APEC Workshop on Strategies to Enhance Integrated People-Centered Health Care

Summary Report

APEC Health Working Group

February 2026

Asia-Pacific
Economic Cooperation

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1. Introduction

As populations age and the prevalence of chronic conditions increases, healthcare systems faced rising challenges in cost and service delivery. An integrated, people-centered approach was crucial to ensuring high-quality, personalized healthcare while fostering supportive working environments across the APEC region.

To address these challenges, Chinese Taipei proposed the “APEC Workshop on Strategies to Enhance Integrated People-Centered Health Care” project to provide a platform where member economies could exchange experiences and learn from each other. The focus was on three topics: (1) Best Practices in Governance, Accountability, and Frameworks to Support Integrated People-Centered Healthcare (2) Empowerment in Healthcare: Using Digital Technologies to Enhance Integrated Care Services and Reduce Health Inequities (3) Effective Integrated Healthcare Models: Community Engagement, Cross-Departmental Cooperation, Enhancing Quality and Outcomes. The workshop comprised of speeches, panel discussions, and a site visit (RICARE Day Care Center).

I. Organizing the APEC workshop

The “APEC Workshop on Strategies to Enhance Integrated People-Centered Health Care” was organized by the Ministry of Health and Welfare, Chinese Taipei. This workshop was held in Taipei on 2-3 September 2025 (GMT+8)**.** The event engaged 14 speakers/experts and attracted around 100 participants from 9 APEC economies, including Australia; Canada; Japan; Republic of Korea; Malaysia; Singapore; Chinese Taipei; Thailand; and Viet Nam.

Day 1 consisted of 3 plenary sessions including panel discussions. The topics are as follows,

(1) Plenary 1: Best Practices in Governance, Accountability, and Frameworks to Support Integrated People-Centered Healthcare

(2) Plenary 2: Empowerment in Healthcare: Using Digital Technologies to Enhance Integrated Care Services and Reduce Health Inequities

(3) Plenary 3: Effective Integrated Healthcare Models: Community Engagement, Cross-Departmental Cooperation, Enhancing Quality and Outcomes

Day 2 consisted of a panel discussion and site visit to RICARE Day Care Center

2. Presentation Summary

I. Plenary 1: Best Practices in Governance, Accountability, and Frameworks to Support Integrated People-Centered Healthcare

(a) Achieving Integrated People-Centered Healthcare: Strategies Framework under NHI (Chinese Taipei)

- In 2025, Chinese Taipei officially became a super-aged society, where one in every five people is over 65. This demographic shift posed a significant challenge to the financial and healthcare systems.
- With an aging population, the prevalence of chronic diseases (especially the "three highs": hypertension, hyperglycemia, hyperlipidemia) and cancer were rising. In response to the current health challenges, the healthcare model was shifting from a traditional "hospital-centric" approach to a "community- and home-based" model, which emphasized empowering patients with the skills for self-health management.
- The Family Physician Program, launched in 2003, was at the heart of Chinese Taipei's people-centered healthcare system. It brought together local clinics and referral hospitals through community medical groups, ensuring patients received coordinated and continuous care. The program also combined medical services with prevention, health management, and education.
- Building on this foundation, the Family Physician Program 2.0, launched in 2024, aimed to provide more coordinated care. It integrated Pay-for-Performance programs for chronic diseases, especially the "3 High" conditions—hypertension, hyperlipidemia, and hyperglycemia—while enhancing prevention through lifestyle assessment, cancer screening, and hepatitis vaccination. The program set evidence-based treatment standards,

introduced value-based payments for patient adherence and outcomes, and used digital tools to improve chronic disease management.

- To better support frontline doctors, the Family Physician Platform was built in 2025 as a digital tool to enhance primary care delivery. The platform featured two main functions: a facility management dashboard, which tracked patient enrollment and service performance, and a case management interface, which displayed laboratory trends, risk stratification, and preventive care status. By integrating these data, it enabled physicians to continuously monitor patients and made timely, personalized clinical decisions.
- We were integrating the Family Physician Platform with the My Health Bank app, used by over half of population, to provide integrated health information for self-management. This upgrade would allow patients and doctors to access clinic data, lab trends, ASCVD risk, and personalized education in one place, enhancing communication and targeted care. In 2024, we partnered with Google to improve chronic disease management, starting with over 3 million people with type 2 diabetes, using AI to assess risk levels. Future plans included embedding AI health agents into both platforms to offer personalized suggestions, support bundled payments, and enable continuous monitoring, advancing towards value-based, people-centered care.
- The Acute Care at Home (ACAH) program offered an alternative to hospitalization for patients with acute conditions like pneumonia or infections, particularly those with limited mobility. Care teams visited patients at home to provide treatments such as IV antibiotics and remote monitoring through IoT devices, along with telemedicine support and access to a 24/7 call center. Patients were closely monitored, and if necessary, they could be referred to hospitals via a "Green Light" mechanism.

- A blueprint had been developed for integrating medical and long-term care services, with a community-based network built to connect long-term care, post-acute care, and palliative services, addressing patient needs from aging to end-of-life care. The Family Physician Platform served as a key tool, linking providers across medical, home, and community settings to facilitate coordinated care and seamless data flow.

(b) UHC of the People, by the People, for the People: Thailand's Journey from Policy to Practice (Thailand)

- Thailand achieved Universal Health Coverage (UHC) around 2002 when the government enacted a law that created the "Universal Coverage Scheme" (UCS). This scheme brought the previously uninsured 30% of the population under its protection, operating alongside existing plans for civil servants and private employees to realize universal population coverage.
- The successful push for UHC was attributed to a strategy known as the "triangle that moves the mountain." This concept emphasized that major reform required the simultaneous alignment of three forces: a foundation of sufficient academic research and evidence, powerful social movements led by NGOs, and the political willingness to seize the opportune moment for change.
- To ensure the long-term sustainability of UHC, Thailand adopted a management framework called "GRASP" as its guiding principle. This framework consisted of five pillars: good governance, ongoing research and capacity building, an adequate and equitable health system, sustainable and efficient financing, and unwavering political commitment.
- A core feature of Thailand's UHC was its deep-rooted sense of "public co-ownership." The initial draft of the law was submitted to parliament by over 50,000 citizens, which made the UHC a public asset, not just a policy. This

strong public ownership ensured the system remained stable through more than ten changes in prime ministers and even periods of military government.

- Citizen participation was formally institutionalized within the governance structure. The law mandated civil society organizations (NGOs) to hold five seats on the top decision-making body, ensuring their voices were heard at every level.
- The system's good governance was built upon robust accountability mechanisms. The law required annual public forums to be held in Thailand to gather feedback and critiques from citizens, which the board was then obligated to formally review and respond to. A public hotline, "1330," was also established to provide an immediate channel for inquiries.
- The power of public participation directly influenced the expansion of the benefits package. For example, expensive treatments like antiretroviral (ARV) therapy for HIV and renal replacement therapy (RRT), which were not initially covered, were successfully added after persistent advocacy from NGOs and patient groups who used research to prove the catastrophic financial impact on families.
- The role of NGOs evolved beyond pure advocacy, as they became innovative service providers. Faced with shortages of official medical personnel, many NGOs stepped in to deliver critical services directly, especially in areas like HIV and long-term care, thereby filling crucial gaps in the public system.
- The initial implementation of UHC led to a massive influx of patients into hospitals, which caused severe burnout and dissatisfaction among healthcare providers. In response to this systemic challenge, Thailand's long-term strategy shifted towards strengthening its primary care system to manage patient flow more effectively and alleviate the burden on major hospitals.

- Ultimately, Thailand's UHC experience demonstrated that a sustainable health system needed to be not only for the people but also genuinely co-owned, shaped, and monitored by the people. It served as a valuable model for economies on maintaining universal health through public trust and engagement, even with limited resources.

(c) A New Clinical Governance Model for Australia: The Foundations of High-Quality Care (Australia)

- Australia's previous clinical governance model from 2017 had become outdated and was unable to address the severe challenges facing the healthcare system, including workforce shortages, budget constraints, and the complexity of integrating care. Leaders widely felt immense pressure, highlighted by serious incidents like the misdiagnosis of hearing in babies, which underscored the necessity for reform.
- An extensive system-wide assessment found that clinical governance suffered from three main problems. First, there was a poor understanding of the concept, with many professionals viewing it as someone else's responsibility. Second, a compliance-driven culture prevailed, where hospitals were drowning in endless risk registers and data reports that lacked analysis. Lastly, siloed approaches hindered collaborative, strategic thinking across departments.
- To develop a new model, the Australian Commission on Safety and Quality in Health Care undertook a comprehensive needs assessment. They interviewed leaders from high-performing hospitals, held focus groups with key stakeholders and consumer organizations, and combined these insights with a literature review and accreditation data to ensure the model was responsive and evidence-based.
- To address the problem of poor understanding, the new model first proposed a clearer, more purposeful definition, stating that clinical governance was the

combination of culture, systems, and processes that enabled everyone in a health service to deliver consistently high-quality and improving care, and to prevent patient harm. This directly linked the act of governance to its ultimate goal of making patients feel confident that they are receiving high-quality care.

- The core of the new model was built around "six foundations of high-quality care," which were framed as positive, action-oriented principles. These foundations were: 1) Leading systems and culture for high-quality care; 2) Partnering with patients, carers, and consumers; 3) Building a healthy workforce culture; 4) Effective clinical practice and integrated care; 5) Managing and responding to risk; and 6) Using data for better care.
- The model specifically emphasized that "Leading systems and culture for high-quality care" was the most important foundation of all. It was noted that without strong leadership from the board and executive teams, a supportive culture, and well-designed systems, the other five foundations could not function effectively.
- A fundamental goal of the new model was to shift healthcare organizations away from a "tick-box" and compliance-oriented mindset toward a culture genuinely focused on "improving patient outcomes." It was not designed as a rigid set of rules but as a flexible framework that encouraged organizations to adapt and continuously improve.
- The model itself was seen as just the first step, with a pipeline of practical resources planned to support its implementation. These included a "how-to guide" for managers and a "maturity self-assessment tool" to help organizations evaluate their performance against the six foundations.
- The most powerful strategy for driving the model's adoption was the plan to embed its six foundations into the next edition of Australia’s new Safety and Quality Standards (due in 2028). This alignment was intended to connect the

governance focus of the boardroom with the implementation activities on the ward.

- The ultimate vision of this reform was to ensure patients and consumers received care that was person-centered, safe, and integrated. For leaders, the goal was to reduce sleepless nights through effective governance. For staff, it was to enhance job satisfaction, ultimately making the health system more equitable, efficient, and sustainable.

(d) Updates to Singapore's Approach Towards Integrated Care (Singapore)

- Singapore was set to enter a super-aged society in 2026, and its healthcare system, though small, was structurally complex. To address this challenge, its core strategy over the past decade was to integrate three major care sectors: acute care centered around hospitals, primary and preventive health, and aged care.
- Integration efforts began in public hospitals because this sector accounted for the highest healthcare expenditure and was strongly led by the government. The initial focus was on two patient groups: "high utilizers," who were frequently readmitted due to poor post-discharge transitions, and nursing home residents, who were often hospitalized in their last year of life.
- For "high utilizers," Singapore launched a "Hospital-to-Home" program that provided safer discharge support and at-home follow-up; this program later evolved into a "Hospital-at-Home" program like Chinese Taipei's. For nursing home residents, hospitals dispatched clinical and palliative care teams into the facilities, which enhanced local care capabilities and respected residents' end-of-life wishes.
- After realizing that a hospital-out approach was not sustainable, the focus shifted to primary care. The challenge at the time was that most General Practitioners (GPs) were in solo practice and lacked the resources and incentive to manage complex chronic diseases. To address this, the

government used a subsidy to guide GPs to follow chronic disease management protocols.

- To overcome the limitations of solo practices, Singapore's most significant reform was supporting individual GPs to voluntarily form "Primary Care Networks (PCNs)". Through networking, these GPs were able to share resources like nurses and allied health professionals and achieved sufficient scale to manage populations with chronic conditions.
- Building on the foundation of PCNs, the government launched the "Healthier SG" initiative. A key change in this initiative was the move to have citizens enroll with a specific GP or network. This addressed the issue of patients "doctor-shopping" and enabled the longitudinal tracking and management of an individual's health.
- In the area of community aged care, Singapore acknowledged that its service system had become overly complex and difficult for the public to navigate. After a visit to Chinese Taipei in 2024, they were inspired by the ABC model of the Long-Term Care Plan 2.0 (LTC 2.0 plan) and began using this concept to restructure their own community care networks to make services easier to understand.
- To implement the ABC model concept, Singapore undertook three key shifts. First, it divided Singapore into 85 smaller sub-regions to encourage local providers to form alliances. Second, it tasked these networks with promoting active aging and providing longitudinal support. Finally, it pushed for service standardization within networks, aiming for a "single assessment tool (interRAI)" and a "single care plan."
- To connect the acute, primary, and community sectors, Singapore used data analytics to shift providers from a siloed to a person-centered mindset and established the common goal of "helping seniors stay well." They also employed a simple "Goals, Roles, Processes, Relationships" (GRPR) framework to help partners improve their collaborative relationships.

- The work of integration was still in progress, especially in strengthening the link between primary and community care. The ultimate vision was to enable seniors to receive appropriate care in their familiar community settings, while ensuring the entire health system remained sustainable in the face of a rapidly aging population.

Panel Discussion:

Q1. I would like to raise a question to our wonderful presenter from Thailand. In your presentation, you mentioned a satisfaction survey conducted from 2003 to the present, and I was particularly surprised to learn that you approached this survey from both the consumer and provider perspectives. It was fascinating to see that the provider satisfaction rate, which started under 40% in 2004, has now risen to over 90%. Currently, we are facing a situation where both consumer and provider satisfaction rates are quite similar to what you experienced in Thailand, with consumer satisfaction remaining high while provider satisfaction continues to struggle. Could you share with us how you were able to significantly improve satisfaction on the provider side?

The speaker from Thailand: Low provider satisfaction in Thailand was initially the result of a rapid and disruptive "big bang" change to the payment system around 2003, which caused widespread confusion and dissatisfaction. However, satisfaction gradually improved over time as providers adapted to the new system and, through consistent communication from the government, gained a better understanding of its rationale and the economy's inherent limitations, such as doctor shortages and tight finances. Rather than just focusing on high satisfaction numbers, a more crucial strategy for improvement is to analyze the reasons behind any remaining dissatisfaction. Also, the satisfaction surveys served a political purpose, used to demonstrate the system's success to the

government to maintain support. Nevertheless, Thailand will continue to face new challenges, such as a policy allowing patients to "go anywhere" for care and are actively looking to learn from Chinese Taipei's experience in managing the potential high costs.

The speaker from Chinese Taipei: We are committed to improving the working environment for our healthcare workers. We are shifting our mindset to view health as an investment, not a cost. We have already taken concrete action; this May, we increased the payment for ER doctors, nursing, and inpatient stays. To address the severe and worsening nursing shortage, we plan to increase payments for the entire nursing workforce next year. To address the lack of a gatekeeper system, which results in patients going to major medical centers for relatively minor illnesses, we are implementing a two-step strategy. The first step is using AI to analyze data and create different risk profiles for patients, starting with high-impact areas like cancer and the "three highs." The second step is to change our reimbursement system. By making the payment difference between care at a medical center and a local clinic much larger, we believe we can change the health-seeking behavior of our citizens and encourage them to use primary care first.

Q2. How do you ensure an adequate number of family physicians at the community level? Given that ideally one family physician should cover 2,000-3,000 people, what strategies are in place for training and retaining them? What challenges arise from differences between public and private healthcare systems in terms of governance, financing, and incentives? How do you address these issues when working with both systems? In terms of financing, how should provider payments be structured to incentivize collaboration among healthcare providers?

The speaker from Singapore: I think we recognize that with the aging population, we will never have enough healthcare professionals. So for us, apart from doctors, I think we are really investing in our nurses and allied health. And in the community, I think they really have to play a larger role than to be able to journey with the patient longer. I think doctors are also our most expensive resource. And it takes the longest to train.

In Singapore, we manage medical schools and can set ratios for specialists and family physicians. However, we also aim to make family medicine an attractive career by emphasizing the rewarding aspect of caring for families throughout life. We recognize that we can't override doctors' natural incentives, so we focus on creating an environment that encourages them to consider family medicine as a viable option.

Regarding providers working together, we believe the distinction between private and public sectors should be less emphasized. The key is understanding their incentive systems and ensuring fairness. With an aging population, we're providing data to help the private sector respond effectively. The private sector can be more agile, setting up services quickly, and we aim to ensure they are compensated fairly.

Our financing schemes are complex, with separate structures for public primary care and private GP services, which sometimes lead people to choose one over the other. Before changing structures or financing systems, we're focused on providing the necessary support for both sectors to succeed. We see ourselves as partners and help them develop viable business cases to thrive in any new system. Once the enablers are in place, we feel more confident about adjusting the financing schemes, ensuring that all health partners can succeed in the new system.

The speaker from Australia: In Australia, our current government, one of the election promises was to increase Medicare rebates, so our payment rebates for general practice practitioners or family physicians, because it has been long

recognized that the general practitioners have not been paid commensurate with their specialist colleagues. So that's in process of lifting the payments for them.

And to your other question about workforce shortages and how to support a smaller workforce with growing demand, we have Primary health networks. Every general practice belongs to a geographic region of primary health networks and their responsibility is to commission services to support general practitioners. Whether it's mental health or addiction services, they can tailor it according to their local priorities. And then the last thing I would say is that there are quite a few incentives for general practitioners to be care coordinators. They get extra additional payments for mental health care plans, for chronic disease care plans, so that they're not providing all of that care, but instead partnering with allied health and nursing. So a few different levers. But I have to say it's a current area of great focus for our government, and there's been several reviews, four reviews on primary care just recently, and they now have a task force to combine the recommendations of all of those reviews to look at what changes can be made.

The speaker from Thailand: I think Viet Nam, like Thailand, faces the challenge of not being able to quickly produce enough doctors. Instead of focusing solely on increasing the number of doctors, we've noticed that in our system, around 200 million visits occur each year, with half of them not requiring a doctor. To address this, we've been promoting other healthcare professionals to take on these roles. For example, in the past two years, we've introduced drug stores to provide primary care for common illnesses. This approach helps to manage the demand in the short term, as producing a doctor takes at least six years. I believe this solution can alleviate the problem more quickly than simply increasing the number of doctors.

The speaker from Chinese Taipei: I will start with financing. So, our financing, if you look at the breakdown now, it comes from 75% from the salary of our

general population and 25% we call it the rich tax from the rentals, dividends from the stocks, things like that. We are trying to think of that without increasing the burden for the general population and trying to have more income from the other 25% from the richer group. Of course, everything's on the table, nothing has been included or excluded, so everything is in the process of a public discussion and public communication. That's for the financing part. As I mentioned, for cancer treatment, for three highs, when we are trying to face the super-aged society, we really need to have more investment to help. That's the financing part.

Regarding the workforce, we approach this strategically, using data from the Medical Affairs Department. The Ministry of Health and Welfare has a dedicated department that calculates the required number of specialists, such as radiologists, psychiatrists, pediatricians, and family physicians. We set a fixed capacity each year for medical student training in each specialty. So for physicians, we do have sufficient. But for nursing, as I mentioned before, it's quite challenging. And I've been to WHA and Geneva this year, and there's a global forum talking about the lack of nursing power. I realized that there's a global challenge.

II. Plenary 2: Empowerment in Healthcare: Using Digital Technologies to Enhance Integrated Care Services and Reduce Health Inequities

(a) Digital Health Eco-System Enabling Integrated Patient-Centered Care: From Treatment to Transformation Medicine (Canada)

- The Canadian healthcare system, while founded on five key principles (public administration, accessibility, universality, comprehensiveness, portability), faced significant challenges. Despite high spending (11.3% of GDP), it ranked low in performance compared to peer economies and struggled with an aging population and access to primary care physicians.
- Canada's digital health transformation has been driven by three key partners: health authorities and departments across all 10 provinces and 3 territories, the Canadian Institute for Health Information (CIHI), and Canada Health Infoway. Both CIHI and Infoway are independent, non-profit organizations. CIHI is responsible for producing reports on the health and healthcare systems in Canada, while Infoway collaborates with provinces and territories to implement digital health solutions ecoomy-wide.
- In Nova Scotia, several major projects were underway to advance digital healthcare. These included the "One Patient, One Record" (OPOR) initiative, which aimed to create a unified health record accessible by any healthcare provider across the province. Another project, the "MyHealth NS" patient portal, allows patients to access their health information, including test results, appointment bookings, and records of emergency and hospital visits. Additionally, the province is implementing ambient AI technology to automate clinical note-taking, converting notes into structured formats that are automatically integrated into electronic health records.
- In the future, a wide range of bots and conversational AI would assist patients in navigating various healthcare processes and provide valuable decision support. One emerging technology being discussed is the digital twin, which

would allow for the simulation of different treatment options for patients, helping to identify the most personalized and effective treatment for each individual.

- Chronic conditions contributed significantly to the economic burden. One of the key applications of patient-centered digital health was in the management of these diseases. By leveraging technology to target modifiable risk factors and deliver personalized interventions, the high prevalence and economic impact of chronic conditions can be alleviated.
- Several digital health solutions have been introduced, including an app for blood pressure self-management and a platform for personalized chronic disease risk assessment. These technologies provide tools to collect and integrate diverse data, creating a unique patient context. By delivering individualized interventions tailored to patients' lives, these solutions are more likely to be effective in improving health outcomes.
- While technology offered great potential, it was noted that significant challenges remained. The speaker specifically highlighted the importance of ensuring digital equity when designing and deploying new solutions.

(b) **Cases of Leveraging Digital Technologies to Ensure Empowerment in Healthcare of the Republic of Korea (Republic of Korea)**

- Korea's Health Insurance system, which had successfully achieved universal health coverage just 12 years after its launch in 1977.
- Health Insurance Review & Assessment Service (HIRA) was introduced as a central public agency. It played a crucial role by reviewing over 1.5 billion medical claims annually, assessed treatment quality, and managed the health data infrastructure with a sophisticated IT system.
- Korea had a specific legal framework for managing innovative medical technologies. Technologies like Artificial Intelligence (AI) and Digital Therapeutics (DTx) underwent a thorough review by public institutions,

including HIRA, before being approved for temporary reimbursement under the NHI.

- The reimbursement models for two technologies currently reimbursed temporarily under Korea's NHI: For AI that assisted physicians in diagnosis, an additional fee was added to existing service fees. For DTx, the physician's consultation fee was covered by insurance, while the app usage fee was paid separately by the patient.
- A concrete example of a digital therapeutic in use was "Somzz," a software-based medical device that provided evidence-based cognitive behavioral therapy to patients with chronic insomnia.
- Anrisk, an AI-based algorithm, estimated the risk of a brain aneurysm using data from routine health checkups. This innovation originated from a startup competition hosted by HIRA, showcasing a successful public-private partnership.
- A major public sector initiative mentioned was the "Health Information Highway." This intermediary system was designed to enable individuals to easily access and view their own medical records from different healthcare providers in one place.
- HIRA offered several digital services directly to the public. These included the "Health Map," a location-based service to find hospitals and pharmacies with quality assessment results, and the "My Medicine at a Glance" service to check up to five years of drug histories and allergies.
- The "My Health Logbook" service further empowered patients by allowing them to track their usage limits for insurance-covered treatments (like physical therapy or dental scaling) and view personalized statistics on their most frequently diagnosed diseases.
- The speaker concluded that while digital technologies were powerful tools for strengthening healthcare, they were not a complete solution. Reducing health inequities required a broader effort that addressed social determinants

of health and involved active participation from local governments to create community-specific programs.

(c) **Deployment of Multi-Modal Digital Solutions for Patient Centric Chronic Disease Management on a Mass Scale (Chinese Taipei)**

- The speaker from a digital health company, Health2Sync, began by framing diabetes as a massive, data-intensive health burden in Chinese Taipei and globally, which his company was founded to address by simplifying data management for patients.
- The speaker defined multimodal disease management as an integrated approach that used case management, lifestyle intervention, and behavioral support, with digital platforms like Health2Sync acting as the interwoven link between all components.
- A critical barrier to implementing integrated care, despite government planning, was identified as the severe and worsening shortage of healthcare personnel, specifically nurses and diabetes educators, across Asia.
- Health2Sync was a digital health platform and therapeutic that centralized user's data from various sources, including medical sensors, health records, and user input, to automate and simplify chronic disease management using AI.
- The speaker indicated that overcoming the challenges of deploying digital health solutions at scale required strong Public-Private Partnerships (PPPs) between government bodies and private technology vendors.
- An example of this cooperation involved the NHI, Google Health, Health2Sync, and Taipei Medical University in 2024. By using de-identified data to train advanced models, the goal was to predict diabetes complications several years in advance. This AI system stratifies patients into low, medium, and high-risk groups, allowing clinicians to intervene earlier and avoid the costly medical expenses associated with complications.

- The speaker emphasized AI's critical role in personalizing care through predictive analytics such as glucose forecasting, automated coaching, food tracking, and behavior-change nudges, as demonstrated by the company's successful AI-powered weight-loss chatbot. Furthermore, the future of disease management was envisioned as a combination of more advanced sensors, eventually incorporating genetic data, AI agents, and supportive policies. Ultimately, the vision is a world where a smart device offers users personalized, actionable health guidance every morning.

Panel Discussion

Q1. In integrated care, like Mr. Deng said, integration care is difficult; it's complicated. So, when we want to integrate more and more functions in one app, that is difficult for elderly people to use. May I ask your experience to use this?

The speaker from Canada: I would like to answer you in a few steps. The first thing is we have to think about the design of the technology itself. So what kind of features are we providing? Whether they are useful and easy to access for the elderly? We have done another project with COPD patients. Again, when I was interviewing a number of elderly people, I was really surprised at how much they wanted, for example, prediction of exacerbations, because that was really detrimental. I just realized that the elderly would be so open to that. They have so many sensors around their houses. They are already collecting the data, but they had no data integration. Nothing was done, so we created a framework where we can predict exacerbations. So that is one thing.

The technology we provide must be integrated into both users' daily lives and communication with healthcare providers, not standalone. Currently, healthcare systems face integration challenges, workflows and data are not connected. While progress is being made, issues like doctor shortages and an aging

population highlight the need for better integration, though there are still problems to resolve.

The speaker from Chinese Taipei: Achieving seamless integration will take 3-5 more years. Key factors include data integration at the policy level, such as through the FHIR standard, and consolidation of apps at the user and physician levels. Both improved data flow and accessibility are needed at the policy level. AI will accelerate this process by enhancing patient and provider experiences, driving demand for a more integrated system.

Moderator: We focus on digital technology and emphasize "digital inclusion" to ensure that digital tools solve problems for everyone. In Chinese Taipei, we have the My Health Bank app, which half the population has downloaded. However, we don't view it as a standalone solution. Our apps with SDK (software developer kit), allowing collaboration with other digital service providers through public-private partnerships. Our goal is for the app to act as a bridge connecting users to various digital health services.

Q2. I have a question for Director General Lee, because we have some similar challenges in Chinese Taipei and Korea that we have fewer and fewer babies and more and more elderlies. You showed us the Health Information Highway. I'm especially curious about the effects of this Health Information Highway. How does it empower people to make them healthier and, furthermore, to alleviate the burden of the healthcare systems, like the crowded emergency rooms or the waiting lists for being inpatients in the emergency sector? And are there any positive effects you have observed, or even you have reported in any kind of way?

The speaker from Korea: The Health Information Highway used by public organizations in Korea, is very difficult. It connects to HIRA, KFDA, clinics, and tertiary hospitals, connects to many organizations. The Health Information

Highway is an open-access platform available to everyone. It consolidates data from public agencies like HIRA, including medical history, prescriptions, health screening, and immunization records. From medical institutions, it provides 12 key types of information, such as patient information, diagnosis, and surgical history. Additional features include a tool to locate nighttime clinics and connect with health monitoring applications, like those from Samsung and Apple, allowing users to track their health status in real time.

The Health Information Highway allows individuals to easily view, store, and share their health data from multiple sources, including HIRA, NHIS, and healthcare institutions. With user consent, this platform helps individuals take control of their health information, contributing to the reduction of regional and socioeconomic disparities in healthcare access.

Q3. My question is going to Director General Ki-Shin Lee. You mentioned the temporary listing for reimbursement about innovative digital health technology, so my question is about how many years the temporary payment and how the cost is covered—from the government or from a special budget?

The speaker from Korea: The innovative medical device designation system has been praised for four years. About 100 devices have been designated. Among them, more than 50 are AI-based diagnosis support software, and around 20 are software for digital therapeutic purposes. In the future, software aimed to treatment beyond diagnosis is expected to emerge. Korea's medical device sector is shifting from a hardware-centered industry to one driven by AI and digital technologies.

III. Plenary 3: Effective Integrated Healthcare Models: Community Engagement, Cross-Departmental Cooperation, Enhancing Quality and Outcomes

(a) Strengthening Health Systems through Research: Malaysia's Experience with People-Centred Integrated Care (Malaysia)

- The research in Malaysia began by studying patients' "unvoiced needs," finding that up to 65% of questions went unasked during consultations. The problem was worse when a computer monitor acted as a physical barrier between the patient and doctor.
- To solve the above challenges, enablers were created for both patients and providers, including a "Forgot to Ask" slip to make consultations more focused and efficient rather than prolonging them.
- When studying providers, it was found that while they had the necessary individual skills for person-centered care, but the major barriers were a lack of organizational support and psychological safety. As a result, communication within the care team was ineffective. For example, nurses may feel unable to voice patient concerns to doctors.
- A case study of a rural oral health program revealed that focusing on simple KPIs led to neglecting the neediest populations and that patients required on-the-spot treatment, but not just screening. This prompted the government to merge the outreach program with a mobile dental clinic.
- Research on Langkawi island, a model for integrated care, identified that the most crucial factor for its success was strong, accessible, and collaborative leadership, that a single leader could be contacted by anyone and would quickly coordinate across departments to solve problems.
- By mapping the entire colorectal cancer care pathway, they identified major integration failures or "losses," starting with a screening uptake of only 2% of the population, which prompted a re-evaluation of Malaysia's screening

guidelines.

- It was shared that for antenatal care, Malaysia used a successful, non-digital integrated record: a physical "pink book" held by the mother, which was updated by all providers she saw, whether in the public or private sector.
- Malaysia's quality policy had made "integrated people-centered initiatives" as its top strategic pillar, and progress was tracked using six level indicators which were in the process of being reviewed for future improvement.
- To create a continual learning system, they established a free online "Quality Hub" accessible to the public, a mentorship program for quality improvement, and a convention that included a "Quality Leap Lounge" to nurture emerging projects.
- The speaker concluded by acknowledging persistent challenges, especially the "silo mentality" where hundreds of separate health programs from the overwhelmed primary care clinics, which were then left with the difficult task of integrating them for the patient.

(b) Community-Based Integrated Care System for Achieving an Inclusive Society in Japan (Japan)

- The speaker indicted that Japan as a "super-aged society", was facing a declining working-age population and a demographic challenge that was creating different issues across the urban, suburban, and rural regions.
- Japan's policy response to aging had included implementing a Long-Term Care Insurance (LTCI) system in 2000, which operated separately from Japan's health insurance system.
- After introducing the LTCI, Japan recognized a need to shift its focus more strongly towards a community-based integrated care model to better support its aging population in their local environments.
- The "Community-Based Integrated Care System" model was introduced, which aimed to comprehensively provide healthcare, long-term care,

housing, and livelihood support, all centered around enabling the elderly to age in their own homes and communities.

- The speaker emphasized that addressing the aging society was not just Ministry of Health's issue but required the whole-of-government effort. Since 1996, the Cabinet Office had consisted of coordinating policies across all ministries.
- Japan's policy for an aging society was revised in 2024, with new principles focused on enabling older adults to continue working, contributing, and fostering a society where all generations could live securely together.
- The concept of a "community-based, inclusive society" moved beyond the traditional "supporter versus recipient" relationship by giving all residents, including the elderly, an active role in co-creating their community.
- Practical examples of this inclusive approach were shared, such as elderly individuals participating in regional revitalization projects, assisting at nursery schools, and collaborating with different age groups on local safety initiatives.
- The speaker stressed the importance of early disease prevention for cost-effectiveness, maintaining the social security systems that underpin universal health coverage, and minimizing the negative economic impacts of an aging population.
- Aging must be viewed as a broad social issue, requiring a cross-sectoral policy approach led by the government, rather than being handled only by one unit.

(c) **Innovation of Healthcare Delivery at Grassroots Level for Strengthening Primary Health Care in Viet Nam (Viet Nam)**

- The speaker introduced that while Viet Nam was strengthening primary health care, a massive administrative reform was also occurring, which included eliminating the district level entirely and significantly reducing the

number of provinces from 63 to 34.

- In the health sector, Viet Nam was facing a 'triple burden of disease,' dominated by non-communicable diseases (NCDs), along with a rapidly aging population. The economy was forecasted to become an aged society by 2036, creating an urgent need for health system reform.
- The core challenge that needed to be addressed for Viet Nam was that the health system was "hospital-centric," with over two-thirds of health spending allocated to hospitals and only 1.5% of social health insurance funds going to commune-level primary care.
- The hospital focus was driven by a lack of public trust in commune health stations (CHSs), causing a widespread "bypass" phenomenon where patients went directly to overloaded hospitals, leaving the vast network of commune facilities underutilized.
- The low public trust was attributed to the limited capacity of CHSs, particularly in managing NCDs, as well as shortages of skilled staff, financing, medicine, and medical devices.
- The government's new high-level policy was to innovate commune-level care by repositioning the commune health station as the true gatekeeper of the health system, capable of meeting 80-90% of people's health needs.
- The reform involved redefining the role of CHSs to provide integrated, continuous, lifecycle care, and expanding their basic service package to cover NCD management, elderly care, and proactive health screenings.
- A key part of the new model was the application of family medicine principles, where each health worker would be responsible for the inhabitants in their area, supported by a strengthened two-way referral system.
- Viet Nam would embrace new innovative delivery methods, including proactive outreach services, home-based care, and the integration of digital health tools like telemedicine and AI applications for health management.
- The speaker concluded that for these service delivery innovations to succeed,

they required a comprehensive policy package that reformed the health workforce, financing, and digital infrastructure, all supported by communication to change mindsets.

(d) **Culture-Centered, Person-Focused: Building Inclusive Models of Integrated Care (Chinese Taipei)**

- The speaker shared her personal and professional story, an indigenous physician who, over 28 years, developed a culturally safe integrated care model for the Truku indigenous community in the remote Xiulin Township of Chinese Taipei.
- A core principle shared was that cultural safety is not defined by the provider but is based on what the patient feels they have received, a lesson the speaker learned by serving in different indigenous communities.
- The speaker argued that for local healthcare workers, culture should be seen not as a barrier but as a crucial bridge to building trust, improving treatment adherence, and truly hearing patients' needs.
- A key framework developed was the "5W cultural safe integrated model" which guided their work by focusing on the Whole-person (body, mind, spirit, and culture), Whole-family (caregiving roles across generations), Whole-process (from screening to long term follow up), Whole-team (collaboration with nurses, dentists, tribal workers), and Whole-risk (cultural screening tools like adapted Integrated Care for Older People (ICOPE), oral health) to ensure care is continuous, inclusive, and rooted in community.
- The culturally rooted model proved to be both effective and efficient, with its costs growing at a much lower rate (1.4%) than NHI spending (5.5%), while it significantly increased preventative care performance from 42% to nearly 67% while achieving a 94% patient satisfaction rate.
- A key highlight was the medical-dental co-care clinic, where doctors and dentists collaborated in joint consultations for elders and diabetic patients.

Through rehabilitation and nutrition support, chewing and swallowing functions were maintained, malnutrition was prevented, and disability was ultimately delayed.

- The impact of the co-care model extended beyond clinical outcomes. It not only restored oral function, enabling elders to eat comfortably, but also rebuilt trust and helped once-isolated individuals reconnect with their communities, ultimately restoring their dignity.
- The Xiulin experience offered broader lessons for healthcare that person-focused care must also be culture-focused, and that true integration must cross both institutional and professional boundaries.
- The speaker concluded that care only completed when it included a person's stories, language, and dignity.

Panel Discussion

Q1. Since Japan has the longest and the most advanced health insurance in place, I have two questions for Japan. My first question is that, what is Japan's plan to sustain your health care financing mechanism with the depleting percentage of the working age group from your first slide that you showed us just now over the years, and is there any additional policy that you will institute to overcome these challenges and maintain the solidarity in your healthcare financing mechanism? And my second question is regarding your community-based integrated care model. How does health insurance play its role to rather incentive or maybe support this concept and vice versa?

The speaker from Japan: Ensuring the sustainability of healthcare systems supported by social security—particularly the securing of financial resources—remains a critical challenge as the working-age population continues to decline. Measures such as optimizing and streamlining medical expenditures, as well as reviewing benefits and burdens, are currently being implemented.

Within this care model, long-term care prevention programs aimed at reducing or delaying the need for care have been institutionalized, promoting independence among older adults. This approach also helps alleviate the financial burden on the long-term care insurance system, thereby contributing to its sustainability.

Q2. I have a question for Dr. Hui Wen Tien. Yeah. I understand that the Indigenous Health Promotion Act is being implemented. Among the barrier to improving the health of indigenous people, what do you think is the most important one that APEC member should recognize?

The speaker from Chinese Taipei: The key factor I highlighted in my presentation is cultural safety, particularly for indigenous people. While cultural sensitivity acknowledges differences, cultural safety goes further by respecting and understanding indigenous cultures in healthcare. It's not enough to provide an interpreter or adapt services superficially; we must ensure that services align with the community's expectations and needs. Indigenous communities may have different views on health and well-being, so the core message is to be sensitive to these differences and recognize that what we think should be done may not align with what they feel is right.

Q3. My question is for Igarashi-san. If you were to summarize one or two key initiatives on behalf of the Ministry of Health, Labour and Welfare of Japan, what would be the pressing issues that it faces?

The speaker from Japan: Our biggest challenge is addressing the declining population. When universal health coverage was first introduced, most elderly people lived at home with no long-term care facilities. Over time, we recognized the social issue of women staying at home to care for the elderly, and this was incorporated into policy. Today, the opposite is happening, with more people in long-term care facilities, but this brings a financial burden. Now, we're shifting

back to home care, but we must consider the cultural and social values in shaping future policies. The Ministry of Health, Labour and Welfare understands this well, but other ministries may have different perspectives. We must consider both the current and future social needs, looking ahead 20 to 40 years, to ensure policies reflect these values. This is the key to sustainable planning.

Q4. My question to Dr. Sararaks will be related to the financing of the health insurance system in your economy, and also your view on whether there's a single-payer versus a multi-payer system for the health insurance system in Malaysia.

The speaker from Malaysia: Currently, we do not have any insurance system, they are trying to go towards multi at the moment. They're trying to see opportunities to get different payers to come in. We are nowhere near where you are.

Q5. Also, I have a question, similar question to Dr. Nguyen Khanh Phuong, because you are a health economist. I wonder whether your view on the single payer versus the multi-payer system economy-wide.

The speaker from Viet Nam: This question is highly relevant to our system. Currently, we have multiple sources of healthcare financing. Public health is funded mainly by the government budget, while social health insurance covers about 94-95% of the population. The social health insurance system is a single-payer model that mainly covers curative care, but preventive services are funded through the government budget.

At the community level, we aim to integrate healthcare by expanding the social health insurance benefit package to include cost-effective preventive services, such as screenings for NCDs, and the management of health through digital medical records. Additionally, we want to allocate government funding based on the performance of community health stations, using a target-based

approach. This means funding will be linked to the services delivered, such as vaccination, screenings for selected NCDs, and elderly care.

For primary healthcare, we believe in combining multiple financing sources with a pooling mechanism that allocates resources based on capitation and performance-based payments. This is our proposal for financing primary healthcare in Viet Nam.

IV. Panel Discussion: Introduction of smart health and established international healthcare ecosystem on private and public collaboration

- Chinese Taipei developed a strategy to build an international healthcare ecosystem through public-private collaboration, leveraging its unique industrial strengths. The core strategy was driven by three global challenges: the need for resilient medical systems post-pandemic, the rapid onset of a super-aged society, and the imperative for sustainable healthcare that balanced cost and quality.
- Chinese Taipei systematically addressed health challenges by integrating its world-leading Information and Communications Technology (ICT) and semiconductor industries with its high-quality biomedical sector. Chinese Taipei's policies, such as the "Aging Society White Book" conducted significant government funding and focus on technology adoption. The Industrial Technology Research Institute (ITRI) acted as a central hub, translating research into commercial products through a model that prioritized patents and spin-offs over academic publications.
- Key discussion points with participants highlighted the practical challenges, particularly in intellectual property management, regulatory approval for novel technologies like AI-driven digital therapeutics, and the slow process of gaining reimbursement through the single-payer insurance system. The new concept pointed toward a hybrid model where public-private partnerships, collaboration with private insurers, and innovative regulatory

frameworks like "sandboxes" were essential for bringing new technologies to market effectively.

3. Key Findings and Corporation Recommendations

- **Healthcare System Transformation to Integrated Care**: Healthcare systems were undergoing a fundamental transformation, shifting from fragmented, institution-centric models to integrated, people-centered care. This change aimed to create more sustainable, equitable, and effective healthcare systems. While the vision for reform was shared across economies, each system had to adapt to its unique context, including healthcare structure, funding sources, and cultural background. Therefore, it was crucial to tailor strategies to local realities, ensuring that reforms align with each economy's governance, political will, and societal values.
- **Leveraging Digital Health for Healthcare Empowerment:** Digital health technologies were being strategically used to shift healthcare from a provider-centric model to one that empowered individual patients. This transformation enabled patients to directly access their health information and utilized personalized tools for managing their conditions. However, fully realizing the potential of these technologies required coordinated efforts in public infrastructure development, private sector innovation, and collaborative partnerships. A key consideration moving forward was ensuring digital equity and addressing broader social determinants of health to prevent these technologies from unintentionally exacerbating health disparities. Both companies and governments had to work together to promote digital equity by addressing gaps in digital literacy and ensuring that vulnerable populations had equitable access to the necessary technology.
- **Contextual Approaches to People-Centered Integrated Care and Collaboration**: Addressing common challenges such as aging populations

and systemic fragmentation required highly contextual and flexible approaches to integrated care. The most successful strategies were prioritizing trust, grassroots empowerment, and broad collaboration. Public-private partnerships were essential for maximizing the potential of digital health technologies and creating sustainable healthcare systems. These collaborations fostered better infrastructure, innovation, and resource-sharing, all of which were critical for achieving integrated care that was responsive to the unique needs of each community.

4. Site Visits to RICARE Day Care Center

The speaker introduced RICARE and led participants on a tour of the center. The summary is as follows:

- RICARE, a subsidiary of the Ritek Group, implemented the "Minimalist Care" concept, a model imported from Japan that emphasized senior autonomy and self-reliance by intentionally reducing unnecessary assistance to preserve functional abilities.
- The "Minimalist Care" was built on three core pillars: Environmental Design, Activity Design, and a Human-Centric Approach. The environment was built to be home-like and non-intimidating and combined with "barrier-free space with barriers" concept to mirror real-world community settings and promoted life rehabilitation. The activities designed were diverse and personalized, with an emphasis on individual choice and decision-making and caregivers would provide encouragement and timely assistance rather than pre-emptive help.
- RICARE highly integrated technology to support its model, using an intelligent day care management system for data analysis, AI-powered fall detection for safety, and smart fitness equipment. This technological approach was combined with a strategic partnership with international care organizations to blend advanced care techniques with innovative software

and hardware.