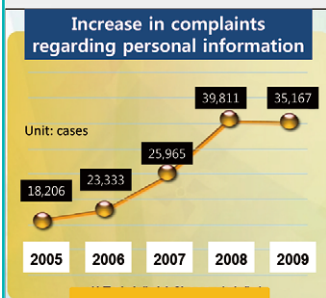

Current status of privacy and personal information protection

Privacy

Privacy protection problem

Increase in complaints regarding personal information

Unit: cases

18,206 | 23,333 | 25,965 | 39,811 | 35,167

2005 | 2006 | 2007 | 2008 | 2009

Major Types of Violations

1. Violation of personal information and privacy
2. Misuse of personal identification number
3. Improper use beyond initial purposes
4. Collection of information that are not agreed
5. Academic incompletion

Privacy

Leakage of personal information in the medical field

- Non-medical staff illegally inspected the hospital electronic medical records

- E-prescriptions of four thousand patients in a hospital were drawn by some clerks

- Suppliers to a number of hospitals leaked patient medical information from hospital management program

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Privacy

Personal Information Protection Act, 2011

- Data exportation was strictly limited in order to prevent leakage of personal information

- Data coding: resident ID number → randomized secret code

- New randomized number should be given during clinical trials

- The same principle applies genetic research
  - Bioethics and Safety Act, revised 2013
  - Institutional Review Board

Privacy

Bioethics and Safety Act

Article 18 (Provision of Personal Information)

(1) When a human subject of research consents in writing to providing his/her personal information to a third party pursuant to Article 16 (1), the relevant human subjects researcher may provide his/her personal information to a third party, subject to examination thereof by the competent institutional committee.

(2) When a human subjects researcher intends to provide personal information about a human subject of research to a third party under paragraph (1), he/she shall anonymize such personal information: *Provided*, That the foregoing shall not apply where a human subject of research consents to leaving his/her personally identifiable information therein.

Privacy

	PAT_JUMIN_NO						
1	00010131>	K529	13800	100128	10	1	40627752010060010126500
2	00010131番	K529	12280	100216	10	1	41418132010010010122500
3	0001013★	K529	12280	100111	10	1	03610382010040010044100
4	00010131←	K529	8780	100419	10	1	40761092010070010215000
5	00010131I	K529	12290	100427	10	1	42638842010010010210700
6	00010134L	K529	11930	091221	9	1	40082492010060010251000
7	00010134s	K529	8780	100224	10	1	40910552010060010139700
8	00010134量	K521	8780	100118	10	1	40310332010040010045400
9	00010131M_T	K529	14460	091027	9	1	40204972010030010206500
10	00010131?	K529	12280	100205	10	1	06410102010010010052200
11	00010131?	K529	12280	100421	10	1	12610072010010010091100
12	00010131-M	K529	19980	091230	9	1	40066822010020010004400
13	0001013l?	K529	12280	100412	10	1	41668462010060010114900
14	00010131W	K529	12280	100415	10	1	42837522010010010158700
15	0001013l)	K529	12280	100115	10	1	40540802010060010056400
16	0001013l懸	K529	10280	100410	10	1	12617822010060010039800
17	0001013l懸	K529	8820	100421	10	1	12617822010060010039900
18	0001013l+n	K529	12280	100106	10	1	40308242010040010057200
19	0001013+F	K529	12280	100331	10	1	40572042010020010000100
20	00010131N	K529	13340	091221	9	1	40052372010060010047300
21	00010131質	K529	15330	100515	10	1	43192752010010010053900
22	0001013l?	K529	15330	100313	10	1	40901822010040010192200
23	0001013l?	K529	11240	100422	10	1	40935432010000010035700
24	0001013l?	K529	12280	100326	10	1	41325932010060010003200
25	0001013-3	K529	8780	100408	10	1	42650382010010010054400
26	0001013-	K529	13910	100302	10	1	40795692010040010042000
27	0001013-D1	K529	12280	100303	10	1	41355302010060010002100
28	0001013-曾	K529	12290	100407	10	1	41218002010030010106200
29	0001013-?	K529	8780	100317	10	1	42393802010010010160800
30	0001013D	K529	10700	100105	10	1	40232782010020010064000
31	0001013(	K529	23720	100110	10	1	40438222010040010015000
32	0001013(	K529	15700	100221	10	1	40666412010040010012100
33	0001013測	K529	13430	100315	10	1	42438022010010010079800

Privacy

[별지 제20호서식] <개정 2009.12.31>

유전자 검사·연구 동의서

Consent form for genetic research

Consent form for research on any derivative of human body, including gene

Merits and demerits of
health care supported by ICT

Merits and demerits

Challenges to Healthcare delivery in Korea

Aging of Population

Increasing Chronic Diseases

Integration with U-Society

New Demands for Healthcare Delivery

Increasing Concerns on Wellness / Prevention

Consumer Empowerment

Demands for Access, Quality, Efficiency of Healthcare Delivery

Merits and demerits

Government

Overcoming increasing medical expenditures

Health care industry as growth engine for next generation

Merits and demerits

Enterprises

Provide new business opportunities for companies

Efficiency and advancement of the health care industry

Merits and demerits

Growth of U-Health Market

CAGR 12.5%

2010년 → 2020년

$ 2.8 billion → $ 10 billion

Ministry of Trade, Industry & Energy

Merits and demerits

Medical Communities

ICT as an supportive tool

Lack of doctor-patient relationship

Doctor-patient relationship can not be replaced by ICT

Irreplaceable feature of healthcare

Merits and demerits

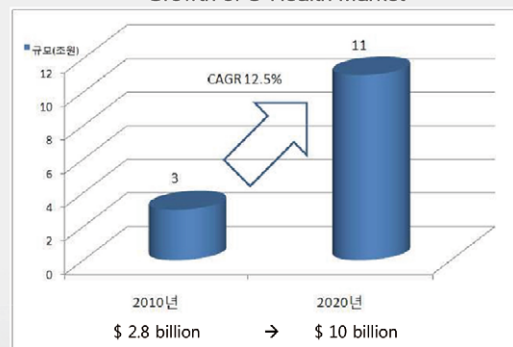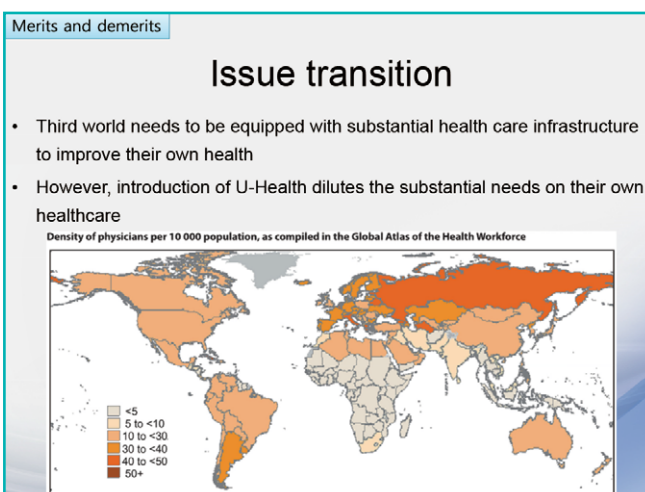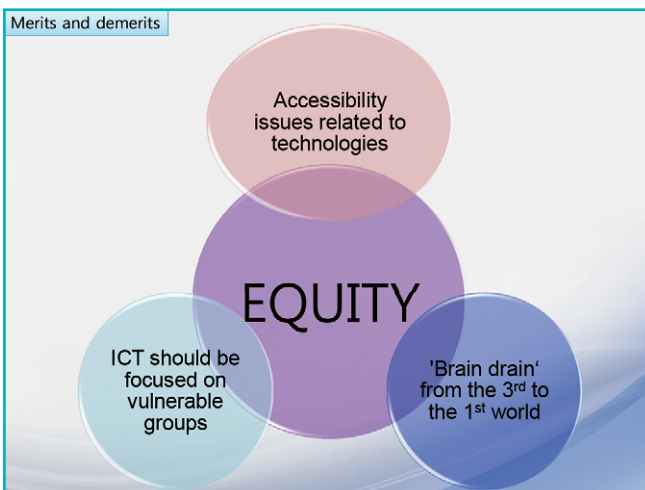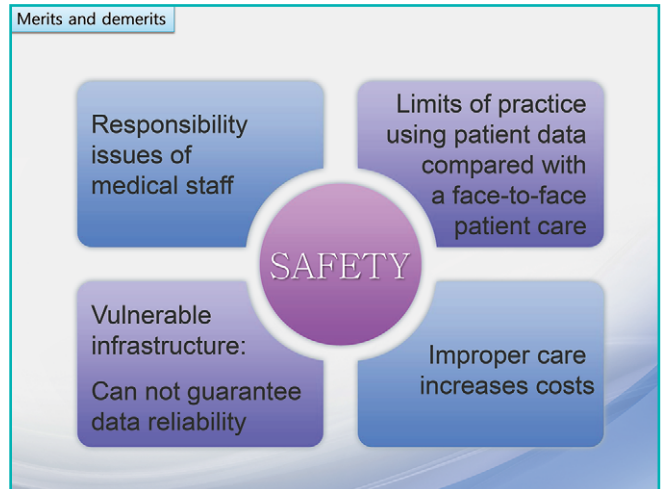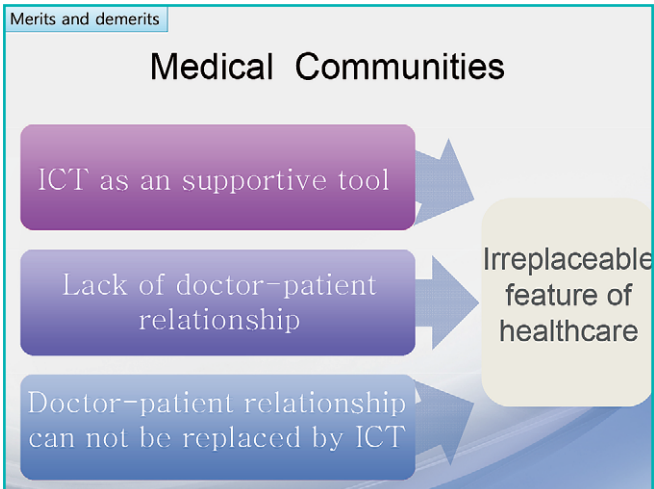Responsibility issues of medical staff

Limits of practice using patient data compared with a face-to-face patient care

SAFETY

Vulnerable infrastructure:
Can not guarantee data reliability

Improper care increases costs

Merits and demerits

Accessibility issues related to technologies

EQUITY

ICT should be focused on vulnerable groups

'Brain drain' from the 3rd to the 1st world

Cost-effectiveness

01 No definite evidence that U-Health brings improvement of healthcare so far

02 In terms of cost reduction, there is no conclusive evidence

03 U-Health's cost-effectiveness concluded that there is insufficient evidence, EU, 2008

04 Limited enforcement in developed countries: Education, Training

05 Trying to find evidence in the third world

Merits and demerits

Issue transition

- Third world needs to be equipped with substantial health care infrastructure to improve their own health
- However, introduction of U-Health dilutes the substantial needs on their own healthcare

Density of physicians per 10 000 population, as compiled in the Global Atlas of the Health Workforce

<5
5 to <10
10 to <30
30 to <40
40 to <50
50+

Thank you.

[Malaysia]

The Health Database*¹

Ashok PHILIP¹
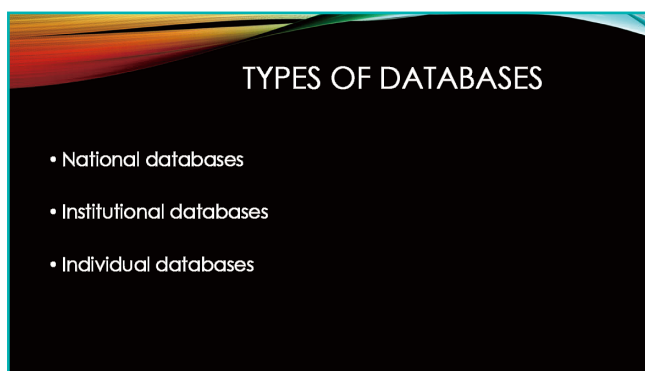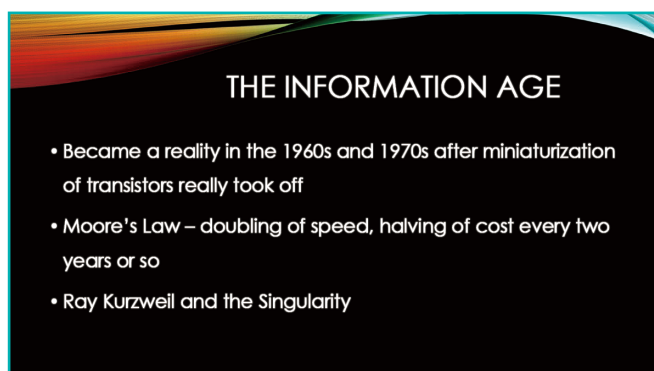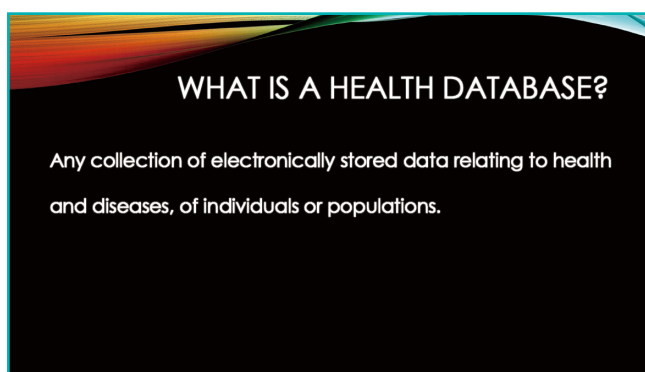
NATIONAL DATABASES

- Usually contain large amounts of data, often disease specific
- Rarely contain any personal information
- Useful in health policy formulation and drawing up treatment guidelines
- Possible rationing of healthcare?

INSTITUTIONAL DATABASES

- By far the most vulnerable databases are the ones maintained by hospitals and clinics.
- They contain patient identities and information about their health
- Vulnerable to malicious attacks and careless handling of data

INSTITUTIONAL DATABASES

- Legislation addresses the vulnerability of these databases.
- The European Directive on Data Protection lays down guidelines on how data should be gathered, stored and disseminated
- The United States has no single Data Protection Act
- The United Kingdom has a Data Protection Act passed in 1998

INSTITUTIONAL DATABASES

- In the ASEAN region, Malaysia, Singapore and the Philippines are enacting Data Protection Acts
- The Singapore Act came into force in July this year, and the Malaysian Act is in the process of registering data users.
- Malaysian doctors feel that existing legislation and ethics relating to the handling of patients' data is sufficient

INSTITUTIONAL DATABASES

- Doctors in individual or group practices are also becoming increasingly dependent on computerized records.
- Their cybersecurity measures may be inadequate.
- In Malaysia, written permission needs to be given by the Ministry of Health if records are to be kept in purely electronic form.

INDIVIDUAL DATABASES

- In many countries, patients are increasingly becoming custodians, at least in part, of their medical records.
- Such data, in Malaysia at least, consists of cards or books with brief details of disease and treatment. They are often lost or forgotten, and are rarely integrated across various specialties.

[Nepal]

Present Progress of Information Technology in Health Care System of Nepal[*1]

Mukti Ram SHRESTHA[1]

Nepal is the landlocked multiethnic, multilingual, multi-religious country with India in the Southern, Eastern, Western sides and China in the northern side. It is divided into three ecological zones, the lowland, the midland and the highland.

Information Technology (IT) has been proven a pioneering technology for the lives of people all around the world. IT is a basic infrastructure necessary for economic and social development of a country by which it can support the central nervous system of complex societies, transmitting and processing information and commands among the various parts of such societies.

With IT, individuals can see and share valuable information online. Patients in remote villages can see their specialist online rather than traveling for hours to the nearest clinic. School-teachers can download educational materials and lesson plans for their classes. IT is improving access to healthcare is through the availability of geographical information systems through digitized maps, aerial images, and geographic data.

The National Health Policy 1991 has been a bench mark in the history of Health Care Delivery system in Nepal through decentralization and regionalization of Health Services and recognition of private sector in health system.

The current Management Information System of Nepal includes Health Management Information System which was implemented in Nepal from Fiscal Year (FY) 1995/96 by the Ministry of Health and Population (MoHP) to strengthen management of health facility and to receive standard information. This section manages health service information from community to the Department of Health Services (DoHS)

through predefined process and procedure. This system is almost 19 years old robust and well set that provide base for planning, monitoring and evaluation of Health system at all levels. It provides information about achievements, coverage, continuity and quality of health services on monthly basis. Logistic Management Information System (LMIS) is a unit at Department of Health Services receives reports from all health facilities on supply, consumption and stock level of selected essential drugs and commodities. There is web based LMIS since 2009/10 and is in gradual manner.

Human Resource Information System (HuRIS) started from 1994 for the management of information of health worker in the country focusing on computerized personal record system. Drug Information Network is started by Department of Drug Administration from 1991 with the publication of Drug Bulletin of Nepal. It is used to develop and disseminate information on drug. Rural Telemedicine Program is prioritized during three-year interim plan (2007/08-2010/11) which was started from 25 districts and started in hospital of hilly and mountainous districts of Nepal from 22nd January 2011 and further extended to reach 30 districts. Pilot programs like SMS reporting of neonatal health information and malaria surveillance in certain pilot districts through Female Community Health Volunteers (FCHVs).

The benefits of information technology are access to Health Service of rural people, increase in quality of health services, increased availability of information for health planning as well as increased effectiveness of monitoring and evaluation of public health programmes.

There are some challenges in Present prog-

ress of Information Technology in Public Health System of Nepal too such as cost of health service, nationwide wide coverage of IT, Handling of personal level information and security of the information.

Present progress of Information Technology in Public Health System of Nepal

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Background

- The National Health policy 1991 has been a bench mark in the history of Health care delivery system in Nepal.
  - Decentralization of Health Service
  - Recognition of Private sector in health system

Current Situation

1. **Health Management Information System(HMIS):**
   - Dept. of Health Services established HMIS since 1994
   - Manages information on health services mainly through government health facilities.
   - Monthly basis
   - Web based HMIS up to District level

Current situation:

2. Logistics Management Information System (LMIS)
   - LMIS unit at Dept. of Health Services receives reports from all health facilities on supply, consumption and stock level of selected essential drugs and commodities.
   - Web Based LMIS since 2009/10 in gradual manner

Current situation:

3. Human Resource Information System (HuRIS)

- Started from 1994 for the management of information of health workers
- Focusing on computerized personnel record system

Current situation:

4. Drug Information Network

- Dept. of Drug Administration started from 1991 with the publication of Drug Bulletin of Nepal
- Drug Information Network : to develop and disseminate information on drug

Current situation:

5. **Rural Telemedicine Programme:**

- prioritized during three-year interim plan (2007/08-2010/11)
- Started from 25 district hospitals of hilly and mountainous districts of Nepal from 22nd January 2011 and further extended to reach 30 districts

6. **Other pilot programs:**

- SMS reporting of neonatal health information and malaria surveillance in certain pilot districts through Female Community Health Volunteers (FCHVs)

National ID

- Recently some works has been started for the establishment of National Identification system
- Government is planning to use the information gathered by Election Commission for Nation ID

Benefits and Challenges of IT in Health care

Benefits

- Access to Health service of rural people
- Increase in quality of health services
- Increased availability of information for health planning
- Increased effectiveness of monitoring and evaluation of public health programmes

Child Labour

- Government of Nepal is committed to eliminate all exploitative forms of Child Labour. This commitment is duly expressed through the ratification of the ILO Convention No. 138 ,182 and Child Right Convention of United Nations. Besides, there are activities underway under several ministries to really catch the spirit of these conventions and realisation of the objective of elimination of child labour.
- National Master Plan has also emphasised on the issue and incorporated many activities for the development of child and elimination of child labour.
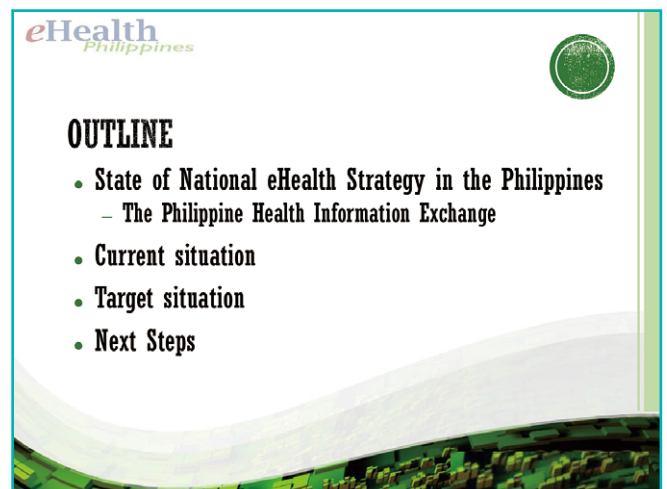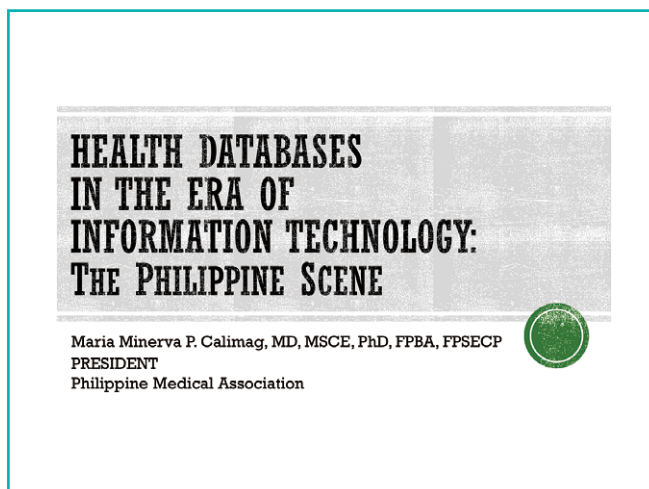
Challenges

- Cost of health service
- Nationwide coverage of IT
- Handling of personal level information
- Security of the information

Thank You for your kind Attention.

[Philippines]

Health Databases in the Era of Information Technology: The Philippine Scene[*1]

Maria Minerva P. CALIMAG[1]

HEALTH DATABASES IN THE ERA OF INFORMATION TECHNOLOGY: THE PHILIPPINE SCENE

Maria Minerva P. Calimag, MD, MSCE, PhD, FPBA, FPSECP
PRESIDENT
Philippine Medical Association

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eHealth Philippines

OUTLINE

- State of National eHealth Strategy in the Philippines
  – The Philippine Health Information Exchange
- Current situation
- Target situation
- Next Steps

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eHealth Philippines

STATE OF HEALTH IT IN THE PHILIPPINES

- Last July 2013, the Department of Health, Department of Science and Technology and PhilHealth formed the National eHealth Governance Steering Committee to evaluate, direct, and monitor the use of information and communications technology in healthcare.

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eHealth Philippines

STATE OF HEALTH IT IN THE PHILIPPINES

- In their first meeting October 2013, they approved the Philippine eHealth Strategic Framework and Plan 2014-2020

NATIONAL HEALTH SYSTEM GOALS

CURRENT SITUATION

- Prior to the creation of the eHealth Steering Committee, there was no clarity on how major decisions on eHealth were made.
- There were no standards and no privacy guidelines.
- The various stakeholders were also at a loss as to how they can participate in the larger eHealth program.

CURRENT SITUATION

Data/health information comes from disparate systems and locations.
Problems are:
- Different Data Formats
- Lack Data Harmonization
- Data Quality Problems in terms of reliability, timeliness, accuracy and completeness

DIRECTION OF THE PHIE
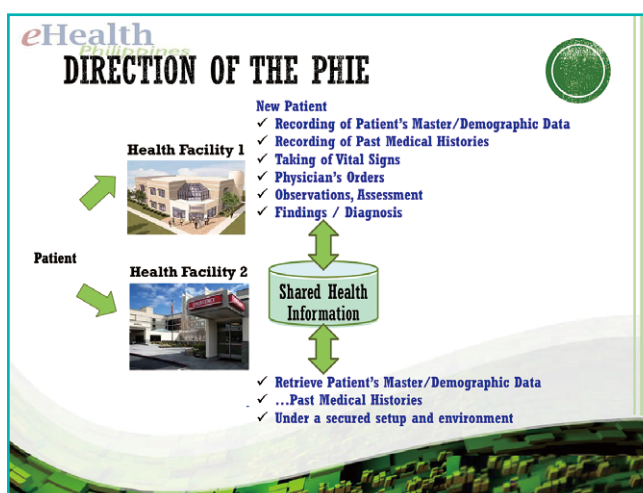
ACTION: PRIVACY

- The Data Privacy Act of 2012 explicitly prohibits sharing of personal information except with consent and/or public health emergencies.
- A National Health Data Privacy and Security Experts Group was created to draft the Privacy Guidelines. For public hearing this October.
- PMA is a participant of both the Standards and Privacy Experts Group.

NATIONAL HEALTH ID

- The country is in the middle of distribution of the Unified Multipurpose ID (UMID).
- The most expansive ID for all Filipinos is the PhilHealth ID.
- The DOH Administrative Order for Health Data Standards recommends the use of the PhilHealth ID as national health ID. It is now being deliberated by the Health Data Standards Experts Group.

PHILIPPINE HEALTH INFORMATION EXCHANGE

- The National eHealth Governance Steering Committee approved the Philippine Health Information Exchange as the framework for standardized communication between stakeholders in the health sector.

STANDARDS AND INTEROPERABILITY

NATIONAL eHEALTH CAPACITY ROADMAP

PROCESSES FOR GOVERNANCE OF IT
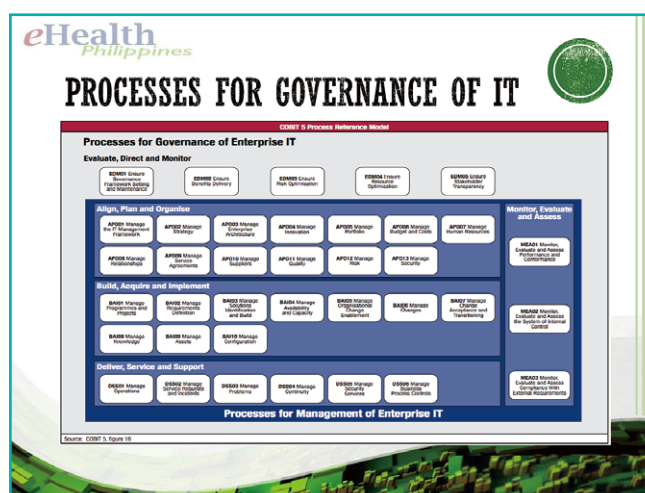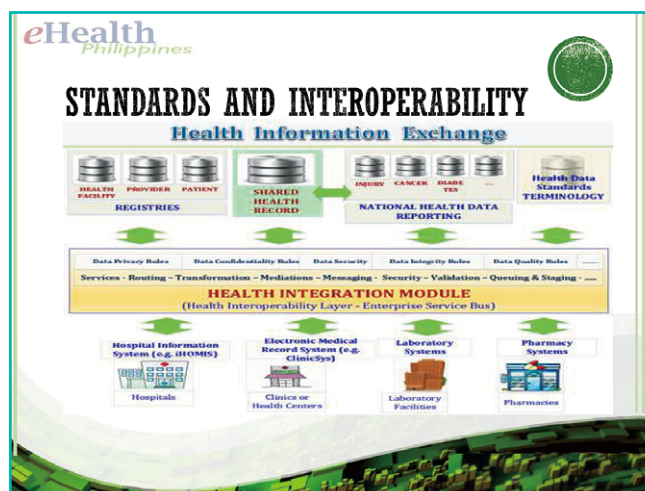
MERITS OF HEALTH IT

- Automation
- Efficiency
- Audit
- Patient safety
- Research

DEMERITS OF HEALTH IT

- Lack of capacity amongst healthcare and IT professionals
- Lack of human touch
- Additional expense with infrastructure investments

[Singapore]

Health Database in an IT Society[*1]

Bertha WOON[1]

Present Progress of IT in Healthcare in Singapore

The National Electronic Health Record (NEHR) system allows sharing of medical info, mainly accessible in public institutions and a few selected private clinics on a trial basis.

The GP Clinic Electronic Medical Record and Operation System ["Project CLEO"] allows some GP clinics to view NEHR information.

In the long run, GPs are expected to contribute to the NEHR so that information flow can be in both directions

Current Status of Protection of Personal Information

The Personal Data Protection Act (PDPA) took effect recently. Many organisations are still trying to cope with full effects of the new Act. Advisory guidelines have been developed to help clarify the main legislation.

A public consultation on proposed Advisory Guidelines for Healthcare was held recently to gather comments.

The guidelines highlight Consent, Purpose Limitation and Notification Obligations, e.g. document verbal consent to referrals by making a note inside patient file, or when collecting for purposes unrelated to patient's care, e.g. teaching purposes

On Access and Correction Obligations, patients can request for details on personal data kept by an organisation [e.g. via a medical report]. Patients can also request for correction of error(s) in personal data [for professional opinion, the organisation is not required to correct or alter]. Organisations can charge a reasonable fee for requests for access.

Regarding Protection, Accuracy, Retention Limitation, Transfer Limitation and Openness Obligations, the advisory guidelines acknowledge that there is no "one size fits all" solution. No specific retention period is prescribed.

Singapore Medical Association (SMA) dialogued with the Ministry of Health & PDPC before and after law came into effect, providing feedback on medical research, managed care companies, and medical records. SMA also organised seminars as part of educating its members on PDPA.

Use of the Citizen Numbering System

The National Registration Identity Card (NRIC) system is used extensively in Singapore, for verification of identity and other transactions. PDPC advisory guidelines on NRIC numbers highlight that consent is needed for collection, usage, and disclosure of NRIC numbers.

The SingPass system is a password that allows access to government e-services, and is used in conjunction with the NRIC. Services include car road tax, HDB flat, electrical, water and gas utilities, CPF, income tax, and medical records.

Merits and Demerits of Healthcare Supported by IT

Pros

Using a common database leads to fewer duplicate or unnecessary tests, reduced medication errors and adverse drug events. It is also easy to search and retrieve data in a digital format. IT also facilitates easier communication.

Cons

Doctors need to be mindful to ensure that patient confidentiality is not compromised. Assistance needs to be provided to less IT-savvy doctors, so that the move towards IT does not exclude a

1 Council Member, Singapore Medical Association, Singapore (sma@sma.org.sg).

segment of doctors.

An example of the misuse of IT, involved a doctor from a government hospital, who accessed electronic medical records of two women who were not his patients, in 2007 and 2009. He was fined $10,000 and censured by the Singapore Medical Council (SMC)

It was the 1st time a doctor had been disciplined and convicted for such a breach of conduct. Following this case, Ministry of Health (MOH) assured that access to electronic medical records of patients in public hospitals is tracked and audited.

Conclusion

Ensuring patient confidentiality needs to be the priority, while the usage of IT spreads throughout all aspects of healthcare. IT is not a substitute for the fundamentals of medicine, e.g. clinical skills, doctor-patient communication, etc.

Health database in a IT society

Singapore Medical Association – presentation at CMAAO 2014 Manila

Overview

1. Present progress of IT in healthcare in Singapore
2. Current status of privacy protection and personal information protection including handling of gene information
3. Use of the citizen numbering system
4. Merits and demerits of healthcare supported by IT

1. Present progress of IT in healthcare in Singapore

- Electronic medical records
  - National Electronic Health Record (NEHR) system
  - Sharing of medical info, mainly accessible in public institutions and a few selected private clinics on trial basis
  - data contributed by restructured hospitals and government polyclinic, who have gone paperless and running electronic medical records

1. Present progress of IT in healthcare in Singapore [2]

- Electronic medical records
  - types of patient information available in phase 1
    - Admission and visit history
    - Hospital inpatient discharge summaries
    - Laboratory results
    - Radiology results
    - Medication history
    - Operative procedure history
    - Allergies and adverse drug reactions
    - Childhood immunisations

Present progress of IT in healthcare in Singapore [3]

- GP Clinic Electronic Medical Record and Operation System ["Project CLEO"]
  - in progress in GP clinics
  - they can view NEHR to help them manage patients
  - In the long run, GPs are expected to contribute to the NEHR so that information flow can be in both directions
  - security - one pass, two factor authentication (2FA) token

2. Current status of protection of personal information

- Personal Data Protection Act (PDPA) took effect in phases
  - starting with the provisions relating to formation of Personal Data Protection Commission (PDPC) on 2 January 2013
  - provisions relating to Do-Not-Call (DNC) Registry came into effect on 2 January 2014
  - main data protection rules on 2 July 2014
  - many organisations still trying to cope with full effects of the new Act
- Advisory guidelines developed for various sectors and scenarios
  - help clarify main legislation

Medical aspects of PDPA (1)

- Public consultation on proposed Advisory Guidelines for Healthcare
  - Consent, Purpose Limitation and Notification Obligations
    - Deemed consent [similar to existing medical concepts of consent-taking]
    - Referrals – guidelines suggest to document verbal consent by making a note inside patient file
    - Collecting data of other individuals from patients (e.g. asking about family history of cancer) – collection w/o consent granted under exemptions within the PDPA
    - Collecting for purposes unrelated to patient's care, e.g. teaching purposes – organisation should notify patient, and obtain consent if the data cannot be anonymised
    - Disclosing personal data to managed care providers or employers – organisations may only disclose with patient consent, or under a PDPA exemption; should also consider if such disclosure would be in breach of other legal obligations or ethical requirements

Medical aspects of PDPA (2)

- Public consultation on proposed Advisory Guidelines for Healthcare (con't)
  - Access and Correction Obligations
    - Patients can request for details on personal data kept by an organisation [advisory guidelines clarify that organisations can provide this info in another format, e.g. via a medical report]
    - Also the ways the data has been used or disclosed
    - Patients can also request for correction of error(s) in personal data [advisory guidelines clarify that where diagnosis is a professional opinion, the organisation is not required to correct or alter]
    - Organisations can charge a reasonable fee for requests for access

Medical aspects of PDPA (3)

- Public consultation on proposed Advisory Guidelines for Healthcare (con't)
  - Protection, Accuracy, Retention Limitation, Transfer Limitation and Openness Obligations
    - Protection – no "one size fits all" – organisations to make reasonable security arrangements
    - Retention - retaining personal data of existing patients for the purpose of having access to their consultation history would be considered a valid purpose – no specific retention period prescribed
  - Rights and obligations, etc. under other laws
    - E.g. doctors should still continue to notify the Ministry of Health regarding reportable infectious diseases; no need to obtain consent

Medical aspects of PDPA (4)

- SMA dialogued with Ministry of Health & PDPC before and after law came into effect
- submitted feedback during public consultation period
  - Medical research
  - Managed care companies
  - Medical records
- SMA also organised seminars as part of educating its members on PDPA

3. Use of the citizen numbering system

○ National Registration Identity Card (NRIC) numbers used extensively in Singapore
  ○ government [verification of identity]
  ○ private [e.g. banks, telecommunications, etc.]
  ○ winners of lucky draws [typically, only last three or four digits are published to prevent identity theft]
○ advisory guidelines on NRIC numbers
  ○ consent needed for collection, usage, and disclosure of NRIC numbers
  ○ organisations to ensure protection from accidental disclosure
  ○ organisations should avoid over-collecting personal data; consider if alternatives are available
○ SingPass system
  ○ password that allows access to government e-services; used in conjunction with NRIC
  ○ car road tax, HDB flat, electrical, water and gas utilities, CPF, income tax, and medical records.

4. Merits and demerits of healthcare supported by IT

○ Pros
  ○ Common database - fewer duplicate or unnecessary tests, reduced medication errors and adverse drug events
  ○ Easy to search and retrieve data in digital format
  ○ Easier communication [many doctors already use messaging apps for communication with other doctors in an informal basis, e.g. Whatsapp, Google Talk, Facebook message, etc.]
○ Cons
  ○ Need to ensure patient confidentiality is not compromised
  ○ Some doctors may not be ready [need to provide assistance to less IT-savvy doctors, e.g. training & funding assistance]

Case relating to misuse of IT

○ case involving a doctor from a government hospital, who accessed electronic medical records of two women who were not his patients, in 2007 and 2009
○ Fined $10,000 and censured by the Singapore Medical Council (SMC)
○ 1st time a doctor has been disciplined and convicted for such a breach of conduct
  ○ checked the first woman's records after learning that she was seeking treatment for a suspected sexually transmitted disease
  ○ accessed the records of the second woman to check when she had appointments at the hospital, so as to avoid hostile run-ins with her
  ○ actions came to light after the second woman filed a complaint against him in August 2009
○ Following this case, Ministry of Health (MOH) assured that access to electronic medical records of patients in public hospitals is tracked and audited

Conclusion

○ Patient confidentiality has to be the priority

○ Usage of IT will spread throughout all aspects of healthcare

○ IT not a substitute for clinical skills, doctor-patient communication, etc.

References

○ http://www.pdpc.gov.sg/docs/default-source/public-consultation-4-–education-healthcare-social-services-photography-submissions/proposed-advisory-guidelines-for-the-healthcare-sector.pdf?sfvrsn=0

○ http://www.egov.gov.sg/egov-programmes/programmes-by-citizens/the-electronic-medical-record-exchange-emrx

○ https://www.healthxchange.com.sg/News/Pages/Access-to-Patients-Medical-Records-is-Tracked-MOH.aspx

○ http://www.moh.gov.sg/content/dam/moh_web/Publications/Educational%20Resources/2011/NEHR%20Brochure_ENG_CH.pdf

The End

Thank You

[Taiwan]

The Health Database in an Information Society[*1]

Yu-Chuan (Jack) LI[1]

Besides paperless-ness and efficiency, the most valuable application of accumulated, aggregated Electronic Health Record data may well be their use to improve quality and patient safety. This talk describes a Data Interaction Model (DIM) and a Probabilistic Association Model (PAM) that would allow healthcare professionals a new perspective to look at their own Big Data, while also provides an architecture to fully take advantage of the data in hands to continuously improve healthcare quality and patient safety.

Why EHR?

- Paper-less?
- Easier to read?
- Automatic translation? (e.g. different languages, pro terms → layman's language)
- Speedy access
- Concurrent access
- Provide (big) data to Improve quality and safety! (thru decision support systems)

Defining Big Data

- Big Data is a collection of data sets so large and complex that it becomes difficult to process using on-hand database management tools or traditional data processing applications.

http://en.wikipedia.org/wiki/Big_data

Elements of "Big Data"

- The degree of complexity within the data set
- The amount of value that can be derived from innovative vs. traditional analysis techniques
- The use of longitudinal (time-series) information supplements the analysis

http://mike2.openmethodology.org/wiki/Big_Data_Definition

Challenges Biomedical BD

- Locating/accessing data and software tools
- Standardizing data and metadata
- Extending policies for sharing BD
- Organizing, managing, and processing
- Developing new methods for analyzing & integrating BD
- Training researchers who can use BD effectively

From http://bd2k.nih.gov/about_bd2k.html#sthash.jNfoKrca.dpbs

Current State of Healthcare

- Care is complex
- Care is uncoordinated
- Information is often not available to those who need it when they need it
- As a result patients often do not get care they need or do get care they don't need

IOM, Crossing the Quality Chasm, 2000

Poor Quality

- 45% did NOT receive recommended care
  - Pneumonia → 61% X
  - Asthma → 47% X
  - Hypertension → 35% X

McGlynn et al., New England Journal of Medicine, 2003

EHR Data to Improve QPS

Data Interaction Model (DIM)

- Patient profile[1]
- Lab and exam data[2]
- Medications[3]
- Procedures[4]
- Diagnoses and problem list[5]

Data Interaction Model for Adverse Event detection

YC (Jack) Li et. al., 2004
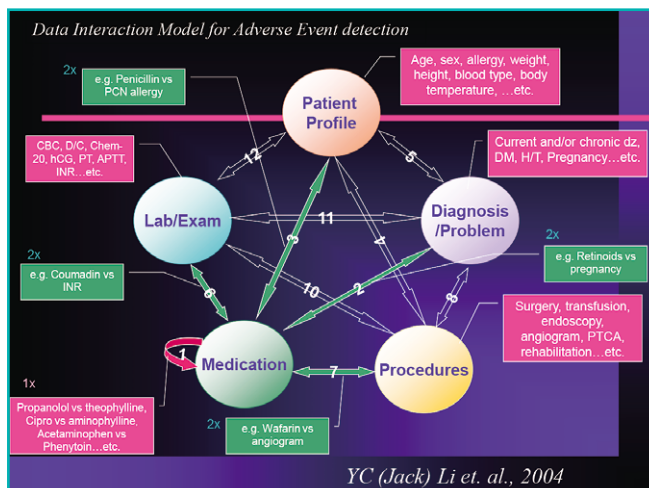
One-way Interaction Examples

- Drug-Drug Interaction as example
- Redundant drugs
- Max daily dose (for children and adults)
- Unusual frequency
- Inconsistent route/dosage form
- High alert medication

Two-way Interaction Examples

- Drug vs Patient Profile
  - Age, Sex, Pregnancy restrictions
- Drug vs Diagnosis/History
  - Contraindications, inconsistent Dx-drug combination
  - Drug-allergy detection
- Drug vs Lab
  - Liver, kidney function restrictions
  - Therapeutic dosage
- Drug vs Procedures
  - Blood-thinners with angiogram

Results of the Anti-CIN Program

RISK	Baseline 12 months	Anti-CIN 12 months
A+ Cre>2	5.50%	3.48%
A Cre>1.4	14.00%	9.57%
C	38.60%	38.23%
BDE	47.40%	52.20%
#Exam	3,624	5,318

≈ 200 cases/year saved!

Data Interaction Models

- One way: 5
- Two way: 10
- Three way: 10
- Four way: 5
- Five way: 1
- Total: 31 combinations

Limitations on DIM (Drug vs Dx)

- Diagnosis
  - Diabetes Mellitus
- Medications
  - Euglucon (Glibenclamide) ✔ (lower sugar)
  - Euclidan (Nicametate) ✗ (vasodilator)
- Difficult for manually crafted rules
  - Too many combinations and exceptions

Probabilistic Association Model (PAM)

- Take any number of data elements from the DIM and compute their association strengths (Q)
- Q = P(A and B) / P(A)•P(B)
- Use the combinatorial Q among the data elements to determine the probability of the occurrence of a specific combination

PAM example on Drug-Dx Interaction

- Drug-Dx interaction in PAM
- Go through 103 million prescriptions (204m diagnoses in ICD-9CM and 347m drugs in ATC code) from Taiwan's National Health Insurance database
- Compute all the association strength (Q) between Dx/Drugs and Drug/Drug

AOP (Appropriateness of Prescription) determined by Q's

The AOP model is expressed mathematically as:

$$\forall M : \begin{cases} \left\{ Q_{D,M_j} \right\} + \left\{ Q_{M_j M_k} \right\} \geq m \\ \exists Q_{D,M_j} : \left\{ Q_{D,M_j} \right\} \geq 1 \qquad (i \in \{1,2\ldots n\}; j,k \in \{1,2,\ldots m\}) \\ \begin{bmatrix} \exists Q_{D,M_j} : \# \left\{ Q_{D,M_j} \right\} \geq 1 \\ \exists Q_{M_j M_k} : \# \left\{ Q_{M_j M_k} \right\} \geq 1 \end{bmatrix} \end{cases}$$
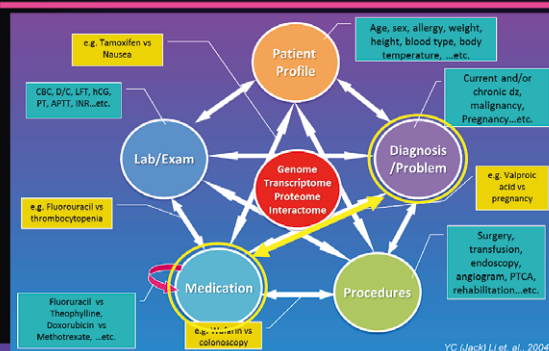
Conclusion

◆ With the Big Data approach, QPS can be improved several orders of magnitude

◆ One hospital captures 20,000 high risk events every year

◆ Moving from
Detect → Predict → Prevent

Thank you for your attention

[Thailand]

Health Database in an Information Society[*1]

Wonchat SUBHACHATURAS[1]

I don't think anyone of us or any country would deny the usefulness and beneficial of the new information technology or IT. IT can both produce the modern trend of communication as well as the data keeping, development of rapid evaluation, expansion and sharing of the information as never before.

In health care, information technology has come to the use since 1981 and rapidly growing from the US, European countries, Australia to our Asian community in 1990 especially in Japan, Korea, Hong Kong, Taiwan and Singapore. Since then this new technology has been in use in all countries depending on the economy status.

In Thailand the use of this new technology has been developed since 1994 and growing in both Private and Governmental sectors. Many aspects of health care both in consumers and providers sides including health delivery system have been implemented but still at a low level as comparing with those countries, I mentioned before. Why? It is because Thailand is a technology purchasing country. We, of cause, can produce and export many of the IT components or accessories but we need to import back the assembled or completed hard wares and also the soft wares.

A perfect system of information technology is still in our dream but in reality, only parts of the system exist in the dairy use such as the tele-conferences, consultation, reporting, referring, statistical analysis and evaluation. Most of these are used in the intranet system. Each hospital or the health care stations have been developing their own link between the registration desk, the doctor examination rooms, laboratory facilities and dispensary including in-patients department and home health care.

For the internet and the inter-organizational linkage such as smart card or e-health card are still not well developed and not yet implemented nationwide in Thailand.

The issues of concern of the full use of modern information technologies are

1. The system must be established under the national policy and commitment to achieve a well collaboration from all parties or stake holders in the governmental and private sectors as well as the patients.
2. The system needs a huge sum of budget to establish and maintenance. Investment is not only for the hard wares but also the appropriate soft wares and the training for the people ware.
3. The system needs a close collaboration from all stake holders to be transparent and data sharing.
4. The system needs a perfect access security for the protection of personal database privacy.
5. A good system needs complete data filing and updating.
6. Trustful and transparency of the data.

Achievement of the IT in Health Database
1. Instant information......Instant diagnosis....... Instant treatment......Instant cure....Prevention of damage
2. Health information transferring (Public-Private Partnership)
3. Reduce time...reduce cost of transportation and logistics......reduce morbidity.....reduce mortality
4. Less paper.....Paperless
5. Better and sustainable home care and reporting
6. Consultation especially in EMS
7. Intranet......Internet........Global connection
8. Increase the use of education via social media, teleconferences, and telemedicine
9. Availability of devices at present: Web, Line, Linked in, Skype, Google, Face-book, Twitter, U-Tube etc.

Confederation of Medical Associations in Asia and Oceania

CMAAO Resolution on Ethical Frameworks for Health Databases and Human Genetic Databases

Adopted by the CMAAO General Assembly in Manila, the Philippines on September 24-26, 2014

Rapid advancement in information and communication technology (ICT) has enabled vast amounts of health related information including genetic information to be collected, processed, analyzed and integrated, which in turn has contributed to unprecedented breakthroughs in medicine.

At the same time, an individual's health related information including physical condition, illness, treatment, medical history, family history and genetic information is one of the most sensitive types of personal information to be fully protected.

For such reasons, any ethical framework on the handling of personal health information including genetic information should follow strict principles designed to guarantee individual rights by taking into full consideration such special characteristics.

This resolution aims to reaffirm the special characteristics involved in the collection and use (for both research and non-research purposes) of health and genetic information and to propose an ethical framework that reflects such special characteristics. The resolution's primary objective is to propose principles that reflect the regional characteristics of Asia and Oceania in order to provide direction and guidelines to NMAs in this region in their efforts to play a leading role in related fields. Ultimately, CMAAO hopes to contribute to public health and human rights by encouraging the governments and all the related people to urgently develop the statutes that clearly require protection of personal health information and explicitly stipulate the permitted scope of usage of such health information.

Security and Confidentiality

Health databases, including human genetic databases shall be collected and used for only ethical and medically justified purposes and shall never be used for purposes that may lead to infringement of individual freedom and rights.

Medical information confidentiality of the information donor ("donor") shall be protected in all cases, and information shall not be divulged to third parties without consent.

Personal identifiers shall be stored in an encrypted form so as to guarantee their security and confidentiality and shall be used for research only when absolutely necessary within a scope that does not harm individual rights.

All physicians and researchers that handle health databases including human genetic databases have a solemn responsibility and duty to guarantee their confidentiality and shall exert efforts to manage such databases securely.

The number of researchers and assisting staff with access to the information shall be main-

tained at a minimum level at which the research is possible. Unauthorized creation or distribution of data copies or the use of data for purposes other than originally intended shall be prevented.

Personal identifiers shall be used only when the data is linked for the first time and shall be separated from the integration process and the output.

An organization that builds or stores the database independently from the researchers shall conduct the integration of data, and researchers should be provided with the data without any personal identifiers.

Results of research should only be reported in aggregate terms.

Informed Consent

The entire process of collection, storage and use of data that are included in health databases including human genetic databases shall be conducted using methods that are ethical and compliant with each country's laws and guidelines. In particular, the WMA Declaration of Helsinki on Ethical Principles for Medical Research (DoH) involving Human Subjects shall be adhered to.

In collecting an individual's health or genetic information, consent from the donor or his/her legal agent shall be the result of a voluntary decision reached based on sufficient explanation and understanding of details related with the donation including the clear present purpose of research, possible future research purposes, the type of genetic information collected, the method of collection and the entire donation related process from collection to use. The informed consent, in principle, shall be obtained in advance, using an explicit, written form.

The donor's right to determine the use of information that he/she provided shall be respected. Therefore, even after a donor provides his/her informed consent, he/she still reserves the right to withdraw such consent at any time for whatever reason without any restriction and without concerns of suffering from any disadvantage due to withdrawal. All information provided by a donor who has withdrawn his/her consent shall be immediately destroyed.

A donor has the right to know of the current status of the research that is related with the information he/she provided as well as whether his/her information is being managed properly.

Fair Access and Sharing

The data incorporated into health databases including human genetic databases shall be treated as public goods. Access to such databases shall be guaranteed to researchers who are pursuing research for ethical and publicly beneficial purposes.

Also, the results of research related with health databases including human genetic databases shall be shared among nations as much as possible in order to maximize the benefit to the entire human race and to minimize research redundancy and the risks inherent in this field of research.

Any research that uses health databases or human genetic databases shall ultimately contribute to enhancing equality in health and in society.

Protection of Vulnerable Groups

Research that uses health databases or human genetic databases also require devices designed to protect vulnerable groups.

Researchers must provide sufficient consideration for such donors in all stages of research. The Research Ethics Committee must also identify any potential vulnerable group during its review process and examine whether the planned research properly provides devices for the protection of such groups.

Ethics Committee

With regards to research using health databases including human genetic databases, the Ethics Committee shall examine whether the research purpose, scope of data collection and the entire collection process are ethical and whether the collected information has been used for the correct purpose and verify the capabilities and qualification of the research team that is conducting the research.

An international Research Ethics Committee shall be formed in the case where multiple nations collaborate on research that uses health or genetic information from databases.

International Cooperation

The creation of human genetic databases and the results of research emanating from its use is potentially powerful technology that may change the quality of life for the entire human race. However, it also raises issues of inequality because many developing countries are blocked from participating in such research due to cost issues. Thus, international cooperation including creation of related infrastructure and support for technology development and participation in research activities is necessary to enable even developing nations to participate in research that uses health databases including human genetic databases and to benefit the achievements from such research.

Recommendations for CMAAO Members

1. Each NMA shall urge each government to prepare the necessary legal systems and procedures so that the principles proclaimed in this resolution are shared and realized, and if necessary, is responsible for providing related advice as an expert group.

2. Also, each NMA shall exert efforts in the development and distribution of education and training programs for not only health database or human genetic database researchers, related personnel and physicians but also the general public so that the principles proclaimed herein are widely communicated.

3. Also, each NMA shall exert efforts to support research activities on ethical approaches to this issue and also to monitor whether such ethical principles are being well followed. For this purpose, member NMAs shall build broad and close cooperative relationships with each of the governments, health authorities, academia and related organizations.

BANGLADESH MEDICAL ASSOCIATION[*1]

M. Iqbal ARSLAN[1]

Bangladesh Medical Association (BMA) is a well-recognized professional organization in Bangladesh. Government consults this body regularly in health related matters. BMA has contributed significantly in the formulation of National Health Policy by the present government. Although it has to go a long way to have a health system that is efficient, equitable, effective and financial risk protective Bangladesh has progressed much in health sector particularly in attaining MDG-4 and MDG-5 (millennium development goal) targets for which it has achieved MDG award. The present government has given much emphasis on health sector. It has extended health service to the doorstep of the common people by building community clinics— each one serving 6,000 people in its vicinity. Basic healthcare package is provided in the community clinic by a short term trained community health care provider. All these clinics are provided with a laptop computer and a wireless modem which is used for collection of local health related data provision of telemedicine service, community health education and certain other ICT based health solutions.

Bangladesh has introduced eHealth (electronic health) and mHealth (mobile health) which is proved to be very effective. In Bangladesh several private hospitals have been established which maintain international standard like JCI. BMA has organized a workshop on "Policy Dialogue on Tobacco Control" jointly with Bangladesh Center For Communication Programme. BMA plays an advisory role in the medical subject related societies who organize scientific seminar/symposium time to time.

BMA is negotiating with the government to find out the means to solve the crisis arising out of absenteeism of the health workforce specially doctors in the rural setting. It is trying to convince the policy makers and the bureaucrats to introduce incentives both financial and non financial to retain the health workforce in the rural areas.

BMA is working closely with the government to increase the number of health workforce in the country which is only 5.7 per 10,000 population. As a result more than 6,000 doctors and 4,000 nurses recruitment is finalised recently. Another 10,000 nurses will be appointed soon to balance the existing disproportionate doctor-nurse ratio which is 1:0.6.

Frequency of violence against the doctors has increased alarmingly in recent times. The law enforcing agency also arrest the doctors on an assumption that homicide has been committed. BMA has sought the court's verdict compelling the law enforcing agency not to practice such a measure merely on an assumption. We are also working with the government to formulate a law to curve the violence on doctors and other health workforce. At the same time we are working with Bangladesh Medical and Dental Council to make regulations on ethical behavior and practice by the doctor which will be required to follow.

BMA has supported the victims of natural and man made disaster by its medical teams. It also regularly conducts Free Friday Clinic which are visited mostly by poor. BMA regularly publishes its scientific journal which contains articles written by eminent physicians of the country.

BMA office bearers participate in the congress of World Medical Association, Commonwealth Medical Association and medical associations of SAARC countries. A formal healthcare standard, hospital accreditation system, private healthcare act and proper quality assurance programme were lacking in Bangladesh. BMA has encouraged and assisted the authority to formu-

*1 This article is base on a presentation made as the Report of Activities by each NMA at the 29th CMAAO General Assembly and 50th Council Meeting, Manila, the Philippines, on September 24-26, 2014.

1 Secretary General, Bangladesh Medical Association, Dhaka-1000, Bangladesh (bma.org.bd@gmail.com).

late these.

BMA is supporting the government to launch Universal Health Coverage programme within a shorter period. Government has targeted to achieve UHC by 2032. Bangladesh Medical Association pledges to work with international community to improve the health situation throughout the world. We hope to getting cooperation from all to create a world we will love to live.

29th General Assembly and 50th council meeting of CMAAO
COUNTRY REPORT
BANGLADESH MEDICAL ASSOCIATION

Presented by
Dr. Jamal Uddin Chowdhury
Member, Central Executive Committee
Bangladesh Medical Association

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MDG-4: Reduce Infant Mortality

Target	Indicator	Benchmark (Year)	Current progress (Reference)	Target (Year)
Reduce by two-thirds the mortality rate among under-five children	Death rate among under-five children/1,000 livebirths	144.0 (1990)	41.0 (UNICEF 2013)** 44.0 (SVRS 2011) 53.0 (BDHS 2011)	48.0 (2015)
	Infant mortality rate/1,000 livebirths	94.0 (1990)	33.0 (UNICEF 2013)* 35.0 (SVRS 2011) 43.0 (BDHS 2011)	31.3 (2015)
	1-year old children immunized against measles (%)	52.0 (1991)	85.5% (BECES 2012)* 87.5 (BDHS 2011)	100.0 (2015)

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MDG-5: Reduce Maternal Mortality

Target	Indicator	Benchmark (Year)	Current progress (Reference)	Target (Year)
Reduce by three-quarters the maternal mortality ratio	Maternal mortality ratio/100,000 livebirths	574.0 (1990)	194.0 (BMMS 2010)*	143.5 (2015)
	Births attended by skilled health personnel (%)	7.0 (1990)	26.5 (BMMS 2010) 31.7 (BDHS 2011)	50.0 (2015)
Ensure, by 2015, universal access to reproductive healthcare	Contraceptive prevalence rate (%)	39.9 (1991)	61.2 (BDHS 2011)* 58.4 (SVRS 2011)	72.0 (2016)
	Birth rate among adolescent mothers/1,000 women	77.0 (1990/91)	105.0 (BMMS 2010) 118.3 (BDHS 2011)	-

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Sheikh Hasina, Prime Miister of Bangladesh is receiving the award

- The present government has given much emphasis on health sector
- It has extended health service to the doorstep of the common people by building community clinics - each one serving 6000 people in its vicinity

- Basic healthcare package is provided in the community clinic by a short term trained community health care provider
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Only 3 software

DHIS2
HRM
OpenMRS

One common shared ICT infrastructure

Bangladesh has introduced e-Health (electronic health) and m-Health (mobile health) which is proved to be very effective

eHealth enterprise architecture   Standardization & Interoperability
www.dghs.gov.bd
120 million citizens
Life Time eHR
eHR   Personal Info
Health Information Exchange   Population√
Geo-location√
Why standardization?
Asset info   Facility Info
Doctor Info   Facility√
Asset   Health workforce√
eRegistry Systems
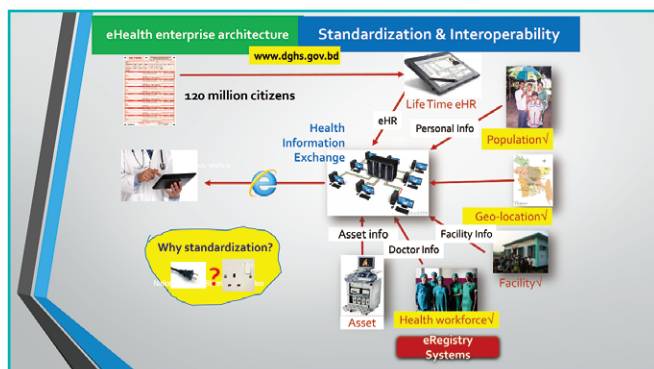
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- As a result more than 6000 doctors and 4000 nurses recruitment is finalized recently
- Another 10000 nurses will be appointed soon to balance the existing disproportionate doctor - nurse ratio which is 1:0.6.

Country	Density of skilled health professionals (doctors, nurses and midwives) per 10000 population, c. 2010	Percentage change in workforce required to reach 22.8 threshold[a] by 2035
Group 1		
Bangladesh	5.7	404
Ethiopia	2.7	1,354
Group 2		
Ghana	13.6	221
Indonesia	16.1	78
Peru	22.2	33
Vietnam	22.3	19**
Group 3		
Brazil	81.4	0
Thailand	17.4	32
Turkey	41.1	0
Group 4		
France	126.6	0
Japan	63.3	0
Source: Global Health Workforce Alliance 2013.		

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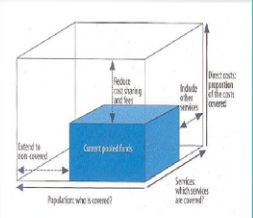
Bangladesh Medical Association pledges to work with international community to improve the health situation throughout the world. We hope to getting cooperation from all to create a world we will love to live

THANK YOU

HONG KONG MEDICAL ASSOCIATION[*1]

Alvin Yee Shing CHAN[1]

With the continuous efforts of our colleagues, the Association's membership continued to grow steadily over the past year. The tie between colleagues and the Council continued to be strengthened through various activities—including but not limited to the countless Continuous Medical Education (CME) programmes, community projects, research projects and social and recreational activities. The citizens of Hong Kong was involved and benefited a lot through our public education events and press statements.

With the unfailing support from our members, we continued to speak for the profession and safeguard the health and welfare of the public. We worked closely with the Government, the Hospital Authority (HA) and the Department of Health (DH) on important issues relating to political reform, public-private partnership (PPP), legislation on medical devices, revamp of HA, medical manpower planning, the Health Protection Scheme (HPS) and communicable diseases. We also worked with The Medical Council of Hong Kong on relaxation of the Licentiate Examination for overseas medical graduates.

On political reform and 2017 universal suffrage, we had conversations with a number of key persons and opinion leaders. We learned from them their philosophies of democracy. We listened to the voice of the people—our members, whose views and visions of Hong Kong's 2017 universal suffrage were reflected in questionnaire survey. The report was released to our members and the press. In brief, members expressed a majority acceptance of nominating the next C.E. candidate through a nomination committee in accordance with the Basic Law, and it is a majority consensus that the threshold for nomination should be no higher than that in the 2012 C.E. election. From disparity of opinion we find agreement.

It has been a decade's effort for the Hong Kong Medical Association (HKMA) to build up public private partnership (PPP), which has very much been an offspring of our Association. The Cataract Surgeries Programme and vaccination programmes were milestones. Negotiations were made with the Hospital Authority of Hong Kong in their initiation to partner with private family doctors in the day-to-day care of stable, hypertensive patients. We shall continue to strive for sustainable and suitable PPP programs for the betterment of the people of Hong Kong.

Reverberation of the DR incident two years ago remains intense, and the Government has stepped forth to risk manage medical procedures and legislate medical devices. A number of steering committees and expert groups were formed. We were heavily involved in the committee discussions that followed. It has been common practice for doctors well-trained in endoscopy to perform colonoscopy in their own clinics as well as non-hospital endoscopy facilities. Patients enjoy a more affordable choice other than hospital endoscopy. The Government decided to regulate and set a standard for non-hospital colonoscopy facility. We set up a Task Force to explore what the standards could be. We came up with a consensus statement which was submitted to but then brushed aside by the Government. Adding fuel to the fire is the Government's intention to contract by tender for colonoscopy services. Tendering is intrinsically biased towards HMOs and insurance groups. The Government's stance will foreseeably slash public choices of their endoscopists.

On the educational front, the 15th Beijing/Hong Kong Medical Exchange on "Recent Advances in Cancer Medicine" was successfully held at Changsha, Hunan. Numerous CMEs, certificate courses and training courses were

[*1] This article is base on a presentation made as the Report of Activities by each NMA at the 29th CMAAO General Assembly and 50th Council Meeting, Manila, the Philippines, on September 24-26, 2014.

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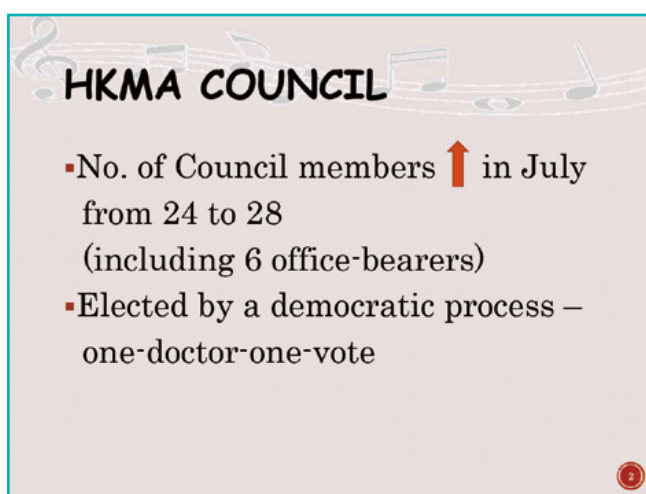
organized with practical topics like clinical issues and updates, chronic pain, increasingly common diseases associated with the ageing population, medico-legal issues and many others. To improve doctor's communication skills, we continued to organize series of risk management workshops. To help doctors become expert witness for inquiries, courts and tribunals, a two-day training course was held on a September weekend. After four years' hard work in drafting, exchanging comments and refinement among the Association, Medical Protection Society and lawyers from the two local panel law firms, the Clinical Risk Management Handbook was finally published. We also organized an exchange visit to Yunnan. It has a multi-cultural inhabitants with 26 ethnic groups living in harmony with one another, many retaining their own traditions and languages alongside Putonghua. We attended an enlightening lecture featuring ethnic minorities of China and Sino-ASEAN relations, and visited a major provincial hospital, a local community health centre and the Kunming Medical University.

On social and recreational events, just like previous years, we arranged countless activities for our members. Sports events included the many ball games and matches—football, basket-ball, volleyball, badminton, tennis, table-tennis, squash, bowling, snooker and golf etc. We also had bench pressing and power-lifting, not to mention the usual dragon boat, trailwalker, hiking activities, annual swimming gala and family sports day. Our professional choir and orchestra continued their expertise in performing for various fund-raising activities, including our annual Charity Concert. The Hong Kong Medical Association Photographic Society spell bind the city with the beauty they captured. Our photographers are our pride of the year.

Internationally, we participated in the 49th CMAAO Council Meeting held in New Delhi, India in September 2013 and attended the 64th WMA General Assembly in Fortaleza, Brazil in October 2013.

Hong Kong is a multivariate society in all aspects. We might even be multi-polar, whether in medicine or in politics and spanning from the practicality of our daily life to metaphysical philosophy. Our culture is one of acceptance and inclusion, one of respecting difference and one with wisdom to nurture growth from common grounds: harmony. Under the concerted efforts of all, the HKMA will continue to serve our profession and the public in all areas related to our health care system.

REPORT~

THE HONG KONG MEDICAL ASSOCIATION

For Year 2013-2014

Dr. Alvin Y.S. CHAN
Vice-President
The Hong Kong Medical Association

HKMA COUNCIL

- No. of Council members ↑ in July from 24 to 28 (including 6 office-bearers)
- Elected by a democratic process – one-doctor-one-vote

HKMA COMMITTEES

- No. of Standing Committees: 26
  1. Annual Ball Committee
  2. Beat Drugs Action Committee
  3. Choir Committee
  4. Advisory Committee on Communicable Diseases
  5. The HKMA Community Network - Central Coordination Committee
  6. Complaints and Mediation Committee
  7. Continuing Medical Education (CME) Committee
  8. Ethics Committee
  9. Finance Committee
  10. Health Education Committee
  11. Healthcare Policy Committee
  12. House Committee
  13. Information Technology Committee

HKMA COMMITTEES (cont'd)

  14. International Affairs Committee
  15. Liaison Committee
  16. Management Committee on Medical Protection Scheme
  17. Manpower Committee
  18. Membership Services Committee
  19. National Affairs Committee
  20. Newsletter Committee
  21. Orchestra Committee
  22. Committee on Organ Donation Register
  23. Public Relations & Public Affairs Committee
  24. Recreational and Cultural Committee
  25. Sports Committee
  26. Youth Committee

HKMA COMMITTEES (cont'd)

- No. of Ad hoc Committee/Task Forces: 10
  1. Ad Hoc Committee on HKMA CME Programme on Advanced Cardiology
  2. Task Force on Advising Government on the Standard of Ambulatory GI Endoscopic Centre
  3. Organizing Committee for the 15th Beijing/Hong Kong Medical Exchange
  4. Task Force on "Exercise for Health" Project
  5. Task Force to Deal with LINK
  6. Task Force on Functional Constituency Transition to Universal Suffrage
  7. Ad Hoc Committee on GOPD PPP
  8. Task Force to Review the Operation of the Hospital Authority
  9. Task Force for the Production of HKMA Corporate Video
  10. Task Force on Vaccination PPI

PUBLIC HEALTH ISSUES

- Public-Private Partnership (PPP)
- Vaccination Public-Private Interface
- Communicable Diseases
- Exercise Prescription
- Etc.

MUSIC FOR PUBLIC EDUCATION

- HKMA theme song: "Give Your Heart" written by Dr. Alvin CHAN
- Campaign songs:
  1. Exercise prescription
  2. Take shots with no fear
  3. Flu vaccine power
  4. DASH diet
  5. Serving chopsticks & spoons
  6. Healthy 8,000 steps campaign
  7. Dengue Fever

MEMBERSHIP

- >12,000 registered doctors in Hong Kong
- >9,000 HKMA members
- ½ in private, ½ in public
- Plus another >700 student members

CHARITY

- Annual Charity Concert to raise funds for RainLily
- Donations for rehabilitation from Ya'an, Sichuan Earthquake

MEMBER WELFARE & ACTIVITIES

- HKMA Choir
- HKMA Orchestra
- HKMA No. 1 Band
- Annual Ball Committee
- Sports Committee
  1. Joint Professional Tournaments
  2. Ball games
  3. Family Sports Day
  4. Swimming Gala
  5. Dragon boat, trailwalker, family hiking
  6. 4th GHM Sports Meet
- Recreational & Cultural Committees
  1. Photo competitions, singing competitions
  2. Wine & Gourmet dinner
  3. Music Fiesta Show
  4. Trips to Mainland
  5. Career talks
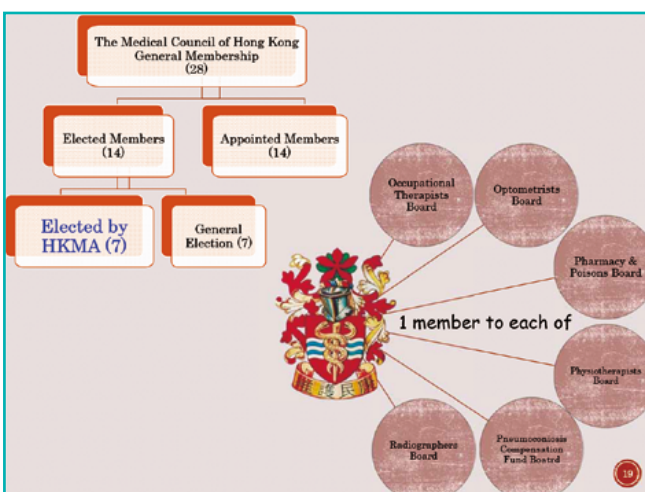
Medico-legal Seminars

Clinical Risk Management Handbook & Doctors' Fees Survey
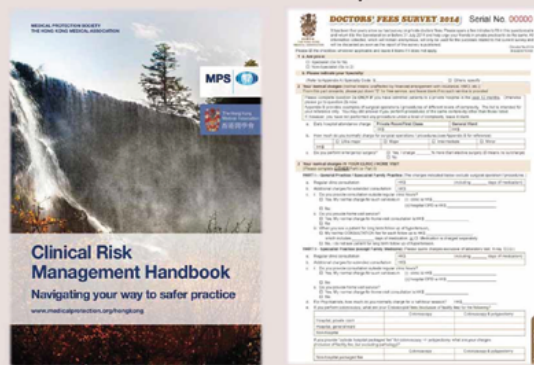
CONTINUING MEDICAL EDUCATION (CME)

GENERAL

- Council Meetings
- 49th Council Meeting in New Delhi, India in September 2013
- 64th WMA General Assembly in Fortaleza, Brazil in October 2013
- 12 monthly HKMA News
- 12 monthly CME Bulletins
- Bimonthly Hong Kong Medical Journal

BEIJING/HONG KONG MEDICAL EXCHANGE

- 12 – 13 October 2013 in Changsha, Hunan
- Theme: Recent Advances in Cancer Medicine

INTERNATIONAL AFFAIRS

SOCIAL & POLITICAL ISSUES

- Political reform:
  - 2017 universal suffrage in election of Chief Executive
  - 2016 Legislative Council election
- Relaxation of Licentiate Examination for overseas graduates
- RESCUE "Reasonable and Early Screening for Caring and Universal Engagement" Drug Testing ("RDT") Scheme Consultation Paper
  - Purpose: identify drug abusers early and refer them to counselling and treatment programmes in a timely manner.
  - Means: introduce legislation to authorize drug testing on a person when there are reasonable grounds, based on strong circumstantial conditions, to suspect that the person has taken dangerous drugs.

~THANK YOU~

INDIAN MEDICAL ASSOCIATION[*1]

Jitendra B. PATEL,[1] Narendra SAINI[2]

Indian Medical Association (IMA) is a well established pan-India voluntary organization of modern medicine doctors. It has a membership of 2.5 lacs doctors spread over 1,650 branches in almost all the districts of India. IMA is reaching to approximately 35 crores of people every month and ensuring affordable & quality treatment.

IMA born in 1928 mainly out of the burning need to organize the medical professionals of the time for the national freedom struggle, IMA eventually reached an agreement with the British Medical Association, which had opened a few branches in India to cater to the local needs, that they will have no branch in India and got mutually affiliated. This relationship continues till today. This was as a result of the select few stalwarts of the medical professionals in the country at that time.

In the year 1946, IMA was one of the founder constituent members of the world body, World Medical Association (WMA). IMA has been and continues to play an important role in the deliberations of WMA. In 1966, we hosted the III World Conference on Medical Education under the joint auspices of WMA and IMA followed by the WMA General Assembly in 2009 in the national capital.

Vision of Leaders of IMA

IMA work started from where we left last year. The new team of office bearers took over the office with new vigor and dedication. We thank all the National leaders and Past National Presidents of IMA for their advices and guidance offered to us. Our National President, Dr. Jitendra B. Patel gave a clarion call along with the Hony. Secretary General, Dr. Narendra Saini promising "Affordability, Accessibility-quality healthcare for all." We have strived hard and taken effective steps to involve IMA State/Local Branches, Government Authorities, other National Medical Specialist Organizations, National and International Agencies, Media and Residents' Welfare Associations etc. as partners in Healthcare. Various MoUs have been entered to this effect during this year with many stakeholders for the benefit of the society. We have requested our state leaders and opinion leaders to create awareness of these projects and take effective steps for implementation.

To make IMA "Vibrant, many programmes have been started by IMA this year for the benefits of its members, like:

Academic activities of IMA and its wings

IMA College of General Practitioners (IMA CGP), an academic wings of IMA for General Practitioners. Following are courses started by IMA CGP:

1. Fellowship Course on Cancer Palliative Medicine
2. International Post Graduate Paediatric Certificate Course
3. P.G. Course in Emergency Medicine
4. P.G. Course in Family Medicine
5. Fellowship Course in Diabetology
6. Fellowship Course in Nephrology
7. Fellowship Course in Echocardiography
8. Fellowship Course in Practical Oncology
9. Fellowship Course in Sexual Medicine
10. Fellowship Course in Practical Endocrinology

Recently on 16th August, 2014 IMA College organized World Congress of Family Medicine, WONCA South Asia Region at Chennai, India. Convergence of lot of ideas, innovations, and experiences in the conference would take family doctor practice to a new height. We are

very happy to inform you that every SAR country & every state of India was represented was represented.

IMA Academy of Medical Specialities (IMA AMS), the Specialists' wing of IMA, publishes its Annual publication, the Annals of IMA AMS every year, which is an important publication for specialists. Moreover, the following courses are being organized by this Wing:
• Infertility
• Fluorescein Angiography
• Laser Photocoagulation in Retinal, Excismer, Laser & Lasik Surgery
• Phacoemulsification
• Training in Laparoscopic Surgery, Noninvasive Cardiology, Echocardiography, TMT, etc.,
• Critical Care in Cardiology, Advance Microear Surgery
• Functional Endoscopic Sinus
• Laser in ENT
• Tracho-Bronchial. Rhinoplasty Joint Replacement
• Orthoscopic
• Spine Surgery

IMA AKN Sinha Institute of IMA, the wing of IMA involved in Distance Learning Courses, is organising a large number of Distance Learning Certificate courses for the members of IMA e.g.
• Family Planning
• HIV/AIDS & STDs Management
• Lactation Management
• Geriatrics Medicine
• Torture Medicine
• Environment & Occupational Health
• Adolescent Health
• Tuberculosis & Chest Diseases
• Paediatrics
• Reproductive & Child Health
• Medical Negligence & C.P.A.
• Psychiatry & Psychosexual Medicine
• Clinical Cardiology
• Clinical Diabetes
• Rheumatology

IMA Medico Legal Helpline: IMA have signed an MoU with Institute of Medicine & Law. For that IMA has created a separate email ID (imamedicolegalcases@gmail.com). All IMA members are requested to register by providing one mobile number along with their IMA membership number and email address on the above said email. The registration is free for IMA Members. After verification by IMA Office their

name will be forwarded to the Medico Legal Helpline. Once their name will be registered, they will get confirmation through SMS's and then they can avail the services of Medico Legal Helpline.

IMA & NIPCCD, organized a one-day Workshop on POCSO Act & Rules, 2012 for Medical Professionals on Sunday, 18 May, 2014 in NIPCCD, New Delhi. The main objectives of the programme was to: enhance the knowledge of the medical professionals about salient features of POCSO Act, 2012; develop an understanding of their role in implementation of the Act; and discuss with them about medical and forensic services in order to investigate sexual offences.

Symposium on Child Protection and Child Rights: IMA organized 28th CMAAO Congress & 49th CMAAO Council Meet at New Delhi on September 12-14, 2013. The participants included representative from CMAAO Countries and also from government, non-governmental organizations, networks and institutions, including professionals from all sectors and disciplines working on this issue. The theme of the conference was **"Be Human-Stop Child Abuse."** In this regard a symposium on Child Abuse was also organized during this conference. CMAAO Conference outcome document "Resolution on Child Abuse" was prepared and released. At the conclusion of the conference, the delegates pledged "the resolve to stand against the neglect and abuse of children and to strive for achievement of child rights and the building of a caring community for every child, free of violence and discrimination."

Symposium on Child Sexual Abuse-Prevention & Response: Further to take this issue, recently UNICEF and the IMA recently organized a Symposium on Child Sexual Abuse-Prevention & Response held on 7th June, 2014 at Stein auditorium, India Habitat Center, Lodhi Estate, and New Delhi. The symposium enhanced the understanding and awareness of the medical sector and allied professionals to how to response to sexually abuse children. Besides Delhi State holding working on this issue were also invited. During this symposium a booklet on "Child Sexual Abuse" was released which provided key information on how medical professionals can prevent, detect and respond to child sexual abuse. The IMA is committed to the principles of protecting UN child rights, prevention and

management of child sexual abuse in all settings in India.

For implementation of IMA ambitious project **"Child Sexual Abuse-Prevention & Response"** in various parts of the country, the State/local branches of IMA have been requested to take up this project in various districts and under developed areas in their jurisdiction, so that the movement against child abuse can be spread in the entire country.

Health Agenda: Health is one of the most important aspects of any progressive community. IMA's motto is "Affordable & Accessible Quality Health for All." We are carrying out all steps to ensure success in achieving our aim. IMA had prepared its Health Agenda and we had circulated the same to all the political parties.

Ebola Virus Disease: World Health Organization (WHO) has declared Ebola Virus Disease outbreak as public health emergency" and called for a global health alert in all countries which has a mortality of around 60%. The Ebola virus is dangerous and can spread easily through bodily secretions. Right now there is no threat to India but more than 45,000 Indian Origin people are working in West African Countries. Many people also visiting these countries for business purposes. Because of migration of people there is always a chance of this disease entering in our country at any time. Ebola Virus being a new disease, there is a need to apprise our doctors and citizen of this country about this disease and to prepare guidelines. In this regard IMA has constituted an advisory committee.

Rational use of antibiotics: Development of resistance to antimicrobial agents and increase of cost in healthcare as the result of unnecessary and inappropriate use of antibiotics has become a global problem. Therefore, there is a need to develop a strategy for rational use of antibiotics. In this regard IMA, in collaboration with Indian Academy of Pediatrics (IAP) organized first Advisory Committee Meeting on Rational Antibiotic Practices (RAP) on 5th August, 2014 at IMA House, New Delhi, in which it was decided to develop module for family physicians. Every hospital should have antibiotic policy. Training of Trainers (TOT) Workshops are planned for sensitizing the health professionals for proper usage of antibiotic. Public awareness campaign is also being initiated on rational use of antibiotics. A campaign has been started on IMA website asking member to register and take oath for stopping the misuse of antibiotics.

Disaster Management Wing: Last year, India witnessed one of the worst natural disasters in hilly terrains of Devbhoomi i.e. the State of Uttrakhand. Many houses & human lives were taken away due to huge landslides as a result of cloud bursts during the Monsoon season. A large number of pilgrims and local residents were buried alive or were left stranded with no food or shelter. IMA members reached the disaster hit areas before any other help could reach there and started providing medical relief immediately to the survivors. IMA started rehabilitation work in Kedar Valley, one of the worst hit areas and constructed a well equipped New Health Centre. The Disaster Management Wing is functioning effectively and efficiently at various places.

Aao Gaon Chalen Program: IMA prepared the road map to conduct the Aao Gaon Chalen project at all levels. Under this project our main aim will be to look after the village population as reformist, as social worker, as a preventive health care provider. Our suggestion is to run this projects on following line:

1. social structure—
    1) safe drinking water
    2) safe sanitation
    3) hand washing & hygiene
2. literacy—we can help in giving basic education
3. Health—
    1) immunization
    2) anemia detection
    3) deworming of children
    4) Medical Melas—Health Check-up Camp

On these lines all local branches are working in adopted villages/slums areas where health services are not easily available. State and local branches join hands with other NGOs who are working on such project. School health is also being taken care of under this project.

Vector Borne Disease Program: It is a well known fact that the Vector Borne Disease like Malaria, Dengue, Chickungunya and Kalah Azar poses immense public health concern and continue to be major causes of significant morbidity and mortality in the country. These disease are prevalent both in rural and urban areas mostly among lower socio-economic groups of the population, the marginalized and disadvantaged members of the society.

IMA has taken up a responsibility to reduce the deaths due to Malaria, Dengue, Chikungunya, Kala Azar and other Vector Borne Diseases. The branches of IMA have taken up this project in their area and State Headquarters is coordinating for effective and meaningful results. IMA in collaboration with National Institute of Malaria Research Department and other inter-sectoral partners is committed to contribute its role in Control of vector borne diseases by strategically addressing the problem through conducting Training of Trainers (TOT) workshops in various parts of the country. We are confident that capacity building of medical professionals is an important component for such diseases. Training of family physicians in private sector is important so as to equip them to take up the challenge to control this menace by adequately treating patients in the out patient's clinics in urban as well as rural area. Though, it is herculean and challenging task. IMA is committed to approach the problem more aggressively & vigorously in all states.

Voluntary Blood Donation Camps: The Doctors Day is celebrated on the Date of Birth of **Dr. Bidhan Chandra Roy** (1 July 1882-1 July 1962) viz: 1st July every year. He was a highly respected physician & a renowned freedom fighter & a great social worker. He was awarded "Bharat Ratna" (India's highest civilian honor.) in 1961. On this occasion, we decided to organize blood donation camps throughout the country with the help of 1,700 local branches.

Before the event to motivate our membership we send mailers and visited number of state branches for the same. We also went in partnership with NACO for their help in arranging camps and for proper storage of collected blood in blood banks. On regular basis we send SMS and emails to our branches to know the progress of camps. Guideline on IEC material and full details about preparation before and during Voluntary Blood Donation camp were prepared and circulated to our membership. I am pleased to inform you, we were able to collect 26,927 of blood units with the help of our state/local branches. The basic aim of this exercise was to wipe off the scarcity of blood by creating awareness among general public, motivating them to donate voluntary blood as this is the best charity a human being can do to another and in no way

it harm the donor.

Healthy Doctor Healthy Patient: While we take care of the health of our patients day-in and day-out, we seldom take care of our own health. Even World Medical Council has shown concern about the health of medical professionals because of constant stress. Life-style diseases among the doctors are increasingly taking their toll in the form of premature death or disability. IMA organized various camps to screen doctors for some basic life-style parameters.

IMA GFATM-RNTCP Project: IMA in collaboration with the Revised National Tuberculosis Control Program (RNTCP), is running a public-private partnership (PPM) project. Under this project IMA has facilitated in sensitizing 92,700 & training 15,730 private practitioners under RNTCP & ISTC (international standards of TB care).

In addition 4,174 DOT centers are opened by IMA through these trained practitioners. Further in lieu of the TB notification order by the govt. IMA facilitated the notification of 34,919 cases (since Feb 2014-June 2014) through its members.

IMA Paramedical Courses: Different short term and Govt. sponsored certificate courses are conducting by the IMA. We are also running the following paramedical courses in this wing:
• Medical Laboratory Technology
• Radiology
• O.T. Technology
• Medical Record Technology Cardiac Technology

All these courses have a tremendous future and will help the paramedical staff to get more jobs in various healthcare sectors and will also meet the challenges and shortage of qualified technicians. MoU has been signed between IMA, New Delhi and Society for the School of Medical Technology (SSMT), Kolkata for starting certificate courses in lab technology. Dr. Chandrima Bhattacharya, Minister of Health & Family Welfare Department, Govt. of West Bengal inaugurated these vocational courses.

A new paramedical course—Diploma in **Dialysis** Technician has been introduced by IMA H.Qrs., New Delhi.

Our Motto:
"Affordability, Accessibility and Quality Healthcare for All. Together we always achieve more."

INDIAN MEDICAL ASSOCIATION – COUNTRY REPORT

DR. JITENDRA B. PATEL
National President 2014
INDIAN MEDICAL ASSOCIATION HEADQUARTERS, NEW DELHI

DR. NARENDRA SAINI
Hony. Secretary General 2013-14
INDIAN MEDICAL ASSOCIATION HEADQUARTERS, NEW DELHI

INDIAN MEDICAL ASSOCIATION

- Born in 1928.

- Founder constituent member of World Medical Association in 1946

- IMA has a membership of 2.5 lacs doctors spread over 1650 branches in almost all the districts of India as on today.

BUILDING PARTNERSHIPS IN HEALTH CARE

EFFECTIVE FUNCTIONING OF IMA

- "Affordability, Accessibility-quality healthcare for all"

- Various MoUs have been entered to this effect during this year with Government, NGOs & other organizations for the benefit of the society.

ACADEMIC ACTIVITIES OF IMA AND ITS WINGS

- IMA College of General Practitioners.

- IMA Academy of Medical Specialities.

- IMA AKN Sinha Institute of IMA.

MEDICAL STUDENTS AND YOUNG DOCTORS NETWORKING

- IMA Medical Students Wing.

- Young Doctors -membership Drive

MEDICO LEGAL HELPLINE

IMA signed an MOU with Institute of Medicine & Law. For that IMA has created a separate email ID imamedicolegalcases@gmail.com All IMA members are requested to register. The registration is free for IMA Members, then they can avail the services of Medico Legal Helpline.

IMA ACTIVITIES ON CHILD HEALTH

- Workshop in collaboration with NIPCCD, on POCSO Act & Rules for Medical Professionals
- Symposium on Child Protection & Child Right & the theme of the Symposium was "Be Human-Stop Child Abuse" during CMAAO Conference last year
- Symposium in collaboration with UNICEF on Child Sexual Abuse-Prevention & Response
- Regional TOTs and Regional Workshop in collaboration with UNICEF.

ACTIVITIES ON RATIONAL USE OF DRUGS

- Training of Trainers(TOT) Workshops for sensitizing the health professionals for proper usage of antibiotic and public awareness campaign is also being initiated on rational use of antibiotics.
- Oath for rational use of antibiotics
- A booklet on Rational Use of Drugs
- TOTs on Ebola Virus Disease
- TOT on Vector Borne Disease

BLOOD DONATION CAMPS

- Conducted Voluntary Blood Donation Camps on a single day throughout the country on the occasion of the Doctors Day
- Total Blood units collected-

IMA GFATM-RNTCP PROJECT

- Sensitized- 92700
- private practitioners trained- 15730
- Notification -
- DOT Centers- 4174
- PHI-

IMA PARAMEDICAL COURSES

Paramedical courses :
- Medical Laboratory Technology
- Radiology
- O.T. Technology
- Medical Record Technology Cardiac Technology

- Certificate Course in Lab Technology with School of Medical Technology (SSMT), Kolkata.

- New paramedical course-Diploma in Dialysis Technician.

ACTION TAKEN ON ATTACK ON DOCTORS

- Hospital Protection Act
- Attrocities on Kanpur Medical Students:- IMA Protest- All India Bandh

ACTIONS INITIATED

- Against Clinical Establishment Act
- Consumer Protection Act- Asking for Medical Tribunal.
- Anti-quackery Act - Demanded at National level.

DISASTER MANAGEMENT

- Worst natural disasters in hilly terrains in the state of Uttrakhand.
- IMA Members reached the disaster hit areas before any other help could reach there and started providing medical relief immediately to the survivors.
- Started rehabilitation work in Kedar Valley, the worst hit areas and constructed well equipped New Health Centre.

MEMBERS BENEFIT SCHEMES

- IMA Privilege Card - Subsidized Tickets for Travel, Transport, Hotel Accommodation for our members.
- IMA Family Protection Scheme - Helping the family of deceased Doctors with Rs.15 to 20 Lakhs.
- IMA National Social Security Scheme.
- IMA National Professional Protection Scheme.

DOCTOR - PUBLIC RELATIONSHIP

- Partnership with Media partner- medical professional CME & public awareness program.
- School Adoption Project.
- PPP Clinics (Public Private Partnership Clinics)- Aao Gaon Chalen Project
- Hygiene Awareness Campaign

DOCTOR - PUBLIC RELATIONSHIP (CONT...)

- Care of the Elderly.
- Welcome the Girl Child and Empowerment of Females.
- Tobacco Control & Awareness Campaign
- Polio Eradication.
- Other Govt. Health Schemes.

INDONESIAN MEDICAL ASSOCIATION[*1]

Ihsan OETAMA[1]

The critical success factors of national health insurance

- **Every Indonesian citizen has access to point of care (POC) are the same quality.** Implementation of national health insurance will be hampered if there is no POC in a region. national health insurance provides medical services. So although there are POC but if there is no doctor, care national health insurance will also be hampered.
- **The availability of POC and reliable primary care physicians as a Gate Keeper.** The more reliable primary care physicians, the higher the public acceptability of national health insurance and more health problems that can be solved local individuals and fewer who need expensive medical care in the strata secondary / tertiary.
- **POC is the basic unit held by the primary care physician with the multidisciplinary team.**
- **Following the mandate of the law practice of medicine, IMA has a strategic role in the distribution and equitity of physician (licensed to practice recommendation), Increased physician competency (certification, CPD)**

Recommendation of IMA

- In the era of national health insurance, need horizontal and vertical integration in order to various health facilities that overlap and are not structured like the current set up structures in line with national health insurance
- In this structured system, the procedure for using health services set for each citizen can choose I basic unit close to where he lived.
- Each basic unit is designed to be able to overcome most of the day-to-day health issues that required individuals / families, and health care by a multidisciplinary team (doctors, dentists, midwives, nurses, pharmacists, etc.) according to local conditions.
- Referral system begins with every citizen must choose I basic unit that will be visited when he was in need of health care
- Need a new classification based on the function of health facilities and competence. The classification for outpatient facilities and inpatient.

Roadmap in 2013- 2014

INTERNAL

- Booklet FAQ about national health insurance
- Mapping and formation of primary care physicians and specialists
- Models of primary care entities
- Compensation guide primary care physicians (mixed system)
- Practice guide primary care physicians
- Credensialing primary care physicians
- Index compiled Geography Practice (IGP)
- Compiled INA-CPT (Current Procedure Terminology)
- Program to improve primary care physician competence

EXTERNAL

- Advocacy system of primary care-based health care
- Advocacy of bill medical education
- Advocacy & equitable distribution of doctors district
- Advocating quality medical care
- Physician advocacy as a strategic profession

Public – Private Partnership

- the era of independent physician / entepreneur doctor
- mono-loyalty era
- era one source of income

Gallery

IMA involved in the discussion of the draft law of medical education in the legislature

Gallery

Cooperate and coordinate with the national family planning agencies and ministry of health related family planning program

Gallery

in commemoration of the day consecrated Indonesian doctors, IMA doctors launched a movement to plant 1000 trees

Gallery

Together with 4 other health professional association establish **Task Force** to monitor National Social Security System since January 2014

Gallery

Strike against Doctor criminalization for malpractice allegation to 3 obstetricians in Manado

Gallery

Arrange Monthly Discussion About Public Health, Health Development, and other current issue

Gallery

Develop National Guidline for Primary Care Physician, HIV Guidline, TB DOTS at Private Practice, Tobacco Related Disease, and other guidlines

Gallery

avoid smoking and drug campaigns, and also campaigns to reduce intake of sugar and salt

Gallery

- IDI Form Medical Check Up Team for Indonesian President Election at June 2014. Consist about 50 doctors from all specialist.

Gallery

Tolak aturan aborsi, Ketua IDI tak ingin para dokter dipenjara de.tk/VEk3T4 pic.twitter.com/64qutT0PVI

DR ZAENAL ABIDIN, MH:
KAJI ULANG ATURAN ABORSI

- Refusal about new policy about abortion legalitation for rape victims. This policy is contrary with Indonesia Doctor's Oath and Ethic.

Our vision

Indonesian Medical Association as a unifying intellectual and professional potential developers Indonesian doctor

Please contact us,

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JAPAN MEDICAL ASSOCIATION[*1]

Masami ISHII[1]

The Japan Medical Association (JMA) would like to highlight our activities from the last one year in our country report.

At first, Dr. Yoshitake Yokokura was re-elected as a President of JMA, and his term is 2014 June to 2016 June (Slide 1).

In anticipation of 2025, when baby boomers will become late-stage elderly, the development of a system of health care that comprehensively supports the community in the public universal health insurance system that is based on family physicians who are not just gatekeepers but actively coordinate care, should be carried out through functional specialization of and cooperation among hospitals, provision of adequate in-home health care and long-term care, recruiting and retaining health care personnel, and improvements in the workplace environment.

The way of providing health care for the people will change along with this, and the demands and trends in society will also change (Slide 3).

By 2040, this demographic shift will also place some localities at risk of disappearing due to reduced population. But people are unable to live in a place without health care.

The policy to provide care which incorporates health care and long-term care. Cooperative efforts are seen between the central government and the JMA, local government and local medical associations, and municipalities and municipal medical associations to work together under the plan for health care and long-term care in each stage. A "New Foundation" will be used to facilitate these efforts (Slide 5).

Health care is an indispensable lifeline and also the basis for community building.

When thinking about the future of Japan and the coming super-aging society, medical associations that know the community and stand with the community must build a comprehensive community care system that provides integrated, appropriate health care, long-term care, welfare, and livelihood services in a community network centered on family physicians.

The JMA must also cultivate family physicians and develop their capabilities in the aging society.

To establish a comprehensive community health care system, it is necessary to amend the related laws such as "Law on Promotion of Comprehensive Security of Medical Care and Nursing Care in Communities," "Medical Care Law" and "Long-term Care Insurance Act" to ensure comprehensive promotion of health care and long-term care (Slide 7).

A comprehensive system that provides proper medical services, long-term care, welfare, and daily services in centralized fashion.

The goal is to secure everyone a place to live where they can be comfortable in their home community until death.

The basic stance of the JMA toward future development of health care is supported by the following two pillars.

One is to revitalization of local cities led by the local medical associations cooperating with the local governments and occupations of various kinds.

The other one is that the local governments should learn and incorporate various cases from other local areas as example and use these to establish the provision system for medical and nursing care which fit the local cultures of individual communities (Slide 8).

Our country's public debt is over 1,000 trillion yen or ca.10 billion USD, and economic growth is sluggish. Furthermore, the working age population in Japan is projected to shrink by 20% in the future.

Under these conditions, the costs of social

insurance, mainly for health care and long-term care, are projected to rise, so in the future, policies called "regulatory reform" or "growth strategies" will continue to bring pressure to restrict the scope of insurance benefits from the standpoint of tight budget.

Repeated health care reforms driven by fiscal concerns have and will continue to run the risk of leading to the collapse of universal health insurance in Japan.

Even now there have been loud cries for regulatory reform to reduce "excessive medical care" and the move towards commercialization of the core of medical care has accelerated.

Continue to maintain a critical attitude for future government policies, judging according to the criteria of whether these policies contribute to safe health care for the people and whether these policies can protect universal health insurance through public health insurance.

To build a society in which there is neither too much nor too little health care necessary for all people, we must promote lifelong health programs, extend the healthy life expectancy, and

advance reforms appropriate for the times, while at the same time we must preserve universal health insurance that is sustainable.

The JMA has called for the medical community to come together and become even more unified for redevelopment of community health care by working toward solutions to the various problems that are affecting health care.

Along with urging the construction of a health care provision system compatible with the actual situation in our communities, we have also clarified specific goals for facing the super-aged society that is coming in 2025.

What is most important is the position of standing with the people. This is because our duty as a physician is to help provide decent and healthy living for the people throughout their entire lives.

The real task of nation building is to make a society in which people can live healthy and secure lives, as well as to raise people who are able to support such a society.

Health care is certainly at the root of such a society.

The 29th CMAAO General Assembly & 50th Council Meeting
September 24-26, 2014, Manila Marriott Hotel, Manila, Philippines

Country Report

Japan Medical Association

Masami Ishii, MD
Executive Board Member
Japan Medical Association

**Re- elected as the JMA President, 2014.6-2016.6
Dr. Yoshitake Yokokura**

In these past two years, with the slogans of continuity and reform and from the community to the nation, I have called for the medical community to come together and become even more unified for redevelopment of community health care by working toward solutions to the various problems that are affecting health care.

Along with urging the construction of a health care provision system compatible with the actual situation in our communities, I have also clarified specific goals for facing the super-aged society that is coming in 2025. *Form Presidential Policy Address* 1

To Support Community (1)

In anticipation of 2025, when baby boomers will become late-stage elderly, the development of a system of health care that comprehensively supports the community in the public universal health insurance system that is based on family care physicians who are not just gatekeepers but actively coordinate care should be carried out through functional specialization of and cooperation among hospitals, provision of adequate in-home health care and long-term care, recruiting and retaining health care personnel, and improvements in the workplace environment.

The 29th CMAAO General Assembly & 50th Council Meeting
Sep.24-26   Manila, Philippines

2

To Support Community (2)

● The way of providing health care for the people will change along with this, and the demands and trends in society will also change.

Trend of population aging rate

People over 65／total population

Year	2025	30% and more
	2040	36%
	2060	39.9%

The 29th CMAAO General Assembly & 50th Council Meeting
Sep.24-26   Manila, Philippines

3

To Support Community (3)

● By 2040, this demographic shift will also place some localities at risk of disappearing due to reduced population.

● But people are unable to live in a place without health care.

The 29th CMAAO General Assembly & 50th Council Meeting
Sep.24-26   Manila, Philippines

4

Method of Offering both of Health Care and Long-Term Care in a unified manner
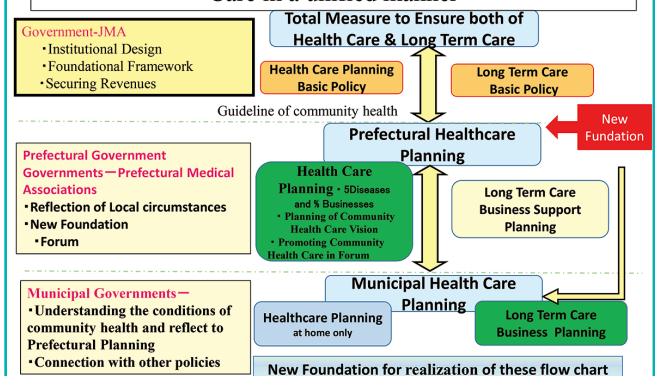
5

To Support Community Health Care

● Health care is an indispensable lifeline and also the basis for community building.

● When thinking about the future of Japan and the coming super-aging society, medical associations that know the community and stand with the community must build a comprehensive community care system that provides integrated, appropriate health care, long-term care, welfare, and livelihood services in a community network centered on family care physicians.

● The JMA must also cultivate family care physicians and develop their capabilities in the aging society.

The 29th CMAAO General Assembly & 50th Council Meeting
Sep.24-26   Manila, Philippines

6

Act on Arrangement of Relevant Acts for Promoting Total Securement of Health Care and Long-Term Care in Community
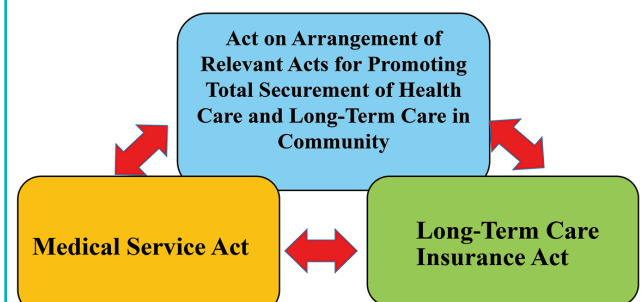
7

Community-based Comprehensive Care System Approach

- A **comprehensive** system that provides proper medical services, long-term care, welfare, and daily services in centralized fashion.

- The goal is to **secure everyone a place to live** where they can **be comfortable in their home community** until death.
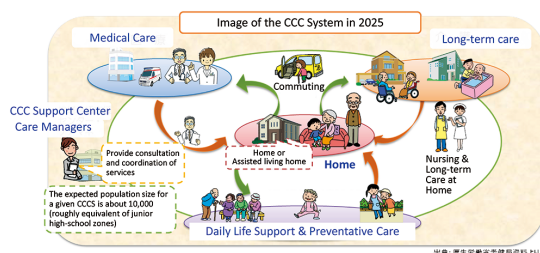
8

To Think about the Future of Health

- Our country's public debt is over 1,000 trillion yen or ca.10 billion USD, and economic growth is sluggish. Furthermore, the working age population in Japan is projected to shrink by 20% in the future.

- Under these conditions, the costs of social insurance, mainly for health care and long-term care, are projected to rise, so in the future, policies called "regulatory reform" or "growth strategies" will continue to bring pressure to restrict the scope of insurance benefits from the standpoint of fiscal crisis.

9

To Think about the Future of Health

- Repeated health care reforms driven by fiscal concerns have and will continue to run the risk of leading to the collapse of universal health insurance in Japan.

- Even now there have been loud cries for regulatory reform to reduce "excessive medical care" and the move towards commercialization of the core of medical care has accelerated.

10

To Government Policies

- Continue to maintain a critical attitude for future government policies, judging according to the criteria of whether these policies contribute to safe health care for the people and whether these policies can protect universal health insurance through public health insurance.

- To build a society in which there is neither too much nor too little health care necessary for all people, we must promote lifelong health programs, extend the healthy life expectancy, and advance reforms appropriate for the times, while at the same time we must preserve universal health insurance that is sustainable.

11

Continuity and Reform and from the Community to the Nation

- The JMA has called for the medical community to come together and become even more unified for redevelopment of community health care by working toward solutions to the various problems that are affecting health care.

- Along with urging the construction of a health care provision system compatible with the actual situation in our communities, I have also clarified specific goals for facing the super-aged society that is coming in 2025.

12

Position of Standing with the People.

- What is most important is the position of standing with the people. This is because our duty as a physician is to help provide decent and healthy living for the people throughout their entire lives.

- The real task of nation building is to make a society in which people can live healthy and secure lives, as well as to raise people who are able to support such a society.

- Health care is certainly at the root of such a society.

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KOREAN MEDICAL ASSOCIATION[*1]

Cheong Hee KANG[1]

Conflict over Introduction of Tele-medicine and Effort to Restore the Health Care System

In October 2013, the Republic of Korea government announced its policy to introduce overall tele-medicine between patients and physicians. The government is trying to push forward the plan despite the opposition and concern of the medical and public community.

Tele-medicine between physicians is already allowed in Korea and tele-medicine between patients and physicians for people with lower accessibility to physicians is being carried out through trial project. Tele-medicine that the government is currently pursuing is overall implementation of tele-medicine between patients and physicians.

This is the promotion of tele-medicine as a substitute to face-to-face consultation rather than as a supportive measure. This will damage the fundamental aspect of medical care of face-to-face interaction. Moreover, Korea has high accessibility to physicians and overall promotion of tele-medicine is not necessary.

Tele-medicine will bring tremendous changes in demands on medical personnel. Regional medical institutions are expected to take the biggest hit with the implementation of tele-medicine where distinctions between larger hospitals and primary clinics are not clear. Overall promotion of tele-medicine will be eventually led to unlimited competition between hospitals and clinics and between medical institutions in the Capital area and regions.

The most concerning aspect of Korean Medical Association (KMA) is that patient safety, effectiveness, legal liability issues were not properly assessed or examined during the preparation process. Despite the strong opposition of the KMA, the government pushed forward with the tele-medicine policy. KMA inevitably took collective action in order to protect public health and the national health system as well as to restore order to the health care system.

On March 10, 2014, as the last resort, there was a one-day suspension of medical service. Even though essential medical staff in emergency rooms and ICUs were excluded, about 60% of clinics and 7,000 interns and residents participated. The action was an expression of not only opposition against the government's plans to introduce tele-medicine but also the physicians' wishes to promote primary care institutions, to improve the national health insurance program, to reform wrong health systems and to improve medical regulations that infringe upon the physician's professional autonomy.

The government and Korean Medical Association entered into talks in order to find a solution and agreed to the step-by-step implementation of 38 policy initiatives including improvement of national health insurance programs including re-discussion of tele-medicine and conducting pilot projects, and improvement of various systems and regulations for activate primary care.

Despite the agreement, difference of opinion still exists between the government and KMA and the discussion with the government on tele-medicine has been stopped. But the government still insists on pushing forward the tele-medicine policy without proper assessment of examination on patient safety, clinical efficacy, and consideration for legal liability.

KMA believes that patient safety, efficacy and legal liabilities related with tele-medicine can never be compromised so KMA plans to strongly resist the government's unilateral approach to tele-medicine policy during the legislative process at the National Assembly.

Aside from the tele-medicine issue, KMA plans to call on the government to continuously implement the initiatives for promotion of primary care, improvement of health insurance and regulatory reform agreed upon through the Korean Medical Association-government talks.

Establishment of KMA Policy

Currently, KMA is in the process of establishing the KMA Policy in order to systematically organize and declare KMA's position regarding various issues related with medical care and medical science.

KMA plans to develop the KMA POLICY as a system that can be referenced at any time with regards to medical policies and medical issues that the public and KMA members are interested in.

Through the establishment of the KMA POLICY, KMA aims to enhance the consistency of KMA's policy towards medical issues, quickly respond to various policies, to achieve efficient operation. We expected that the KMA POLICY will enhance our reliability as a professional organization.

Community Activities

Medical Assistance in the Philippines

KMA dispatched an emergency medical assistance team to the Samar and Leyte Islands of the Philippines damaged by Typhoon Haiyan, and provided care to over 1,000 patients including 6 surgeries during a total of 11 days.

Publishing "The Good Doctors"

KMA published a fun and easy-to-understand book for the public in order to spread correct medical information. This is to strengthen health communication with the public. "The Good Doctors" was written by a total of 76 doctors practicing in various fields, leveraging their knowledge of the latest domestic and international medical research and rich clinical experience.

KMA KOREAN MEDICAL ASSOCIATION
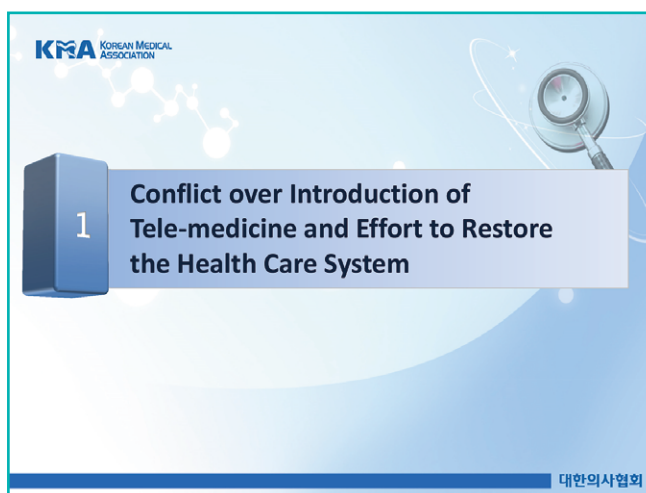
Introduction of Tele-medicine

Government's Policy Announcement (Oct. 2013)

- The government announced its plan to introduce overall tele-medicine between patients and physicians

- The government is trying to push forward the plan despite concerns and opposition of the medical and public community

대한의사협회

KMA KOREAN MEDICAL ASSOCIATION

Introduction of Tele-medicine

Problems of the Government's way of Tele-medicine

- Another example of the government's unilateral approach to health care policy

- Tele-medicine between physicians is already allowed in Korea and tele-medicine between patients and physicians for people with lower accessibility to physicians is being carried out through trial project.

대한의사협회

KMA KOREAN MEDICAL ASSOCIATION

Introduction of Tele-medicine

Problems of the Government's way of Tele-medicine

- The tele-medicine that the government is currently pursuing is overall implementation of tele-medicine between patients and physicians.

- This is promotion of tele-medicine as a substitute to face-to-face consultation rather than as an supportive measure.

Damaging the fundamental aspect of medical care of face-to-face interaction

대한의사협회

KMA KOREAN MEDICAL ASSOCIATION

Introduction of Tele-medicine

Problems of the Government's way of Tele-medicine

- Korea has high accessibility to physicians and overall promotion of tele-medicine is not necessary.

- Tele-medicine will bring tremendous changes in demands on medical personnel.

대한의사협회

KMA KOREAN MEDICAL ASSOCIATION

Introduction of Tele-medicine

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- Regional medical institutions are expected to take the biggest hit with the implementation of tele-medicine where distinctions between larger hospitals and primary clinics are not clear.

- Overall promotion of tele-medicine will be led to unlimited competition between hospitals and clinics and between medical institutions in the Capital area and regions.

대한의사협회

KMA KOREAN MEDICAL ASSOCIATION

Introduction of Tele-medicine

The most concerning aspect of KMA

**Patient Safety,
Effectiveness,
Legal liability issues**
were not properly assessed or examined during the preparation process

대한의사협회

KMA KOREAN MEDICAL ASSOCIATION

Introduction of Tele-medicine

Measures taken by KMA

March 2014

Government pushed forward with the tele-medicine policy

**Collective Action by KMA as the last resort
(One-day suspension of medical service)**

Protect public health and the national health system		Restore order to the health system

The government and KMA find a solution and agreed to the step-by-step implementation of 38 policy initiatives

대한의사협회

KMA KOREAN MEDICAL ASSOCIATION

Introduction of Tele-medicine

one-day suspension of medical service.
- about 60% of clinics and 7,000 interns and residents participated.
- essential medical staff in emergency rooms and ICUs were excluded

대한의사협회

KMA KOREAN MEDICAL ASSOCIATION

Introduction of Tele-medicine

The Current Situation

- Difference of opinion still exists between the government and KMA.

- Discussion between the government and KMA on tele-medicine has been stopped.

- The government still insists on pushing forward the tele-medicine policy without proper assessment or examination on patient safety, efficacy, and consideration for legal liability.

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KMA KOREAN MEDICAL ASSOCIATION

Introduction of Tele-medicine

KMA Stance

Issues of patient safety, efficacy and legal liabilities related with tele-medicine can never be compromised

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KMA KOREAN MEDICAL ASSOCIATION

Introduction of Tele-medicine

KMA Plans

- Strongly resist the government's unilateral approach tele-medicine policy during the legislative process at the National Assembly

- Call on the government to continuously implement the initiatives for promotion of primary care, improvement of health insurance and regulatory reform

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KMA KOREAN MEDICAL ASSOCIATION

2 **Establishment of KMA Policy**

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KMA KOREAN MEDICAL ASSOCIATION

2. Establishment of KMA Policy

KMA Policy

| Medical issues | Physician ethics | Regulations | Affairs |

대한의사협회

KMA KOREAN MEDICAL ASSOCIATION
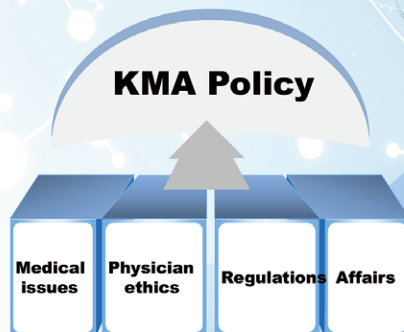
2. Establishment of KMA Policy

KMA Policy

enhance the consistency of KMA's policy towards medical issues

quick respond to various policies

achieve efficient operation by stipulating KMA's policies including the decision making process in writing

provide correct health and medical information to the public

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KMA KOREAN MEDICAL ASSOCIATION

3 Community Activities

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KMA KOREAN MEDICAL ASSOCIATION

3. Community Activities

1) Medical Assistance in the Philippines
- KMA dispatched an emergency medical assistance team the Philippines damaged by Typhoon Haiyan

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KMA KOREAN MEDICAL ASSOCIATION

3. Community Activities

2)Publishing "Good Doctors"
- KMA published book for the public in order to spread correct medical information
- "The Good Doctors" was written by a total of 76 doctors practicing in various fields
- Leveraging their knowledge of the latest domestic and international medical research and rich clinical experience

우리 가족 주치의
굿닥터스

대한의사협회

KMA KOREAN MEDICAL ASSOCIATION

Thank you.

대한의사협회

MALAYSIAN MEDICAL ASSOCIATION[*1]

Rajan JOHN[1]

REAFFIRMS the need for physicians to retain their autonomy and professional integrity with renewed ideals and ethics,

AND RESOLVES to make health care more rational, equitable and affordable, in a system compatible with equal access to quality health care, based on need,

SO THAT IT MAY STAND FIRM AND RESOLUTE in responding appropriately to the challenges ahead and in fulfilling its responsibilities to the medical profession and society.

OBJECTIVES

◈ To promote and maintain the honour and interest of the profession of medicine in all its branches and in every one of its segments and help to sustain the professional standards of medical ethics.

◈ To serve as the vehicle of the integrated voice of the whole profession and all or each of its segments both in relation to its own special problems and in relation to educating and directing public opinion on the problems of public health as affecting the community at large.

◈ To participate in the conduct of medical education, as may be appropriate.

◈ To promote social, cultural and charitable activities in building a united Malaysian nation.

◈ To carry on any business, trade, joint venture, commercial arrangement, transaction or any enterprise whatsoever which may in the option of the Association be advantageous to the Association or calculated directly or indirectly to enhance any of the Association's assets, properties or rights.

MMA COUNCIL 2014/2015
MMA COUNCIL HAS 29 MEMBERS, 9 EXECUTIVE COMMITTEE MEMBERS, 20 BRANCH REPRESENTATIVES FROM THE 14 STATES IN MALAYSIA

SECTIONS, SOCIETIES AND COMMITTEES OF MMA

Sections
Section Concerning House Officers, Medical Officers & Specialist (**SCHOMOS**)

Private Practitioners (**PPS**)

Societies
Society of Medical Students (SMMAMS)

Society of Occupational & Environmental Medicine (SOEM)

Society of Public Health

Society of Sports Medicine

25 MMA Committees
reps on 32 GOVT / NGO committees

SECTION CONCERNING HOUSE OFFICERS, MEDICAL OFFICERS & SPECIALISTS (SCHOMOS)

❖ Its objective is to identify, address and seek the cooperation of the government to resolve issues relating to the welfare, pay, and allowances and working conditions of all grades of doctors in government service.

❖ SCHOMOS over the years has evolved into a powerful Section of the MMA which conducts periodic meetings with the Director General and other top Ministry of Health officers and has achieved many notable successes in its ventures.

❖ The issues discussed periodically includes: clinical allowance for medical officers, review of specialist allowance, overtime pay, promotion prospects for medical officers and specialists, housemen issues, etc.

The Private Practitioners Section (PPS)

➢ Private Practitioners Section of MMA was established to look after the needs of the private practitioners.

➢ PPS continues to be the negotiating arm of the Association in all matters relating to private practitioners. Currently, the PPS Section is concerned on issues related to:

- o Pharmacy Bill-
- o Fomema
- o Third Party Administrator (TPA) / Managed Care Organisation (MCO)
- o National Health Financing Scheme
- o Icare
- o PERKESO

MEMBERSHIP

@ Currently there are over 39,590 registered medical practitioners in Malaysia

@ Almost 9456 are MMA members
  - ➢ 45% of MMA members are from the public sector
  - ➢ 56% of MMA members are from the private sector

@ MMA also has 2355 student members
  - ➢ Conversion to full membership after graduation is still a challenge!

MMA Online Membership System

➢ Easy communication with members;

➢ Convenient for new registration, renewal of membership subscription and updates, etc.

MMA WEBSITE   www.mma.org.my

MMA AGM 2015
MAY
KOTA BAHRU
KELANTAN

INTERNATIONAL AFFAIRS

• **MASEAN**
Medical Associations of South East Asian Nations 16th MASEAN Conference
This conference was held on 9 – 11 May 2014 Regent Hotel, Singapore

Below are the representative that attended this Conference:-

❖ Dato' Dr NKS Tharmaseelan
❖ Datuk Kuljit Singh
❖ Dr Azizan Binti Abdul Aziz
❖ Dr Rajan John
❖ Dr Koh Kar Chai

WORLD MEDICAL ASSOCIATION (WMA)

- The World Medical Association (WMA) is an international organization representing physicians. It was founded on 17 September 1947, when physicians from 27 different countries met at the First General Assembly of the WMA in Paris. The organization was created to ensure the independence of physicians, and to work for the highest possible standards of ethical behaviour and care by physicians, at all times. This was particularly important to physicians after the Second World War, and therefore the WMA has always been an independent confederation of free professional associations. Funding has been by the annual contributions of its members, which has now grown to 106 National Medical Associations.

WORLD MEDICAL ASSOCIATION (WMA)

- The WMA provides a forum for its member associations to communicate freely, to co-operate actively, to achieve consensus on high standards of medical ethics and professional competence, and to promote the professional freedom of physicians worldwide.

- This unique partnership facilitates high-calibre, humane care to patients in a healthy environment, enhancing the quality of life for all people in the world.

WORLD MEDICAL ASSOCIATION (WMA)

World Medical Association was held on 8 - 11 October 2014 in Durban.

MMA Representative who will be attending the meeting is as follows:-

- Dr Krishna Kumar, President

CURRENT NATIONAL PROBLEMS

Datuk Seri Dr. Subramaniam., Minister of Health Malaysia

- MMA has been working with the Ministry of Health so that the views, concerns and welfare of all sectors of doctors are represented and taken into consideration in the implementation of new laws, policies and practices.

GENERAL PRACTITIONERS' WOES MOUNTING

- I Care for I Malaysia is the name given to the transformed healthcare system of the future, which is going to be based on a social health insurance scheme (SHI) i.e. a compulsory health insurance scheme which every contributes to with primary care physicians as "gatekeepers".

- The Ministry of Health will play a more regulatory and policy making role while health services will be run by both public and private sector healthcare providers.

- Care for 1 Malaysia health reform plans were the main concern of General Practitioners;

- Every GP was annoyed and felt that they were the target of every new Medical Act and Regulations, being unfairly micromanaged, their livelihood and professional status being put under the microscope.

- GPs feel policies are made with disregard for their welfare.

THANK YOU....

MYANMAR MEDICAL ASSOCIATION[*1]

Aye AUNG[1]

Myanmar Medical Association (MMA) was founded in 1949 as Medical professional association with registered medical doctors. Membership of 18,000 with both government service and general practitioners together with 33 specialty societies and 12 social supporting groups. There are 90 branch offices in states, regions and townships over the country. MMA is the only professional organization of qualified medical doctors in the Republic of the Union of Myanmar.

2014 central executive committee is led by Dr. Rai Mra as President, Dr. Aye Aung and Dr. Myint Thaung as Vice Presidents and Dr. Saw Win as Secretary General.

Myanmar Medical Association is also the member of
(1) MASEAN in October 1997
(2) CMAAO in November 2009
(3) WMA in October 2012.

Main Objectives

- To promote and advance the Science of Medicine
- To encourage continuing medical education and medical research among the medical professionals
- To support the promotion of health along with the national health care programs and plans
- To promote cooperation and foster a fraternal spirit among its members
- To safeguard the honor and dignity of the medical profession
- To maintain a high ethical standard among the medical profession

Main Activities of MMA

- Education and Training towards the CME accreditation
- Clinical and Public Health Research with ethical and professional needs and standard
- Community Healthcare including public health projects, health promotion including reproductive health
- Collaboration and coordination with allied medical associations and societies in and outside the region
- Partnership approach with allied medical societies, INGOs, NGOs inside the country
- Encourage and support total capacity building of the association at all level with professional aspiration

Conferences 2012-2013

- 60th Annual Conference was held in Yangon in January 2014
- 8th Pathologists' Conference was held in Yangon during January 2014
- First Endoscopic Surgical Conference was held in Yangon during February 2014
- 3rd GI & Liver International Scientific Meeting was held in Yangon during March 2014
- 5th Conference on Myanmar Society of Endocrinology & Metabolism was held in Yangon during in March 2014
- 24th Eye Surgeons' Conference was held in Yangon during November 2013
- 15th General Practitioners' Scientific Conference was held in Yangon during November 2013
- Myanmar-Thai Scientific Meeting and 10th Rehabilitation Medicine Conference was held in Yangon during October 2013
- 19th Medical Specialties Conference was held in Yangon during October 2013
- 11th Radiology Conference was held in Yangon during November 2013
- 10th Obstetrical and Gynecological Congress, Yangon, February 2013

Academic Projects and Public Health Related Projects

Academic Projects and 18 Public Health related Projects funded by various International Donor Agencies including MMA itself, covering 80 townships in the fields of Reproductive Health, Youth, Malaria, TB, Statics & Mobile Health Care Services, etc.

Continuing Medical Education Program for GPs

- Certificate in Family Medicine four courses: (1) Public health, Family Medicine and research course; (2) Diagnostic procedures in Medicine, Surgery, Obstetrics and Gynaecology; (3) emergency medicine; and (4) common clinical problems.
- Distance learning medical education (CME unit MMA)
- Participation in Diploma in Family Medicine course conducted by Department of Medical Sciences

Numbers of Candidates who successfully completed above four courses and in two year and received Completion Certificate in Family Medicine were 526 doctors. Total number of candidates attended was 5,266 and 3,798 candidates have completed the distance Learning medical education program.

Special Training

- Primary Trauma Care Myanmar
PTC Myanmar carried out 7 Instructor courses and 2 Supervisor forums and produced 1,000 candidates as PTC Providers, 120 local Instructors and 20 local Supervisors.

Public Health Programs and Projects Conducing with Collaboration with Ministry of Health and INGOs

Sexual and Reproductive Health (SRH) Project for GP (with UNFPA)

a) District level minimal intervention service package (MISP) for RH training—18 townships (GPs, MMCWA, MRCS, MWAF, Information and Communication, Social welfare, Police and General Administrative Department)

b) Providing mobile RH services in poor and underserved areas (20 sites—9 townships in Yangon Region and 2 township in Raphine State)
c) Clients referral support for Emergency Obstetrics care
d) Client referral support for obstetrics fistulas
e) RH refresher courses for the GPs, Pharmacies and AMW
f) Comprehensive Reproductive Health Services for Underserved Communities (with UNFPA)

Youth Development Program

a) Adolescent RH Project
b) HIV/AIDS Prevention and Education Project
c) Youth Leadership Project

Health education produces two reproductive health education TV series (endless journey and guiding star) in March 2014 will be on public TV program.

MMA-IUD Project (with PSI) in Yangon, Mandalay, Bago and Ayarwaddy Regions

- To reduce Maternal Mortality Rate and Infant Mortality Rate
- To reduce Abortion Rate and Unwanted Pregnancy
- To promote role of IUD in family planning

Provision of Life Saving RH Care (with UNFPA) in Sittwe and Myebon Townships (with Relief International)

Static and Mobile Health Care team to cover Reproductive Health

Malaria Programs

a) Quality Diagnosis and Standard Treatment of Malaria Project (QDSTM) (with GF)
b) Myanmar Artemisinin Resistance Containment (MARC) Project (with 3D Fund)
c) MMA-CAP-Malaria (with USAID)

Goals
- To reduce malaria morbidity and mortality in the project townships by improving early access to quality diagnosis and standard treatment of malaria
- To contribute to the Millennium Development Goals of reducing by 50% of malaria morbidity and mortality in 2015

Objectives
- To ensure that malaria cases received quality assured diagnosis and standard treatment in

accordance with national malaria treatment guidelines. (This is linked to objective 2 of the national operational plan on malaria prevention and control.)

Total 453 QGPs in all state and regions, 123 townships and 14 Fixed and Mobile Clinics

TB Programs

a) MMA-PPM-DOTS Project (with GF)

Vision: Every TB patient seeking treatment from private health provider in Myanmar gets international standards of TB care at free of charge

Mission: To assist the efforts of National Tuberculosis Control Programme in achieving its goal to bring down the burden of Tuberculosis in Myanmar

Area coverage: 122 townships, (5 States & 7 Regions), 34 townships through Scheme III

GPs: (1,300) PPM implementing GPs

b) MMA-Cap-TB Project (with Fhi.360—USAID)

The USAID-funded CAP-TB Project provides technical assistance and support to the Myanmar National Tuberculosis Program (NTP)

To reduce the incidence of and mortality-related to multidrug resistant tuberculosis (MDR-TB) in Myanmar.

c) MMA-ACF TB Project (3 MDG) 3 years project for Urban poor, Hard to reach (Rural) area and Industrial zone (16 townships in 5 States and Regions)

    motto: Find missing TB cases as much as We Can

Objectives

• To empower community health volunteers in TB prevention and care activities for reduction of TB disease burden in community.

• To increase early case detection and prompt treatment of hidden TB cases in urban poor areas, rural areas and industrial zones

• To increase the community awareness of TB

Mobile Medical Services in Remote Areas (with Nippon Foundation)

Agreement for 1st year August 2012, 2nd year from October 2013. Targeted care for 30,000 patients in year 1 but achieved 53,101 cases, and the year 2 targeting 40,000 patients.

a) Rural area difficult to cover and easily reached
b) Socio-economic Status
c) Vacancy of Government Basic Health Staff
d) Close to Border area

Disasters Relief and Care

MMA had experience with Natural disasters like, Cyclone Nargis and Giri.

Men made disasters with Rakhine state experience. Support the health care services with emergency mobile specialists and clinics with DOH.

Disease Surveillance

DOH provided guideline for the reporting and management of disease outbreak.

MMA prepare to collaborate with the guideline at various levels of health care.

Social Activities

(a) Special group for elderly doctors (SGED) to look after the elderly and pensioned doctors for their welfare, health care services and day care services.

(b) Religious groups for meditation and religious ceremonies.

Myanmar Medical Association will continue our aims and objectives, mainly on the continuing medical education, personal development programs and social welfare of the fellow medical professional.

Myanmar Medical Association
Country Report
Professor Aye Aung
Vice President

Main Activities of MMA

1. Education and Training towards the CME accreditation
2. Clinical and Public Health Research with ethical and professional needs and standard
3. Community Healthcare including public health projects, health promotion including reproductive health
4. Partnership approach with international NMAs NGOs and INGOs

CME

Completion Certificate in Family Medicine - 526 doctors
3,798 doctors completed the distance Learning Medical Education

Trainings & Workshop

Training

Workshop

Community Healthcare including public health projects, health promotion including reproductive health

Mobile Medical Services in Remote Areas
(with Nippon Foundation)

- 1st year August 2012
- 2nd year from October 2013.
- Targeted care for 30,000 patients in year 1 but achieved 53,101 cases
- the year 2 targeting 40,000 patients.
- Rural area difficult to cover and easily reached

- Socio-economic Status
- Vacancy of Government Basic Health Staff
- Close to Border area

KAYIN STATE
Myanmar

Hlaing-bwe

Kawkareik

Kyarinseikgyi

Total Pop;	287,550
Rural Pop;	265,799
Total villages	381
MMA -Mobile teams	2
No of Other INGOs	4
Total patients in Year I	15,202
Project Started	Nov; 2012

Total Pop;	306,675
Rural Pop;	250,258
Total villages	252
MMA - Mobile teams	2
No of Other INGOs	4
Project Started	Nov; 2012

Total Pop;	178,031
Rural Pop;	169,760
Total villages	233
MMA-Mobile team	1
No of Other INGOs	2
Project Started	Feb; 2014

MMA Mobile Medical services for the outreach areas

MON STATE
Myanmar

Kyeikhto

Belin

ThanByuZaYat

Total Pop;	163,767
Rural Pop;	131,897
Total villages	86
MMA -Mobile teams	2
No of Other INGOS	3
Total patients in Year I	10,404
Project started	Dec; 2012

Total Pop;	151,030
Rural Pop;	135,138
Total villages	210
MMA - Mobile teams	1
No of Other INGOS	3
Project started	Jan; 2014

Total Pop;	169,950
Rural Pop;	137,615
Total villages	72
MMA -Mobile teams	2
No of Other INGOS	6
Total patients in Year I	10,948
Project started	Nov; 2012

Village based mobile clinic

MMA in Action

MMA in Action

Hand Washing and Tooth Brushing Campaign

Targeted care for 30,000 patients in year 1 but achieved 53,101 cases, and the year 2 targeting 40,000 patients.

MMA in Action

Chlorination of well (Kyaik-Hto)

Out-reach Cataract Campaign
Dental care

MMA in Action

MMA in Action

Emergency Disaster
Medicine Supply to Hlaing-bwe

Special Disease projects
Myanmar Medical Association

Quality Diagnosis and
Standard Treatment of
Malaria

(QDSTM) Project

-107 Townships &
-16 Fixed/ Mobile
clinics
- in 14 States and
Regions

TB - Role of MMA in PPM DOTS

AIM :
To engage all Private Practitioners in TB Care and Control.

T.B Control Activities

NTP/
TMO

PPs

MMA – A BRIDGE
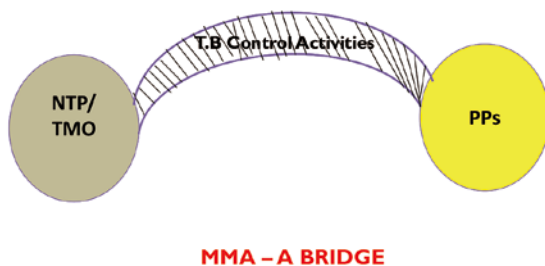
Minimally Intervention Service Package

District level MISP training – 18 townships (GPs, MMCWA, MRCS, MWAF, Information
and Communication, Socialwelfare, Police and General Administrative Department)

Sexual and Reproductive Health Project Activities (2014)
Providing mobile RH underserved areas (20 sites - 9 townships in services in poor and Yangon Region and 2 townships in Rakhine State)

MISP
(minimal intervention service package)

MMA in Action

Youth Training Programme

Emergency Ambulance
Service Foundation

(1/2014)

ACTIVITIES OF
SUPPORT GROUP FOR ELDERLY DOCTORS

Day Care, Recreation and Physiotherapy

THANK YOU !

NEPAL MEDICAL ASSOCIATION[*1]

Mukti Ram SHRESTHA,[1] Anjani Kumar JHA[2]

Nepal Medical Association's Profile

Dr. Mukti Ram Shrestha
General Secretary

Dr. Anjani Kumar Jha
President

Nepal Medical Association
Siddhi Sadan, Kathmandu

This is where Humla is. The red line is the approximate path we took. The small house symbol is where we spent the night.
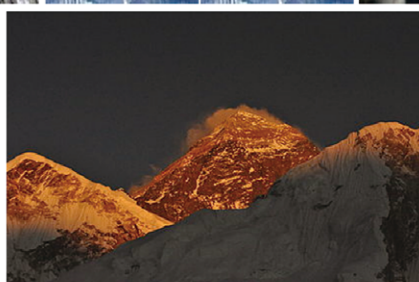
Morning view of Mount Everest

- **Mount Everest** (also known in Nepal as *Sagarmatha* and in Tibet as *Qomolangma*) is the Earth's highest mountain. It is located in the Mahalangur section of the Himalayas. Its peak is 8,848 metres (29,029 ft) above sea level[1] and is the 5th furthest point from the center of the Earth.

Lumbini, is the birthplace of Buddha in Nepal.

Nepal at a Glance

- Nepal is a landlocked country with India in the southern, eastern, western sides and China in northern sides. Nepal has a great variation in languages, religions, ethnic groups, culture and traditions with a strong unity among these variations.

General Information of Nepal Medical Association:

- It is the oldest professional organization in Nepal. It was established on 1951. The association was started only by 20 doctors.

- There are 30 speciality Societies affiliated with Nepal Medical Association Constitution such as
    - ➤ Society of Surgeons of Nepal
    - ➤ Society of Internal Medicine of Nepal and so on.

Objectives of the NMA

- The association shall be committed for the unrestrained enjoyment and protection of democracy and human rights derived for the historical democratic movement.
- To protect the justifiable rights, interest and respect of profession.
- To support and extent encourage various training related to medical field conducted by the association as required by the nation.
- To provide service to the nation by enhancing the competence of medical professional.

Objectives……

- To encourage it members to maintain professional standard, ethics and independence.
- The association shall maintain affiliation with national and international medical association as per necessity.

Implementation of Health Professional Protection ACT 2066

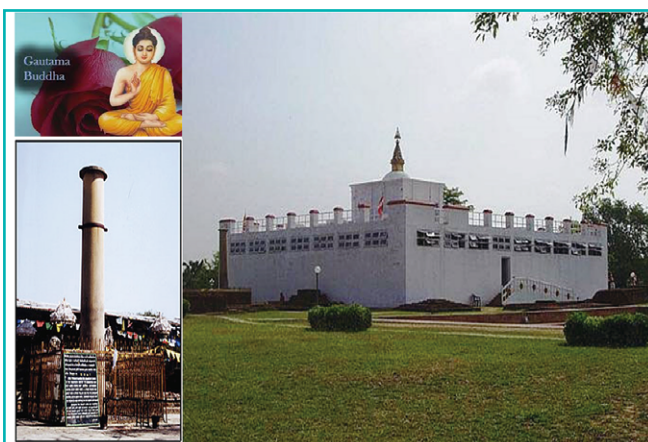- Nepalese doctors and the health instituons have been facing difficult and unpleasant situations. The moral of the doctos and their health service terms has been degraded because of the growing number of attacks they have been encountering.
- NMA has been trying to draw the attention of the concerned authorities about the trend of rising violence against the health-care providers and to the overall negative impact to the health service. Therefore, recently health professional protect Act is implemented.

Picture 1. Protest against the perpetrators by the health professionals in Kanti Children Hospital Kathmandu, Nepal. 11 September 2011

Picture 2. Infrastructure damage of health set-up by perpetrators

Picture 3. A protest rally organized by health professionals in Tribhuvan University Teaching Hospital, Kathmandu Nepal. 31 March 2010

Activities:

- Journal of Nepal Medical Association is an official publication of NMA since 1963 and indexed in PubMed/MedLine since 2005. JNMA has met the international standard and uplifting academic medicine in Nepal.

- The association has been regularly organizing workshops, seminars and conferences to make the medical professionals fully up-to-date with the advances of medical sciences.

Activities……

- We have small guest house with the bed number of 12. It is only the use of NMA Life Member who is coming out of valley.

- We have some scholarship program for Under Graduate and Post Graduate Medical students.

- We have some provision to provide scholarship for Life Members (Who is passed away) children.

- We have completed the Digitalization of Journal of Nepal Medical Association (JNMA) since 1963 to till the date.

Some photos of NMA's some Activities

Proposed activities of NMA

1. Evaluate the quality of care for mothers, babies and children in referral hospitals in five regions by comprehensive assessment.
2. Conduct the survey about find out existing situation of medical doctors all over the Nepal.
3. Capacity Building for NMA members.
4. Training for Medical Journal Editors, Author and Peer Reviewer.
5. Workshop for the proper implement of Health Professional Protection Act in the country.

6. Construction of NMA new business complex.

Cont...

7. Conduct a Medical Conference entitled "The Importance of District Coverage and Primary Health Care Services".
8. Medical Waste Management Workshop.
9. Interaction program on the problems and challenges of NMA at 21st Century.
10. Consultative meeting with Editors and Reporters of health desk of National Newspapers.
11. Interaction program on NMC Act and Drug Act amendment.
12. Lobbing for one window system entrance and ceiling of fees for undergraduate and post graduate students.
13. Consultative meeting with concerned authorities for formation of Medical University in Nepal.

Thank You for your kind Attention.

PHILIPPINE MEDICAL ASSOCIATION[*1]

Maria Minerva P. CALIMAG[1]

Distinguished personalities and fellow Presidents of member countries of the Confederation of Medical Associations of Asia and Oceania (CMAAO), distinguished guests, ladies and gentlemen.

We live in interesting times! This year, the Philippine Medical Association (PMA) celebrates its 111th Foundation Day. The PMA is our Mother Organization since 1903 built upon the age-old ideals of our predecessors. It is the Accredited Professional Organization of Physicians in the country for the longest time. It has weathered many challenges through the years. Members and patients count on the PMA to be the informed, authoritative and independent voice in the art and science of medicine. Public confidence in our objectivity is critical to carrying out our mission. The public relies on the PMA to minimize actual and perceived conflicts of interest and ensure that all its interactions meet high ethical standards. In all of these interactions, the PMA remains committed to acting with integrity and transparency. Now standing here before you as the 93rd PMA President and the 7th female to lead this prestigious association of physicians I recognize the power of organized medicine even more. I see how an issue I faced in my practice could be taken to a higher level. And if resolved at that higher level, the benefits would reach not only my own patients, but also every patient in the country.

As I go around the country this year representing the Philippine Medical Association, I have visited 17 Regions of the PMA and some 60 out of 118 Component Societies in the past 3-1/2 months, I listen to our colleagues' stories and come to understand and appreciate the diversity of ideas and approaches to health care challenges found in different regions—and realize that each has its merits. I am reminded again and

again of the responsibility we have as physicians to provide the best care possible to our patients. In addition I believe we have a dual responsibility to provide the leadership to ensure that the environment in which care is given, the structure of the health care system, is one that promotes good quality care. Now, I also recognize the challenges and fears we physicians have of losing our autonomy—we fear that … crucial health care decisions will be dictated by government, by the hospital administrators, or by health insurance companies.

Advocacies drive changes at the PMA and they have taken notice of the PMA in the Halls of Senate and Congress as I represent the PMA in the Committee of Health on issues of drug safety profile and fake drugs, in the Committee on Budget and Finance on issues of taxation, in the Committee on Economic Reforms on issues related to the ASEAN Harmonization; in the Halls of the Department of Health as Resource Person in the Formulary Executive Committee and the Food and Drug Administration (FDA) Pharmacovigilance Committee and participates in drafting the Administrative for the adoption of Mexico City Principle and the Kuala Lumpur Declaration, in the Advisory Committee and the Standards and Privacy Committees of the Philippine Health Information Exchange Initiative, in the Philippine Burden of Disease Committee; in the Board Rooms of the Dangerous Drugs Board and the Philippine Drug Enforcement Agency on issues of drug regulations and the revision of Board Regulation No. 3, which is the IRR of the Dangerous Drugs Act of 2002; the Board Rooms of PHILHEALTH on issues of fees reimbursement and quality healthcare; in the Professional Regulation Commission (PRC) and the Commission on Higher Education (CHED) on issues related to Outcomes-based

Education, Clinical quality improvement and patient safety through interprofessional education and collaborative practice, the revised framework for the Continuing Professional Development and the ASEAN Qualifications Reference Framework; and in the Conventions and Congresses of the Department of Science and Technology and Philippine Council for Health Research and Development and the different local, national and international Specialty Societies; in the Medical Staff Meetings and corridors of hospitals nationwide; and in the corridors and auditoria of Universities and Medical Colleges, and speaking my mind in the numerous press conferences, while calling for transparency and accountability in all our transactions. Together with the Philippine College of Physicians and the Philippine Society on General Internal Medicine we have launched the Coalition on Primary Care.

The PMA is also set to launch its MOOC site on Online Continuing Medical Education for the Primary Care Physicians. In the international scene, speaking on Adverse Drug Events at the 2014 Conference of the International Society on Pharmacovigilance (ISoP) held at the Asian Institute of Management in Manila; the 2014 Asia Pacific Association of Medical Editors (APAME) in Ulaanbatar, Mongolia to discuss issues on research dissemination in the Asia Pacific Region, and at the APEC Business Ethics for SMEs Forum in Nanjing China as one of nine participants from the Philippines. Speaking in a session on behalf of professionals as stakeholders in the Business Ethics conversation, I was among 200 attendees from 80 organizations across 20 APEC economies to promote ethical environments in the medical device and bio-pharmaceutical sectors. Recognizing that facilitating ethical environments cannot be achieved by one group alone, the Forum convened leaders from industry, government, healthcare professional associations, patient groups and other organizations. The PMA tagline as an organization is be: "PMA: Empowering the Filipino Physician for Nation Building."

Dear colleagues, change can be scary. But we must never forget: change can also be good. Today the PMA stands at a crossroads in the history of health care in this great nation. Behind us lies a century of failed attempts to improve the system. Ahead of us lie two distinct paths.

One is the path of inaction. Of glorifying the past, succumbing to partisan politics that muddle all our issues, and thwarting any attempt to move forward. The other is the path of action. Of collaborating, innovating, and leading the drive toward productive change.

Today, we look back, thank and celebrate three groups of people who played an important role in the development of our organization:

First—to the group of early PMA pioneers who believed and acted upon an idea that such an association would be useful to promote and serve the medical profession in our country;

Second—to the group of leaders and members who expanded the original vision of the organization by offering exciting new activities and events that continue to serve our constituency today;

Third—to the group of future leaders and members who will continue to nurture and develop our association into a vibrant future. If the relevance and vitality of professional organizations is based on the services and support it provides to its members, as well as its ability to change and transform itself to reflect the changes in 'our' world, then we at the PMA, can truly call ourselves leaders and I am honored (and proud) to be among fellow leaders of PMA! We think creatively, work collectively, and lead passionately! We all look forward to many more years of learning, sharing, mentorship and forming lasting friendships. Mahatma Gandi said … If we want to find ourselves … we have to lose ourselves in the service of others …. We celebrate Our Legacy: A Distinguished Past … A Vibrant Future!

There are three types of people: 1. Those who make things happen, 2. Those who watch while things happen, and 3. Those who do not know what is happening.

Colleagues, I know that the Philippine Medical Association is composed of physicians determined to make things happen and I look forward to walking that path of action with my fellow leaders in the year ahead. We are doing right by our patients and we are leveraging the power of organized medicine. The future of health care in our country … is in our hands.

Thank you. Mabuhay ang CMAAO, at Mabuhay ang PMA!

SINGAPORE MEDICAL ASSOCIATION[*1]

Bertha WOON[1]

COUNTRY REPORT

Dr Bertha Woon
SINGAPORE MEDICAL ASSOCIATION

Service before Self

MEMBERSHIP

- 7,029 members and growing!
- Approximately 12,000 registered medical professionals in Singapore and about 1,800 medical students
- Total membership of the Singapore Medical Association (SMA) represents approximately **50%** of all registered medical practitioners in Singapore
- Waiver of membership fees for medical students
- Waiver of membership fees for spouse of members [if they are also doctors]
- **Challenge**: Recruitment & retention as membership is voluntary

54th SMA COUNCIL (2014-15)	
President	A/Prof **Chin** Jing Jih
1st Vice President	Dr **Wong** Tien Hua
2nd Vice President	Dr **Toh** Han Chong
Honorary Secretary	Dr Tammy **Chan**
Honorary Asst Secretary	Dr **Lim** Kheng Choon
Honorary Treasurer	Dr Daniel **Lee**
Honorary Asst Treasurer	Dr **Lee** Yik Voon
Members	
Dr **Chong** Yeh Woei	A/Prof **Tan** Tze Lee
Dr Anantham **Devanand**	Dr **Tan** Yia Swam
Dr **Lee** Pheng Soon	Dr **Toh** Choon Lai
Dr Benny **Loo**	Dr **Wong** Chiang Yin
Dr **Noorul** Fatha As'art	Prof **Wong** Tien Yin
Dr **Ng** Chee Kwan	Dr **Woon** Yng Yng Bertha
A/Prof **Tan** Sze Wee	

The current SMA Council is made up of a mix of doctors, in public and private practice, doctors-in-training and experienced doctors, general practitioners and specialists

Academy & events

- **Aim:** Refresh professional competency and creating tangible benefits for members
- Focus on ethics - SMA Centre for Medical Ethics and Professionalism (SMA CMEP)
- Practice-related issues, e.g. taxation, workplace safety & health, healthcare assistant course
- Member-centric lifestyle activities, e.g. sports, leisure events
- Partnering with other organisations (e.g. Medical Protection Society, Medico-Legal Society)
- **Challenge**: Staying relevant to needs of doctors and changing landscape

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MAJOR EVENTS

- 9th and 10th May 2014 – Medical Association of South East Asian Nations (MASEAN) meeting in Singapore; took over chairmanship (2 years)
- 30 Aug 2014 - Medical Convention for doctors and public - "Active with Allergies"
- 1 Nov 2014 - SMA Lecture 2014 – Professor Tan Chorh Chuan "Innovating for Future Health"

OTHER EVENTS

- Ethics course for doctors-in-training [compulsory for all doctors training to be specialists]
- Risk Management Workshops, in partnership with the Medical Protection Society (MPS)
- Medical Experts Training Course [medical reports, expert witness in court, etc]
- Cardiopulmonary resuscitation (CPR) & Automated External Defibrillator (AED) Courses
- Tax Obligations of a Medical Practice
- Workplace Safety & Health workshops
- Lifestyle events, like Annual Golf Tournament, Social Dance Nite, Wine Chapter Dinner

SMA Centre for Medical Ethics and Professionalism (SMA CMEP)

- To develop and promote the art and science of medical ethics and medical practice for the betterment of patient care and public health
- Domain knowledge: Professionalism, Medical Ethics, Health Law, Medical Practice
  - Medical Confidentiality & consent
  - Medical Negligence & Professional Misconduct
  - Dispute resolution
  - Medical Report Writing, expert witness
  - Death Certification
- Teaching faculty: doctors from various specialties and lawyers with experience in medico-legal cases
- Resource articles on SMA website, and dedicated column in monthly newsletter

PUBLICATIONS

- Singapore Medical Journal (SMJ) – scientific journal
- SMA News – members' newsletter reporting on current local medical landscape
- Both published monthly
- Special themed issues focusing on specific topics throughout the year
  - e.g. SMJ – Endocrinology
  - e.g. SMA News – Doctors-in-Training
- **Challenge**: controlling print costs and keeping publications in public domain

PUBLICATIONS

Singapore Medical Journal (SMJ)
- New features
  - Article processing charge – manage cost of administering peer-review
  - CrossRef membership and article DOIs – enhance online search of published articles
  - Subscription to CrossCheck powered by IThenticate – curtail scholarly plagiarism and duplicate publications
  - E-pub ahead of print (case reports) – ensure timely publication of authors' research findings

PUBLICATIONS

SMA News
- New features
  - "From the Heart" column – complimentary space for Charities, NGOs, etc. to feature their projects and appeals for volunteers
  - E.g. health screening projects, request for volunteer/pro-bono doctors/nurses

SMA Charity fund (SMACF)

- Separate entity, newly set up in 2013 to consolidate charitable activities of SMA and to spearhead new initiatives
- Currently conducting fund-raising, creating awareness
- Activities
  - Financial assistance on living expenses for selected students of all 3 medical schools
  - Financial support for needy medical students for overseas conferences
  - Promote volunteerism amongst members and matching to opportunities available
  - Recognising outstanding mentors & researchers
- Challenge: making a positive impact in the healthcare landscape

Challenges for the medical profession

- Disciplinary processes
  - a Review Committee was formed after several high profile appeal cases in Court
  - recommendations made to improve training , transparency, timeliness, separation of powers, etc.
- Ethics & Professionalism
  - review of SMC Ethical Code has been delayed, but recently SMC has launched a consultation exercise for doctors
- Cost of medical treatment
  - SMA Guideline on Fees (GOF) was withdrawn in 2007 due to concerns of breach of Competition Act
  - Medical fees have been increasing; overcharging difficult to prove
  - Lack of protection for patients
  - Hints from regulatory bodies of a possible revival of GOF

Thank you

TAIWAN MEDICAL ASSOCIATION[*1]

Ching-Chuan SU,[1] Jerry-Y.H. CHU[2]

Taiwan Medical Association (TMA) complied data on membership, physician-patient ratio and distribution of physicians across all levels of healthcare facilities by end of 2013. A summary of TMA's recent activities is presented below:

Government Sponsored Projects

Projects included "2014 Global Budget Implementation Performance and Evaluation," "CME Credits Acknowledgement," "ICD-10-CM/PCS Training," "Community-based Colorectal Cancer Screening," and "Development of Job Stress Inventory for Physicians in Taiwan."

Legislative Advocacy and Policy Formulation

Policies promoted by TMA included "Medical Care Act Amendment," "Medical Malpractice Resolution and Compensation Act" (draft), "Long-term Care Act," "Long-term Care Insurance Act" and a policy governing pharmacist's registration of parallel practices in multiple locations.

International Programs

We visited Japanese Ministry of Health, Labour and Welfare, Japan Medical Association and long-term care facilities in Japan; attended the 67th World Health Assembly and World Medical Association Luncheon Meeting; sent a delegation to the American Medical Association General Assembly; visited Malaysian Health Ministry and Medical Association, and actively engaged with Chinese medical professionals.

Other Activities

We identified critical gaps to be addressed in the NHI system, purchased group insurance for our members, and collaborated with mass media in various occasions.

*1 This article is base on a presentation made as the Report of Activities by each NMA at the 29th CMAAO General Assembly and 50th Council Meeting, Manila, the Philippines, on September 24-26, 2014.

1 President, Taiwan Medical Association, Taipei, Taiwan ROC (intl@tma.tw).

2 Vice Secretary General, Taiwan Medical Association, Taipei, Taiwan ROC (chinchu@ms2.hinet.net).

Contents

1. Government Sponsored Projects

2. Legislative Advocacy and Policy Formulation

3. International Activities

4. Other Activities

3

1) Primary Care

Background:

TMA's work achieved an "Excellent" status in the 2013 Global Budget Implementation Performance and Evaluation Meeting.

Project Objective:

- Planning and management of inspectors.
- Standard operation procedure of handling abnormal claims.
- Quality of inspectors.
- Claims reviewed by inspectors.
- Coherence of inspectors' qualifications.
- Coherence of inspection.

Primary Care

4

2) CME Credits Acknowledgement

Background:

The physician license be renewed every 6 years, upon completion of:

- 162 CME credits of professional courses.
- 18 CME credits of quality, ethics and legal education.

Project Objective:

- TMA, as an accredited provider of CME, offers professional courses in a variety forms from regular, symposium, correspondence to online courses.

5

3) ICD-10-CM/PCS Training

Background:

- ICD-9-CM is in use for over 30 years and inconsistent with current medical practice.
- It cannot accurately describe the diagnoses and inpatient procedures of care

Project Objective:

- To reduce error and measure outcomes with higher accuracy.
- To facilitate care management.
- To enhance clinical research.
- To manage long-term care.

ICD-10 TENTH REVISION
INTERNATIONAL CLASSIFICATION OF DISEASES
ICD-10 is a new code set for reporting medical diagnoses & inpatient procedures.

6

4) Colorectal cancer screening

Background:

- Before 2006, colorectal cancer was the 3rd leading cause of cancer mortality after liver cancer and lung cancer.
- After 2006, it became the NO. 1 killer, followed by liver and lung cancers.

Project Objective: Early detection and early treatment.

- To increase the prevalence of colorectal cancer screening.

7

5) Development of Job Stress Inventory for Physicians in Taiwan

Objectives:

- To facilitate physicians' understanding about sources of stress and assess their mental & physical health conditions.
- To establish a database of stress as work and mental & physical health among Taiwanese physicians.
- To identify risk factors and adopt stress management and prevention policies.

STRESS

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1) " Medical Care Act Amendment "

2) Advocacy for the "Medical Malpractice Resolution and Compensation Act" (draft)

3) Promotion of "Long-term Care Act and Long-term Care Insurance Act"

4) Promoting "Pharmacists to Register Parallel Practices in Multiple Locations"

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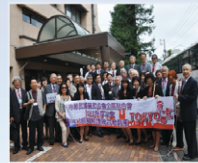
● Visited Japan.

Long-term care facilities

Japan Medical Association   Japanese Ministry of Health

12

● Participation in the 67th WHA & WMA Assembly

Venue of WHA & WMA Assembly

Venue of WMA Luncheon Meeting

13

● Visited Malaysia & USA.

American Medical Association

Malaysian Medical Association   Malaysian Medical Association

Slide 15

● **Visited China.**

Shanghai Planned Parenthood Committee

Shenzhen Medical Association

Chinese Medical Doctor Association

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Slide 16

Contents

1. **Government Sponsored Projects**

2. **Legislative Advocacy and Policy Formulation**

3. **International Activities**

4. **Other Activities**

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Slide 17

1) Identified Critical Gaps in the NHI System

- ● Increase reimbursement rate,
- ● Increase allocated quota,
- ● Subsidize training of resident physicians,
- ● Ensure adequate supply of supportive workforce,
- ● Strengthen PGY training,

for 5 major departments included Surgery, Medicine, Gynecology, pediatrics & emergency.

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Slide 18

2) Group Insurance

- ● No upper age limit.
- ● Monthly premium of NT$100 will be drawan from membership fees, adding no extra levy.
- ● NY$300,000 of life insurance and 200,000 of accident insurance coverages.

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Slide 19

3) Work with Media

Description:
- ● Collaborated with TV, radio, newspapers and magazines.

Objectives:
- ● To build a positive and professional image.
- ● To disseminate comprehensive and correct health news and messages.
- ● To join interview-based programs that provide insights from medical professional perspectives.

Achievement:
- ☆ http://www.kbro.com.tw/SMod/prog_smod_00.aspx?B=1&CatagoryID=a77135b0-0d18-400f-a154-9db46eaf1515
- ☆ http://www.youtube.com/?g1=TW&h1=zh-TW
- ☆ http://www.tma.tw/followDr/indenx_03.asp

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Slide 20

Thank You / Danke / Ευχαριστίες / Dalu / Köszönöm / Tack / Спасибо / Dank / Gracias / Merci / Seé

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THE MEDICAL ASSOCIATION OF THAILAND[*1]

Ronnachai KONGSAKON[1]

The Medical Association of Thailand (MAT) Under Royal Patronage has the new executive committee 2014-2015:
President:
　Assoc. Prof. Dr. Prasert Sarnvivad
President Elect:
　Prof. Dr. Saranatra Waikakul
Vice-President:
　Prof. Dr. Teerachai Chantrarojanasiri
Secretary General:
　Prof. Dr. Ronnachai Kongsakon
Chief Executive Officer:
　Prof. Dr. Somsri Pausawasdi

　The **2013-14 Thai political crisis** was a period of political instability in Thailand. Anti-government protests took place between November 2013 and May 2014. On 22 May 2014, the army formally staged a coup against the caretaker government and formed a junta called National Peace and Order Maintaining Council (NPOMC) to govern the country. On 21 August 2014 army chief General Prayuth Chan-ocha was appointed prime minister by a legislature he had handpicked.

　MAT still have so many activities under the political crisis within Thailand and internationally.

Within the association
- Outreaching Programme on the Medical Ethics for the medical students and newly graduates in several faculties.
- On 17-20 September 2013: Leadership and Negotiation Skill Training Course: Sampran. Thailand
- On 10-13 October 2013: Midyear MAT Scientific Meeting at Khonkaen, Thailand
- Organizing the MAT AGM on February 8, 2014
- Develop 3 regional MAT (New policy of MAT)

At the National level
- Preparing for the coming ASEAN Economic Community (AEC) in 2015 concerning Health care Provision
- Moving medical services to a pay for performance system for doctors
- Increasing the health warning sign on cigarette packaging to 85%
- Cover Dance Anti Smoking Campaign on June 8, 2013
- NATIONAL ALLIANCE FOR TOBACCO FREE THAILAND (NATFT) on Oct 2, 2013

At the Regional Level
- Visited and Attended the National Medical Association Conferences
  ・On January 22-24, 2013 Myanmar Medical Association
  ・On January 26-28, 2013 Chinese Medical Association
  ・Visited Wu Han University in China on March 21-24, 2013
  ・MASEAN Midterm Meeting in Halong Bay, Vietnam on April 25-26, 2013
  ・Australian Medical Association National Conference, Sydney, 24-26 May 2013
  ・16th MASEAN Conference, Singapore, 9-11 May 2014

At the Global Level
- Attended and Chaired the Revision of Declaration of Helsinki in Tokyo 27 February-2 March, 2013
- Attended the 194th WMA Council Meeting in Bali, Indonesia on April 2-7, 2013
- Attended the WMA Leadership Course at the INSEAD Institute in Singapore 28 April-3 May 2014
- Attended American Medical Association Annual Meeting in Chicago on June 7-11, 2014

Future Programmes
- WMA GA at Durban, South Africa, October 6-11, 2014
- Scientific Meeting of the MAT, October 24-26, 2014
- Declaration of Helzinki Celebration, November 11, 2014

NATIONAL ALLIANCE FOR TOBACCO FREE THAILAND
NATFT

We Cordially invite you (CMAAL) to be our international Partners in NATFT

NATFT

Sept 19, 2014: 50th Takeda Science Foundation Scholarship : 170 Thai Doctors

At the Regional Level

Visited and Attended the National Medical Association Conferences
- a. January 22-24, 2013 Myanmar Medical Association
- b. January 26-28, 2013 Chinese Medical Association
- c. Visited Wu Han University in China, March 21-24, 2013

Jan 26-28, 2013

March 21-24, 2013

At the Regional Level

Attended the regional International Conference ;
- MASEAN Midterm Meeting in Halong Bay, Vietnam : April
- 25-26, 2013

NOVOTEL HOTEL
HALONG BAY - QUANG NINH - VIETNAM
25 - 26 APRIL 2013

Halong: April 25-26, 2013

At the Regional Level

Attending Australian Medical Association National Conference, Sydney, 24-26 May 2013

May 24-26, 2013

16th MASEAN Conference

9-11 May 2014
Singapore

masean
**Medical Association
of SE Asian Nations**

- The recognition of the importance of mutual cooperation and collective effort among the national medical associations in attaining
- "the highest possible level of healthcare for people in the region and in upholding the image and dignity of the medical profession".

Challenges: FREE

- **Focus:** more on medical school graduates go into primary care, which is where the highest demand is.

- **Resources:** does within our organization have the resources (staff, time, money) necessary to carry it through its journey to accomplish the goal of MASEAN.

- **Exchange:** through MASEAN level of cooperation, we can share our resources and knowledge to further the advancement of overall healthcare systems.

- **Endeavor:** trying all our best with the same goal in mind, we can achieve.

At the Global Level

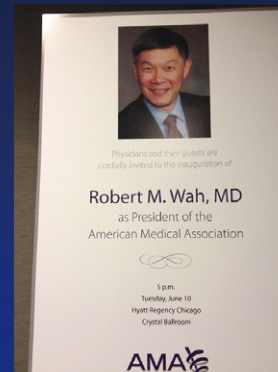**Attended the WMA Leadership Course at the INSEAD Institute in Singapore 28 Apri – 3 May 2014**

WMA - INSEAD Leadership Communication and Medical Advocacy Programme
28 April - 3 May 2014 in Singapore

Thailand Representatives

Inaugural ceremony

The 169th president of the AMA

"The AMA believes that all Americans should have access to health care, especially those who bravely serve our country,"

AMA president: Foundation of tradition required for future of change

Next Generation of Physician

satisfying and sustainable practice

The 169th president of the AMA, and the first Asian American to hold the post

- Highlighted the dichotomy between tradition and innovation in new technologies.
- Physicians can make change in such areas as fighting the nation's chronic disease epidemic, improving medical education to better prepare the next generation of physicians and creating a more satisfying and sustainable practice environment for physicians

Thank You For Your Attention

Kyeizu tin ba de

Terima Kasih

Arigatoo gozaimasu

謝謝

ขอบคุณครับ

Thank you

Trims

Komapsumnida

Maraming salamat.

From the Editor's Desk

The 29th CMAAO General Assembly was held September 24-26, 2014, in Manila, Philippines, with about 70 delegates in attendance from 13 member NMAs.

The main topic of the symposium was "Health Database in an Information Society." While the situations and issues differ among the member nations, this challenge is rapidly becoming more significant in each society. As individual physicians and as members of NMAs, our efforts in this field face increasing difficulties.

This is why the WMA decided to establish a working group for ethical guidelines on this subject, and thereby promote the development of a certain harmony beyond the Declaration of Helsinki, which will celebrate its 50th anniversary in November 2014.

At the CMAAO Assembly, we welcomed important guests as keynote speakers—namely, the WMA President Dr. Margaret Mungherera and the American Medical Association President Dr. Robert Wah. Both underscored the importance of ongoing discussion regarding the ethical aspects of information technology development in the health area for domains such as the CMAAO and the WMA. The Assembly provided a good opportunity to collectively review and discuss the issues our region faces regarding information technology and the pros and cons of health databases. We are happy to have reached some common ground and adopted our resolution.

Since the WHO Western Pacific Region (WPRO) has an office in Manila, we were able to invite main officers to the meeting and have fruitful exchanges encompassing broad perspectives. We are grateful to Dr. Nishikiori from the WPRO for giving a special presentation on multidrug-resistant tuberculosis at the request of delegates from the Indian Medical Association.

It is true that viruses and microorganisms do not pose as much risk as they once did. However, as made clear by Dr. Nishikiori's presentation, as well as recent events such as the Ebola outbreak, the battle is not over. We rely on advanced methodologies and must develop systems to prepare for not only old diseases but also new threats that emerge from remote local areas in distant regions.

Masami ISHII, Executive Board Member, Japan Medical Association (jmaintl@po.med.or.jp); Vice-Chair of Council, World Medical Association; Secretary General, Confederation of Medical Associations in Asia and Oceania (CMAAO).
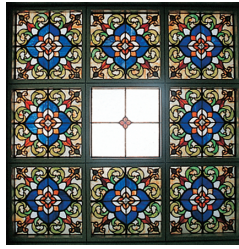
Principles of Medical Ethics

Japan Medical Association

The mission of medical science and health care is to
cure diseases, to maintain and promote the health of
the people; and based on an awareness of the importance
of this mission, the physician should serve
society with a basic love for humanity.

1. The physician should strive to achieve a lifelong dedication
to continuing education, to keep abreast of medical
knowledge and technology, and to support its
progress and development.

2. The physician should be aware of the dignity and
responsibility of his/her occupation and strive
to enhance his/her cultural refinement,
education, and integrity.

3. The physician should respect the individuality of
his/her patients, treat them with compassion,
provide full explanations of all medical treatment,
and endeavor to earn the trust of the patient.

4. The physician should maintain respect for his/her fellow
physician, cooperate with medical care personnel and
serve the cause of medical care to the best
of his/her abilities.

5. The physician should respect the spirit of public
service that characterizes health care, contribute
to the development of society while abiding by
legal standards and establishing legal order.

6. The physician will not engage in medical activities
for profit-making motives.