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WESTERN PACIFIC REGIONAL REPORT

Skin Disease Landscape in the Western Pacific

A Summary of Western Pacific Contributions from the GlobalSkin Asia Pacific Regional Workshop

GlobalSkin, the International Alliance of Dermatology Patient Organizations, along with its 350+ Members, is dedicated to improving the lives of people living with skin conditions worldwide. Through contributions from representatives of skin patient organizations across the Western Pacific region, GlobalSkin identified common areas of need shaping the diagnosis, care, treatment, and daily lives of people living with skin diseases in the region. This work was conducted as part of GlobalSkin's Regional Engagement Workshop Series, a global initiative to understand patient priorities across all six World Health Organization (WHO) regions and to support the community's input into the development of the WHO Global Action Plan on Skin Diseases, along with member advocacy efforts for implementation of the Skin Diseases Resolution. This report presents the findings from the Asia Pacific regional workshop, held on February 11, 2026, and is intended to support GlobalSkin's Western Pacific members in identifying advocacy, awareness, and research priorities. Regional groupings in this report follow WHO regional classifications. Some countries that are geographically and politically part of Southeast Asia and ASEAN, including Malaysia, Singapore, Indonesia, the Philippines, Vietnam, and others, are reflected under the Western Pacific Region in line with the WHO regional classification.

The six areas of need identified in the Western Pacific are: skin conditions sidelined from non-communicable disease (NCD) frameworks; absence of data infrastructure and weak research evidence; sparse specialist workforce and limited cross-divisional coordination; financial burden and lack of insurance coverage; cultural myths and stigma driving discrimination and lack of psychodermatology in care; and need to strengthen patient and community education. These areas are deeply interrelated and largely stem from a tendency to regard skin diseases as cosmetic or non-serious conditions, rather than as complex, chronic, and often systemic disorders that significantly affect patients, families, and health systems. The policy implications of these six themes are discussed, along with the suggested actions identified by participants as the region's most pressing priorities.

The contributors to this report served as proxies for their broader skin patient communities, representing conditions including albinism, epidermolysis bullosa (EB), ichthyosis, lupus, neurofibromatosis, psoriasis, scleroderma, and other rare skin conditions, from countries including Australia, China, Indonesia, Japan, Malaysia, the Philippines, Singapore, Taiwan, and Vietnam. While the challenges described are common across the region, there is considerable variability in political support, healthcare system structure, and patient organization capacity, meaning these needs manifest differently across countries and conditions.

Across contributions globally, a consistent finding emerged: there is a need for greater recognition of the burden of skin diseases at both the individual and societal levels. Increased awareness would lead to more dedicated policy frameworks, proportionate research investment, a stronger, better-trained workforce, equitable access to care and innovation, and greater empowerment for patients and their families. Without this recognition, the cycle of underinvestment and under-prioritization continues. This report aims to make that burden visible and to translate the lived experiences of people across the Western Pacific region into actionable priorities for policymakers, researchers, health systems, and the dermatology community.

Methodology

In 2026, GlobalSkin conducted an exploration of the needs of people living with skin conditions by engaging directly with its members from countries across all regions. Participants reflected a wide range of experiences and perspectives, serving as proxies for their broader communities. The engagement aimed to understand patients' priorities, identify regional differences, and map the strengths and gaps in the health system for the prevention, diagnosis, treatment, and long-term management of skin conditions.

Information was gathered through the Regional Engagement Workshop Series, which included two-hour virtual regional meetings, interactive prioritization of needs, interviews, and offline/post-workshop written contributions. Discussions were structured around topics including data collection, data sharing, research, affordability and accessibility of care, local healthcare, innovative service models, patient empowerment, and social awareness. Insights from these sessions were documented and reviewed to identify common themes, regional variations, and priority areas for action. Workshops were organized for the following regions: Africa, Asia Pacific, Eastern Mediterranean, Europe, Latin America, and North America. The Asia Pacific regional workshop was held on February 11, 2026. Contributions were reported separately for the Western Pacific and Southeast Asia regions following WHO regional classifications. Seventeen of GlobalSkin's Western Pacific members contributed to this report through live interventions and written contributions representing conditions including albinism, epidermolysis bullosa (EB), ichthyosis, lupus, neurofibromatosis, psoriasis, scleroderma, and other rare skin conditions, from countries including Australia, China, Indonesia, Japan, Malaysia, the Philippines, Singapore, Taiwan, and Vietnam.

The findings summarized herein provide a regional overview of the Western Pacific skin community's priorities and are intended to support GlobalSkin's Western Pacific members in identifying advocacy, awareness, and research priorities, as well as supporting national, regional, and global policy advocacy efforts, such as consultations into the development of the World Health Organization Global Action Plan on Skin Diseases.

Results

The following six themes were identified as the key areas of need across skin disease communities in the WHO Western Pacific region.

1. Skin conditions sidelined from NCD frameworks, leaving communities without support
2. Absence of data infrastructure leads to weak research evidence base
3. Sparse workforce and limited cross-divisional coordination create inequitable access
4. Financial burden and lack of insurance coverage leave advanced therapies out of reach
5. Cultural myths and stigma drive discrimination and psychodermatology absent in care
6. Patient and community education needed to increase and improve interactions with the healthcare system

1. Skin conditions sidelined from NCD Frameworks, leaving communities without support

Skin conditions, particularly rare conditions, are frequently excluded from national non-communicable disease (NCD) frameworks and health priorities across the Western Pacific region. This is caused by the perception of skin conditions as non-life-threatening or low-mortality, disregarding the fact that skin conditions and related comorbidities can lead to high mortality. As one contributor observed, even when skin disease is a significant contributor to death, it may not be recorded as such on a death certificate, rendering the condition invisible to mortality-driven policy action. As a result, skin conditions tend not to attract political attention, and without formal recognition within national agendas, patients cannot access dedicated funding, coordinated care, or systemic support.

Contributors noted that psoriasis is beginning to gain recognition in some countries as an NCD. The Philippines community recently received confirmation from the Department of Health that psoriasis will be recognized as an NCD, and Vietnam reported that psoriasis has been included as a priority in its national health strategies. In Malaysia, psoriasis has gained recognition as part of the national NCD agenda, helping create greater visibility and policy attention for the condition. However, rare skin diseases such as Epidermolysis Bullosa (EB), as well as selected rare or severe dermatological conditions such as Generalized Pustular Psoriasis, continue to require clearer policy recognition, data collection, access pathways, and sustainable support. Similar dynamics were described in the Philippines and Vietnam, where NCD classification effectively determines which conditions receive government engagement and funding.

For the many rarer skin conditions, national recognition remains almost entirely absent. In Malaysia, while a National Rare Disease Policy[1] exists, implementation remains limited and requires stronger coordination, sustainable funding, registry development, and clearer integration into public health and service delivery frameworks. Patient advocates are pushing to have rare diseases recognized under the NCD framework with a dedicated technical working group. In some countries, rare disease legislation has created a partial pathway to recognition. The Philippines' Rare Diseases Act[2] has enabled inclusion of some skin conditions in disability categories, providing tangible benefits. However, contributors noted that rare conditions not listed cannot access those benefits, and the absence of data for unlisted conditions makes it difficult to build the case for inclusion. In the Philippines, the scleroderma community was unable to secure the same level of attention as psoriasis, but did manage a small win in being listed as a rare disease. Recently proposed national lupus legislation in the Philippines represents another incremental step, but contributors emphasized that piecemeal legislative gains do not substitute for systematic integration of rare skin diseases within broader NCD and rare disease frameworks. A contributor noted the particular challenge of conditions that sit on the boundary between 'rare' and 'uncommon': conditions like ichthyosis that are not listed on rare disease registers fall through the cracks of both mainstream and rare disease frameworks.

Across the region, contributors identified competing national health priorities, including infectious disease, cardiovascular disease, diabetes, and cancer, as powerful structural barriers. Governments with limited health budgets direct resources toward conditions they can more readily measure and that carry explicit mortality associations. As a contributor from Japan noted, patient experience data and evidence on the burden of skin disease will be essential tools for demonstrating to governments that skin conditions carry comparable weight to other priorities. Without robust

national recognition and dedicated resources, the health and quality-of-life needs of these communities will remain unrecognized and unmet.

2. Absence of data infrastructure leads to weak research evidence base

Across nearly all countries represented at the workshop, contributors described the same fundamental problem: there are no national registries for skin diseases, no standardized data collection practices, and insufficient integration of skin conditions into existing surveillance and electronic health systems. According to contributors from Australia, apart from skin cancer, skin diseases are not named in data collection policies; even so, data sharing on skin cancer prevalence in the albinism community is not seen as a priority. Without this foundation, it is impossible to accurately quantify the burden of skin disease, make an evidence-based case to policymakers, or identify whether interventions are working.

In Malaysia and Indonesia, national data registries do not yet exist, though advocacy efforts are underway to establish them. In Singapore, national-level data on rare and skin conditions is not routinely collected, though a recent policy synchronizing electronic health records across the country offers an opportunity to capture this data if skin conditions are explicitly included.

Even where data exists in some form, significant barriers to meaningful use remain. A contributor from Singapore highlighted that the current challenge in psoriasis is not the lack of data, but rather the inconsistency, fragmentation, and limited secondary usability of what is collected. Data sharing across institutions is slowed by differing governance processes, privacy requirements, and consent practices. Longitudinal data is lost when patients move between public and private providers or discontinue follow-up once symptoms stabilize. Patient-reported outcomes and quality-of-life measures are rarely captured in routine care. Patient evidence should not only capture the clinical diagnosis. It should also capture the daily reality of wound care, treatment costs, school participation, caregiver workload, mental health, quality of life, and long-term family burden.

For conditions such as EB and other rare skin diseases, genetic testing and early diagnosis are essential. Early recognition, appropriate referral, access to genetic testing, and family counseling are important parts of care. When diagnosis is delayed, families may struggle to understand the condition, access the right care, and plan for long-term management. If rare skin diseases are not diagnosed early and recorded properly under standardized registries, their true burden remains invisible in the health system.

Contributors called for the development of sustainable national registry models with stable public funding, clear governance, and defined use cases spanning outcomes benchmarking, safety monitoring, and access evaluation. Regional alignment of core data standards and collaboration across stakeholders were identified as key priorities. This would, in turn, enable data to be pooled and compared across borders, generating a stronger evidence base to support advocacy at both national and international levels. Patient organizations must be active participants in data governance, both to ensure that patient-reported perspectives and patient experience data are captured and to build the trust required for sustained community engagement with data collection efforts.

3. Sparse workforce and cross-divisional coordination create inequitable access

The shortage of dermatologists across the Western Pacific region, and their heavy concentration in major urban centers, creates severe, often insurmountable barriers to care for patients living in rural, remote, or geographically challenging areas. This workforce gap is compounded by a lack of specialist training, a focus on aesthetics among existing dermatologists, and limited dermatology training at the primary care level. For example, local medical teams are usually not trained to recognize skin cancer in nonpigmented skin. The first point of contact for most patients is typically a general practitioner, who often lacks the knowledge or tools to diagnose or manage complex skin conditions effectively. Limited clinical knowledge and training in dermatological conditions contribute to delayed diagnosis, fragmented care, and insufficient integration of specialized support.

The scale of the challenge varies, but it is persistent throughout the region. In Indonesia, approximately 2,000 dermatologists serve a population of 287 million, with the majority concentrated in cities.[3] In China, fewer than 30,000 licensed dermatologists serve the country's vast population, creating a significant deficit, particularly acute in primary healthcare settings.[4] In Australia, where healthcare infrastructure is relatively well developed, limited dermatologist numbers create long wait times, and rural and remote patients must travel significant distances or rely on local clinicians who often lack the training to recognize conditions such as albinism or EB.

For patients with complex conditions requiring multiple specialists, including those with neurofibromatosis, who may need neurology, dermatology, and orthopedic input, the absence of coordinated specialist networks and patient-centered services means that patients must independently locate, navigate between, and reconcile the advice of multiple clinicians. This imposes significant burdens of time, cost, and psychological stress.

Skin disease care requires coordination across different parts of the health system, including public health, medical development, research, pharmaceutical services, genetics and laboratory services, data and registry systems, strategic planning, health financing, social protection, disability support, and patient organizations. For rare skin conditions such as EB, the patient journey crosses many departments and services. At present, many of these areas may still work in separate structures or silos. This can make it difficult for patients and families to move through the system, especially when they require early diagnosis, referral, genetic testing, wound care, access to medicines, registry inclusion, psychosocial support, and long-term follow-up.

Teledermatology has been identified as a promising means of addressing geographic inequity. Contributors from Vietnam and Australia echoed calls for expanded investment in internet infrastructure, digital care tools, and telemedicine. All contributors agreed that strengthening dermatology training and culturally sensitive diagnostic resources at the primary care level is a priority. These approaches cannot substitute for a sufficient specialist workforce, but can extend the reach of existing expertise while longer-term workforce development efforts take effect. Cross-divisional coordination and integrated implementation pathways are also needed to ensure patients do not fall through the cracks of the system; this is particularly relevant in countries where policies exist, but implementation depends on how well the multiple stakeholders work together.

4. Financial burden and lack of insurance coverage leave advanced therapies out of reach

Access to treatments and daily care is an issue across the region. Even where effective treatments exist, the cost of advanced therapies places them out of reach for the majority of patients across the Western Pacific region. Biologics and newer systemic treatments remain unaffordable or unavailable in public health systems, and insurance coverage is frequently incomplete or subject to restrictive criteria. The daily cost of living poses an additional burden for families, particularly in countries with high out-of-pocket costs for individuals. These costs may involve non-adherent dressings, emollients, infection prevention, pain management, nutritional support, and practical home-care guidance. These costs are essential to daily survival, comfort, dignity, and quality of life, and should be recognized as such under access schemes. The cumulative financial burden of managing a chronic condition over the years often forces patients to reduce, interrupt, or abandon treatment altogether.

In Indonesia, insurance coverage has been improving but remains far from adequate. Topical treatments may be covered for limited periods, but systemic and biologic options are largely excluded. Only one injectable treatment for psoriasis is covered, for approximately eight weeks, which is insufficient for a condition requiring long-term management. Biosimilars, which could significantly reduce costs, are not locally available. In Vietnam, biologic treatments face high out-of-pocket costs and strict eligibility criteria that effectively exclude many patients who could clinically benefit. Monitoring tests and supportive care required for long-term treatment similarly constitute a high out-of-pocket burden. A contributor from China noted that the average annual medical costs for children with inflammatory skin diseases can reach up to 32% of the national per capita disposable income, imposing a severe economic burden on families.[5]

In the Philippines, the Rare Diseases Act has not yet translated into meaningful insurance coverage for newly approved medicines, and the lack of local clinical data further limits the regulatory approvals required for access. For patients with lupus and other conditions that are classified as rare, limited treatment approval processes mean that effective therapies remain unavailable through government healthcare packages. Medications, specialized tests, or biopsies for skin diseases are not covered; thus, the bulk of expenses is out-of-pocket, placing a financial burden on individuals living with skin conditions. In Australia, the Pharmaceutical Benefits Scheme provides subsidized access to some systemic and biologic treatments for eczema, though contributors noted ongoing challenges with eligibility criteria and the complexity of steroid-related misinformation, which affects treatment adherence.

A contributor from the albinism community in Australia noted that daily sunscreen application is not cosmetic but medically necessary and represents a large financial burden for families. Contributors called for sunscreen to be added to publicly funded medication lists for people with albinism, drawing on the WHO's recent addition of sunscreen to its model list of essential medicines as supporting evidence.[6]

Climate and tropical weather in many of the countries in the region directly affect skin symptoms, wound care, treatment adherence, and quality of life, as heat, humidity, sweating, friction, and frequent rain can make daily skin disease management more difficult. Climate can affect wound care, dressing comfort, itch, risk of skin breakdown, infection control, sleep, mobility, school participation, and caregiver workload. Tropical weather often requires more frequent dressing

changes, cooling measures, suitable clothing, infection-prevention support, and practical guidance tailored to hot, humid environments.

Contributors from across the region called for equitable access to timely, affordable, and high-quality dermatological care regardless of income level or geographic location. This includes access to essential supportive services, such as nutrition support, wound care, and home-based services. Contributors recommend reimbursement policies structured around clinical need and governments pursuing procurement strategies, including biosimilar accessibility and regional purchasing agreements, to lower the cost of effective treatments.

5. Cultural myths and stigma drive discrimination and psychodermatology absent in care

Skin diseases are widely misunderstood as cosmetic, minor, or contagious across the Western Pacific region, generating significant social stigma and discrimination that compound the clinical burden of disease. In some communities, cultural myths, including beliefs that skin conditions are the result of witchcraft, further isolate patients and delay care-seeking. These dynamics create serious consequences for employment, education, and social participation, and produce a significant psychological burden that is rarely addressed by health systems.

In Vietnam, discrimination in employment, social isolation, and psychological stress are among the most serious challenges reported by people living with psoriasis. In the Philippines, misconceptions that skin conditions are communicable are widespread, and contributors described patients facing stigma from both communities and healthcare providers who lack knowledge of these conditions. In Malaysia, psychosocial support, caregiver support, and social acceptance are often still invisible in policy discussions. For people living with albinism in Australia, mischaracterization in media and popular culture affects social outcomes and contributes to reluctance to seek care or be counted in data systems. For children and young people with visible or fragile skin conditions, stigma can affect school participation, confidence, friendships, and family life. For caregivers, stigma and misunderstanding can also increase isolation and emotional burden.

The psychological impact of these experiences is severe. Contributors across multiple countries described elevated rates of anxiety, depression, and suicidal ideation among people living with chronic skin conditions. Despite this, the integration of mental health support into dermatological care is severely lacking in the region. As one contributor from the Philippines observed, they knew of only one psychodermatologist in the entire country. In Japan, a contributor noted that dermatologists themselves are largely unaware of the mental health dimensions of the conditions they treat and called for dedicated psychodermatology training within medical education.

Caregiver burden is similarly invisible to health systems. The demands placed on family members, particularly for conditions like EB that require intensive daily wound management, represent an aspect of burden that is often overlooked.[7] Contributors called for caregiver burden to be measured, recognized, and supported through dedicated health system resources.

Addressing stigma will require sustained public awareness campaigns that look beyond medical facts to also focus on dignity, inclusion, school support, workplace understanding, and community acceptance. It will also require amplification of patient voices in media and public discourse, sensibilization of dermatology societies, and structural changes within health systems to ensure

that psychological care is not treated as optional. The mental health burden of skin disease, contributors noted, is a unifying concern across conditions and should be treated as a basis for broader coalition-building in advocacy.

6. Patient and community education needed to increase and improve interactions with the healthcare system

Across the Western Pacific region, many patients lack clear, accessible, and trustworthy information about their skin conditions. This knowledge gap drives delayed care-seeking, reliance on unverified remedies, and poor adherence to treatment. It also contributes to the broader stigma problem: communities that do not understand what a condition is, or whether it is contagious, are more likely to respond with fear or discrimination.

The need for multilingual and culturally appropriate education was emphasized throughout the workshop. In a region as linguistically and culturally diverse as the Western Pacific, materials developed in one language or for one cultural context often fail to reach the communities that need them most. In China, where primary healthcare institutions provide over half of all medical services, raising patient awareness of the importance of seeking specialist care and equipping primary care providers to recognize and respond to skin conditions were identified as foundational steps. In rural areas across the Philippines and Indonesia, unreliable internet access adds another barrier to digital education initiatives.

For rare conditions, the educational challenge begins with basic awareness. Contributors from the albinism community in Australia noted that the term ‘albinism’ itself is largely unrecognized in the general population, creating significant barriers to understanding and support. For EB, both the general public and healthcare providers frequently lack awareness of the condition’s severity and long-term impact, leading to under-recognition and inadequate support for patients and caregivers.

Contributors called for patient organizations to play a leading role in developing and disseminating accessible educational resources, and for collaboration between patient organizations, healthcare providers, policymakers, and academic institutions to ensure that patient perspectives are embedded in patient evidence collection, registry development, care pathway design, education, policy feedback, and implementation monitoring. Patient and community education should include practical guidance for families, schools, childcare settings, primary care providers, and local communities. Families need clear information on daily care, infection prevention, referral pathways, psychosocial support, and where to seek help. Equipping patients to engage more actively in shared decision-making and supporting clinicians to understand the lived experience of the conditions they treat were identified as complementary goals.

Policy Landscape and Recommended Actions

All six thematic areas reflect a broader systemic issue. Skin diseases are not treated as a policy priority at the national or regional levels. Decision-makers focus on conditions associated with mortality or severe disability, and the burden of skin disease in terms of quality of life, mental health, and economic productivity is poorly captured by existing research.

A foundational shift is needed: skin diseases must be explicitly recognized within national NCD frameworks and rare disease strategies, not as an afterthought or a concession to advocacy pressure, but as a deliberate policy choice informed by the true scope of their impact. The World Health Organization Global Action Plan on Skin Diseases provides a meaningful opportunity to create an international framework, but its potential will only be realized if governments in the Western Pacific translate it into domestic commitments, binding clinical pathways, and dedicated resource allocation.

Generating and communicating robust evidence on the economic and societal burden of skin disease is essential to making this case. Framing investment in skin health as a measurable societal return, through reduced productivity losses, lower caregiver burden, and prevention of costly comorbidities, rather than as a discretionary spend, is the most effective approach for engaging government audiences. Patient organizations are uniquely positioned to drive this evidence generation and must be structurally supported to do so.

Priorities for Policy Action

- Explicitly integrate skin diseases, including rare skin conditions, into national NCD frameworks and rare disease strategies, with dedicated funding streams to support long-term care
- Measure and support caregiver burden as a distinct policy priority, developing services and funding mechanisms that recognize and respond to the hidden costs carried by families managing complex chronic skin conditions
- Develop and publicly fund national skin disease data registries with stable governance, standardized case definitions, and patient-reported outcome measures, aligned with regional and international data standards to enable cross-country comparison and pooling
- Invest in teledermatology and digital care infrastructure as a targeted strategy to reduce geographic inequity in access, particularly for rural, remote, and island communities
- Reform insurance reimbursement policies to cover advanced therapies, including biologics, on the basis of clinical need rather than financial capacity, and pursue biosimilar availability and regional procurement strategies to reduce treatment costs
- Expand dermatology training at the primary care level and build specialist capacity at regional and district hospitals, with particular attention to rare condition recognition and diagnostic skills for diverse skin types
- Integrate psychodermatology training into medical education and establish formal referral pathways between dermatology and mental health services
- Implement national public awareness campaigns to reduce stigma and address cultural misconceptions about skin diseases
- Develop multilingual, culturally appropriate patient education resources and diagnostic support tools in partnership with patient organizations
- Ensuring meaningful participation of patient organizations in health policy development, healthcare system planning, and educational initiatives

Conclusion

Contributions from patient organization representatives across the Western Pacific region tell a consistent and urgent story: skin diseases remain significantly underrecognized, underfunded, and poorly served by national health systems. The consequences are borne directly by patients, through delayed diagnoses, unaffordable treatments, geographic barriers to care, social stigma, and unaddressed mental health needs, and by their families and caregivers, whose burdens remain largely invisible to health systems and policymakers.

Despite variation across countries, from the relative policy gains in psoriasis and lupus in some settings to the near-complete absence of recognition for rarer conditions in others, the same core problems recur across the region: low political prioritization, insufficient data, geographic inequity, limited specialist workforce, unaffordable therapies, unrecognized mental health burden, and inadequate patient participation in the decisions that affect them. Patient organizations across the region are doing essential work with limited resources, often without compensation and without a genuine seat at the policy table.

The pathway forward requires coordinated action across clinical, institutional, and national levels, including the development of binding care pathways, investment in data infrastructure, an expanded and better-distributed specialist workforce, proportional research funding, and meaningful patient inclusion in governance. Skin health must be recognized as an essential component of overall health and human dignity across the Western Pacific region, with patient organizations as equal partners in achieving that goal.

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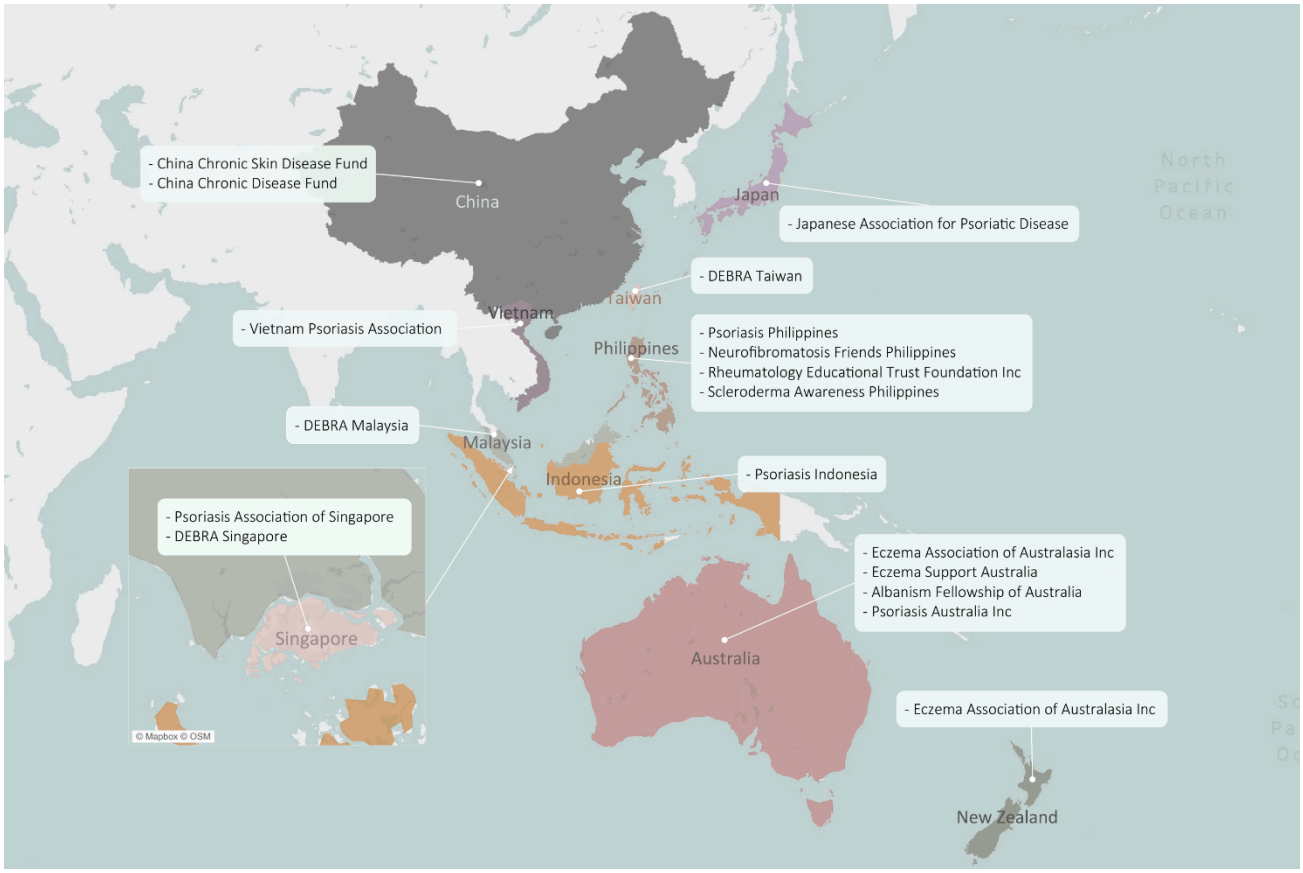
- Rheumatology Educational Trust Foundation Philippines
- Scleroderma Awareness Philippines
- Taiwan EB Patient Association (DEBRA Taiwan)
- Vietnam Psoriasis Association (PsorViet)

Western Pacific Contributor Map



Geographic distribution of contributing organizations across online and offline engagement.