For further information, please contact

PRINCE MAHIDOL AWARD CONFERENCE SECRETARIAT OFFICE
INSTITUTE FOR POPULATION AND SOCIAL RESEARCH, MAHIDOL UNIVERSITY

Salaya, Nakhon Pathom, 73170, Thailand
tel: (66) 2441-0203 ext 627 or 628
fax: (66) 2441-9333
e-mail: pmaconference@mahidol.ac.th
website: www.pmaconference.mahidol.ac.th

Conference Partners

The Rockefeller Foundation China Medical Board The International Labor Organization Results for Development Institute
Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH National Institute for Health and Clinical Excellence

Prince Mahidol Award Conference 2012
MOVING TOWARDS UNIVERSAL HEALTH COVERAGE
HEALTH FINANCING MATTERS

PRINCE MAHIDOL AWARD CONFERENCE
World Health Organization
THE WORLD BANK
JICA Japan International Cooperation Agency

Prince Mahidol Award Conference 2012

MOVING TOWARDS UNIVERSAL HEALTH COVERAGE
HEALTH FINANCING MATTERS

January 24-28, 2012
Centara Grand & Bangkok Convention Centre
at Central World, Bangkok, Thailand

Prince Mahidol Award

The Prince Mahidol Award was established in 1992 to commemorate the 100th birthday anniversary of Prince of Mahidol of Songkla, who is recognized by the Thais as 'The Father of Modern Medicine and Public Health of Thailand'.

His Royal Highness Prince Mahidol of Songkla was born on January 1, 1892, a royal son of Their Majesties King Rama V and Queen Savang Vadhana of Siam. He received his education in England and Germany and earned a commission as a lieutenant in the Imperial German Navy in 1912. In that same year, His Majesty King Rama VI also commissioned him as a lieutenant in the Royal Thai Navy.

Prince Mahidol of Songkla had noted, while serving in the Royal Thai Navy, the serious need for improvement in the standards of medical practitioners and public health in Thailand. In undertaking such mission, he decided to study public health at M.I.T. and medicine at Harvard University, U.S.A. Prince Mahidol set in motion a whole range of activities in accordance with his conviction that human resources development at the national level was of utmost importance and his belief that improvement of public health constituted an essential factor in national development. During the first period of his residence at Harvard, Prince Mahidol negotiated and concluded, on behalf of the Royal Thai Government, an agreement with the Rockefeller Foundation on assistance for medical and nursing education in Thailand. One of his primary tasks was to lay a solid foundation for teaching basic sciences which Prince Mahidol pursued through all necessary measures. These included the provision of a considerable sum of his own money as scholarships for talented students to study abroad.

After he returned home with his well-earned M.D. and C.P.H. in 1928, Prince Mahidol taught preventive and social medicine to final year medical students at Siriraj Medical School. He also worked as a resident doctor at McCormick Hospital in Chiang Mai and performed operations alongside Dr. E.C. Cord, Director of the hospital. As ever, Prince Mahidol did much more than was required in attending his patients, taking care of needy patients at all hours of the day and night, and even, according to records, donating his own blood for them.

Prince Mahidol's initiatives and efforts produced a most remarkable and lasting impact on the advancement of modern medicine and public health in Thailand such that he was subsequently honoured with the title of "Father of Modern Medicine and Public Health in Thailand".

Prince Mahidol Award

In commemoration of the Centenary of the Birthday of His Royal Highness Prince Mahidol of Songkla on January 1, 1992, the Prince Mahidol Award Foundation was established under the Royal Patronage of His Majesty King Bhumibol Adulyadej to bestow international awards upon individuals or institutions that have made outstanding and exemplary contributions to the advancement of medical, and public health and human services in the world.

The Prince Mahidol Award will be conferred on an annual basis with prizes worth a total of approximately USD 100,000. A Committee, consisting of world-renowned scientists and public health experts, will recommend selection of awardees whose nominations should be submitted to the Secretary-General of the Foundation before May 31st of each year. The committee will also decide on the number of prizes to be awarded annually, which shall not exceed two in anyone year. The prizes will be given to outstanding performance and/or research in the field of medicine for the benefit of mankind and for outstanding contribution in the field of health for the sake of the well-being of the people. These two categories were established in commemoration of His Royal Highness Mahidol's graduation with Doctor of Medicine (Cum Laude) and Certificate of Public Health and in respect to his speech that:

> ***"True success is not in the learning, but in its application to the benefit of mankind."***

The Prince Mahidol Award ceremony will be held in Bangkok in January each year and presided over by His Majesty the King of Thailand.

Message from the Chairs of the International Organizing Committee

In recent years, the goal of Universal Health Coverage has become an increasingly important issue - featuring more and more prominently on global, regional and national agendas. This is a most welcome development. It is our task to make a difference to the 150 million people in the world who currently suffer severe financial hardship each year because they fall ill, use health services, and need to pay for them at the point of delivery. It is our job to make a difference to the 1 billion people who cannot use the health services they need - partly because they cannot afford to do so.

Universal Health Coverage has various social meanings not only on health status itself of individuals. Universal Health Coverage facilitates economic development. If people do not have to pay financially crippling health bills and if they can remain healthy for longer, they keep working, keep producing, and keep earning. Universal Health Coverage fosters social cohesion - binding people together into what is effectively a mutual support system.

Universal Health Coverage depends on strong and well-designed health financing systems that assure sufficient financial resources for health. They guarantee that people do not have to pay catastrophic out-of-pocket payments for health services, and that funds are used as efficiently and equitably as possible.

But Universal Health Coverage requires more than this. Health financing is not the only component. Universal Health Coverage means ensuring that people can easily access the services they need, and that these services are of good quality. It means having enough health workers close by and ensuring that they are well trained and motivated. It means ensuring that the medicines and equipment they need are available, affordable and distributed appropriately.

Country after country has shown the world that Universal Health Coverage is achievable. But it never appears overnight. Moving towards Universal Health Coverage requires concerted efforts from within and outside the health sector - strong links between efforts to promote health, social development and economic growth. And even when it has been achieved, it is essential to assure systematic monitoring and evaluation - not just of the health financing system, but of the health systems themselves and the impact on the population's health.

As Chairs of the International Organizing Committee, we, the Prince Mahidol Award Conference, the World Health Organization, the World Bank and the Japan International Cooperation Agency are very pleased to welcome you to the Prince Mahidol Award

Conference on *"Moving towards Universal Health Coverage: Health Financing Matters"*, in Bangkok, Thailand, where you join more than seven hundred fellow champions of Universal Health Coverage from around the world.

Over the next few days, we will share presentations from a number of countries, at different stages of economic development and with different types of health systems, which have taken innovative steps in health financing to move closer towards Universal Health Coverage. The main conference programme features five plenary and eighteen parallel sessions. These explore the wide range of health systems financing options, partly from a policy perspective, and partly from the practical perspective of implementation. Some sessions focus on measuring the impact of Universal Health Coverage.

We urge you to take advantage of the varied range of toolkits and side meetings. You are also invited to take part in one of the site visits, which will offer you a taste of Thailand's own efforts to achieve Universal Health Coverage - and to maintain it over the last decade. An independent assessment of the Thai scheme has recently been completed and we hope to share this with you.

With this unique opportunity, we hope that you will be able to strengthen your networks and build new alliances and, above all, strengthen your determination to undertake new actions to deliver on our joint vision.

We would like to thank the many committed individuals and organizations that have worked together to prepare and execute the plan for this conference, in particular the international partners, the Prince Mahidol Award Foundation, Ministry of Public Health, Ministry of Foreign Affairs and Mahidol University. Last but not least, we would like to extend our thanks to all speakers, moderators, discussants and participants whose wealth of experience, knowledge and skills will benefit us all this week - and help us achieve our common objective - Universal Health Coverage.

This conference provides us a chance for all stakeholders to work together to effectively translate ambitious policy intentions into concrete actions that can make Universal Health Coverage a reality for all people, everywhere, ensuring better health for everyone - whoever they are, wherever they live.

Dr. Vicharn Panich
Chair
Prince Mahidol Award Conference

Dr. Carissa Etienne
Co-Chair
World Health Organization

Dr. Cristian Baeza
Co-Chair
The World Bank

Mr. Kiyoshi Kodera
Co-Chair
Japan International Cooperation Agency

TABLE OF CONTENTS

TABLE OF CONTENTS

CONFERENCE PROGRAM IN BRIEF

Tuesday 24 January 2012		
08:30-17:30	**Side Meetings and Toolkit Sessions**	
Wednesday 25 January 2012		**Room**
07:00-18:00	**Optional Field Trip** - Connecting and managing all health insurance schemes through ICT system - Central design with flexible decentralized UC management system at Saraburi Province - Managing referral system for better access to excellent centres of UCS beneficiaries - Beyond medical education, roles of university hospitals in UCS - Engaging community organizations in the management of Universal Coverage Scheme - Integrated healthcare system: a pre-requisite for universal coverage system - Private healthcare providers: involvement is better than exclusion? - Can private clinics provide comprehensive care for beneficiaries of the UC Scheme?	Bangkok Convention Centre Lobby, Ground Fl.

Thursday 26 January 2012		Room
09:00-10:30	**Opening Session by HRH Princess Maha Chakri Sirindhorn & Keynote Address**	Bangkok Convention
10:30-11:00	**Break**	Bangkok Convention
11:00-12:30	**Plenary session 1:** Universal Health Coverage: Utopia or Mirage to Human Development?	Bangkok Convention
12:30-14:00	**Lunch**	Bangkok Convention
14:00-15:00	**Plenary session 2:** The complex nexus: Political will, civil society and evidence in achieving UHC	Bangkok Convention
15:00-15:30	**Break**	Bangkok Convention
15:30-17:30	**Parallel Session 2.1** Raising more domestic resources for health	World Ballroom C
	Parallel Session 2.2 Role of Development Assistance in Universal Coverage	Lotus 1-2
	Parallel Session 2.3 Macroeconomics and Universal Health Coverage	Lotus 3-4
	Parallel Session 2.4 Governance structure and institutional capacities in advancing UHC	Lotus 5-7
	Parallel Session 2.5 Voice of the People	World Ballroom A
	Parallel Session 2.6 The Role of the Private Sector in Universal Health Coverage: a Blessing or a Curse?	World Ballroom B
18:00-20:30	**Welcome Dinner**	Bangkok Convention

Friday 27 January 2012		Room
09:00-10:00	**Plenary session 3:** Pathways to UHC: Debates on critical policy choices	Bangkok Convention
10:00-10:30	**Break**	Bangkok Convention
10:30-12:30	**Parallel Session 3.1** Defining, Measuring and Monitoring Universal Health Coverage	Lotus 1-4
	Parallel Session 3.2 Voluntary insurance schemes: what lessons for low- and middle-income countries seeking to cover the informal sector?	World Ballroom C
	Parallel Session 3.3 Beyond Bismarck and Beveridge: Lessons from hybrid financing to cover a billion people	Lotus 5-7
	Parallel Session 3.4 Reaching and protecting the poor in Low Income Countries: What challenges?	Bangkok Convention
	Parallel Session 3.5 Portability of financial risk protection across schemes, across borders	World Ballroom A
	Parallel Session 3.6 Universal Health for the Working Poor: Barriers to Access	World Ballroom B
12:30-14:00	**Lunch**	Bangkok Convention
14:00-15:00	**Plenary session 4:** Achieving universal coverage: a key role of health systems	Bangkok Convention
15:00-15:30	**Break**	Bangkok Convention
15:30-17:30	**Parallel Session 4.1** Measuring the impact and outcome of universal coverage	Lotus 1-4
	Parallel Session 4.2 Resource scarcity, efficiency and coverage with health services	Lotus 5-7
	Parallel Session 4.3 Provider payment: aligning proper incentives and efficiency	World Ballroom A
	Parallel Session 4.4 Using financing as a platform for quality improvement	World Ballroom C
	Parallel Session 4.5 Ageing populations: What challenges for health financing?	World Ballroom B
	Parallel Session 4.6 Giants Racing Towards UHC: Health Financing Reforms in China and India	Bangkok Convention

Saturday 28 January 2012		Room
09:00-10:00	**Synthesis: summary, conclusion & recommendations**	Bangkok Convention
10:00-10:30	**Break**	Bangkok Convention
10:30-12:00	**Plenary session 5:** Ministerial Round Table: Advancing UHC Agenda	Bangkok Convention
12:30-13:00	**Closing session**	Bangkok Convention
13:00-14:00	**Lunch**	Bangkok Convention
14:00 onwards	**PMAC 2012 & PMAC 2013 International Organizing Committee Meeting**	Lotus 7

Note: Bangkok Convention Centre and Lotus 1-7 are on the 22nd floor
World Ballroom A-C are on the 23rd floor

Side Meeting Program

Time	Meeting	Organizer	Room
Monday, 23 January 2012			
08:30 – 17:00	Universal Health for the Working Poor: Barriers to Access (Closed meeting and continue on 24 Jan)	WIEGO and HomeNet Thailand	Lotus Suite 9
08:30 – 17:30	Leveraging Universal Health Initiatives to Achieve High Quality Care (Closed meeting and continue on 24 Jan)	The Institute for Healthcare Improvement (IHI), partnering with NICE International	World Ballroom C
09:00 – 17:00	Providing for Health (P4H) - Moving together towards universal coverage and social health protection	WHO in collaboration with ILO, World Bank, France, Germany, Spain and Switzerland	Lotus Suite 7
Tuesday, 24 January 2012 (Morning coffee break at 10:30 – 11:00 / Lunch break at 12:30 – 13:30 / Afternoon coffee break at 15:00 -15:30)			
08:30 – 16:30	Results-Based Financing: good results or just a lot of hype? A critical review of what we know so far	The World Bank	Lotus Suite 4
09:00 – 12:00	Asia Pacific Observatory on Health Systems and Policies	WHO/WPRO on behalf of the APO	Lotus Suite 6
09:00 – 12:30	Ten Years Assessment of the Thai Universal Coverage Scheme	Health Systems Research Institute (HSRI)	Lotus Suite 7
09:00 – 12:30	Shaping health financing institutional design for universal coverage	World Health Organization	Lotus Suite 10

Side Meeting Program

Time	Meeting	Organizer	Room
Tuesday, 24 January 2012			
09:00 – 12:30	Health expenditure tracking: what is new?	World Health Organization, USAID/HS2020	Lotus Suite 11
09:30 – 12:30	Mobilising for Health: Challenging Power Relations	People's Health Movement	Lotus Suite 12
09:00 – 15:00	Harmonizing health insurance information system standards – sharing tools and strategies	PATH and Pharm Access	World Ballroom A
09:00 – 16:30	Evidence-informed resource allocation, health technology assessment (HTA) and basic package of care: the missing link	Health Intervention and Technology Assessment Program (HITAP) Thailand, Center for Global Development (CGD) USA, NICE International, UK	Lotus Suite 2
09:00 – 17:00	Measuring and monitoring health equity: application of ADePT	The World Bank, International Health Policy Program (Thailand)	Lotus Suite 1
09:00 – 17:00	GHD - NET Side Meeting	The Global Health Diplomacy Network	Lotus Suite 8
09:00 – 17:00	Universal Health for the Working Poor: Barriers to Access (Closed meeting and continue from 23 Jan)	WIEGO and HomeNet Thailand	Lotus Suite 9
09:00 – 17:00	Leveraging Universal Health Initiatives to Achieve High Quality Care (Continue from 23 Jan)	The Institute for Healthcare Improvement (IHI), partnering with NICE International	World Ballroom C

Side Meeting Program

Time	Meeting	Organizer	Room
Tuesday, 24 January 2012			
13:30 – 17:00	Capitation and DRG: how to session	National Health Security Office (Thailand)	Lotus Suite 12
13:30 – 17:30	Launch Seminar of the Japan–World Bank Partnership Program: Challenges and Opportunities for Achieving Universal Health Coverage	Japan Center for International Exchange (JCIE), Japan International, Cooperation Agency (JICA) and The World Bank	Lotus Suite 10
13:30 -17:30	OneHealth tool for strategic planning and costing in health	World Health Organization	Lotus Suite 11
14:00 – 17:00	Emerging Voices for Global Health about health systems research mapping in low and middle income countries: Health Systems Research, Knowledge Management and Capacity Building	The Institute of Tropical Medicine, Belgium (ITM)	Lotus Suite 6
16:30 – 19:30	'Good health at low cost' 25 years on – what makes an effective health system?	International Health Policy Program (IHPP), Ministry of Public Health, Thailand and London School of Hygiene & Tropical Medicine (LSHTM)	World Ballroom B
18:00 Onwards	Regional Asian Network for Health Professional Education in 21st Century (Closed meeting)	5 Countries for HRH Education Network	Board Room
Thursday, 26 January 2012			
17:30 – 19:00	AAAH Steering Committee Meeting	AAAH Secretariat	Board Room
Friday, 27 January 2012			
07:00 – 09:00	UHC Global Advocacy Working Group	World Health Organization	Lotus Suite 14

Side Meeting Program

Time	Meeting	Organizer	Room
Friday, 27 January 2012			
07:30 – 09:00	Global HRH Movement and the Way Forward (Closed meeting)	International Health Policy Program Thailand	Board Room
18:00 onwards	Expert-level meeting of the Foreign Policy and Global Health Initiative (Closed meeting)	Ministry of Public Health, Thailand	Lotus Suite 11
Saturday, 28 January 2012			
7:30 – 9:00	Prince Mahidol Award Conference 2014	PMAC Secretariat	Board Room

Note: Bangkok Convention Centre and Lotus Suite 1-12 are on the 22nd floor
World Ballroom A-C, Boardroom and Lotus Suite 13-14 are on the 23rd floor

LIST OF SPEAKERS, PANELISTS, CHAIRS, MODERATORS AND RAPPORTEURS

Speaker/Panelist	Chair/Moderator	Rapporteur
Keynote Session		
Ruth Bishop Vashaben Thakor		Seye Abimbola Rungsun Munkong Sirinya Pulkerd
Plenary session 1: Universal Health Coverage: Utopia or Mirage to Human Development?		
Peter Anyang' Nyong'O Fran Baum Daniel Cotlear Carissa Etienne Tien Nguyen Thi Kim Keizo Takemi	Toomas Palu	Raoul Bermejo III Lara Brearley Passawee Tapasanan
Plenary session 2: The complex nexus: Political will, civil society and evidenee in achieving UHC		
Timothy Grant Evans Heather Grady David Legge Bheki Ntshalintshali Jon Ungphakorn	Michael Cichon	Gina Lagomarsino Areekul Puangsuwan Amal Shafik
Parallel session 2.1: Raising more domestic resources for health		
Seng Eun Choi Jean Pierre Mbeng Mendou Anne Mills P.A. Nitiema Kotsaythoune Phimmasone Hasbullah Thabrany	Poonam Singh Joseph Kutzin	Jittinan Aukayanagul Claude Meyer Chanwit Tribuddharat
Parallel session 2.2: Role of Development Assistance in Universal Coverage		
Rifat Atun Stephen Kido Dalipada Lal Shanker Ghimire Eva Jarawan Veasna Kiry Lo Ingvar Theo Olsen	Benedict David	Michael Adelhardt Maki Ozawa Natalie Phaholyothin

LIST OF SPEAKERS, PANELISTS, CHAIRS, MODERATORS AND RAPPORTEURS

Speaker/Panelist	Chair/Moderator	Rapporteur
Parallel session 2.3: Macroeconomics and Universal Health Coverage		
Walaiporn Patcharanarumol Baoping Shang Juan Pablo Uribe	Adam Wagstaff	Akhnif El Houcine Robert Marten Tanavij Pannoi
Parallel session 2.4: Governance structure and institutional capacities in advancing UHC		
Eduardo P. Banzon Valeria de Oliveira Cruz Andrew Makaka Qingyue Meng Ikuo Takizawa Wim Van Damme	Mushtaque Chowdhury	Por Ir Kanang Kantamaturapoj Kanokwaroon Watananirun
Parallel session 2.5: Voice of the People		
Sam Adjei Matthew Anderson Orajitt Bumrungskulswat Douglas Munoreveyi Gwatidzo Abhay Shukla	David Sanders	Asmus Hammerich Anawin Sanguankeo Iyarit Thaipisuttikul
Parallel session 2.6: The Role of the Private Sector in Universal Health Coverage: a Blessing or a Curse?		
Jane Doherty Gustavo Nigenda-Lopez Sakthivel Selvaraj	Ravindra Rannan-Eliya Marie-Gloriose Ingabire	Christopher James Manasigan Kanchanachitra Rapeepong Supanchaimatr
Plenary session 3: Pahways to UHC: Debates on critical Policychoices		
Peter Berman Naoki Ikegami Pongpisut Jongudomsuk Nathaniel Otoo Kanuru Sujatha Rao	David de Ferranti	Baktygul Akkazieva Yibeltahl Assefa Cha-aim Pachanee
Parallel session 3.1: Defining, Measuring and Monitoring Universal Health Coverage		
Tan-Torres Edejer Ainura Ibraimova Xenia Scheil-Adlung Adam Wagstaff	Ariel Pablos-Mendez Apiradee Treerutkuarkul	Trassanee Chatmethakul Manasigan Kanchanachitra Inke Mathauer

LIST OF SPEAKERS, PANELISTS, CHAIRS, MODERATORS AND RAPPORTEURS

Speaker/Panelist	Chair/Moderator	Rapporteur
Parallel session 3.2: Voluntary insurance schemes: what lessons for low- and middle-income countries seeking to cover the informal sector?		
Solène Favre Yogesh Rajkotia Yemale Tiawara	Marty Makinen	Jean-Marc Thome Vuthiphan Vongmongkol Orn-anong Waleekhachonlert
Parallel session 3.3: Beyond Bismarck and Beveridge: Lessons from hybrid financing to cover a billion people		
John Langenbrunner Jui-fen Rachel Lu Ammar Siamwalla	Toomas Palu	Juthaporn Assawachananont Por Ir Sutayut Osornprasop
Parallel session 3.4: Reaching and protecting the poor in Low Income Countries: What challenges?		
Mursaleena Islam Chansaly Phommavong Fredrick Ssengooba	Daniel Cotlear	Bart Jacobs Parunyou Julayanont Taro Kikuchi
Parallel session 3.5: Portability of financial risk protection across schemes, across borders		
David B. Evans Qingyue Meng Alexander De Las Alas Padilla Bong-Min Yang	Richard Smith	Leizel Lagrada Tanapat Laowatutanon Aungsumalee Pholpark
Parallel session 3.6: Universal Health for the Working Poor: Barriers to Access		
Laura Alfers Chris Atim Mirai Chatterjee Kalpana Jain Boonsom Namsomboon	Francie Lund	Luc Van Leemput Jirawat Panpiemras Jutamas Saoraya
Plenary session 4: Achieving universal coverage: a key role of health systems		
Evelyn Korkor Ansah Narayanan Devadasan Samrit Srithamrongsawat Andrei Usatii	Carissa Etienne	David Hercot Rapeepun Jommaroeng Mariyam Suzana

LIST OF SPEAKERS, PANELISTS, CHAIRS, MODERATORS AND RAPPORTEURS

Speaker/Panelist	Chair/Moderator	Rapporteur
Parallel session 4.1: Measuring the impact and outcome of universal coverage		
Peter Annear Supon Limwattananon Yogesh Rajkotia Peter C. Smith Van Tien Tran	Masato Mugitani David B. Evans	An Appelmans Chalermpol Chamchan Moe Ko Oo
Parallel session 4.2: Resource scarcity, efficiency and coverage with health services		
Kara Hanson Rozita Halina Tun Hussein Naoki Ikegami Manuel Inostroza Palma Winai Sawasdivorn	Poonam Singh Tan-Torres Edejer	Sarbani Chkraborty Pennapa Kaweewongprasert Thinakorn Noree
Parallel session 4.3: Provider payment: aligning proper incentives and efficiency		
Irene Agyepong Martin Edgar Braun Ainura Ibraimova Christopher D. James Joseph Kutzin Qingyue Meng	Sudha Pillai Cheryl Cashin	Charamporn Holumyong Bart Jacobs Noppakun Thammathach-aree
Parallel session 4.4: Using financing as a platform for quality improvement		
Pierre Barker Gerard La Forgia Mei-Shu Lai Yogan Pillay Anuwat Supachutikul	Kalipso Chalkidou	Sawarai Boonyamanond Kari Hurt Suthee Rattanamongkolgul
Parallel session 4.5: Ageing populations: What challenges for health financing?		
Hideki Hashimoto Ajay Mahal Christian Peters	Daniel Cotlear	Valeria de Oliveira Cruz Zurnila Marli Kanjana Tisayaticom
Parallel session 4.6: Giants Racing Towards UHC: Health Financing Reforms in China and India		
Mirai Chatterjee Wen Chen Srinath Reddy Kolli John Langenbrunner Anne Mills	Robert Hecht	Joanne McManus Natalie Phaholyothin Thananan Ratnachotpanich

LIST OF SPEAKERS, PANELISTS, CHAIRS, MODERATORS AND RAPPORTEURS

Speaker/Panelist	Chair/Moderator	Rapporteur
Plenary session 5: Ministerial Round Table: Advancing UHC Agenda		
Peter Anyang' Nyong'O Wittaya Buranasiri Aaron Motsoaledi Ali Ghufron Mukti Enrique T. Ona	Lincoln Chen	Wilfred Gurupira Joanne McManus Yuttapong Wongswadiwat
Lead Rapporteur Team		
David Evans Jeff John Timothy Johnston Anne Mills Viroj Tangcharoensathien		
Rapporteur Coordinator		
Walaiporn Patcharanarumol		

Prince Mahidol Award Conference 2012

Moving towards Universal Health Coverage: Health Financing Matters

Rationale

Health financing is one of the six building blocks of the WHO health systems framework, i.e., service delivery; health workforce; information system; medical products & technologies; financing; and leadership & governance. The Framework provides clear functions and poses major challenges of each building block, in particular healthcare financing faced by the developing countries. It is clear that health system strengthening requires integrated responses of all six building blocks.

It is well recognized that functional health system requires equitable, efficient and sustainable health financing which ensures access and utilization of essential health services without financial barrier and people are protected from financial catastrophe or impoverishment due to illnesses. This is the goal of health financing system aiming at universal health coverage (UHC).

The World Health Assembly resolution, WHA 58.33 in 2005 on "sustainable health financing, universal coverage and social health insurance" urges member states to ensure that the health financing systems include prepayment method with a view of risk sharing and solidarity. WHO and partners convened the first global symposium on health system research with the theme of "science to accelerate universal health coverage" in Montreux in November 2010. About 1,200 registered participants who are researchers, policy-makers, funders, academia and other stakeholders representing diverse constituencies gathered to share evidences and experiences and identify knowledge gaps and need of research in low and middle income countries to foster the momentum of universal coverage movement. The latest World Health Report in 2010 on "health system financing: the path to universal coverage" was launched in Berlin, Germany in 22-23 November 2010 and subsequently in Beijing, China on 29 November 2010. The report reaffirms all countries can improve the health financing system and strongly persuades faster moving towards universal health coverage goals.

There are also other concerted movements to improve the health financing systems and to move towards universal health coverage. The 2009 G8 summit in Toyako committed on health system strengthening which focused on three interrelated components: health information systems, human resources for health and health care financing. There are also movements at global, regional and country levels to support technical collaboration e.g., the High Level Task Force on UHC, the Joint Learning Network supported by Rockefeller Foundation as well as South-South collaboration.

Given the rich context on UHC, time has come to share the country experiences and challenges on financing reforms and to push this momentum forward in order to effectively translate good policy intention into concrete actions in accelerating towards UHC.

The Prince Mahidol Award Conference is an annual international conference hosted by the Royal Thai Government, the Prince Mahidol Award Foundation, and other relevant International Organizations, Foundations and Civil Society Organizations. The Conference serves as an international forum for sharing evidences for health related policies and strengthens social commitments for health development. This conference is linked to the annual Prince Mahidol Award for public health and medicines, one of the most prestigious international health awards. The 2012 Prince Mahidol Award Conference is dedicated to deliberation on experiences on health financing reform, support global dialogue and foster movements towards universal health coverage.

Resilient and responsive health system is foundation and pre-requisites to successful UHC achievement; it requires functioning healthcare delivery system particularly at PHC level where the majority poor can access and use service when needed, adequate number and skill-mix of health workforce who are responsive to the population health needs, adequate, equitable and efficient health financing, health information systems which guide evidence based policy decision, availability of medicines and medical products and governance of the system. This Conference focuses on the contribution of health financing in advancing towards UHC; however other enabling environment would be addressed.

Objectives

1. To position the universal health coverage in the global and national development agendas.
2. To identify enabling factors contributing to success of health financing reforms e.g. political, economic, societal support, health services infrastructure especially primary health care, human resources for health, acceptability and expectation of people.
3. To review and share experiences among low, middle and high-income countries at different stages of achieving universal health coverage, on different dimensions of universal coverage such as financing sources, risk pooling, strategic purchasing, governance and outcome of different designs of universal coverage

Structure of the conference

The conference will be convened during the week of 24-28 January 2012.

Pre-conference activities

Tuesday 24 January 2012

08:30-17:30
Side Meetings and Toolkit Sessions

- Registration and side meetings, skill development workshops, policy discussion round tables, convened by interested co-hosts and all concerned partners on topics related to universal health coverage.

Wednesday 25 January 2012

07:00-18:00
Optional Field Trip

Field visits to expose to the Thai health systems: health delivery systems, financial risk protection schemes and briefings of outcome of and challenges even when reaching universal coverage

- Connecting and managing all health insurance schemes through ICT system
- Central design with flexible decentralized UC management system at Saraburi Province
- Managing referral system for better access to excellent centres of UCS beneficiaries
- Beyond medical education, roles of university hospitals in UCS
- Engaging community organizations in the management of Universal Coverage Scheme
- Integrated healthcare system: a pre-requisite for universal coverage system
- Private healthcare providers: involvement is better than exclusion?
- Can private clinics provide comprehensive care for beneficiaries of the UC Scheme?

The Main Conference

Thursday 26 January 2012

09:00-10:30
Opening Session & Keynote Address
Opening Ceremony: Her Royal Highness Princess Maha Chakri Sirindhorn
Keynote Speeches:

- **Ruth Bishop**, Professorial Fellow, Murdoch Children's Research Institute, Australia
- **Vashaben Thakor**, Board Member, National Insurance VimoSEWA Cooperative Ltd., India

10:30-11:00
Coffee Break

11:00-12:30
Plenary session 1
Universal Health Coverage: Utopia or Mirage to Human Development?

Background:
The session aims at stimulating all participants to realize the importance of UHC and stimulate dialogue and sharing as well as links to the theme and the other sessions of the conference.

It discusses the positioning of UHC in the context of various global development agendas such as human right, effective social protection instruments to protect and mitigate the vulnerabilities against all kinds of shocks including health shocks to the households. This session will address a few key issues:

1. What is the ideology behind the UHC as a development agenda – human right?, poverty reduction?, impediment to global economic growth, etc?
2. Is it really feasible to achieve UHC when the countries are still at low-income level?
3. Can UHC lead to uncontrollable financial burden? How to ensure adequate fiscal space to invest on UHC?
4. What should be considered to ensure that investment in UHC will really allow sustainable and affordable universal access to essential health services and not be an uncontrolled financial burden to the extent that it is a barrier to development by itself?

Objectives:
To stimulate the dialogue and set the stage towards the rest of the conference program.

Moderator: Toomas Palu, Sector Manager, Health Nutrition and Population, East Asia and Pacific Region, The World Bank, Thailand

Panelists:

- **Keizo Takemi**, Senior Fellow, Japan Center for International Exchange, Japan
- **Fran Baum**, Director, Southgate Institute and South Australian Health Community Health Research Unit (SACHRU), Flinders University, Australia
- **Tien Nguyen Thi Kim**, Minister, Ministry of Health, Vietnam
- **Peter Anyang' Nyong'O**, Minister, Ministry of Medical Services, Kenya
- **Carissa Etienne**, Assistant Director-General, Health Systems and Services, World Health Organization, Switzerland
- **Daniel Cotlear**, Lead Economist, The World Bank, USA

12:30-14:00
Lunch

14:00-15:00
Plenary session 2
The complex nexus: Political will, civil society and evidence in achieving UHC

Background:
Recent history provides ample evidence of the power relations surrounding the debate on universal health coverage: The new enthusiasm for UHC has emerged in a context of the debt and financial crises that impacted on already dismantled and fragmented social health protection systems in many countries. Unanswered questions in this context include: How can the protection of the most basic needs such as that of the vulnerable to health care attract at least the same level of political support, with the funding it implies, as given to the banking sector during the global financial crises? How was it possible for countries such as Thailand and India to achieve progress despite the existence of vested interests and challenges e.g. from the Asian economic crisis in the past decade? What was the role of civil society including trade unions, NGOs and universities in progress towards achieving the objectives and agenda setting?

This session reviews the complex interaction of political will, civil society and evidence using country examples from e.g. Thailand, India and South Africa.

Objectives:
- Share and discuss the impact of clear political will and visions on achieving universal coverage in an adequate time frame
- Review the role of civil society and evidence in progressing towards universal coverage
- Draw lessons on the complementarities of government, civil society and evidence in accelerating progress on UC

Moderator: Michael Cichon, Director, Social Security Department,
International Labor Organization, Switzerland

Panelists:
Political Will: **Jon Ungphakorn**, Board Secretary, AIDS Access Foundation, Thailand

Civil Society:
Trade Union: **Bheki Ntshalintshali**, Deputy General Secretary, Congress of South African Trade Unions (COSATU), South Africa
NGO: **David Legge**, Associate Professor, Teacher and Researcher, School of Public Health, La Trobe University, Australia

Foundation: **Heather Grady**, Vice President, Foundation Initiatives, Rockefeller Foundation, USA

Evidence: **Timothy Grant Evans**, Dean, James P Grant School of Public Health, BRAC University, Bangladesh

---

15:00-15:30
Coffee Break

15:30-17:30
Parallel Session 2.1
Raising more domestic resources for health

Background:
Modifying health financing systems for Universal Coverage (UC) requires raising funds for health; reducing financial barriers through prepayment and subsequent pooling them to spread risks; and resources more efficiently and equitably. Over the last two decades, most attention in the area of domestic health financing policy has focused on how to reduce financial barriers to services through prepayment and pooling, with growing interest recently in questions of efficiency and equity in use. However, questions of raising more money for health have generally been focused entirely on obtaining extra funding from external partners. This session, therefore, will focus on the options for raising more funds for health domestically, drawing on actual country experiences.

Objectives:
The objectives of this session are to allow the audience to consider and debate the evidence on:

- What are some ways that low and middle income countries have used to raise additional domestic funding for health?
- How appropriate are they in other settings?
- What is the political economy of raising more money for health when that is necessary – e.g. who has to be persuaded, and how?

Chair: Poonam Singh, Deputy Regional Director, World Health Organization, South East Asia Regional Office, India

Moderator: Joseph Kutzin, Coordinator, Health Financing Policy, World Health Organization, Switzerland

Speakers:

- **P. A. Nitiema**, Permanent Secretary of the National Health Development Plan, Ministry of Health, Burkina Faso – **Africa and Abuja:** have African Union countries moved closer to the target of 15% of government expenditures allocated to health since the Abuja declaration of 2001?

- **Jean Pierre Mbeng Mendou**, Legal Advisor, National Health Insurance Fund, Gabon**:** Gabon has taken some very innovative approaches to raising additional funds domestically for health including a tax on forms of foreign exchange transactions. The presentation will discuss them, so that the audience can reflect on how generalizable they might be for other countries.
- **Kotsaythoune Phimmasone**, Head of Planning Division, Department of Planning and Finance, Ministry of Health, Lao PDR– Laos**:** Hydropower as a source of revenue for the social sectors
- **Seng-Eun Choi**, Research Fellow, Korea Institute for Health and Social Affairs, South Korea **–** Sin Taxes: The political economy of raising taxes on harmful products – the experience of Republic of Korea on tobacco taxes

Panelists:

- **Hasbullah Thabrany**, Professor, the School of Public Health, Universitas Indonesia, Indonesia. Are there lessons that can apply to other countries from the four case studies?
- **Anne Mills**, Vice Director for Academic Affairs and Professor of Health Economics and Policy, London School of Hygiene and Tropical Medicine, United Kingdom

---

15:30-17:30
Parallel Session 2.2
Role of Development Assistance in Universal Coverage

Background:
In estimated X Low Income Countries (LICs) in the World, Development Assistance in Health (DAH) finances more than 50% of public health expenditure. And even then, the public expenditure accounts often for less than a half of total health expenditure. It may be farfetched to think about universal coverage in such circumstances but over the last decade with unprecedented increase of global development assistance in health, universal coverage has entered into the LIC policy speak. Universal access to Expanded Program of Immunization, universal coverage with ARV treatment, free health care for mothers and children, universal access to essential package of services have been integrated into national health strategies and annual work programs funded by DAH.

There are a number of challenges that need to be overcome. Financial sustainability is one that depends on macro-economic situation, available fiscal space, and Governments' political commitments. But it is not the only one. Expanding coverage is challenged by health systems constraints linked to availability of human resources, infrastructure, organizational ability to manage, oversee and steer the health system, including via incentives and accountabilities embedded in health financing. In fragile country settings,

access to essential services may need to be secured via bypassing non-functional government health services through contracting arrangements to non-government providers. Sometimes DAH support has further entrenched vertical disease oriented programs away from mainstream health services provision and financing creating challenges of re-integration upon phasing out the DAH. Fragmentation of DAH into multitude of projects has also challenged the effectiveness and efficiency of DAH prompting the push for improved aid effectiveness and coordination, increased reliance and strengthening of country systems, sector wide approaches, and also given birth to International Health Partnership that now counts 40 countries (both donor and developing countries), all major international organizations and partnerships as members.

Objectives:
The session will discuss the above challenges and DAH's role in responding to them in the universal coverage context. It will bring together international organizations, donor and recipient countries to debate and take up the sustainability and health systems strengthening challenge and DAHs role in it.

Chair: Benedict David, Principal Health Advisor, Health and HIV Thematic Group, AusAID, Australia
Key presenter: Eva Jarawan, Lead Health Specialist, The World Bank, USA

Panelists:

- **Ingvar Theo Olsen**, Senior Advisor, NORAD, Norway – Health Financing, Norwegian Agency for Development Cooperation
- **Rifat Atun**, Director of Strategy, Performance and Evaluation Cluster, Global Fund to Fight AIDS, Tuberculosis and Malaria, Switzerland
- **Lo Veasna Kiry**, Director of Planning and Health Information Department, Ministry of Health, Cambodia
- **Stephen Kido Dalipada**, Financial Controller, Ministry of Health and Medical Services, Solomon Islands
- **Lal Shanker Ghimire**, Joint Secretary, Ministry of Finance, Nepal

---

15:30-17:30
Parallel Session 2.3
Macroeconomics and Universal Health Coverage

Background:
For many countries, Universal Health Coverage poses a macroeconomic challenge. Health care expenditures in most high income countries grow faster than GDP. Rapid growth of health expenditures is also significant in middle income countries where a billion people have recently been provided with health insurance. Health expenditures have also grown

in many LICs which in recent years have benefitted from significant donor support. The trends in health care spending and the macroeconomic impact of health care growth (on fiscal stability, productivity and competitiveness) are attracting interest of researchers and policymakers. New research in the area includes: (i) an IMF paper which projects health expenditures to 2040 for developed countries and for emerging countries; (ii) World Bank analytic work including a new Flagship study by the World Bank ("Health and the Economy") and a number of country papers analyzing issues of fiscal space and health care; (iii) a number of studies underway by R4D with support from the Rockefeller foundation centered on the likely trajectory of health expenditures over the next 40 years and its relation with UHC; (iv) a book financed by the Rockefeller Foundation that documents five countries that have achieved "good health at low cost". The WB, IMF and R4D are separately presenting their results to international audiences over the next few months.

A common theme emerging from these studies is that "*UHC is a worthy objective, but care is needed in ensuring that the expansion of health expenditure to achieve it does not create undue fiscal risks or negatively impact country competitiveness. Recent history can provide important lessons."*

Objective:

To identify trends in health care spending for middle and low income countries and to obtain lessons from countries that appear to be positive or negative outliers in balancing the fiscal and macroeconomic risks potentially associated with rapid expansion of health coverage.

Chair: Adam Wagstaff, Research Manager, DECHD, The World Bank, USA

Speakers:

- **Baoping Shang**, Economist, International Monetary Fund, USA – Trends in health expenditure
- **Walaiporn Patcharanarumol**, Technical Officer, World Health Organization, Switzerland – Positive outliers: Good Health at low cost (a summary of the recent book describing Thailand, Bangladesh, Ethiopia, Kyrgyz, and Tamil Nadu)
- **Juan Pablo Uribe**, Director General, Fundación Santa Fe de Bogotá, Colombia – Negative outliers: The experience of countries that suffered from macroeconomic imbalances resulting from the expansion of health care (will include the case of Colombia and the USA)

15:30-17:30
Parallel Session 2.4
Governance structure and institutional capacities in advancing UHC

Background:
Health system governance covers several dimensions e.g. institutions involved in regulating, providing and funding health services. The scope can be at the national health system, health authorities, healthcare providers and health insurance institutes. This session focuses on governance arrangements in financial health risk protection system, in particular at health insurance institution level (at scheme level), not the governance at system and healthcare provider level.

Refer to the World Bank Working Paper [1], 'governance' is defined as the combination of political, economic, social, and institutional factors that affect the behavior of organizations and individuals and influence their performance.

Based on different model of health financing schemes [i.e. voluntary or community based health insurance, social health insurance, national health scheme [in particular public financed public provision nature], non-contributory financial health risk protection scheme such that protecting the poor], this session reviews international experiences from three countries with different governance structure and mechanisms focusing on factors influencing performance of the health insurance schemes with different outcomes.

Governance factors determining the performance of health insurance schemes are for example, the legal status of governing body, representation of governing body ensuring balanced of interests across different stakeholders, in particular the insurance fund, the public and private healthcare providers, the beneficiaries and the tax payers. The performance also depends on how deliberative decisions were made such as that based on evidence or political influence, how objectives were set and form and scope of supervision, reporting and auditing system. In the context of contractual arrangement between health insurance institutes and healthcare providers, assessment of institutional capacity to regulate and enforce contract and mechanisms to counteract the non-compliance is crucial and will be covered by this session.

Objectives:
Overall objective
To gain an in-depth understanding on governance arrangement in financial health risk protection system

[1] Savedoff D W., Governance in the health sector: a strategy for measuring determinants and performance. Policy Research Working Paper 5655, the World Bank; May 2011.

Specific objectives

- To draw international experiences on governance arrangement of different health financing mechanisms such as voluntary or community based health insurance, social health insurance, national health scheme or non-contributory financial health risk protection for protecting the poor
- To identify factors in relation to governance which contributes to better financial health risk protection of the population from different health financing mechanisms

Moderator: Mushtaque Chowdhury, Senior Advisor and Acting Managing Director, Rockefeller Foundation, Thailand

Speakers: to draw experiences from country perspectives

- **Andrew Makaka**, Health Financing Director, Ministry of Health, Rwanda – Community based health insurance
- **Rep. from Sierra Leone** – Free health care initiative
- **Eduardo P. Banzon**, President and CEO, Philippine Health Insurance Corporation, Philippines – Social health insurance
- **Qingyue Meng**, Dean School of Public Health, Peking University, China– Scheme in a decentralized system

Panelists:

- **Wim Van Damme**, Professor of Public Health and Health Policy, Institute of Tropical Medicine, Antwerp, Belgium
- **Ikuo Takizawa**, Health Division Director, Human Development Department, Japan International Cooperation Agency, Japan
- **Valeria De Oliveira Cruz**, Programme Management Officer (Health Systems), World Health Organization, Lao PDR

15:30-17:30
Parallel Session 2.5
Voice of the People

Background:
This session will provide space for hearing voices of the people who use public health systems. Case studies from Africa and America will highlight the impact of the related countries health financing systems on their ability to access services, as well as highlighting the catastrophic effect medical bill payment has on individuals and households. Poor households face a higher burden of disease and are most affected by user fees. The case studies will further highlight the determinants behind the lack of access and the impact this has on different sectors of society for example the elderly, migrants, children, etc.

An example of government mechanisms to hear people's voices and resolve problems will be demonstrated by a presentation on the processes established by the Thai National Health Security Office, which undertakes to resolve conflicts within 72 hours.

Finally, a case study on the Indian Right to Health Care Campaign will demonstrate the role national and global civil society can play in highlighting violations of the right to health care; holding governments accountable and mobilizing communities to effect changes in their health systems.

Objectives:

- To highlight the impact that user fees have on people's ability to access services and/or the impact these health financing systems have on poor households.
- To demonstrate government systems that can be established for direct communication between users and the health system and facilitate resolution of problems;
- To demonstrate the role of civil society in monitoring health services; highlighting violations of access to health care; mobilizing communities; and holding governments accountable

Moderator: David Sanders, Professor and founding Director of the School of Public Health,University of the Western Cape and People's Health Movement, South Africa

Speakers:

- **Douglas Munoreveyi Gwatidzo**, Chairperson, Harare Hospital Management Board, Zimbabwe – Africa case study
- **Matthew Anderson**, Medical Doctor, Department of Family and Social Medicine, Montefiore Medical Center and Editor Social Medicine, USA – 20% of Americans are completely without health insurance – what happens to these people when they need to access health services? Has the economic crisis in the US worsened access to health care?
- **Orajitt Bumrungskulswat**, Director, Bureau of Public and Private Participation, National Health Security Office, Thailand – Government mechanisms to hear and address complaints
- **Abhay Shukla**, Coordinator, Support for Advocacy and Training to Health Initiatives (SATHI), India – Indian Right to Health Care Campaign and Community Based Monitoring of Health Services in India
- **Sam Adjei**, President and Chief Executive Officer, Center for Health and Social Services, Ghana

15:30-17:30
Parallel Session 2.6
The Role of the Private Sector in Universal Health Coverage: a Blessing or a Curse?

Background:
In the recent past, a growing number of low and middle-income countries (LMICs) have been working towards improving financial risk protection and population health through Universal Health Coverage (UHC) reforms, and many more are starting to show an interest. Where countries have a substantial private health sector, this process involves discussions about its role vis-à-vis that of the public sector in implementing UHC. Specifically, reform leaders have to decide how to balance the preferences of different stakeholders in terms of health financing options, to effectively increase coverage and service quality in the context of mixed systems, and extend financial protection to the most poor and vulnerable. This may include issues such as the role of private financing mechanisms, including private insurance intermediaries, and the potential for private providers to be part of service delivery within the universal system, particularly where a purchaser-provider split is created.

In most cases, the relationship between the public and private sectors has proven challenging and the entanglement of public and private interests complex. While in recent efforts to promote universal coverage, an expanded role for the private sector is often advocated as essential to broaden coverage and ensure service access for all, there is a need to look more closely at the costs of contracting and monitoring the private sector, and to assess the quality and reach of the provided services. The government's purchase of privately-delivered care, and its implications for UHC sustainability and public health efforts deserves attention, especially in contexts with weak regulatory frameworks for quality and price control and a lack of well-developed provider payment mechanisms that incentivize efficient service delivery. The link between private insurers and hospitals (and other private providers), their relation to government officials, and the role of international donors and lobby groups in shaping choices should also be examined. Most importantly, there ought to be a better understanding of the implications of an expanded private sector role, not only in terms of coverage, but also in fostering equitable quality services for the poor and vulnerable and in producing positive public health outcomes. An expert panel of members of the Global Network for Health Equity (GNHE) and other key practitioners and scholars will reflect on these issues and discuss risk impact assessments of the role of private actors in recent and ongoing UHC reforms in selected mid-level income countries across the globe with a large, and poorly regulated, private sector.

Objectives:
- To provide a broad overview of the role of private actors and interests in major health financing policy reforms in selected countries with large, and generally poorly regulated, private sectors;

- To examine the interests of private insurers and providers and their entanglement with public agents;
- To outline key equity, quality and public health challenges in achieving UHC, which are related to the role of the private sector, in the context of mixed financing and provision;
- To explore critical issues in achieving efficiency, equity, quality and financial protection gains, as well as positive public health outcomes from health financing reforms for the poor and vulnerable populations.

Chair: Ravindra Rannan-Eliya, Director, Institute for Health Policy, Sri Lanka

Co-chair: Marie-Gloriose Ingabire, Senior Program Specialist, International Development Research Centre(IDRC), Canada

Speakers:

- **Jane Doherty**, Independent researcher and part-time lecturer, School of Public Health, University of the Witwatersrand, South Africa
- **Sakthivel Selvaraj**, Health Economist, Public Health Foundation of India, India
- **Gustavo Nigenda-Lopez**, Research Director, Harvard Global Equity Initiative, USA

18:00-20:30
Welcome Dinner hosted by the Royal Thai Goverment

Friday 27 January 2012

09:00-10:00
Plenary session 3
Pathways to UHC: Debates on critical policy choices

Background:
Lower and middle-income countries face a number of critical policy choices and difficult compromises they must contemplate when starting on the path towards universal health coverage (UHC). This session will frame the policy debates, present the current empirical evidence surrounding the alternatives, and will call on country representatives to illuminate trade-offs they must balance when making critical choices between the following: (1) emphasizing population health versus financial protection; (2) providing universal entitlement to services versus targeted programming; (3) leveraging a single, population-wide financial pool versus separate pools for sub-populations; and (4) supply- versus demand-side financing. The opening presentation will highlight the differences between the goals and means of the policy options and will be followed by an in-depth exploration of the first two topics. Keeping in mind that the "choices" are not always so dichotomous, representatives will comment on whether the alternatives framed are the rights ones, how relevant they are to their countries, and how this type of discussion can advance moving towards universal health coverage.

Objectives:
By the end of the session, participants should have a better understanding of some of the critical health financing decisions facing countries. They should be able to:

- Understand the importance of getting on the *pathway* towards universal health coverage;
- Describe the critical health financing decisions facing countries;
- Identify the advantages and trade-offs inherent in each choice;
- Recognize the value that empirical evidence can play in making these decisions; and
- Acknowledge that policy decisions are often very context specific.

Moderator: **David de Ferranti**, President, Results for Development Institute (R4D), USA

Speaker: **Peter Berman**, Adjunct Professor, Harvard School of Public Health, USA

Panelists:

- **Naoki Ikegami**, Professor, Keio University School of Medicine, Japan
- **Nathaniel Otoo**, Director of Administration and General Counsel, National Health Insurance Authority, Ghana
- **Pongpisut Jongudomsuk**, Director, Health Systems Research Institute (HSRI), Thailand
- **Kanuru Sujatha Rao**, Former Secretary, Ministry of Health and Family Welfare, India

---

10:00-10:30
Coffee Break

10:30-12:30
Parallel Session 3.1
Defining, Measuring and Monitoring Universal Health Coverage

Background:
Evidence-based policies that aim at achieving UHC call for the measurement of progress as compared to the status quo. However, currently neither a globally agreed definition of universal coverage and access to health services exist nor conformity on methodologies for describing and monitoring related developments.

Barriers to access health services are often closely related to the socio-economic context of countries and social determinants of specific groups of the population. Thus, to be meaningful monitoring of universal access requires an approach reflecting characteristics at country level of both the health system and aspects beyond such as income level

of countries, labour market structure particularly the extent of the informal economy, poverty, etc.

International organizations and regional networks of researchers in Africa and Asia recently focused their work on monitoring progress of UHC using distinct concepts for global comparisons and country assessments. How can effectiveness of coverage regarding access to health care and financial protection be measured? Which evidence exists and is used to inform policy making at country level?

Objectives:
This session will provide an overview of current concepts and approaches on measuring and monitoring progress towards universal coverage and discuss the use of results in policy making in global comparisons and local policy-making.

Chair: Ariel Pablos-Mendez, Assistant Administrator for Global Health, US Agency for International Development, USA

Moderator: Apiradee Treerutkuarkul, News Reporter, Bangkok Post, Thailand

Speakers:
- **Adam Wagstaff**, Research Manager, DECHD, The World Bank, USA
- **Tan-Torres Edejer**, Coordinator, Health Systems Financing, World Health Organization, Switzerland
- **Xenia Scheil-Adlung**, Health Policy Coordinator, International Labour Organization, Switzerland

Panelists:
- **Ainura Ibraimova**, Regional Health Finance and HSS Director, USAID Quality Project, Kyrgyzstan

---

10:30-12:30
Parallel Session 3.2
Voluntary insurance schemes: what lessons for low- and middle-income countries seeking to cover the informal sector?

Background:
A number of low- and middle-income countries have tried to begin their path to universal coverage by beginning with voluntary health insurance schemes, particularly to try to cover households with employment in the informal sector. For this session the voluntary schemes taken up are those that offer the principal coverage for health service use by members (not

complementary packages) that are in the public or non-profit private sector, and are not "opt outs" from otherwise mandatory insurance programs. These experiences have had only mixed success, with difficulties reaching coverage at scale, collecting premiums, adverse selection, matching benefits to the ability to contribute of target populations, and re-enrollment of members. Nevertheless, there are some successes, such as Rwanda and Ghana, or countries that have begun with voluntary systems that have used them as a platform to going to mandatory health insurance system. One element contributing to enrollment into such schemes is their ability to benefit from "collectiveness", for example, through working to enroll members of agricultural cooperatives or by community health workers promoting and selling health scheme memberships.

Objectives:
The objectives of the session are to (1) learn about some specific positive/promising and negative/discouraging experiences with voluntary insurance and (2) assess benefits and risks and draw lessons that can be applied to low- and middle-income countries considering or already involved with voluntary systems to help accelerate the path to universal coverage.

Moderator: **Marty Makinen**, Managing Director,
Results for Development Institute, USA

Speakers:

- **Solene Favre**, Project Manager, Health Insurance Project, GRET, Cambodia
- **Yemale Tiawara**, Social Marketing Manager, Community Base Insurance Nouna (CBI/Nouna), Burkina Faso
- **Yogesh Rajkotia**, Managing Director, Institute for Collaborative Development, Bangladesh

---

10:30-12:30
Parallel Session 3.3
Beyond Bismarck and Beveridge: Lessons from hybrid financing to cover a billion people

Background:
For years, economists have been discussing the best way to finance an expansion of health insurance; no intellectual consensus has been achieved in a debate often described as "Bismarck vs. Beveridge". At the same time during the last decade, over a billion people in middle income countries have been added to those benefitting from health insurance. Much of this increase has happened in Asia – especially in China, India, Indonesia, Thailand, Vietnam and the Philippines; but large increases in the number of beneficiaries have also taken place in Latin America (e.g. Mexico, Colombia, Chile), Africa (e.g.

Ghana, Nigeria) and Eastern Europe and Central Asia. In most of these countries, civil servants and formal sector workers were already covered through a payroll-tax-financed social insurance system. The increase in coverage of the last decade has been aimed at the poor and informal sector families and has been financed with general taxes (while retaining the previous system and its payroll taxes).

This session will highlight the challenges of hybrid financing (combining payroll taxes and general taxes to finance health insurance). It would focus on two related questions:

- What is the appropriate governance structure for the new programs? SHI often has a tripartite governing body of representatives of workers, employers and government, but without representation of other stakeholders such as the civil society or public and private providers. Is this also the best governance structure for the new programs?
- In these countries, formal sector workers continue to pay payroll taxes for the SHI, but they also now pay an additional tax to fund the new programs. This has two implications:
    - Is there a problem of fairness? The formal sector workers now pays double health tax, one for themselves, and the other for other members of the society.
    - Does this further discourage the formalization of workers and firms? If workers and firms can avoid the payroll tax, will they choose informality (where health insurance if free or highly subsidized)?

Defenders of the expansion often admit that the system of hybrid financing is not ideal and may create distortions, but defend it as "pragmatic". The pragmatic argument often is presented in two ways:

- In the short run, there is insufficient institutional capacity to abandon payroll taxes and substitute them exclusively by general taxation. The long term objective however is to incrementally move to a general taxation model.
- Politically, there is a need to incorporate the informal sector to generate momentum for the difficult reforms that are needed in public finance and health systems. Once a large part of the total population is covered, the political momentum is there.

Objective:

This session will discuss the challenges faced by governments advancing universal health coverage using hybrid health financing systems (systems that combine tax and governance mechanisms borrowed from social health insurance and from civil service based systems.)

Chair: Toomas Palu, Sector Manager, Health Nutrition and Population, East Asia and Pacific Region, The World Bank, Thailand

Speakers:

- **Ammar Siamwalla**, Distinguished Scholar, Thailand Development Research Institute (TDRI), Thailand – A Public Finance analyst describing the risks and distortions created by hybrid financing
- **John Langenbrunner**, Lead Economist, The World Bank, USA
- **Jui-fen Rachel Lu**, Professor and Dean, College of Management, Chang Gung University, Taiwan - A political economist who will describe the politics of creating a unified health system starting from a highly segmented one (perhaps describing the experience of Korea and Taiwan, republic of China and of one/two European systems)

10:30-12:30
Parallel Session 3.4
Reaching and protecting the poor in Low Income Countries: What challenges?

Background:
Many Low income Countries (LICs) are experimenting with health schemes designed to reach the poor populations with basic services and to protect the poor from the financial consequences of user fees and other medical costs. Responding to budget shortages, in past decades most LICs adopted formal or informal systems of user fees for health care to pay for part of their recurrent costs and to provide incentives for front line health care workers. These countries are confronted with the dilemma of how to make a needed system of financing compatible with the goal of preserving equitable access to services for the poor. Previous attempts to solve the problem by simply decreeing universal or targeted "exemptions" from payment often resulted in reduced access for the poor, scarcity of medical inputs and informal payments. Increasingly, countries are testing various *third party payment systems* designed to pay providers for services rendered while exempting users from the need to pay at the point of service; some of the better known schemes include:

(i) Schemes that directly pay health providers for services rendered and documented such as RBF (Results Based Financing) , or Pay for Performance (P4P) – these schemes usually emphasize interventions related to the "basic package" provided in primary care clinics;

(ii) Reproductive and maternal health vouchers which are given to poor mothers for them to "pay" for reproductive health services – these schemes aim to empower users by providing them with an element of choice;

(iii) Emphasize the expansion of access to the basic package and (ii) Health Equity Funds (HEFs), which emphasize financial protection for users of hospital services beyond the basic package. These schemes are subsidized by donors and by governments and in many cases there are attempts to scale up the implementation of schemes that began at the pilot level.

Objective:
A major challenge faced by funders contemplating scaling up these schemes is related to problems of accountability and governance in these schemes. Specifically: (i) how to ensure that the poor benefit from these schemes, and (ii) how to ensure the validity of claims of service by providers? **This session would focus on the operational challenge faced by LICs, which typically have low capacity, to ensure that benefits reach the poor and to verify the accuracy of reporting on the volume of services provided.**

Chair: Daniel Cotlear, Lead Economist, The World Bank, USA

Speakers:

- **Fredrick Ssengooba**, Senior Research Fellow, Makerere University, School of Public Health, Uganda – RFB in Africa
- **Mursaleena Islam**, Principal Associate/Senior Economist, International Health Division, Abt Associates Inc., USA – Reproductive and maternal health vouchers in Bangladesh
- **Chansaly Phommavong**, Deputy Director of Health Project, Ministry of Health, Lao PDR – Health Equity Funds

---

10:30-12:30
Parallel Session 3.5
Portability of financial risk protection across schemes, across borders

Background:
People are increasingly mobile within and across countries. Unless financing systems are designed explicitly to deal with this phenomenon, there is a risk that people will not be covered by health insurance or tax-funded health services when travelling within and across countries, when migrating, and when their employment status changes. The last issue is particularly important where insurance systems are fragmented, with different population groups covered by different schemes. This session will consider the experience of two countries focusing on what the problem is, and how it is being faced. It will then turn its attention to the European Union where a European Health Card is now available. The purpose is to understand how this might relate to national systems with fragmented insurance pools.

Objectives:
The objectives of this session are to allow the audience to understand the health financing problems posed by increased mobility and how different countries and regions are facing them. This issue can only get bigger over time.

Moderator: Richard Smith, Head of Faculty of Public Health and Policy,
London School of Hygiene and Tropical Medicine, United Kingdom

Speakers:

- **Qingyue Meng**, Dean, School of Public Health, Peking University, China
- **Bong-Min Yang**, Professor and Director, School of Public Health, Seoul National University, South Korea
- **Alexander De Las Alas Padilla**, Executive-Vice President and Chief Operating Officer, Philippine Health Insurance Corporation, Philippines
- **David B. Evans**, Director, Health Systems Financing, World Health Organization, Switzerland

---

10:30-12:30
Parallel Session 3.6
Universal Health for the Working Poor: Barriers to Access

Background:
Over the past two decades, employment in the informal economy has risen rapidly in all regions. Even before the recent global recession, during which countless retrenched formal workers found work in the informal economy, the share of the informal economy in the non-agricultural workforce ranged from 60 percent in Latin America, to 45-85 percent in different parts of Asia, to 75 percent in Africa.

The extent of risk is high in the informal economy for a number of reasons. First, those who work in the informal economy have a high exposure to risks given the conditions under which they live and work. Secondly, they tend to have low levels of income and are, therefore, less likely to be able to save for contingencies. This means that, for them, predictable financial needs – such as expenditures on life cycle events and education – often become financial risks or, at least, a source of financial stress. Thirdly, they have little or no access to formal means of managing risks (e.g., health insurance, pensions, and social assistance) or financing housing and education (e.g., mortgages, loans, and scholarships).

A number of countries have recently introduced inclusive social protection policies which, though not always primarily or explicitly targeted at informal workers, do hold the potential to include them. Some of the most innovative examples of such policies have been health schemes. These include Thailand's Universal Health Care Coverage Scheme, introduced in 2002, which soon moved from a contributory insurance scheme to a universal non-contributory scheme; Ghana's National Health Insurance Scheme, introduced in 2003; and India's Rashtriya Swasthya Bima Yojana, the National Health Insurance Programme, introduced in 2007.

Through its work with membership-based organizations (MBOs) of informal workers, WIEGO knows that access to health services is a high priority for the working poor,

especially women, in the informal economy. Their most immediate concern is to get back to good health in order to continue earning an income for themselves and their families. In this respect the introduction of inclusive health insurance schemes, such as those mentioned above, could be an important step forward in terms of ameliorating some of the more significant risks faced by informal workers.

However, the more inclusive design of health schemes does not always automatically translate into better access to healthcare and services on the ground for many poorer people, including informal workers. There are often numerous barriers to access, which can include anything from poor dissemination of information to more complex technical aspects of the scheme design, and other factors that influence the distribution of who gets what.

Objectives:
The objectives of the panel are to share lessons from three case studies of the universal health schemes in Ghana, India, and Thailand that examined whether and how such schemes have been accessed by the working poor in the informal economy. What factors act as barriers to access and are there ways to lift them? Conversely, where schemes, or parts of schemes, have been successfully inclusive, what were the factors that contributed to success? Other questions that were asked include: How do poorer informal workers (especially women) assess how the health schemes work for them, or do not work for them, and what do they feel would improve their access? For those who implement such programmes, what in their view are the main barriers to implementation, and how do these differ or correspond to those of the workers themselves?

Moderator: **Francie Lund**, Director, Social Protection, WIEGO, United Kingdom

Speakers: the authors of the three case studies
- **Laura Alfers**, Researcher, WIEGO, United Kingdom – Ghana National Health Insurance Scheme
- **Kalpana Jain**, Health Journalist, India – India National Health Insurance Scheme, and one large non-governmental scheme
- **Boonsom Namsomboon**, Secretary General, HomeNet, Thailand – Thailand Universal Health Scheme

Panelists: experts on health insurance and health care for the poor
- **Chris Atim**, Senior Health Economist, The World Bank, Senegal
- **Mirai Chatterjee**, Director of Social Security, Self Employed Women's Association (SEWA), India

12:30-14:00
Lunch

14:00-15:00
Plenary session 4
Achieving universal coverage: a key role of health systems

Background:
Countries can move closer to universal coverage by adjusting their health financing systems in one or more of the following ways - raising additional funds for health, reducing financial barriers to access and spreading financial risks through prepayment and pooling, and using resources more efficiently and equitably. While financing changes by themselves are necessary, by themselves they are not sufficient to ensure the ultimate objectives of improved coverage with needed health services and reduced impoverishment or financial hardship associated with direct out-of-pocket health payments. Health insurance, for example, will not result in population health improvements unless the services that people need are available and of good quality. Good quality services will not be available without skilled and motivated health workers located in the right places, or without the appropriate medicines and technologies. This session will focus on how countries seeking to improve their health financing systems in the search for universal coverage are addressing the other parts of the health system as well. The session will begin with a presentation from a minister representing a country that has substantially modified its health financing system in the search for universal coverage, describing what complementary actions they needed to take in service delivery, quality of care, health infrastructure, access to medicines, and in the health workforce. This will be followed by a moderated panel discussion consisting of one central government representative, one district health officer, and one civil society representative from a lower income country. The two government representatives will reflect on the key components of the health system that need to be strengthened in their settings to accompany health financing chances. The panelist from civil society will reflect on what people need and expect and special issues of groups such as migrants.

Objectives:
- To highlight the need to strengthen all parts of the health system if health financing reforms designed to move closer to universal coverage are to result in improved health, the ultimate objective.
- To learn what countries have done to ensure complementarity between health financing and other health systems reforms. Because the roles of central and subnational governments differ in decentralized systems, representatives of both levels of government will participate.
- To understand how the different components of change are viewed by the people who should benefit from them.

Moderator: **Carissa Etienne**, Assistant Director-General, Health Systems and Services, World Health Organization, Switzerland

Speakers: **Andrei Usatii**, Minister, Ministry of Health, Republic of Moldova

Panelists:

- **Samrit Srithamrongsawat**, Director, Health Insurance System Research Office, Thailand – How other parts of the health system had to adjust to ensure that the financing changes associated with the UC scheme translated into increased availability and quality of services in Thailand.
- **Evelyn Ansah**, Deputy Director, Research and Development Division, Ghana Health Services, Ghana – The perspective of a district health system and how they have to adapt to health financing changes developed at the central level.
- **Narayanan Devadasan**, Director, Institute of Public Health, India – How health financing changes affect people and whether they are meeting people's needs and expectations.

15:00-15:30
Coffee Break

15:30-17:30
Parallel Session 4.1
Measuring the impact and outcome of universal coverage

Background:
The outcome of Universal Coverage (UC) has three components: the first two are access to needed health interventions of good quality and the existence of financial risk protection. The third is the proportion of the population covered by the first two dimensions where particular attention needs to be placed on the poor and vulnerable. Understanding what universal coverage means (including how disease-specific coverage targets relate to the concept of UC) and where countries are in relation to universal coverage is a critical step to inform health financing policies and reforms. Monitoring progress is critical to understand if these policies and reforms are working. This session will focus on outcome and impact evaluation of financing policies for UC after a brief discussion of what is meant by UC from a health financing perspective.

Objectives:

- Present a framework for monitoring UC;
- Demonstrate evidence from countries who have undertaken UC monitoring and analysis showing its impact and outcomes;
- Discuss the evidence linking these outcomes with health financing polices and reforms and broader social protection efforts in the countries.

Chair: Masato Mugitani, Assistant Minister for Global Health, Ministry of Health, Labour and Welfare, Japan

Moderator: David B. Evans, Director, Health Systems Financing, World Health Organization, Switzerland

Speakers:

- **Peter C. Smith**, Professor of Health Policy and Co-Director of the Centre for Health Policy, Imperial College Business School, United Kingdom – A framework for evaluating progress towards universal coverage.
- **Supon Limwattananon**, Associate Professor, Khon Kaen University, and Senior Researcher, International Health Policy Program (IHPP), Thailand – "The framework and results of the review of the Thailand UC scheme"
- **Van Tien Tran**, Vice Director of Health Insurance Department, Ministry of Health, Vietnam – How is Vietnam monitoring and assessing its progress towards UC?
- **Peter Annear**, Senior Research Fellow, Nossal Institute for Global Health, University of Melbourne, Australia – Cambodia and Laos

Panelist: Yogesh Rajkotia, Managing Director, Institute for Collaborative Development, Bangladesh

---

15:30-17:30
Parallel Session 4.2
Resource scarcity, efficiency and coverage with health services

Background:
Universal coverage has three dimensions – the proportion of the population, the proportion of health services, and the proportion of the costs covered. Resource constraints mean that no country has yet been able to ensure that everyone can gain immediate access to every health service that could possibly extend life or increase the quality of life at zero out of pocket cost. Some form of rationing always takes place. Sometimes particular population groups – e.g. the poor, or the vulnerable – are excluded from a wide range of health services because they must pay on the spot. Frequently, tradeoffs are made between the types of health services and medicines that are made available and the proportion of the costs that people are asked to meet out of their own pockets. Even if active steps are taken to improve efficiency, perhaps through active purchasing or by modifying provider payment mechanisms, these tradeoffs still have to be made. Sometimes the tradeoffs are specified explicitly – for example, a benefits package is defined showing the health services (and medicines) that will be available (and, by implication, those that will not be available). Sometimes the implications of the tradeoffs are not so explicit – e.g. waiting lists are used to adjust to resource constraints, or only a limited set of health services are available to the population although these services are not explicitly specified.

Objectives:
The objectives of this session are to explore the various ways that countries decide what health services should be universally available, or have first versus last dollar protection, and the link between these choices and questions of efficiency.

Chair: Poonam Singh, Deputy Regional Director, World Health Organization, South East Asia Regional Office, India
Moderator: Tan-Torres Edejer, Coordinator, Health Systems Financing, World Health Organization, Switzerland

Speakers:
- **Manuel Inostroza Palma**, Director of Clinical Campus and Director of the Master of Public Administration (MPA), Andrés Bello University, Chile – After many years where the benefits package was not explicitly stated, Chile introduced recently a specified benefits package which everyone has the right to obtain. The talk will focus on the historical reasons for this change, and the impact particularly the links with efficiency and equity. It will compare the earlier situation of an unspecified package with the current situation.
- **Rozita Halina Tun Hussein**, Deputy Director, Unit for National Health Financing, Planning and Development Division, Ministry of Health, Malaysia – The advantages and disadvantages of explicit and implicit benefits packages.
- **Winai Sawasdivorn**, Secretary General, National Health Security Office, Thailand – Provider payment methods and efficiency questions linked with deciding on which benefits should be made universally available and at what cost to beneficiaries

Panelists:
- **Kara Hanson**, Reader, Health System Economics, London School of Hygiene and Tropical Medicine, United Kingdom
- **Naoki Ikegami**, Professor, Keio University School of Medicine, Japan

---

15:30-17:30
Parallel Session 4.3
Provider payment: aligning proper incentives and efficiency

Background:
To a large extent, the pressures for cost-containment are attributable to the higher growth rate of health spending compared to the country's aggregate income. One reason is that because of aging society which requires more health services and the advancement of medical technology resulting in more expensive medical care. Interventions for cost-containment through appropriate provider payment methods are deemed necessary when 'capacity to pay' of the country's economy as a whole is lower than the costs of the

population's health care requirement. In general, the latter relates to budget constraints in the public sector as well as to limits on what households can afford to allocate to health from their incomes.

Both developed and developing countries have struggled to curb their public spending on health care through the use of both demand-oriented and supply side regulations. Empirical evidence indicates that the simultaneous use of different provider payment methods can restrain expenditure on health, while maintaining good quality care and equitable access to services. Regulatory commitment is necessary to maximize the efficiency of these tools.

It is widely accepted that the level and structure of provider payments are a core element for influencing providers' behavior. To pay providers has been an area of contention among policy makers. The most prevalent provider payment methods among developing countries are salaries, fee-for-service payments, diagnosis related groups (DRG), capitation or per-diem payments. Another way of paying providers is via a budget remunerating a set of pre-defined health-related activities in a lump-sum fashion. In this regard, there is a need to review country experiences in the strengths and weaknesses of different provider payment methods, and how to establish the regulatory systems to mitigate negative impact of each payment method.

Objectives:

- To review international experiences on positive and negative impact of implementation of different provider payment methods towards health care systems including provider's responses,
- To discuss country experiences on health care costs and resources use, access to care, patients' and professional's behaviour (moral hazards) and health outcome of different provider payment methods in particular, open ended and close ended methods.
- To highlight a country experiences on appropriate provider payments aiming for efficiency and quality achievements.

Chair: Sudha Pillai, Member-Secretary, Planning Commission, Government of India

Moderator: Cheryl Cashin, Lead, Provider Payment Track, Joint Learning Network for Universal Health Coverage, Results for Development Institute, USA

Speakers:

- **Christopher D. James**, Technical Officer in Macroeconomics and Health, World Health Organization, Philippines – The impact of different provider payment methods on incentives and efficiency achievements: International perspectives

- **Martin Edgar Braun**, Expert and Consultant for Public Health, Health Care Management, Germany – Country experiences in implementing DRG: Germany
- **Ainura Ibraimova**, Regional Health Finance and HSS Director, USAID Quality Project, Kyrgyzstan – Country experiences in implementing capitation for primary health care providers and other provider payment methods in Kyrgyz Republic
- **Qingyue Meng**, Dean, School of Public Health, Peking University, China– Country experiences in implementing fee for services in China
- **Irene Akua Agyepong**, Regional Director of Health Services, Accra Regional Ghana Health Service, Ghana – Country experiences in implementing new provider's payment methods in Ghana

Panelist: Joseph Kutzin, Coordinator, Health Financing Policy, World Health Organization, Switzerland

---

15:30-17:30
Parallel Session 4.4
Using financing as a platform for quality improvement

Background:
As new health financing schemes emerge, particularly those that contract with private and public providers to purchase care, it is important to consider how these schemes can influence quality of care. This is particularly relevant as countries pursuing universal health coverage look to not only increase breadth of coverage, but to provide depth of service with respect to quality. Third party purchasing can align incentives, but in practice, higher quality is not always the result.

This session will explore how purchasing agencies can support quality improvement in a legitimate and affordable fashion. Based on work undertaken by the Joint Learning Network, the session will provide an overview of possible mechanisms, ranging from development and monitoring of performance indicators, and facility accreditation, to more sophisticated pay-for-performance mechanisms. It will describe the range of options available to countries as well as the potential to use complementary approaches tailored also to a country's stage of development. The group will then discuss three specific country experiences with designing and implementing such programs.

Objectives:
- Provide an overview of specific interventions and financing mechanisms that can be used by health financing agencies to influence quality of care
- Discuss the experience of three countries implementing such interventions

Moderator: Kalipso Chalkidou, Director, National Institute for Health and Clinical Excellence, United Kingdom

Speaker: Pierre Barker, Senior Vice President, Low and Middle Income Countries Program, Institute for Healthcare Improvement (IHI), USA

Panelists:

- **Yogan Pillay**, Deputy Director General, National Department of Health, South Africa
- **Mei-Shu Lai**, Professor, College of Public Health, National Taiwan University, Taiwan
- **Anuwat Supachutikul**, CEO, Healthcare Accreditation Institute, Thailand
- **Gerard La Forgia**, Lead Health Specialist, The World Bank, USA

15:30-17:30
Parallel Session 4.5
Ageing populations: What challenges for health financing?

Background:
Population aging is a global issue that is affecting or will soon affect virtually every country around the world. In most of the 228 countries in the world, the increase in child population dominated the changes in age structure between 1950 and 1975. The increase in the working-age population is the dominant change between 1975 and 2015. After 2015, the increase in the 60+ population will be greatest in over half of the world's countries.

Population aging affects health care financing: As there are more elderly at each age relative to the working age population and as average annual costs of health care rise steeply with age, there will be a greater share of the population with higher care needs and a lower proportion of the population of working age to finance this care for the elderly. Most health systems suffer from a similar problem to that faced by PAYGO pension programs – they have no problem paying for the elderly while the population is young, but this becomes harder once the population ages.

Population aging also affects long term care: As individuals age, they are at increasing risk of functional impairments and disability. Their state in this regard is generally measured by their loss of capacity for ADLs (Activities of daily living). Need for nursing home care or other intensive care is strongly related to the number of ADLs of an individual. Research from OECD countries show that some countries (but not all) are succeeding at extending the healthy life of the elderly, but even where this is successful, long term care becomes a major factor for those in their 80s and older.

Population aging further increases the need for risk pooling. Increasing longevity and low fertility increase certain risks for adult children and for their elderly parents. Through

cultural norms and altruistic linkages, risks for the parents become risks for their adult children. With falling fertility, many elders will have no surviving children in a position to provide care and support, and some adults will have multiple elderly parents requiring care; thus elder reliance on familial old age support is risky. New systems become necessary to pool these kinds of individual risk.

Objective:
To raise awareness about the impact of population aging on financing health care and long term care

Moderator: Daniel Cotlear, Lead Economist, The World Bank, USA

Speakers:

- **Ajay Mahal**, Alan & Elizabeth Finkel Chair of Global Health and Professor, School of Public Health, Monash University, Australia – Financing health care
- **Christian Peters**, Head of the Department for Ambulatory Care, Federal Association of AOK, Germany – Financing long-term care
- **Hideki Hashimoto**, Professor, School of Public Health, University of Tokyo, Japan – Reliance on family vs state for elderly support

---

15:30-17:30
Parallel Session 4.6
Giants Racing Towards UHC: Health Financing Reforms in China and India

Background:
Both China and India are moving rapidly to expand health coverage for their populations, backed by ambitious financing schemes supported with significant increases in public expenditures. As the two most populous nations on earth, together accounting for more than a third of all humans on the planet, these efforts by India and China are unprecedented and hugely important for all of us.

What exactly are the two countries doing to attain UHC? What are the salient similarities and differences? What are their main motivations, and what are the potential gains as well as the downside risks faced by China and India as they implement these ambitious health financing reforms?

The session will aim to elucidate the key dimensions of recently implemented health systems changes in China and India, as well as the two countries' policies and plans for the rest of the current decade. Key issues that may be broached in the proposed "Davos" style session (need to select just a few of those listed below) may include: (1) what was

the underlying political and economic motivation behind the current UHC reforms? (2) how to expand enrollment and population coverage to hundreds of millions in just a few years? (3) how to design and implement center-state fiscal transfers that are fair, sustainable, and drive improvements in efficiency and quality of care? (4) whether/how to engage private as well as public providers under tax-financed insurance, and to use private intermediaries in some roles in managing the demand side? (5) how to design a benefits package that prioritizes outpatient and preventive care? (6) what have been the largest difficulties and obstacles to achieving UHC, and how are these being addressed?

Objectives:
At the end of the session, participants should: (a) understand more clearly the similarities and differences across the ongoing and planned health reforms in India and China, and how these are intended to enable both countries to achieve UHC; (b) have a better grasp of the top 3-5 challenges facing the two countries, and of how national leaders are trying to address them; and (c) be able to highlight some of the lessons from India and China that could be relevant to other countries moving toward UHC, especially those rapidly growing middle income countries with significant informal sectors and segments of population living in poverty.

Moderator: **Robert Hecht**, Managing Director, Results for Development Institute, USA

Panelists:

- **Mirai Chatterjee**, Director of Social Security, Self Employed Women's Association (SEWA), India
- **K. Srinath Reddy**, President, Public Health Foundation, India
- **Wen Chen**, Professor of Health Economic and Deputy Dean, School of Public Health, Fudan University, China
- **Anne Mills**, Vice Director for Academic Affairs and Professor of Health Economics and Policy, London School of Hygiene and Tropical Medicine, United Kingdom
- **John Langenbrunner**, Lead Economist, The World Bank, USA

Saturday 28 January 2012

09:00-10:00
Synthesis: summary, conclusion & recommendations

10:00-10:30
Coffee Break

10:30-12:00
Plenary session 5
Ministerial Round Table: Advancing UHC Agenda

Background:
Given the importance of universal coverage as a means towards achieving health related MDG and equitable health outcome, how high, middle and low income countries with different paces of health systems development in particular health care delivery systems, human resource for health, fiscal capacities, and political context, advance the UHC agenda and beyond.

China, Germany and Thailand had achieved universal coverage for the whole population, what are the remaining challenges in these three countries and how to move forwards in better financial protection to the population in a sustainable way.

Rwanda and Vietnam are at advanced stage of Universal coverage movement, what are the current policy challenges and how to overcome them in order to achieve the UHC goals?

Experiences from countries who are the Founding Members of Foreign Policy and Global Health namely Brazil, France, Indonesia, Norway, Senegal, South Africa, and Thailand who place importance of life and health of population in their foreign policies and different pace of health systems and universal coverage development have much to share with international audiences in this important conference.

Objectives:
Minister of Health's reflections on challenges and strategies in moving UHC agendas or beyond even UHC has been achieved.

Moderator: Lincoln Chen, President, China Medical Board, USA

Panelists:

- **Enrique T. Ona**, Secretary of Health, Department of Health, Philippines
- **Peter Anyang' Nyong'O**, Minister, Ministry of Medical Services, Kenya
- **Ali Ghufron Mukti**, Vice Minister, Ministry of Health, Indonesia
- **Aaron Motsoaledi**, Minister, Ministry of Health, South Africa
- **Wittaya Buranasiri**, Minister, Ministry of Public Health, Thailand

12:30-13:00
Closing session

13:00-14:00
Lunch

14:00 Onwards
PMAC 2012 & PMAC 2013 International Organizing Committee Meeting

Keynote Session

Ruth Bishop

Professorial Fellow
Murdoch Childrens Reserch Institute
Australia

Professor Ruth Bishop AO,DSc,FASM,FRACP (Hon)
Professorial Fellow, Murdoch Childrens Research Institute,RCH,
Professorial Fellow, Department of Paediatrics, University of Melbourne

Professor Ruth Bishop graduated from the University of Melbourne with a B.Sc, majoring in Microbiology and Pathology. She began a research career focussing on the microbiology of the intestinal tract of young children in health and disease, gaining a PhD, and later a DSc. After early studies on the involvement of abnormal gut flora in conditions associated with fat malabsorption, she became interested in carbohydrate malabsorption, particularly associated with acute gastroenteritis in young children who had been admitted for treatment at the Royal Children's Hospital in Melbourne. Dr. Rudge Townley and Dr. Graeme Barnes had identified acute inflammation of the duodenal mucosa in these young children. Ruth Bishop then assembled a team to re-examine ultrathin sections of duodenal mucosa using electron microscopy. This revealed the presence of a 'new virus", now known as rotavirus. This virus was subsequently shown to be the single most important cause of severe acute "life-threatening" diarrhoea in young children worldwide. Ruth and her team at the RCH,Melbourne have undertaken many studies investigating the immunology and epidemiology of rotavirus infection. Evidence that the initial rotavirus infection was followed by immunity to severe life-threatening disease on later reinfection became the strategy for vaccine development. The development of live oral vaccines has led to successful prevention of severe rotavirus disease in many countries. Today the challenge is to extend vaccination to developing countries where lives of young children due to rotavirus infection are still at risk.

Ruth Bishop served as a Consultant to WHO, Geneva, and headed the WHO Rotavirus Reference Laboratory for many years. She has received Awards that include the Pasteur Award, Children's Vaccine Initiative, Clunies Ross National Science and Technology Award, Warren Haynes Memorial Award, White Flame Award, Save the Children Fund. She has received an Honorary Fellowship, Royal Australasian College of Physicians, Honorary Life Membership Australian Society for Microbiology.

Varshaben Jayantibhai Thakor

Board Member
National Insurance VimoSEWA Cooperative Ltd.
India

Address: Thakor Vaas, Navapura Village, P.O.Timba,
Taluka Daskroi, Ahmedabad District,
Gujarat, India

Education: upto 7th Standard

Occupation: Farmer and raising livestock

Work Experience:

November 2009 – present Board Member
National Insurance VimoSEWA Cooperative Ltd, India's first women-owned and managed insurance cooperative.

2010 – present Committee member, Village Health & Sanitation Committee. Responsible for health and sanitation activities in Navapura.

2001 – present Health worker for Navapura village and five other villages. Main services provide:

- Health education
- Referral care
- Linking with and facilitating access to government and private health providers and facilities.
- Primary health care, including sale of low cost medicines, allopathic and Ayurvedic.
- Selling insurance for VimoSEWA
- Monitoring government programmes like the Rashtriya Swasthya Bima Yojana (RSBY), the government's health insurance.

Plenary Session 1

Universal Health Coverage:
Utopia or Mirage to Human Development?

Peter Anyang' Nyong'O

Minister
Ministry of Medical Services
Kenya

PROF. PETER ANYANG' NYONG'O

B.A., Political Science and Philosophy (First Class Honors), Makerere University, Kampala, 1971
M.A., Political Science, University of Chicago, 1974
Ph.D., Political Science, University of Chicago, 1977
Minister for Medical Services
Afya House
Cathedral Road
P.O. Box 30016-00100
Nairobi, Kenya
Tel. 254-020-2271077
Fax.254-020-2719008
Mobile: +254-724-264703

Present Positions

- Minister for Medical Services, Government of Kenya (2008 to date)
- Secretary General, Orange Democratic Party (ODM)
- Member of Parliament, Kisumu Rural Constituency
- Member, Committee of Experts on Public Administration (CEPA) of the Economic and Social Council (ECOSOC) of the United Nations Organization
- Member, Board of Directors of the Nelson Mandela Institution for Science, Technology and the Advancement of Knowledge in Africa
- Director, African Research and Resource Forum (ARRF), Nairobi, Kenya.
- Fellow of the African Academy of Sciences
- Member, Board of Directors of the *African Monitor*

Previous Positions

- President, Makerere Students Guild, 1969/70
- Special Lecturer, University of Nairobi, Department of Government, 1971
- Rockefeller Fellow, Universities of Nairobi and Chicago, 1971-1977.
- Lecturer and Senior Lecturer, Political Science and Political Economy, University of Nairobi, 1977-82.

- Associate Research Professor, Center for African and Asian Studies, El Colegio de Mexico, Mexico D.F., 1981-84.
- First Officer (P4), Department of Special Political Affairs, Office of the Under-Secretary General for Special Political Affairs, UNO, Dec. 2003-June 2004.
- Associate Professor, College of Social Sciences, Addis Ababa University, Ethiopia, 1984-86.
- Research Professor, East and Southern Africa Management Institute (ESAMI), Arusha, Tanzania, June 1986-July 1987,
- Head of Programs, African Academy of Sciences, 1987-1992.
- Member of Parliament, 1993-present.
- Minister for Planning and National Development, Kenya, 2003-2005.

Honors

- German-African Award for contribution to scholarship and democratization, 1995.
- Africa Brain Gain Award, by Kenyan American Professional Association and Career Nation, 2005.
- Fellowship of the African Academy of Sciences, 1989.

Major Publications

Articles in Journals

- "The Civil Servant in Uganda," *East African Journal,* (April 1971).
- "The Agrarian Question in Kenya", guest editor and contributor, *Review of African Political Economy No. 20,* 1981.
- "An African Perspective on Peace and Development in Africa", *International Social Science Journal,(UNESCO: Paris,* 1986).
- "Military Intervention in African Politics", *Third World Affairs,* (London: Third World Foundation,1986).
- "Democracy and Political Stability in Africa," *Africa Development ,XII,1986*
- **"**Political Stability and the Prospects for Development in Africa," *Africa development, XIII, 1988*
- **"**Crises and Conflicts in the Horn of Africa," *Geneve-Afrique, Vol. XXVII, No.2,* 1989
- "State and Society in Kenya: The Disintegration of the Nationalist Coalitions and the Rise of Presidential Authoritarianism, 1963-78," *African Affairs, Vol. 88* (1989).
- "Africa: The Failure of One-Party Rule," *Journal of Democracy Vol. 3, No. 1 (*January 1992).
- "Comprehensive Solutions to Refugee Problems in Africa: Bilateral, Regional and Multilateral Approaches," *International Journal of Refugee Law* (Special Issue), 1995.

- "Governance, Security and Conflict Resolution in Africa," *Diogenes, No.184, Vol. 46/4,* 1998.
- "Parliaments, Parliamentary Democracy and Building Democracy in Africa," *United Nations Economic Commission for Africa,* Special Consultative Paper (Addis Ababa, 2000).

Chapters in Books

- "South Africa and Israel as Settler Regimes," in I. Abu Lughod (ed.) *Settler regimes in Africa and the Arab World: the Illusion of Endurance* (The Medina University Press International, 1975).
- "The Possibilities and Historical Limits of Import Substitution Industrialization in Kenya," in P. Coughlin and G. Ikiara (eds.), *Industrialization in Kenya: In Search for a Strategy (*Nairobi: Heinemann, 1985).
- "The Military and Counterrevolution in Liberia: 1980-85," in P. Anyang' Nyong'o (ed.) *Popular Struggles for Democracy in Africa,* (London: Zed Books, 1987).
- "Alliances Populaires, militaries et counter-revolution au Liberia, de 1980 a 1985," dans
  P. Anyang' Nyong'o (dir.), *Afrique: La Longue Marche vers la Democratie,* (Paris: Editions Published, 1988).
- **"**Regional Integration in Africa" in P. Anyang' Nyong'o (ed.) *Regional Integration: An Unfinished Agenda,* (Nairobi: Academy Science Publishers, 1990).
- "The One-Party State and Its Apologists," in P. Anyang' Nyong'o (ed.) *Thirty Years of Independence in Africa: The Lost Decades?* (Nairobi: Academy science Publishers, 1992.
- "Regional Integration, Security and Development in Africa," in Olusegun Obasanjo and Felix Mosha (eds.) *Africa: Rise to Challenge, (*Lagos: Africa Leadership Forum, 1992).
- La participation popular y el desafio de la autosuficiencia en Africa, in Celma Ahuero Dona (ed.) *Africa: Inventando el Futuro (*Mexico: El Colegio de Mexico, 1992).
- "Privatization in Africa: the Kenyan Experience in a Comparative Perspective," in P. Anyang' Nyong'o (ed.) *The Context of Privatization in Kenya* (Nairobi: Academy Science Publishers, 2000).
- "Issues and Problems in the Implementation of Privatization," in Anyang' Nyong'o (ed.), ibid.
- "Challenges for Transitional Politics in Kenya," in A. Ghirmaizon (ed.) *In Quest for a Culture of Peace in the IGAD Region* (Nairobi: Heinrich Boll Foundation, 2006).

Books

- *Popular Struggles for Democracy in Africa* (ed.) (London: Zed Books, 1987).
- *Afrique: La Longue Marche Vers la Democratie* (Paris: Editions Publisud, 1988).
- *Economic Integration in Africa: An Unfinished Agenda* (Nairobi: Academy Science Publishers, 1989).
- *La Politica Africana y la Crisis del Desarrollo* (Mexico: El Colegio de Mexico, 1988).
- *Estado y Sociedad en el Africa Actual* Mexico: El Colegio de Mexico, 1988).
- *Industrialization at Bay: African Experiences* (Nairobi: Academy Science Publishers, 1990).
- *Thirty years of Independence in Africa: The Lost Decades* (Nairobi: Academy Science Publishers, 1992)
- *Arms and Daggers in the Heart of Africa: Studies on Internal Conflicts* (Nairobi: Academy Science Publishers, 1993)
- *The Context of Privatization in Kenya (*Nairobi: Academy Science Publishers, 2000).
- *The Study of African Politics: A Critical Appreciation of an Intellectual Heritage* (Nairobi: Heinrich Ball, 2002).
- (With A. Ghirmazion and D. Lamba) *NEPAD: A New Path? (*Nairobi: Heinrich Boll Foundation, 2006).
- (With Michael Chege)*Winning the Peace and Starting (Re)construction in Southern Sudan (N*airobi: ARRF Conference Series No. 3, 2004).
- *The Political Economy of Corruption in Kenya* (Nairobi: ARRF, 2006).
- *A Leap into the Future: A Vision for Kenya's Socio-Economic Transformation* (Nairobi: ARRF Press, 2007).

Fran Baum

Director
Southgate Institute
and South Australian Health Community
Health Research Unit (SACHRU)
Flinders University
Australia

Fran Baum is Professor of Public Health and an Australia Research Council Federation Fellow at Flinders University, Adelaide. She is also Foundation Director of the Southgate Institute for Health, Society and Equity & the South Australian Community Health Research Unit. She is Co-Chair of the Global Steering Council of the People's Health Movement – a global network of health activist (www. phmovement.org).She also served as a Commissioner on the World Health Organisation's Commission on the Social Determinants of Health from 2005-08. She is a member of the steering committee for the Asia Pacific Health GAEN, a group working to implement the recommendations from the CSDH. She is a Fellow of the Academy of the Social Sciences in Australia and of the Australian Health Promotion Association. She is a past National President and Life Member of the Public Health Association of Australia.

Fran Baum is one of Australia's leading researchers on the social and economic determinants of health. She holds grants from the NH & MRC and the ARC which are considering aspects of health inequities and social capital, neighbourhoods and work. She has been involved in the Australian and international Healthy Cities Movement and from 2005-2009 was a program leader with the Co-operative Research Centre in Aboriginal Health. Her book, *The New Public Health* (3rd edition 2008 Oxford University Press), is widely used as a public health text.

Daniel Cotlear

Lead Economist
The World Bank
USA

Daniel Cotlear is Lead Economist at the Health, Nutrition and Population Unit in the Human Development Network. He holds a PhD in Economics from Oxford University, a Master's Degree from Cambridge University and a Bachelor's Degree from the Catholic University of Peru. Prior to his current appointment, he was the Lead Economist at the World Bank's Human Development Department for Latin America and the Caribbean Region. Prior to that, within the World Bank he was Sector Leader for Human Development covering the Andean Countries. He has also served as health economist for Latin America, as macroeconomist in the Central America Department and as Agricultural Economist in the Southern and Eastern Africa Department. Before joining the Bank he was an advisor at the Ministry of Agriculture of Peru, university lecturer and author of several publications including a book on poverty reduction in the Peruvian Sierra.

Carissa Etienne

Assistant Director-General,
Health Systems and Services
World Health Organization
Switzerland

Dr. Carissa F. Etienne assumed the role of Assistant Director-General for Health Systems and Services in February 2008. Prior to that, she was the Assistant Director of the Pan American Health Organization. As Assistant Director in PAHO from July 2003, she directed five technical areas - health systems and services; technology and health services delivery; health surveillance and disease management; family and community health; and sustainable development and environmental health.

A national of Dominica, Dr. Etienne began her career as a medical officer at the Princess Margaret Hospital in her country, where she eventually became the Chief Medical Officer. Other high-level posts she has held include the Coordinator of Dominica's National AIDS Programme, Disaster Coordinator for the Ministry of Health of Dominica, Chairperson for the National Advisory Council for HIV/AIDS and the Director of Primary Health Care for Dominica.

Dr. Etienne received her MBBS degree from the University of the West Indies, Jamaica, and her M.Sc. degree in community health in developing countries from the University of London.

TIEN NGUYEN THI KIM

Minister
Ministry of Health
Vietnam

Family name: NGUYEN THI KIM First name: TIEN
Birth day: August 1st, 1959
Nationality: Vietnamese
Situation of family: married
Occupation: Medical Doctor
Position: Minister - Ministry of Health, S.R. Vietnam
Member of Party's Central Committee of Vietnam
Member of the parliament of Vietnam

OFFICE ADDRESS
138A Giang Vo, Ba Dinh Distric, Hanoi, Vietnam
Telephone: 84-4-62732368 Fax: 84-4-68464051
E-mail: kimtien.moh@vnn.vn

EMPLOYMENT RECORD

University education:

1976 – 1982: Medical student, Faculty of Medical in Hanoi, Vietnam

Post graduated education:

1982 – 1985: Internal doctor specialized in Epidemiology and public Health, Faculty of Medicine in Hanoi, Vietnam
1990 – 1995: Ph.D. in Epidemiology, Faculty of Medicine in Ho Chi Minh City, Vietnam
1993 – 1994: Master in Epidemiology and Public Health in Bordeaux II University, France.

Duration, occupation and name of institution:

1985 – 1987: Teacher on epidemiology, Epidemiology Department, Faculty of Medicine, Hanoi, Vietnam
1987 – 1993: Epidemiologist, in charge of program management for control of diarrhoeal diseases and dengue haemorrhagic fever, Epidemiology Department, Pasteur Institute, Ho Chi Minh City.
1993 – October 1998: Vice chief of Planning Department, responsible to research and Cooperation of Pasteur Institute, Ho Chi Minh City Member of Scientific Council of

Pasteur Institute, Ho Chi Minh City
November 1998 to January 2002: Deputy Director of Pasteur Institute, in charge of planning, Research, Training January
2002 to February 2007: Director of Pasteur Institute Deputy Director of National Program for Control Dengue and dengue Haemorrhage fever
2007 to July 2011: Vice Minister of Ministry of Health, Vietnam
July 2011 to Presence: Minister of Health, Vietnam
2011 to presence: Member of Vietnam Central Party's Committee
Presence: Member of the National Assembly

PUBLICATIONS:

Publications in Vietnam Journal:

1 Nguyen Kim Tien L'influence de la pollution d'air sur l'évolution des maladies dans la région industrielle de l'usine super phosphate de Lamthao. 1984. Rapport annuel des travaux scientifiques de la Faculté de Médecine de Hanoi: 71-78.

2 Nguyen Kim Tien. Iceberg en épidémiologie de la fièvre de dengue hémorragique de la population à Hanoi 1985. Rapport annuel des travaux scientifiques de la Faculté de Médecine de Hanoi: 32-38.

3 Do Quang Ha, Nguyen Kim Tien, et al Epidemic of dengue haemorrhagic fever in South Vietnam: Epidemiological and virological studies, 1987. Dengue News Letter. WHO. Volume 14, February 1989: 46-59.

4 Nguyen Kim Tien. Association entre le mode d'alimentalion et les maladies diarrhéiques chez les enfants de moins de deux ans à Ho Chi Minh ville: Etude Cas-témoins. J Hyg Epidemiol Ass Vietnam. 1993, Vol. 2. No 3(12): 25-8.

5 Nguyen Kim Tien. Le rôle de l'allaitement au sein dans la prévention des maladies diarrhéiques chez les nourrissons de moins de six mois à Ho Chi Minh ville. J Hyg Epidemiol Ass Vietnam, 1993. Vol. 3. No. 4(13): 31-6.

6 Nguyen Kim Tien, Ha Ba Khiem et al. Epidémiologie, Baclériologie, Résistance aux antibiotiques et Facteurs de risque d'une épidémie de typhoïde en 1993 au Sud du Vietnam. J Hyg Epidemiol Ass Vietnam, 1993. 2:5-8.

7 Nguyen Kim Tien, Pham Ngoc Thanh, Le Van Tuan. Facteurs de risque de la diarrhée persistante chez les enfants de moins de trois ans hospitalises au Sud du Vietnam. J Hyg Epidemiol Ass Vietnam, 1996, Vol. 6. No 2(27):80-85.

8 Nguyen Kim Tien, Do Gia Canh. Risk factors associated with diarrhoeal disease in children below 5 years of age and habits seeking for health care in community of Ho Chi Minh City. J Hyg Epidemiol Ass Vietnam 1997, Vol. VII. l(31): 37-43.

9 Nguyen Kim Tien. Huynh Thu Thuy. Le Hoang San. Survey on hygiene and environmental situation and diarrhoeal disease in children below 5 years of age in Cai Be district, Tien Giang province. Hygiene and Epidemiology Bulletin South Vietnam. November 1996: 24-25.

10 Nguyen Kim Tien. Pham Kim Sac. Ha Ba Khiem. A.L. Corwin. Epidemiological

role of E hepatitis virus in acute viral hepatitis in epidemic and endemic area. Hygiene and Epidemiology Bulletin South Vietnam. January 1997: 8-10.
11 Nguyen Kim Tien. Huynh Thu Thuy. Truong Xuan Lien. Rapport préliminaire de la surveillance de l'infection par le VIH d'une population des femmes enceintes représentatives de la grande agglomération d'Ho Chi Minh Ville 1995-1997. Bulletin d'hygiène and d'épidémiologie du Sud du Viet Nam. Feb 1997: 34-35.
12 Nguyen Kim Tien, Ha Ba Khiem, Pham Kim Sac, Corwin A.L. Epidemiological characters of hepatitis E virus in epidemic and epidemic areas, in An giang province, Vietnam (1995 - 1997). Hyg Epidemiol Ass Vietnam, Vol. VIII, 3 (33), 1997: 23 – 30.
13 Nguyen Kim Tien, Nguyen Van Tam, Nguyen Phuong Lan. Epidemiological characters of rota virus in acute and persistant diarrhea of children in Mekong delta (1993 - 1997). Hyg Epidemiol Ass Vietnam, Vol VIII, 3(37), 1998: 11-15.
14 Nguyen Kim Tien, Huynh Thu Thuy, Truong Xuan Lien, Tran Xuan Lap. Serological surveillance on HIV, HBV, Syphilis Toxoplasmose of pregnant women in Ho Chi Minh City (1995 - 1997). Hyg Epidemiol Ass Vietnam, Vol VIII, 3(37), 1998: 16 - 17.
15 Nguyen Kim Tien, Edward T. Clayson, Pham Kim Sac, Andrew L. Corwin, Khin S.A. Mint, David W. Vaughn. Detection antibody anti hepatitis virus E in some animal species (An Phu, An Giang, Vietnam). Hyg Epidemiol Ass Vietnam, Vol VIII, 4(38), 1998:39-42.
16 Huynh Ngoc, Nguyen Kim Tien. Application of computer system in technical and administrative management in Pasteur Institute. Full report in workshop on Medical information 1999, Medicine House: 120-135.
17 Nguyen Kim Tien. Study of transmission of Hepatitis virus E in school children cohort. Hyg Epidemiol Ass Vietnam, Vol. IX, 4(42), 1999: 38-42.
18 Nguyen Kim Tien, Huynh Thu Thuy. Knowledge – Attitude – Practice (K.A.P) survey on Dengue Haemorrhagic fever in Mekong Delta: 1998. Hyg Epidemiol Ass Vietnam, Vol. IX, 1(43): 2000: 20-25.
19 Nguyen Kim Tien, Huynh Thu Thuy, Le Hoang San. Risk factors associated to the duration of Diarrhea in children under 5 years of age at Cai be, Tien giang province. Hyg Epidemiol Ass Vietnam, Vol. X, 1(43), 2000:20 - 25.
20 Nguyen Kim Tien, Ha Ba Khiem, Tran Van Tien, Nguyen Thu Yen, Luong Chan Quang, Nguyen Thi Dan, Nguyen Thi Vui. Establishing the epidemiological surveillance system for infectious disease in Vietnam. Hyg Epidemiol Ass Vietnam, Vol. X, 1(43), 2000: 26-32.
21 Do Quang Ha, Ha Ba Khiem, Nguyen Kim Tien, Vu Thi Que Huong, Huynh Thi Kim Loan. Dengue fever/dengue haemorrhagic fever epidemic in Southern Vietnam, 1998. Hyg Epidemiol Ass Vietnam, Vol. X, 2(44), 2000: 10-14.
22 Nguyen Kim Tien, Nguyen Trong Toan. Character of DHF death cases in the south Vietnam 1999. Hyg Epidemiol Ass Vietnam, Vol. X, 3(45), 2000: 83-87.
23 Nguyen Thi Kim Tien, Do Quang Ha, Tran Khanh Tien, Luong Chan Quang. Predictive indicators for Forecasting Epidemic of Dengue/Dengue Haemorrhagic Fever

through epidemiological, virological and entomological surveillance. Collection of scientific research 1997-2000, Medical Publisher, 2000: 230-237.
24 Nguyen Kim Tien, Nguyen Trong Toan, Luong Chan Quang, Nguyen Ngoc Anh Tuan, Khau Minh Tuan. Character of DHF death cases in the south Vietnam 2000. Hyg Epidemiol Ass Vietnam, Vol. XI, 2(48), 2001: 63-67.
25 Nguyen Kim Tien, Nguyen Trong Toan, Luong Chan Quang, Nguyen Ngoc Anh Tuan, Khau Minh Tuan. Effectiveness of community based program for control DHF through health collaborator network. Hyg Epidemiol Ass Vietnam, Vol. XI, 2(48), 2001: 68-75.
26 Nguyen Kim Tien, Nguyen Trong Toan, Nguyen Huu Cuong, Vu Sinh Nam. Using mesocyclopes in community based program for control DHF in Kiengiang province. Hyg Epidemiol Ass Vietnam, Vol. XI, 3(49), 2001: 21-27.
27 Nguyen Thi Kim Tien, Nguyen Thi My Thanh, Luong Chan Quang, Surveillance and treatment for clearance on bacterial carriers of typhoid fever in community Cailay district, Tien giang province, 1998-1999. Hyg Epidemiol Ass Vietnam, Vol. XI, 3(49), 2001: 45-52.
28 Nguyen Thi Kim Tien, Luong Chan Quang et al. Detection and clearance treatment on typhoid fever patient in Cailay district (Tiengiang), 1998-1999. Hyg Epidemiol Ass Vietnam, Vol. XI, 3(49), 2001: 38-44.
29 Nguyen Thi Kim Tien, Nguyen Trong Toan. DHF epidemic and its active control method in the south Vietnam, 2000-2001. Hyg Epidemiol Ass Vietnam, Vol. XI, 4(51), 2001: 5-9.

Publications In international Journal:

1 Do Quang Ha, Nguyen Kim Tien et al. Epidemic DHF in South Vietnam, 1987. Dengue Newsletter WHO, 14: 46-57.
2 Chau Huu Hau, Tran Tinh Hien, Nguyen Thi Kim Tien, Ha Ba Khiem, Andrew L. CORWIN et al. Prevalence of enteric hepatitis A and E viruses in the Mekong River delta region of Vietnam. Am. J. Trop. Hyg. 60(2), 1999: 277-280.
3 Andrew L. Corwin, Nguyen Thi Kim Tien, Khanthong Bounlu, Jarot Winarno et al. The unique riverine ecology of hepatitis E virus transmission in South-East Asia. Transactions of the Royal Society of tropical medicine and Hygiene (1999) 93, 255-260.
4. Truong Xuan Lien, Nguyen Thi Kim Tien, G. Fraser Chan Pong, A. L. Corwin et al. Evaluation of Rapid diagnostic tests for the detection of Human immuno-deficiency virus types 1 and 2,
Hepatitis B surface antigen, and syphilis in Ho Chi Minh City, Vietnam. Am. J. Trop. Hyg. 62(2), 2000: 301-309.
4 Nguyen Thi Kim Tien, Do Quang Ha, Tran Khanh Tien, Luong Chan Quang. Predictive indicators for forecasting epidemic of Dengue/Dengue haemorrhagic fever through epidemiological, virological and entomological surveillance. Dengue Bulletin, Vol23,1999: 44-50.

Oral communications in international conferences:

1 Nguyen Thi Kim Tien. Experience in implementing the Oral Rehydration Therapy (ORT) and ORS distribution for management of diarrhoeal diseases in commune of South Viet nam. International workshop of program for control of diarrhoeal diseases. WHO, Manila, Philippines 7/1989

2 Nguyen Thi Kim Tien. Association between breast feeding and acute diarrhoeal diseases of infants below 6 months of age in Ho Chi Minh city: a case - control study. Journée scientifique de l' EPITER, Veyrier du Lac, France. 9/1992

3. Nguyen Thi Kim Tien, Chau Huu Hau, A.L. Corwin et al. Cross-sectional survey on Hepatitis

A.B.E in population in an area of Mekong delta, Viet nam. International Conference on Tropical Medicine. Nagasaki, Japan. 11/1996.

3 "Epidemiological characters of viral hepatitis E in epidemic and epidemic areas, in An giang province, Vietnam." Journée scientifique d' EPITER, à verier du Lac, France, September, 1997

4 "Detection of antibody anti HEV in some animal species, in Angiang, Vietnam." Scientific conference of American Society of Tropical Medicine and Hygiene, Orlando, Florida, December, 1997.

5 "Community based study on HEV transmission in An giang province, Viet nam 1995 -1998." Scientific conference of American society of tropical Medicine and Hygiene, Washington D.C, December, 1999.

6 "Epidemiological, virological, entomological of DF/DHF in Southern Vietnam 1998 – 1999 and setting research priorities for DF/DHF in Vietnam. WHO workshop, Geneve, January, 2000.

Toomas Palu

Sector Manager,
Health Nutrition and Population;
East Asia and Pacific Region
The World Bank
Thailand

Toomas Palu is the Health Sector Manager for the World Bank's South East Asia and Pacific Region. He has led World Bank health programs in Vietnam, Cambodia, Thailand and Laos and in several countries in Eastern Europe and Former Soviet Union. He has also served as a Director in the Estonia Social Health Insurance Fund Management Board and as a Deputy Director of the Tallinn Emergency Care Hospital in Estonia. His key qualifications and experience include health policy and health sector reforms in middle-income transition economies and health systems strengthening in developing countries. Toomas has a Medical Doctor degree from the Tartu University in Estonia and a Master of Public Administration degree from the Harvard University in the US.

Keizo Takemi

Senior Fellow

Japan Center for International Exchange

Japan

Keizo Takemi is a senior fellow at the Japan Center for International Exchange (JCIE), a fellow at the Sasakawa Memorial Health Foundation, and a professor of political science and economics at Tokai University. He was a research fellow at the Harvard School of Public Health from November 2007 to June 2009. Professor Takemi was a member of the House of Councillors (Liberal Democratic Party) in the Japanese Diet for 12 years until August 2007 and served in the Abe cabinet as senior vice minister for health, labour, and welfare. He led the initiative to establish the UN Trust Fund for Human Security when he was state secretary for foreign affairs in 1999 and was subsequently named by then UN Secretary-General Kofi Annan to serve as a member of the High Level Panel on UN System-Wide Coherence in Areas of Development, Humanitarian Assistance and Environment. Since September 2007, he has been serving as the chair of a policymaking platform for public and private partnership on global health, known as the study group on "Challenges in Global Health and Japan's Contributions" before it was restructured as the executive committee of JCIE's program on Global Health and Human Security in August 2009. In the global health field, he has been involved in various global initiatives, including the Commission on Information and Accountability for Women's and Children's Health (2010–2011); Global Health Workforce Alliance (2010–present), as a champion; WHO Expert Working Group on R&D Financing (2009–2010); and the International Organizing Committee of the Prince Mahidol Award Conference (2009–present).

Plenary Session 2

The complex nexus:
Political will, civil society and evidence in achieving UHC

Michael Cichon

Director, Social Security Department
International Labour Organization
Switzerland

Michael Cichon holds a Masters degree in Pure and Applied Mathematics (Technical University, Aachen, Germany), a Masters degree in Public Administration (Harvard University) and a Ph.D. in Economics (University of Göttingen, Germany). He is a member of the German Actuarial Association (DAV), and worked in the Planning Department of the German Ministry of Labour and Social Affairs in Bonn as an actuary for eight years before joining the Social Security Department of the ILO in 1986 as senior actuary and health economist. Between 1992 and 1995 he served as social security specialist on the ILO advisory team for Central and Eastern Europe in Budapest and provided social protection policy advice to governments and social partners in Central and Eastern Europe. Between 1995 and 2005 he was the Chief of the ILO's International Financial and Actuarial Service. In 2005 he was appointed Director of the ILO's Social Security Department. He writes on policy, financial, economic and governance issues related to social security and the global financing of social protection, and he teaches in the joint ILO/University of Maastricht Masters Programme in Social Security. He has undertaken and supervised technical cooperation assignments in social protection in over 30 ILO member countries worldwide. He and his wife have four children.

Timothy Grant Evans

Dean
James P Grant School of Public Health
BRAC University
Bangladesh

Tim Evans has an under-graduate degree in social sciences (University of Ottawa), a D.Phil in Agricultural Economics (University of Oxford on Rhodes Scholar), a Medical degree from McMaster University, and a research-residency in Internal Medicine at the Brigham and Women's Hospital in Boston with a joint appointment as a MacArthur post-doctoral fellow at the Harvard Center for Population and Development Studies. He was an Assistant Professor, International Health Economics, at Harvard School of Public Health as well as an Attending Physician at the Brigham and Women's Hospital. In 1997, he was appointed the Director, Health Equity at the Rockefeller Foundation in New York. He led the development of a range of programs from new drugs and vaccines for neglected diseases, to access to HIV treatment, disease surveillance, and the monitoring of inequities in health. He was a co-founding Board member of the Global Alliance on Vaccines and Immunization (GAVI) and the Global Forum for Health Research.

From 2003-2010 Tim was Assistant Director General-Evidence, Information, Research and Policy for the WHO. He pioneered institution-wide strategies for health systems, knowledge management and research and oversaw the annual production of the World Health Report. He led the global Commission on Social Determinants of Health and was a co-founder of partnerships for strengthening health systems including the Health Metrics Network; the Global Health Workforce Alliance; the World Alliance for Patient Safety and the Providing for Health Partnership. He is currently Dean at the James P. Grant School of Public Health at BRAC University and ICDDR,B in Bangladesh.

Heather Grady

Vice President, Foundation Initiatives
Rockefeller Foundation
USA

Heather Grady joined the Rockefeller Foundation in 2010. As Vice President for Foundation Initiatives, she sets strategic direction for the Foundation's broad initiatives of grant making and oversees initiatives on issues including climate change, employment, health and transportation. She provides vision, leadership and direction to help achieve the Foundation's mission to expand more equitable growth opportunities and build resilience, and oversees the Foundation's program staff, a diverse group of professionals working in the US, Asia and Africa.

Prior to joining the Rockefeller Foundation, Ms. Grady was the Managing Director of Realizing Rights: the Ethical Globalization Initiative, founded by former Irish President Mary Robinson. There she managed strategy and operations, and helped lead programs on employment, climate justice, corporate responsibility and women's leadership. Throughout her career Ms. Grady has managed development and humanitarian programs with Oxfam Great Britain and other international organizations, and has lived and worked for over twenty years in a diverse range of settings, including Viet Nam, China, Egypt, Sudan and the Gaza Strip.

She has written and taught on international development, human rights, and climate change, and served as an Adjunct Professor at Columbia. She is a member of the Global Philanthropy Committee of the Council on Foundations. She is conversant in Vietnamese and Chinese. Ms. Grady received a bachelor's degree from Smith College and a master's degree in Public Administration from Harvard University.

David Legge

Associate Professor, Teacher and Researcher
School of Public Health, La Trobe University
Australia

David Legge is a teacher and researcher in the School of Public Health at La Trobe University in Melbourne where he has been teaching health services management and health policy since 1995. He started his career as a physician but moved early on into health services research, health policy and public health. David has teaching and research interests in the political economy of health, comparative health systems, primary health care and international health policy. From 1998 to 2010 he directed the La Trobe China Health Program which is a research and teaching collaboration with a number of universities in China in the areas of health management and health policy. David has also been involved with the international People's Health Movement since its formation in December 2000 in Bangladesh. As well as being a member of the Steering Council of PHM David is the academic coordinator of the International People's Health University. This is a short course program in the political economy of health for health activists in low and middle income countries. Since the first course in Cuenca, Ecuador, in 2005 there have been 18 further IPHU courses in developing countries around the world with around 800 participants by end 2011.

Bheki Ntshalintshali

Deputy General Secretary
Congress of South African Trade Unions
(COSATU)
South Africa

Mr. Bheki Ntshalintshali is the Deputy General Secretary of the Congress of South African Trade Unions (COSATU).

Mr. Ntshalintshali also serves on a number of forums and institutions both nationally and internationally among others the following:
Internationally:

- He represents workers as at the International Labour Organisation (ILO) where he serves as a member of the Governing Body. He also serves as a Board Member as well as a the workers group spokesperson at the International Training Centre of the ILO
- He represents workers as part of the South African tripartite member at the African Union's Ministers of Labour and Social Affairs Commission
- He is a member of the African Union's Economic, Social and Cultural Council (ECOSOC)
- He represents his organisation at the World Social forum International Council
- He represents his organisation at the United Nation Commission on Sustainable Development as well as at the UNFCCC lobbying for positions that support the interest of workers and the working class.

Nationally:

- He serves as the organised Labour Convenor at National Economic, Development and Labour Council (NEDLAC) as social dialogue institution in which government, labour, business and community constituency meet and negotiate all socio and economic policies before parliament could consider them.
- He is the Deputy Chairperson of the Human Resource Development Council of South Africa. He also serves a Governing Body Member of the Commission for Conciliation, Mediation and Arbitration a body that deals with workplace disputes between employers and workers.
- He also serves as a commissioner at the Employment Condition Commission a body that sets up minimum wages and condition for vulnerable workers and advises the Minister of Labour on these matters.

Jon Ungphakorn

Board Secretary
AIDS Access Foundation
Thailand

Jon Ungphakorn, a former Senator for Bangkok, is a Thai social activist who has spent most of his life working with Thai NGOs on human rights and development issues. His particular interests during the past 25 years have been HIV/AIDS (prevention, treatment, and rights), access to health, development of the welfare state, and development of civil society media.

In 1991 Jon founded and was the first executive director of the AIDS Access Foundation, a Thai NGO which provides confidential counselling services for people with HIV/AIDS and their families, gives training and support to organisations of people living with HIV/AIDS, campaigns against public stigma of AIDS, and advocates the rights of everyone to effective and affordable health treatment. In 2000 he was elected to the Thai Senate for six years with the support of the NGO and HIV/AIDS communities, and in 2005 he was a recipient of the Ramon Magsaysay Award (a prestigious Asian award) for his advocacy work on human rights.

Jon was an active participant in the civil society movement which successfully campaigned for a universal health service in Thailand, and is an advocate for Thailand and other developing countries to make full use of flexibilities allowed under the WTO TRIPS agreement and the 2001 Doha Declaration in order to provide their citizens with access to life-saving medicines that are readably available in developed nations. At present he is Vice-Chairperson of the Thai Foundation for AIDS Rights, a member of the National Human Rights Committee's Sub-Committee on Civil and Political Rights, and Executive Director of Internet Law Reform Dialogue (iLaw).

Parallel Session 2.1

Raising more domestic resources for health

Burkina Faso's efforts in health financing in the context of implementing the Abuja Declaration of 2001

By Pagomdzanga Abdoulaye NITIEMA
Doctor, Specialist in Public Health (MD, MSc)

E-Mail : abdoul_nitiema@yahoo.fr ;
abdoulaye.nitiema@sante.gov.bf

I. BACKGROUND

I.1 GENERAL INFORMATION ON BURKINA FASO

Burkina Faso, a landlocked country in the Sahel region, is located in the heart of West Africa covering an area of 274 200 km^2. With a high population growth rate of about 3.1% per year, the population has progressed from 14,017,262 inhabitants in 2006 to an estimated 15,730,977 inhabitants in 2010. The population is very young (over 46% of the population is under 15 years). Women represent 51.7% of the total population. Approximately 77.30% of the population lives in rural areas. The crude birth rate is estimated at 46.0 %, the overall mortality at 11.8 % and life expectancy at birth at 56.7 years. The total fertility rate stands at 6.2.

The country's agriculture based economy is poorly diversified and is vulnerable to internal (mainly climatic) and external (volatility of energy and food prices) shocks. With a per capita income of US$ 300 per year, Burkina Faso is one of the least developed countries. According to the UNDP 2010 Human Development Report, Burkina Faso was ranked 161st out of 169 countries with a Human Development Index of 0.305. The level of tax burden remains low despite improved government revenue (13% against a regional average of 17.

GDP growth in real terms was 3.1% in 2009 against 5.2% in 2008, a decrease of 2.0 percentage points.

Table 1: Evolution of economic growth by sector (%)

Sectors	*2005*	*2006*	*2007*	*2008*	*2009*
Primary	11,7	0,8	- 4,3	9,2	2,4
Secondary	5,9	5,6	8,1	6,0	5,8
Tertiary	5,1	8,0	5,6	1,5	2,5
GDP	*7,1*	*5,5*	*3,6*	*5,2*	*3,1*

Source : DGEP MEF January 2010

In 2008, the price of crude oil weighed heavily on the capacity of the country to import goods; oil represented 25.8% of imports while the share of food products accounted for 12.5%. Employment is marked by the predominance of agriculture and the informal sector.

Despite the weak progress regarding poverty reduction, substantial improvements have occurred in social sectors, especially in health, including the fight against HIV and AIDS, and in education and in access to safe drinking-water.

The country has developed strategic frameworks such as the National Prospective Study (Etude nationale prospective (ENP)): "Burkina 2025"; the Strategy of Accelerated Growth and Sustainable Development (Stratégie de croissance accélérée et de développement durable (SCADD)) and the National Plan for Land Development (Schéma national d'aménagement du territoire (SNAT)).

The vision for Burkina Faso, outlined in the ENP "Burkina 2025", reflects the country's long term development ambition, namely the challenge of transforming Burkina Faso into an emerging economy.

I.2 SITUATION REGARDING THE IMPLEMENTATION OF THE ABUJA DECLARATION

I.2.1 Interpreting the Abuja Declaration

It was seen necessary to clarify, at the national level, the notion of allocating at least 15% of the government budget to the health sector. This contextualization of the Abuja Declaration target defined it as covering: "budget allocations devoted to the health sector broadly defined, and not strictly according to the national health accounts definitions."

Following this definition of the Abuja Declaration target for the context of Burkina Faso, the items that should be included in the calculation are:

- Budget allocations instead of health expenditure,
- Budget allocations not only at the Ministry of Health but also at all other ministerial departments, which may include budget allocations to civil society and/or non-profit institutions serving households active in the field of health.

I.2.2 Budgetary allocations to the health sector

Table 2 provides a summary of 2002-2009 government budget allocations to the health sector.

Table 2 Evolution of the health budget and of total government expenditure

Headings								
	Year 2002	**Year 2003**	**Year 2004**	**Year 2005**	**Year 2006**	**Year 2007**	**Year 2008**	**Year 2009**
II	9 734 211	10 697 351	11 536 073	12 628 882	14 898 333	17 067 435	22 028 593	22 274 558
III	4 879 837	5 411 172	5 463 716	6 461 485	9 072 906	9 218 605	14 336 024	14 336 024
IV	10 128 628	10 860 549	11 405 346	13 190 123	15 284 398	17 159 144	18 855 703	20 112 823
V	13 524 209	13 165 215	14 655 715	12 958 879	24 077 866	32 936 488	33 229 400	42 586 715
Health Insurance Fund	36 370	34 205	61 900	65 400	76 000	61 153	70 579	72 188
HIPC	8 440 000	9 724 000	8 850 000	8 525 000	6 200 000	-	-	-
TOTAL MoH Budget	**46 745 257**	**49 894 495**	**51 974 754**	**53 831 774**	**69 609 503**	**76 442 825**	**88 520 299**	**99 382 308**
Total health related budget for other Ministries and institutions	913 242	1 853 265	6 101 526	8 041 500	18 576 455	12 708 940	28 222 903	25 545 773
HEALTH BUDGET (MoH+ budget for other Ministries and institutions)	**47 658 499**	**51 747 760**	**58 076 280**	**61 873 274**	**88 185 958**	**89 150 940**	**116 743 202**	**124 928 081**
General Intersectoral Expenditure (GIE)	**111 095 349**	**104 200 900**	**116 413 770**	**122 286 747**	**90 676 802**	**157 254 528**	**216 968 342**	**235 619 298**
STATE BUDGET	**567 584 667**	**616 212 919**	**666 129 347**	**779 337 292**	**892 097 099**	**925 135 151**	**984 171 356**	**1 043 874 882**
STATE BUDGET without GIE	**456 489 318**	**512 012 019**	**549 715 577**	**657 050 545**	**801 420 297**	**767 880 623**	**767 203 014**	**808 255 584**
MoH Budget/ State Budget without GIE	10,24%	9,74%	9,45%	8,19%	8,69%	9,96%	11,54%	12,30%
HEALTH BUDGET/ STATE BUDGET without GIE	**10,44%**	**10,11%**	**10,56%**	**9,42%**	**11,00%**	**11,61%**	**15,22%**	**15,46%**

Source : *Loi des Finances de 2002 à 2009*

According to the Burkina Faso data on the implementation of the Abuja Declaration, there has been a positive evolution in the part of government budget allocated to the health sector.
In terms of government contribution to the health sector (which is the basis for comparison for the 15% target in Burkina Faso), the country achieved the Abuja target in 2008 (15.22%) and in 2009 (15.46%). Indeed, the Minister of State, Minister of Health, announced this result in 2008 during the International Conference on Primary Health Care held in Ouagadougou from 28 to 30 April 2008.

From the perspective of government budget allocation to the Ministry of Health the evolution has been positive, although the 15% Abuja target has not been met: 11.54% in 2008 and 12.30% in 2009.

The following Figure 1 is a graphical presentation of the calculations according to the two different assumptions.

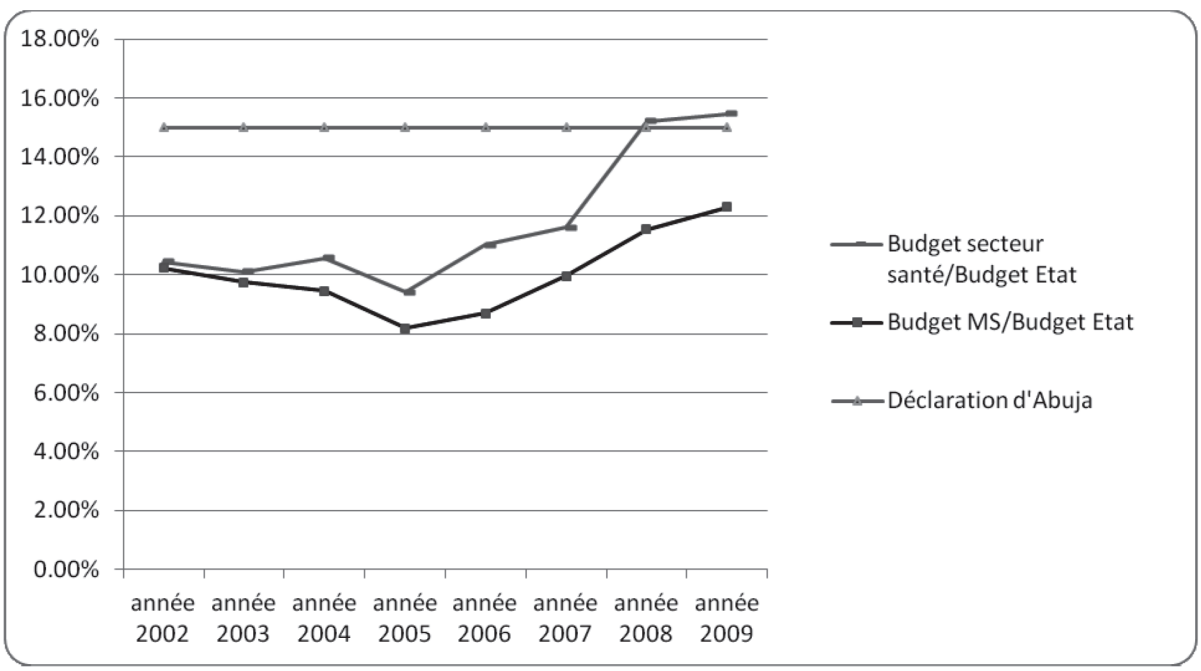


Figure 1 : *Evolution of the Abuja Declaration implementation in Burkina Faso*

These results are confirmed by a study conducted by Public Health Info Africa in 2010 [2010 Africa Health Financing Scorecard], which states that out of 53 countries, six, including Burkina Faso, have met the 15% target of the Abuja Declaration. In West Africa, Burkina Faso and Niger have reached the target, with respectively 15.8% for Burkina Faso and 17.8% for Niger[1].

Regarding private funding, the part of household health expenditure of total health expenditure decreased from 49.8% in 2003 to 38.4% in 2008. In addition, the health

sector receives relatively large financial contributions from NGOs and associations.

External financing is the third largest source of health funding after the State and households.

I.2.3 Concrete actions undertaken by the country

These actions have included:

- Increased budget allocations for investment that contributed to the geographical expansion of health facilities: an individual was in average 7.34 km away from the nearest health facility in 2010, while in 2001 this distance was 9.18 km. In addition, the catchment population of a primary health facility (centre de santé de base (CSPS)) decreased from 14 177 inhabitants in 2001 to 9813 inhabitants in 2010. This has contributed to improved geographical access to health services. The uplift of the clinical equipments and infrastructure also contributed to improving the quality of care.
- Increased allocations for salaries with a consequent improvement of the ratio of health workers/population;
- Subsidies for deliveries and obstetric and neonatal emergencies to improve financial accessibility to care by the population. Over ten billion CFA have been made available through the government budget to finance this strategy from 2006 to 2011.
- Initiatives of payment exemptions such as free vaccines under the Expanded Programme on Immunization, free mosquito nets and free care of severe malaria in children under 5 and pregnant women, free prenatal visits and free preventive care of malaria for pregnant women.
- Promoting mechanisms for risk sharing (mutual health organizations, cost sharing, experimenting with different types of exemptions from fees in public health facilities etc.

II. Conclusion and lessons learned

The major lessons are:

- There has been a positive evolution of government budget allocations to the health sector due to heavy advocacy and a determination of the Government to increase funding for health;
- The low level of health expenditure, currently below US$ 30 to 40 per capita, does not allow large scale improvements in the health outcomes;
- The level of social protection coverage is low: the formal coverage mechanism covers only about 11% of the population and the informal schemes 1%;
- There is a need to continue efforts to increase funding for health;

- Household contributions still continue to constitute a significant part of total health expenditure despite the government's efforts to reduce household health spending through subsidy measures and free deliveries and free care of severe malaria in pregnant women and children under 5 years.

III. OUTLOOK

The outlook for health financing based on the new national health policy and the National Health Plan 2011 -2020 (Plan National de Développement Sanitaire (PNDS)) aims at achieving the strategic direction No. 8 which deals with the "Increased funding for health and improving the financial accessibility of health services to the population"

This strategy will be implemented by improving the mobilization of additional resources for health, by streamlining the management of resources allocated to health, by promoting alternative health financing mechanisms, and by reducing the households' share of expenditures on treatment and medicine, particularly for low income households. Of course, various advocacy efforts targeting the decision makers in order to improve the performance in terms of implementation of the Abuja Declaration will be continued. In fact, there is no other possible way, since under the PNDS major reforms of the health system will be implemented. Thus, it is envisaged to increase the yearly health expenditure per capita from a projected US$ 34 USD in 2011 to US$ 62 in 2015.

Referneces

1. Document d'analyse de la situation sanitaire, comté technique de révision de la politique de santé et d'élaboration du PNDS 2011-2020, ministère de la santé, Burkina Faso
2. Politique nationale de santé, ministère de la santé, Burkina Faso, 2011
3. Plan national de développement sanitaire 2011-2020, ministère de la santé, Burkina Faso, 2011
4. Harmonisation pour la santé en Afrique, Cadre d'action, WCARO, concept note, 2008
5. Lois de finances, 2002 à 2009, Ministère de l'économie et des finances, Burkina Faso
6. Evaluation de la Déclaration d'Abuja : cas du Burkina Faso, OOAS, 2010
7. Africa public health info en 2010 [2010 Africa health financing scorecard] http://www.hoffmanpr.com/world/PMNCH/InvestmentinAfrica/A3

Laos: Hydopower as a source of revenue for the social sectors.

By Kotsaythoune Phimmasone

The objectives of this session are to allow the audience to consider and debate the evidence on:

- What are some ways that low and middle income countries have used to raise additional domestic funding for health?
- How appropriate are they in other settings?
- What is the political economy of raising more money for health when that is necessary – e.g. who has to be persuaded, and how?

Introduction

The hydropower sector has the potential to play a pivotal role in achieving the social and economic development objectives of the Government of the Lao People's Democratic Republic by expanding the availability of low cost, reliable electricity within the country and earning revenue from export sales to the region.

The power sector in Lao PDR serves two vital national priorities: (1) it promotes economic and social advancement by providing a reliable and affordable domestic power supply; (2) it earns foreign exchange from electricity exports.

The Government of the Lao PDR has to date signed MOUs or is undertaking research studies on a total of more than 70 hydropower projects. Of these 15 are either operational or under construction.

Namtheun 2, the biggest (1,070-megawatt), is a hydroelectric power project supporting sustainable economic development and Poverty Reduction Strategy implementation in Lao PDR. This project would build a power plant on the NamTheun river in central Lao People's Democratic Republic.

About 93% of the electricity generated by the plant would be exported to Thailand and would generate revenue for Lao PDR through taxes, royalties, and dividends. The remaining 7% of electricity produced would be available for domestic consumption.

The project will:

- export 5,354 gigawatt-hours (GWh) of electricity to Thailand
- supply about 200-300 GWh of electricity to consumers in the Lao People's Democratic Republic (Lao PDR), and

- generate about $1.9 billion of revenue for the Government over the 25-year operating period;
- official inauguration, December 9th 2010.

The project has a great potential to fight against poverty. The National Growth Poverty Eradication Strategy (NGPES) is central to the national development agenda. The NGPES encapsulates the essence of Lao PDR's approach towards achieving the goal set in 1996 by the 6th Party Congress, namely, exiting the group of Least Developed Countries (LDCs) by 2020.

The Lao Government believes production and exports of hydropower will bring many benefits to the country. Primarily it will boost revenues, which can be used to alleviate poverty and improve the standard of living of the average Lao citizen.

Expanded revenues from hydropower projects can be committed to:
- *Expansion of health, education and other social services;*
- *Improvements in transport, communications, water supply, electrification and other infrastructure;*
- *increasing the resources of the Lao Government's environmental agencies to improve the effectiveness of their protection programs.*

What are some ways that country has used to raise additional domestic funding for health?

It is the high level of the government decision and leadership through the Prime Minister instructions to inform that the MOH will received extra budget from the revenue of Namtheun 2, as part of the Public Investment Project of the budget chapter. The appropriate moment to rise additional domestic funding is during the preparation of the annual plan (see Planning process chart). In overall, we strictly follow the fundamental principles of State budget of the Article 6 of the State Budget law. Lao fiscal year covers for 12 months starting from October to 31 September of the following year. Then, from the procedure of budget preparation, starting from the line Departments of the MOH internal discussion to develop our annual plan based on the guidelines by the Prime Minister (see Chart of the Planning process). During this preliminary consultative meeting to identify priorities plan/activities and resources needed, the MOH invited the technical staff from the Ministry of Planning and Investment, and the Ministry of Finance to participate. Usually, the development of annual budget plan begins from the grassroots level upwards. For the 2 first year of receiving revenue from Namtheun 2, the budget plans are much more centralized at MOH level. The approval of budget is a top-down process. The Department of Planning and Finance of the MOH brings all health sector priorities plans into a single plan after an internal consensus. The MOH Steering Committee is leading in developing and implementing the MOH priority plan through a broad consultative process of Sector Wide Coordination mechanism for Health. This process is the first stage of inter-sector

prioritization which, one copy will be submitted to the Ministry of Planning & Investment, and other copy to the Ministry of Finance. During the consolidation plan from the line ministries, the Department of Planning-Finance is authorized to negotiate with MPI and MOF for adjusting the MOH priority plan and budget into the national plan. The Minister of Health will present and defend the MOH priority plan in the government meeting. The Ministry of Planning-Investment and the Ministry of Finance compiled the entire sector plan from different ministries and organizations, after examination and discussion with concerned ministries in the view to ensuring the linkage with the State economic policies, the targets under the national socio-economic development plan and the objectives of the macro-economic balance, readjusted budget plan and presented the compiling plan to the government for consideration. After consideration by the government, the draft budget is presented to the National Assembly (NA) 30 days before the opening of it plenary session for consideration and approval. Here, sometime, MOH team needs to debriefing our sector priority plan to the Social and Cultural Affairs Committee and the Planning-Finance Committee before the NA plenary session. Here, necessary data and information need to be prepared, as requested.

Within 30 days, after the NA adopted the annual budget plan of the government, an indicative budget ceiling from the Namtheun 2 with guideline for preparation and submission the detail proposal to the MOH. The line Department of the MOH, PHO, DHO prepare the expenditure plan according to the approved budget allocation. The treasury can follow and inspect every disbursement. Every month, quarter the treasury reports the disbursement progress to DPF who will report to the MOH Steering Committee and the Ministry of Finance and the Ministry of Planning-Investment.

Key organization involve during the planning process

The key decision to propose to rise additional domestic funding for health is decided both at central and local levels. At central level, for the health sector is the Minister of Health with strong support from the Ministry of Planning and Investment and Development Partners are key players, after consensus from the line Departments; at local level, requested were made from grassroots level, support from the local authorities, particularly at District and Provincial level are also playing an important roles. In this context, the identification of focus areas to be the most priority areas that all government effort should be intervenes. During the government meeting, they are participated and can have considerable attention from their perspective on the priority program of the health sector.

What is the political economy of raising more money for health when that is necessary – e.g. who has to be persuaded, and how?

Key organization to be persuaded: The Department of State Budget (Ministry of Finance), the Department of Planning and the Department of Public Investment Programme

(Ministry of Planning and Investment), through the participation during the prioritization of the planning process; the Social and Cultural Affairs Committee before the plenary session of the National Assembly; and the local Parliament member through an informal discussion. Development partners (JICA, ADB, UNDP) and International Advisory Group (IAG-WB) play an important role as well. In the Lao PDR case, we have to consider both the allocation of the revenue and their efficient use of the resource allocate, in the same importance. The efficient use of the Resource allocation, has direct impact on the increase of budget plan for the further coming year.

The government commitment to allocate Namtheun revenue for different sector, as: The Government of Lao PDR seeks to generate revenues, through environmentally and socially sustainable development of NT2's hydropower potential, which will be used to finance priority poverty reduction and environmental management programs. The electricity generates increasing revenue for Lao PDR, but it could be variable. On the average, government allocation Namtheun revenue for the health sector represents around 17 to 20% of total government allocation, which is lower than for education, Public Works and Transport (see table 1). Except for the fiscal year 2010-2011, 72% of the revenue are transfer directly to local levels, where 21% belonging to the Poverty Reduction Funds as an implementer.

For the fiscal year 2009-2010, the distribution of revenue from Namtheun 2 within the Health sector is (see table 2), 31% dedicate for the activities within the Health Centers; 22% for the Central-PHO-DHO; 21% for the Health financing activities; 18% for improving service quality at District level; 6% for the administrative cost and 3% for the monitoring and evaluation. The fiscal year 2010-2011, small revenue of 5.07 billion (6% of total revenue) are transfer directly to PHO and DHO, as executers that will not easier to monitor and evaluate. The distribution for the fiscal year 2011-2012 is split into 3 main priority components, strengthen health financing in 10 poor districts (54%), improving MNCH services in 24 focus districts (33%) and HRD in 24 focusing district (14%).

Issues in the additional Domestic Funding Process

In terms of decentralization in planning and budgeting, a clear roles and responsibilities between MOH, PHO and DHO need to be in place. Coordination system between national and sub-national level health plan need to be enhance. In recent year, there have been good efforts to introduce medium to long term financial planning in health sector. Within the reforms in overall public finance, the first Health sector Medium Term Expenditure Framework (MTEF) has been finalized with the assistance of the Asian Development Bank (ADB) and the Ministry of Finance. However, at Provincial level, planning is still difficult. As result of decentralization, some planning and budgeting responsibilities have been devolved to provincial health offices and district health offices. However, this transfer of responsibilities has not been accompanied by clear guidelines from the

MOH about how to plan and budget at local level. There is no mechanism for ensuring that province reflect national priorities in their budget plans. The connection between resource allocation and achieving health outcomes need to be defined. Well coordination from different sources of funding need to be improved.

Budget expenditure should be implemented in line with the annual budget targets, amounts and timeframe as approve by the national assembly.

Budget information, budget execution and assessment should be accurate, transparent, open, made accessible to the public and controlled, inspected, audited and certified by competent agencies.

There is a limited technical capacity in all subsystems of the financial management including weak authority and capacity of treasury offices at all level, ineffective implementation of the public procurement, weakness in accounting and reporting system, and deficiencies in public financing accountability and transparency. There is an acute shortage of staff with adequate training and experience in accounting or finance throughout the public sector. The shortage of trained personnel is particularly acute at provincial and district level. The decentralization has happened at a fast pace than capacity development.

Intervention Recommended

- Improving coordination among the line MOH Departments, through the Sector Wide Coordination mechanism; between MOH, MPI, MOF and others Development Partners for better allocate of resources.
- Enhancing the budget planning process at the central and local levels with a comprehensive guidelines on how to plan and budget at different level;
- Strengthening the financial management systems to deliver and report on the public finances in timely and accurate manner through (a) enhancing fiscal reporting; (b) modernizing accounting and auditing standards (MOF roles); (c) clarifying roles responsibilities and coordination between central and PHO, DHO in improving service delivery, managing the budget allocation.
- In overall, human capital investment and information systems should be one of priority of the public sector management reforms.

Table 1: Summary an overall allocation from Namtheun 2, (units in billion kips)

	2009-2010		2010-2011		2011-2012	
	Central	% of total Namtheun budget	Central	Locals	Central	% of total Namtheun budget
Education	17.5	35%	23.82		40	40%
Energy and Mines	6	12%	17.10		20	20%
Public Works and Transport	15	30%	23.79		20	20%
Health	**10**	**20%**	**5.07**		**17**	**17%**
Natural Resources and Environment	1.5	3%	0.50		1.5	2%
Agriculture and Forestry	0		9.42		1.5	2%
Poverty Reduction Funds	0			21%	0	
	50		**79.70**		**100**	
			28%	51%		

Source: MPI, 2011

Table 2: Distribution of investment by sub priority in the health sector for the fiscal year 2009-2010 (units in billion kips)

		Total of Namtheun budget for Health sector **10.000**	% of total Namtheun budget
Priority program	**Improvind quality of MNCH services focusing in Comprehansive emergancy obstetricare in some Districts**	Investment at each sub sector	
Sub priority sector 1	Sending Technical staff from central to strengthen capacity building for Provincial and District level	2.197	22%
Sub priority sector 2	Improving services quality at District level, with focusing to the poor	1.785	18%
Sub priority sector 3	Integrated activities at Health Center level, focusing to the poor	1.592	16%
Sub priority sector 4	Provide Outreach activities at Village level, with focusing to the poor	1.500	15%
Sub priority sector 5	Support HEF project	2.050	21%
Sub priority sector 6	Monitoring-Evaluation	0.287	3%
Sub priority sector 7	Administrative cost	0.589	6%

Source: MOH, 2010

Table 3: Distribution of investment by sub priority in the health sector for the fiscal year 2011-2012 (units in billion kips)

		Total of Namtheun budget for MOH **17** Investment at each sub sector	% of total Namtheun budget
Priority program 1	**Improvind quality of MNCH services focusing in 24 Focusing Districts**	**6**	**33%**
Sub priority sector 1.1	Sending Technical staff from UHS and 4 CHU at central to strengthen capacity building at District level	2.50	15%
Sub priority sector 1.2	Supporting technical staff at Provincial Hospital to District hospital	0.50	3%
Sub priority sector 1.3	Expanding 10 MR to 21 District hospitals and Health center	0.60	4%
Sub priority sector 1.4	Providing Essential/Basic Medical Equipments for 21 District hospitals	2.00	12%
Priority program 2	**Strengthning the Health Financing in 10 poor Districts for improving the service utilisation**	**9.10**	**54%**
Sub priority sector 2.5	Extend the CBHI in 8 Districts of Savanakhet Province	1.60	9%
Sub priority sector 2.6	Extend the HEF in 8 Districts of Savanakhet Province	1.50	9%
Sub priority sector 2.7	Supporting the Free delivery and Under five OPD/IPD in 10 poor Districts	5.00	29%
Sub priority sector 2.8	Supporting Additional Nutrition policy in 10 poor Districts	1.00	6%
Priority program 3	**Human Resources Development in 24 focus Districts**	**2.30**	**14%**
Sub priority sector 3.9	Family Medicine training	0.70	4%
Sub priority sector 3.10	Up grading medical personnel, nurse and midwife	1.60	9%

Source: MOH, 2010

Chart of the Lao PDR, Public Health Network

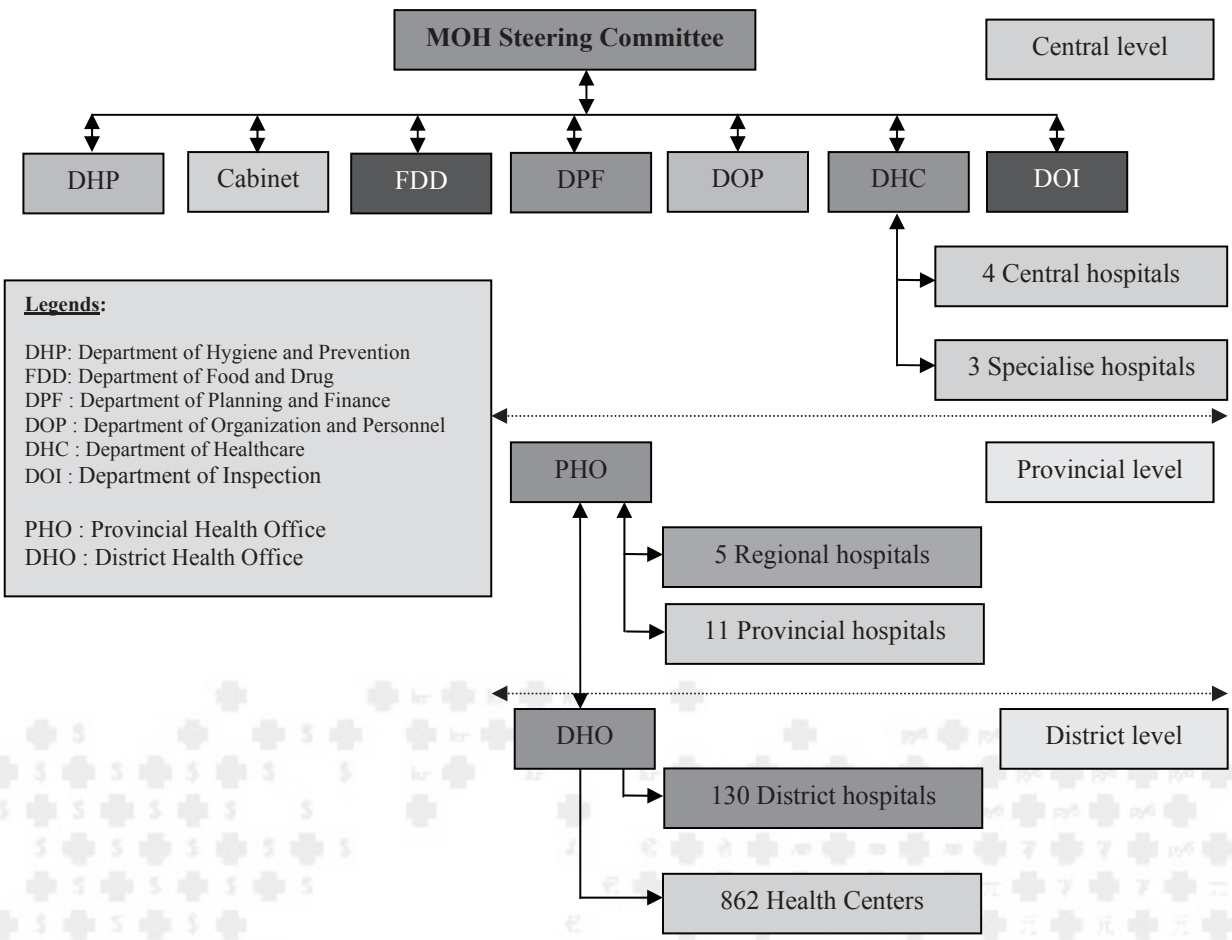
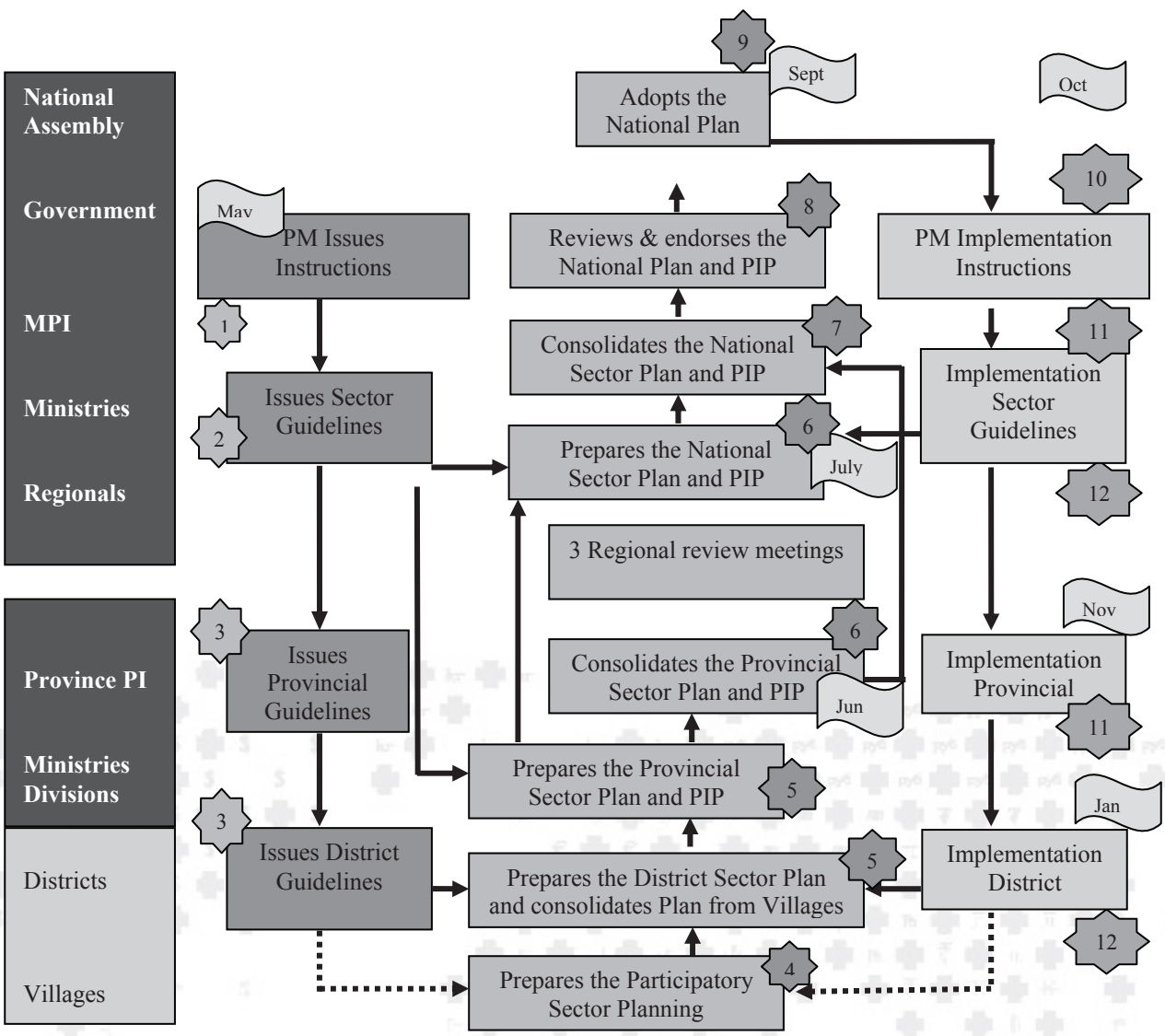


Chart of the MOH planning process



Seng-Eun Choi

Research Fellow

Korea Institute for Health and Social Affairs

South Korea

Seng-Eun Choi is research fellow of Korea Institute for Health and Social Affairs, government affiliated research institute working widely with Ministry of Health and Welfare. Advisory Board of the Korean Social Security Association. Member of the Korean Association of Public Finance and the Korean Economic Association. Ph.d in Economics specialized in Public Finance at Syracuse University. Working extensively on financing social expenditure and health expenditure, tobacco taxes and sin taxes, social expenditure, social budget and social insurance. Acted as a consultant on these issues to government departments, non-profit organizations, and research institutes.

Joseph Kutzin

Coordinator
Health Financing Policy
World Health Organization
Switzerland

Joseph Kutzin is a health economist with over 25 years' experience in health financing policy and health system reform, working in Africa, Asia, the Caribbean, and Europe. He has published numerous conceptual and empirical articles as well as co-authored and edited books on health financing in Europe as well as in low and middle-income countries elsewhere. Notable among these was a chapter in the book *Achieving Universal Coverage of Health Care,* edited by Sanguan Nitayarumphong and Anne Mills, published in 1998. His most recent work is as lead editor of a book entitled *Implementing Health Financing Reform: Lessons from Countries in Transition,* published in 2010.

Following the completion of a Master's Degree in Development Economics from Boston University in 1985, he worked in a private health foundation and for the World Bank before joining WHO Headquarters in Geneva in 1994. In 2000 he became WHO's Senior Resident Policy Advisor to the Ministry of Health of Kyrgyzstan, where he established and managed a health policy analysis unit that has since become an integral part of the health system. He moved to Copenhagen in 2003 as the WHO European Region's Advisor for Health Systems Financing, a role he continued when he became Head of the WHO Barcelona Office for Health Systems Strengthening in 2007. In Barcelona, he led a team responsible for providing support, guidance, and capacity strengthening on health financing policy and health policy analysis for the 53 countries of the European Region. He also supported WHO's work on health financing globally, including contributing to the World Health Report 2010 entitled *Health Systems Financing: the Path to Universal Coverage.* In July 2011, he moved to WHO Headquarters in Geneva where he is leading the Health Financing Policy Team within the Division of Health Systems Financing.

Jean Pierre MBENG MENDOU

Legal Advisor

National Health Insurance Fund

Gabon

Mr. Jean Pierre MBENG MENDOU was born on March, 1962 in OYEM, in northern GABON. After primary and secondary studies in his hometown, he files to Libreville, the capital of the country, continue the studies at the Catholic BESSIEUX College where he obtained the Bachelor in 1982.

Begin graduated studies at the Faculty of Law and Economic Sciences of the University Omar BONGO in Libreville, where he obtained successively the Office of Legal studies Diploma University in 1984 and the master of law in 1986.

In 1986, soon after the master degree, he spent with success the competition for entry into the national school of Administration, where two years later in 1986, Major General of the Promotion, Section social.

Integrated as a public servant in the public service, it will be appointed in turn:

- 1991-1996: Director of social security of the Ministry of Social affairs and national Solidarity;

- 1996-2003: Deputy Director General of the social Protection of the Ministry of Social affairs and national Solidarity;

- 2003-January 2007: Director General of the Social Protection.

In 2002, as Deputy Director General of the social Protection, he is responsible for his responsible Ministry technically lead reform of the Gabonese social protection system in which fits the project of universal and compulsory health insurance. In this reviewed it developed forward Bill establishing a compulsory system of insurance and social security in Gabon.

In January 2007, the draft text on the establishment of health insurance and universal is adopted by the Government and was appointed technical adviser of the Director General of the national health insurance Fund young.

Since 2009, he is the legal adviser of the Fund. It can be considered one of the pioneers of the mandatory health insurance in Gabon. He is married and father of family.

Anne Mills

Vice Director for Academic Affairs and Professor of Health Economics and Policy London School of Hygiene and Tropical Medicine

United Kingdom

Professor Anne Mills is known globally for her contributions to health economics and health systems research. Following a long career as researcher and teacher at the London School of Hygiene and Tropical Medicine, she took up the position of Head of the Faculty of Public Health and Policy between 2006 and 2011, and recently became the School's Vice Director for Academic Affairs. She is Professor of Health Economics and Policy and holds degrees from the Universities of Oxford, Leeds and London.

Her research expertise is built on nearly 40 years' experience of the health systems of low and middle income countries, which started with a position as health economist in the Ministry of Health in Malawi between 1973 and 1975. Since joining the LSHTM in 1979, she has researched and published widely in the fields of health economics and health systems. Between 1990 and 2005 she directed the LSHTM's Health Economics and Financing Programme, which together with its many research partners, undertook an extensive programme of research focused on increasing knowledge of how best to improve health systems in low and middle income countries. Her main research contributions lie in the areas of health financing, including strategies for achieving universal coverage; the organisation of health systems including evaluation of contractual relationships between public and private sectors and related questions of the role of the private sector; economic analysis of disease control activities, especially with respect to cost-effectiveness analysis of malaria control interventions and scaling up of malaria control efforts; and economic analysis of maternal and child health programmes including tracking donor funding to such programmes in high burden countries.

Professor Mills has had extensive involvement in supporting capacity development in health economics in low and middle income countries, for example through supporting the health economics research funding activities of the WHO Tropical Disease Research Programme, and Chairing the Board of the Alliance for Health Policy and Systems Research between 1999 and 2009. She has taught generations of LSHTM masters' students, and more than 25 research degree students have completed their degrees under her supervision.

Professor Mills has advised multilateral, bilateral and government agencies on numerous occasions; acted as specialist advisor to the House of Commons Select Committee on Science and Technology's enquiry into the use of science in UK international development policy; was a member of WHO's Commission on Macro-economics and Health and co-chair of its working group 'Improving the health outcomes of the poor'; co-chaired one of the two Working Groups for the 2009 High Level Taskforce on Innovative Finance for Health Systems co-chaired by Gordon Brown and Robert Zoellick; and most recently chaired one of the two working groups for WHO's Commission on Accountability and Information for Women's and Children's Health. In 2006 she was awarded a CBE for services to medicine and elected Foreign Associate of the US Institute of Medicine. In 2009 she was elected Fellow of the UK Academy of Medical Sciences and received the Prince Mahidol Award in the field of medicine. She is President of the International Health Economics Association for 2012-2013.

P.A. NITIEMA

Permanent Secretary of the
National Health Development Plan
Ministry of Health
Burkina Faso

Pagomdzanga Abdoulaye NITIEMA, Doctor, Specialist in Public Health (MD, MSc)

E-Mail : abdoul_nitiema@yahoo.fr;
nitiemapabdou@hotmail.com;
abdoulaye.nitiema@sante.gov.bf

Address : 06 B .P. 9953 Ouagadougou 06, BURKINA FASO (Private) or 03B.P. 7009, Ministère de la santé, Ouagadougou 03, Burkina Faso (professional)

Tel (226) 70 25 24 08 (Private) ; or (226) 50 32 65 80 (professional)

Born in 1961, married, ***chevalier de l'Ordre national of Burkina Faso***, **Dr. Pagomdzanga Abdoulaye NITIEMA** has an ***MD degree*** from the University of Ouagadougou (Burkina Faso), and a ***Masters in Community Health*** from Laval University, Québec (Canada). In addition, he holds around twenty certificates/attestations showing participation at various conferences and seminars at both regional and international levels such as : participation as the expert representing Burkina Faso at the preparatory meeting for the conference of health ministers from the African Union in April 2007 à Johannesburg, South Africa; at the Tunis meeting of June 2006 following a series of High Level Forums to discuss the MDGs for health; and his participation in the first meeting of the steering committee for the initiative "Acceleration of progress for health", in Paris, September 2006

- ***Professional Experience***

  April 2011 to January 2012 : Permanent Secretary for the National Development Plan for Health (SP/PNDS), member of the steering committee for four projects/ programs for health in Burkina Faso.

  January 2010 to August 2011 : Coordinator of the technical committee for the revision of health policies and for development of the national development plan for health 2011-2020;

  August 2005 to April 2011 : Technical Secretary for the National Development Plan for Health (ST/PNDS), member of the management committees of three health Projects/ Programs

In 2006 : Temporary advisor for WHO/AFRO on a mission to the Ministry of Health and Family Planning of Madagascar.

From 2003 to today : National training expert in contracting policy between the Ministry of Health and NGOs and civil society organizations; in sector wide approaches and in public-private partnerships.

April 2003 to August 2005 : Chief of the section on Planning, Monitoring and Evaluation of the Department of Research and Planning. Focal point on contracting policy and financial risk sharing mechanisms in health (e.g. micro insurance and health insurance more generally).

December 2003 : Final evaluation of a three year program to improve accessibility to generic essential medicines in three districts of Burkina Faso, (Pharmacists Sans Frontières – CI. PSF – CI, EU).

June 2002 to April 2003 : Officer responsible for planning, monitoring and evaluation in the Department of Research and Planning. In addition, focal point for health insurance and micro insurance, as well as for HIV/AIDS.

October 2001 to March 2002 : Technical Advisor for Safe Motherhood for the Centre for International Cooperation in Health and Development (CCISD Inc Burkina) in a health district in the north of Burkina Faso.

1994 to 1999 : held various posts at both district and regional levels in Burkina Faso (e.g. Chief of Surgery for Kongoussi, District Medical Officer for Kongoussi, Chief of Maternal Health at the regional hospital in Dori etc.)

- ***Publications and scientific papers***

Author/co-author of around seven publications and scientific papers.

- ***Other information***

2008 to date : member of the National Committee for the Elimination of Female Genital Mutilation.

2002 to date : member of the Burkina Faso Association of Public Health (ABSP).

1995 to date : member of the Medical Society of Burkina Faso

1992-1996 : member of the National Committee for the Elimination of Female Genital Mutilation.

Kotsaythoune Phimmasone

Head of planning division
Department of Planning and Finance,
Ministry of Health
Lao PDR

NAME	POSITION TITLE
Kotsaythoune PHIMMASONE	Senior staff

EDUCATION/TRAINING

INSTITUTION AND LOCATION	DEGREE	MM/YY	FIELD OF STUDY
School of Medicine, Vientiane, Lao PDR	MD	06/82	General practitioner
Centre International des Enfants, Paris	Diploma	06/92	MCH
Business and Administration, at National school of administration and management, Vientiane, Lao PDR	Bachelor	06/97	Management
Business and Administration at Asean Institute of Technology, Thailand.	Master	06/99	Management

Professional Experience

Since Jun 2011-Present Ministry of Health, Department of Planning and Finance

2004 – 2011 Ministry of Health, Department of Planning and Finance.
Deputy-director of Health Service Improvement Project (WB support)

1999 – 2004 Ministry of Health, Planning Division.
Head of Planning Division.
Responsible for Long-term and Short-term health planning.

1996 - May 1996 Ministry of Public Health, Planning Section.
Manager of District Health System Project (DHS), in collaboration with WHO.

	Responsible for assisting in improving district health system in Lao PDR.
1990 - 1995	Mother and Child Health Institute, Vientiane; Chief of Planning Section, Manager of MCH and Birth Spacing Project (MCH/BS Project).
1984 - 1989	International Clinic, Vientiane. Head of clinic. *Responsability to set up and manage the clinic.*
1983	Ministry of Public Health, Health Statistics Division. Technical assistant.

Hasbullah Thabrany

Professor
School of Public Health
Universitas Indonesia
Indonesia

Hasbullah Thabrany is a professor and former Dean of the School of Public Health, Universitas Indonesia, the largest and the best univerity in Indonesia. He had a Medical Degree from Universitas Indonesia, a MPH and Dr.PH degrees from the University of California at Berkeley, USA. He had work with Rand Corporation, a leading research corporation in the USA while he was studying in the USA. After returning to Indonesia in 1995, he served as Director of Finance and Administration of the Graduate School at Universitas Indonesia. He teaches health insurance, social security, and health policy. He was Secretary General of the Indonesian Medical Association (997-2000). Realizing that there had been severe shortage of professionals knowledgeable with health insurance and social security, he established PAMJAKI (Association of Health Insurance Professionals of Indonesia) in 1998, since then he had been the chairman of the organization until October 2010. He had been one of the key persons in reforming health care and social security in Indonesia after the crisis of 1998. He was a member of the Task Force for Social Security Reform established by the President Megawati. During 2004-2008 he was selected as the Dean of the School of Public Health Universitas Indonesia. He is currently the President of SEAPHEIN (South East Asia Public Health Education Institutes Network) serving 14 countries and 54 institutions in Asia. In addition to teaching he has been serving as a consultant in the field of public health and services for various national and international organization such as the ADB, WHO, and GTZ. He assisted the Government of Aceh to establish universal coverage in health care implemented in 2010. He has published four books, on health system reform, health financing, and health insurance. He had eddited three books in tobacco control. Hasbullah had also published more than 80 national and international journal articles.

Poonam Khetrapal Singh

Deputy Regional Director
World Health Organization,
South East Asia Regional Office
India

Dr. Poonam Khetrapal Singh is the WHO Deputy Regional Director for South-East Asia for the last eleven years. She has overall responsibility for managing all technical departments in WHO South-East Asia Region, and supervises all financial and human resources in this regard. Before joining WHO SEARO, Dr. Singh was Executive Director in WHO's Headquarters in Geneva and a member of the Director General's Cabinet.

Dr. Poonam Singh has held several important portfolios in India including Secretary, Health, Family Welfare and Medical Education; Chairperson, Health Systems Development Corporation; Secretary, Finance; Managing Director, Punjab Financial Corporation among others in the Government of Punjab, India. She has also worked as a Specialist in Health, Nutrition and Population in the World Bank.

Dr. Poonam Khetrapal Singh has three masters degrees including one in Health Management and another in Population Studies. Dr. Singh has a Ph.D. in Public Health and is a Fellow of the Royal College of Physicians, Edinburgh.

Parallel Session 2.2

Role of Development Assistance in Universal Coverage

Rifat Atun

Director of Strategy, Performance and Evaluation Cluster
The Global Fund to Fight AIDS, Tuberculosis and Malaria
Switzerland

Professor Rifat Atun is Director of Strategy, Performance and Evaluation Cluster at the Global Fund to Fight AIDS, Tuberculosis and Malaria in Geneva, Switzerland.

Professor Atun joined the Global Fund in September 2008 as a member of the Executive Management Team. He is on extended leave from Imperial College London where he is a Professor of International Health Management. In 2009, he was elected as the Chair of the Stop TB Partnership Coordinating Board.

Before joining the Global Fund, he worked with the UK Department for International Development, including the DFID Resource Centre for Health Systems, the World Bank, World Health Organization, and a range of international health agencies in a large number of countries to design, implement and evaluate health sector reform programmes. This work also focused on the introduction of communicable disease programmes and complex health innovations in health systems. He has also worked with a number of blue chip private and public sector health organisations in policy and strategy development.

Prof Atun was member of the Strategic Technical Advisory Group (STAG) of the World Health Organization for Tuberculosis, and has also serviced as a member of the Advisory Committee for WHO Research Centre for Health Development in Japan. He is currently a member of the Scientific Advisory Board for PEPFAR, and the Global Health Group at the UK Medical Research Council. He has published extensively on health systems, communicable disease control, and innovation in health and biopharmaceutical sectors.

STEPHEN KIDO DALIPADA

Financial Controller
Ministry of Health and Medical Services
Solomon Islands

No of years' experience: 21 years of work experience

Education:

Graduate with Bachelor in Business, Charles Sturt University, NSW Australia 1994
Diploma in Business Finance, Solomon Islands College of Higher Education, 1989

Background:

Stephen is a Solomon Islander, born on May 6, 1969, in Wewak, PNG but grew up in Solomon Islands. He is currently employed by Ministry of Health & Medical Services (MOHMS) to provide financial support to the Ministry as well as developing financial support and liaising with both government and donor partners. Stephen holds a Bachelor in Business (Accounting/Computing) from Charles Sturt University-Riverina, Wagga Wagga, Australia. Stephen has 15 years financial and management experience with a NGO and gained experience in budgeting, financial management, financial reporting, audit and strategic management.

Most recent experience was working with EU funded project – Rural Advancement Micro-projects Programme (RAMP) as Programme Coordinator in coordinating and facilitating all activities of the national project management team in executing RAMP and ensures that all administrative and financial functions of the programme are carried out in an efficient and effective manner. As a Programme Coordinator represent the "public face" of the Programme and as such I articulate the policies and activities to a wide range of interested parties in the Solomon Islands. Role is to ensure compliance with current national labour regulations, agreed operational and financial reporting arrangements and standard human resource requirements. Initiate and maintain active relationships with relevant government departments – particularly those.

Develop and maintain close working relationships with other development agencies ensuring coordination and promoting consistency of approach, in order to avoid duplication of effort and confusion amongst beneficiaries. This involves increasing alignment of development assistance with the government development strategies and associated operational frameworks like planning, budget and performance frameworks.

Other work experience was working with WWF Solomon Islands Country Programme as Finance and Administration Manager. Accountable and responsible for the overall coordination, management, planning, implementation, evaluation and documentation of WWF's finance and administration operations within the Solomon Islands Country Programme, and take primary responsibility for budgeting and accounting.

WWF Solomon Islands is a multi - donor funded programme both from International and regional donors such as EU, World Bank, AUSAID, NZAID, UK DFID and private foundations like Macarthur Foundation, Packard Foundation. WWF annual operating budget is SB$ 5 million. Dealt with the financial management of all the grants. Involves monitoring, financial reporting and implementing projects in a complex cultural, social and political environment to meet donor requirements as per grant contracts.

Assist in the development and implementation of the country's strategic plan. Work in cooperation with the WWF South Pacific Programme Office (SPPO) Finance, the WWFSPPO Executive Committee, Ecoregional Coordinators, and Regional Programme Coordinators, and in accordance with WWF policies, procedures and standards.

Representation

- Facilitate programme and project agreements with government
- "Focal point" for other national partners/organizations
- Understand and familiar with external issues which impact national programme

Lal Shanker Ghimire

Joint Secretary
Ministry of Finance
Nepal

Mr. Ghimire was born in Okhaldhunga, North-East Nepal in 1961. He went to Chandeshwari Middle School of Ragani - Okhaldhunga, and Shree Mahabir Janata Secondary School of Haripur-Sarlahi and graduated from the Tribhuvan University of Nepal and the University of Bradford of the United Kingdom with degrees in Educations, Business Administration, Law and Economics.

In 1989, Mr. Ghimire was appointed Section Officer in the Ministry of Finance; Under Secretary in 1996 and Joint Secretary in 2009. Since his appointment to the post of Section Officer to now, Mr. Ghimire continues working in the areas of foreign aid coordination and mobilization in Nepal. In 2004 Mr. Ghimire moved to Manila, the Philippines and worked in the capacity of Directors Advisor in the Board of Directors of the Asian Development Bank.

In 2010, Mr. Ghimire was appointed an Alternate Governor of Nepal for the Governing Board of International Monetary Fund, Director for the SAARC Development Fund, and Operational Focal Point for Nepal to the Global Environment Facility.

Highly competent in operating most of the computer soft-wares and programmes, Mr. Ghimire has extensively travelled many countries of all continents, attended and participated various high-level and ministerial meetings, workshops, seminars, conferences, training programmes, and has also published copious articles in leading News Papers and Journals mostly on economic development, economic and development planning and aspects and dynamics of foreign aid.

Mr. Ghimire is married to Radha Ghimire. He is an avid follower of most sports, Badminton in particular and has also a particular interest in understanding the dynamics and economics of foreign aid, and reading. He is a life member of various professional organizations and alumni in Nepal.

Eva Jarawan

Lead Health Specialist
The World Bank
USA

Eva Jarawan has more than 20 years of experience in human development, covering a range of countries in Sub-Saharan Africa as well as the Middle East and North Africa. She has recently joined the East Asia and Pacific Health Team of the World Bank as a Lead Health Specialist, based in Washington, DC. Prior to that, she held managerial as well as technical positions at the World Bank in DC – as Health Manager for the Africa Region, Human Development Manager for West Africa, and as a Lead Health Specialist for Africa, and the Middle East and North Africa. She has worked in the areas of health system strengthening, public health and disease control, population and reproductive health.

She is particularly interested in multi-sectoral work, in applying innovative methods to health, as well as in South-South collaboration.

She holds a Ph.D. in Business Administration with a focus on Health Policy and Management and an MBA from Georgia State University, as well as a Master of Public Health from the American University of Beirut.

Ingvar Theo Olsen

Senior Advisor

NORAD

Norway

Ingvar Theo Olsen works as a Health Economist at the Health Unit in Department for Health, Education and Research at the Norwegian Agency for Development Cooperation (Norad), which he joined in 2007. His current responsibilities and tasks are wide, but particular attention the past few years has been on different types of results-based financing and results-based aid (RBF and RBA) in the health sector, especially exploring potentials for such mechanisms in relation to maternal and child health in countries like Tanzania and Malawi. He is also the focal person for a multi-donor trust fund in the World Bank on RBF in health, Health Results Innovation Trust Fund, supported by UK and Norway. These projects are all part of the Norwegian Prime Minister's initiative to support the health MDGs. In this relation, he has also been strongly involved in GAVI work on health systems strengthening (HSS) and more recently in a task team aiming at strengthening its performance based support to countries through its different cash support windows. His current work also covers a wide number of areas in health economics/financing, as well as health systems issues more broadly, and global health more generally. Recently he was part of the team writing the upcoming Norwegian Government white paper on global health.

Before joining Norad he had more than 17 years experience in consultancy, as well as some research. The work included a wide range of areas in health economics, health care financing and health care systems, with emphasis on low and middle income countries. In the nineties this included financial and organisational sustainability, issues around equity, costs and cost containment, financing mechanisms, health care and public reform, sector-wide approach programmes, etc. After year 2000 and the establishment of global health initiatives most of the work has been around global health more broadly, organisation, financing, and other related issues, and he has been member of a number of task forces and working groups related to such initiatives. A number of the projects have focused on new and innovative financing mechanisms in global health, international health, as well as in bilateral support.

He also has administrative and management experience, with more than five years as Managing Director at HeSo, as well as project leader in numerous projects and programmes. Some teaching experience, e.g. Masters Course in International Health and the International Summer School at the University of Oslo. Apart from Norwegian he speaks English, and basic German and French.

Veasna Kiry Lo

Director of Planning
and Health Information Department
Ministry of Health
Cambodia

Born 1963 in Cambodia
Marital Status Married, 3 children

Veasna Kiry Lo graduated as Medical Doctor from the University of Health Sciences in Cambodia in 1989, and then he worked as Assistant-Surgeon in a National Hospital in Phnom Penh until 1993, and afterwards moved to work at the Ministry of Health as Planning Officer. In 1996, he earned the Master Degree of Arts in Health Management, Planning and Policy from the University of Leeds in the United Kingdom. Dr. Kiry has taken over the current position as Director of Department of Planning & Health Information since 2005.

As a public health policy planner, Dr. Kiry's main responsibility includes executive management and maintenance of the national health policy, strategic planning including monitoring and evaluation, and health financing in the Cambodian health sector, providing technical inputs for the development of sub-sector strategic plans, development of technical guidelines to support the implementation of sector policy and plans, and active engagement in sector-wide coordination and partnership.

Dr. Kiry has a long and strong professional working relationship with the government agencies and development partners, as well as international and national NGOs active in health in the overall context of health system strengthening and under a challenging environment of harmonization and alignment at both national and sub-national levels in Cambodia. He has been a member of the Cambodian National Social Security Funds Board and joined a number of inter-ministerial working groups. Dr. Kiry has recently taken the position of Program Coordinator for Health Sector Support Program Phase II (2008-2013), which is financed by AFD, AusAID, BTC, DFID, UNFPA, UNICEF and the World Bank.

Furthermore, Dr. Kiry had experience in academic teaching as a visiting lecturer on health policy and planning at the Royal School of Administration and the National Institute of Public Health and Research. He also has extensively experience in attending regional and international conferences and other high level official meetings.

Parallel Session 2.3

Macroeconomics and Universal Health Coverage

WHY AND HOW DID THAILAND ACHIEVE GOOD HEALTH AT LOW COST?

By Walaiporn Patcharanarumol[1], Viroj Tangcharoensathien[1], Supon Limwattananon[1], Warisa Panichkriangkrai[1], Kumaree Pachanee[1], Waraporn Poungkantha[1], Lucy Gilson[2,3] and Anne Mills[3]

1 International Health Policy Program, Ministry of Public Health, Thailand
2 University of Cape Town
3 London School of Hygiene and Tropical Medicine

The full chapter can be found in http://ghlc.lshtm.ac.uk/files/2011/10/GHLC-book_Chapter-7.pd

Key messages

Thailand has outperformed many other countries in improving health outcomes at relatively low per capita health spending. Interventions essential to child survival and maternal health, notably free antenatal care, skilled birth attendance, family planning, and immunization, reached universal coverage by the 1990s, and all health Millennium Development Goals (MDGs) were achieved by the early 2000s.

These services are provided mainly by the public sector – in primary health care centres and district hospitals geographically accessible to the rural poor. Longstanding policies of government bonding and rural deployment of all graduates of the health-related professions have been critical to the successful expansion of district health systems.

Financial risk protection, introduced initially to protect the poor and vulnerable, was subsequently extended to achieve universal coverage of the entire population by 2002.

Nine successive five-year national health plans ensured continuity over four decades of health system development. Generations of charismatic leaders and highly influential technocrats and medical leaders inside and outside of the Ministry of Public Health (MOPH), sharing a common vision of improving the health of the poorest, ensured that pro-poor, pro-rural health policies remained the priority of health system development.

Royal Health projects, promoted by the Royal Family, contributed to comprehensive rural development, not only improving health but also empowering rural communities.

Other contributing factors to Thailand's good health outcomes have been economic growth and poverty reduction, a high level of female literacy and a fall in the gender literacy gap.

Thailand has developed the institutional capacity to generate evidence to inform policy, which puts it in a good position to deal with current and future health challenges.

Walaiporn Patcharanarumol

Technical officer
World Health Organization
Switzerland

Walaiporn Patcharanarumol, BSc in Pharm from Khon Khaen University, Thailand (1992), MSc in Health Development from Chulalongkorn University, Thailand (1998), MSc in Social Protection Financing from Maastricht University, the Netherlands (2003) and PhD in Public Health and Policy, London School of Hygiene and Tropical Medicine, University of London (2008). Her PhD thesis is "Health Care Financing for the Poor in Lao PDR". She had experiences in public hospitals of Thailand for several years. She has become a researcher in health care financing at the International Health Policy Programme (IHPP-Thailand) since 2001. Her fields of interest are on hospital costing, National Health Account (NHA), estimation of health expenditures both in short term and long term projection and Universal Health Coverage, in particular the Universal Health Coverage Scheme in Thailand. The recent book publication is the Chapter 7: Why and how did Thailand achieve Good Health at Low Cost. During August 2011 – April 2012, she is seconded by the Thai Government to work at WHO-HQ, Department of Health System Financing.

Baoping Shang

Economist

International Monetary Fund (IMF)

USA

Baoping Shang is an economist at the Expenditure Policy Division of the Fiscal Affairs Department of the International Monetary Fund (IMF). Prior to his current position, he worked at several leading research institutions in the United States, including RAND, the National Bureau of Economic research (NBER) and the Urban Institute. His research to date has covered a wide range of health care issues, including health expenditures, health care financing, health insurance benefit design and provider payment methods. In addition, he has also been involved in research projects on social assistance, social insurance, poverty and employment. His work has appeared in various journals, such as the Geneva Papers on Risk and Insurance, Health Economics and Health Affairs. He holds a master degree in applied economics from Xi'an Jiaotong University and a Ph.D. in policy analysis from the RAND Graduate School.

Juan Pablo Uribe

Director General
Fundación Santa Fe de Bogotá
Colombia

Juan Pablo Uribe, a medical doctor by training, is the Director General of the Fundación Santa Fe de Bogotá, a leading private not-for-profit health organization in Colombia. Previously, he was the World Bank´s Health Sector Manager for East Asia and the Pacific, based in Washington D.C. With master degrees in public health and public administration from the University of Michigan (Ann Arbor), he has held various health positions in the public and private sectors, nationally and internationally. He is former Vice Minister of Health for Colombia (1998–1999) and former National Director of Public Health (1994). He was also CEO of the Fundación Santa Fe de Bogota between 2005 and 2009, and senior health specialist for the World Bank in Latin America (2000 - 2004). He has been board member of various public and private organizations in Colombia and abroad, health sector consultant for various organizations and invited speaker at numerous conferences.

Adam Wagstaff

Research Manager

Development Research Group, World Bank

USA

Adam Wagstaff is Research Manager of the Human Development & Public Services team in the Development Research Group. He holds a doctorate in economics from the University of York (U.K.), and before joining the Bank was a Professor of Economics at the University of Sussex. He was an associate editor of the Journal of Health Economics for 20 years, and has published extensively in academic journals and in books on a variety of aspects of the field, especially health equity, financial protection, and health system reform. He has worked extensively on countries in Asia including China, India, Laos, and Vietnam, but has also worked on Latin America, Europe and Central Asia, and the OECD. With colleagues in the Bank's research group, he recently developed the health module of the computer software program ADePT, which automates and simplifies health equity and financial protection analysis.

Parallel Session 2.4

Governance structure and institutional capacities in advancing UHC

Eduardo P. Banzon

President and CEO

Philippine Health Insurance Corporation

Philippines

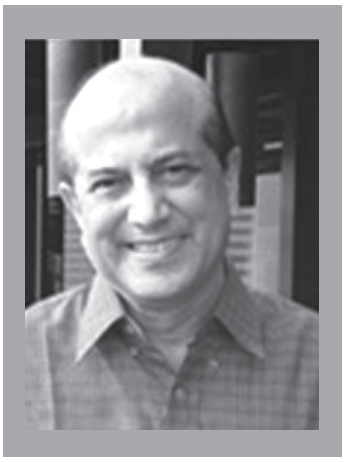
Dr. Eduardo P. Banzon is the newly appointed President and Chief Executive Officer of the Philippine Health Insurance Corporation (PhilHealth), the country's national social health insurer. He worked at the World Bank as Senior Health Specialist. However, he is not new to PhilHealth as he was the Vice President of Health Finance Policy Sector, before leaving PhilHealth for the World Bank.

Dr. Banzon graduated from the University of the Philippines, College of Medicine, with a degree of Doctor of Medicine, and he obtained his Master of Science degree in Health Policy, Planning and Financing from the London School of Economics and the London School of Hygiene and Tropical Medicine.

Dr. Banzon was a faculty member of the Health Unit of the Ateneo Graduate School of Business, where he taught in the MBA-Health and Leaders for Health Program. He was also a Clinical Associate Professor at the University of the Philippines, College of Medicine where he taught health economics, health policy studies and community medicine, in both the Medicine and post-graduate degree programs. He was also a Research Associate Professor of the National Institute of Health, where he focused on health sector reform and health screening interventions.

He has provided consultancy and research services for various national and international agencies. He has been published both locally and internationally.

He has worked as a community health physician with the Philippine Rural Reconstruction Movement and the International Institute of Rural Reconstruction.



Mushtaque Chowdhury

Senior Advisor and Acting Managing Director
Rockefeller Foundation
Thailand

Dr. Mushtaque Chowdhury is Senior Advisor and Associate Director of the Rockefeller Foundation. Based in Bangkok, Thailand, he works globally with a particular focus on regional health systems and disease surveillance initiatives.

Prior to joining the Foundation, Dr. Chowdhury was a Deputy Executive Director of BRAC, where he set up and directed its Research and Evaluation Division. He was the founding Dean of the prestigious James P. Grant School of Public Health. Throughout his career he has pursued an evidence-based approach to improve the well-being of people globally.

Dr. Chowdhury is also a Professor of Population and Family Health at the Mailman School of Public Health of Columbia University in New York. He also served as a MacArthur Fellow at the Harvard University Center for Population and Development Studies. Dr. Chowdhury holds a PhD from the London School of Hygiene and Tropical Medicine, an MSc in demography from the London School of Economics and a BA (Hon's.) from the University of Dhaka.

Dr. Chowdhury was a co-coordinator of the *UN Millennium Task Force on Child Health and Maternal Health,* set up by the former Secretary General Kofi Annan and of the Joint Learning Initiative on Human Resources for Health working group on Priority Diseases. He was also the coordinator for two civil society initiatives in Bangladesh called the Education Watch and the Health Watch. He is the co-recipient of the 'Innovator of the Year 2006' award from the Marriott Business School of Brigham Young University in USA and in 2008 he received the PESON oration medal from the Perinatal Society of Nepal. He has a wide interest in development, particularly in the areas of public health, primary education, poverty alleviation and environment. Dr. Chowdhury is a prolific writer and has published over 150 articles in peer-reviewed international journals including the Lancet, the Social Science & Medicine, The Scientific American and the New England Journal of Medicine. His recent book (co-edited with Richard Cash et al.), *From One to Many: Scaling Up Health Programs in Low Income Countries,* was launched in Montreux, Switzerland in November 2010.

He is on the board and committees of several organizations and initiatives. Some of these include: International Advisory Board of the Centre for Sustainable International Development at the University of Aberdeen, Independent Monitoring Board (IMB) of Global Polio Eradication Initiative of WHO, the Mekong Basin Disease Surveillance (MBDS) Foundation, Steering Committee of the 2nd International Symposium on Health System Research and the Advisory Committee of the International Field Epidemiology Training Programme (IFETP) in Thailand. He is also a member of the International evaluation teams for Thai Health Promotion Foundation and Thai Universal Health Coverage (UHC) initiative.

Valeria de Oliveira Cruz

Health Systems Expert

WHO

Lao PDR

Dr. Valeria de Oliveira Cruz is a health systems expert, with experience in health financing and health systems advice, research and project implementation in a range of countries in Africa, Asia, and Latin American. She is currently based in Lao PDR as a technical officer at the World Health Organization. Her areas of work in Lao PDR include technical assistance on: scaling up of health insurance; exemption of user fees; strengthening of health HMIS; improvement of HRH development and management; and health systems analysis/research. Prior to this, she worked at the London School of Hygiene and Tropical Medicine (LSHTM) as a lecturer in health systems development. During this time she was part of the technical team of Working Group 5 of the Commission on Macroeconomics and Health and the Health Systems Development Programmed. She has also worked as a project officer in HIV/AIDS in Brazil for the Ministry of Health and the United Nations Office on Drugs and Crime (UNODC). In her publications, Valeria has explored a range of conceptual and empirical issues such as performance based pay, constraints to scaling up health interventions, sector wide approaches and Global Health Initiatives. Valeria received her first degree from the Universidade de Brasilia and her MSc and PhD from the LSHTM.

Qingyue Meng

Dean School of Public Health
Peking University
China

MENG, Qingyue, MD, PhD, is Professor in Health Economics, Dean of School of Public Health, Peking University, and the Executive Director of Peking University China Center for Health Development Studies (CCHDS). Prior to this position, he was Dean of Shandong University School of Public Health.

He obtained MD from Shandong University (Previously Shandong Medical University); MSc from Fudan University (previously Shanghai Medical University); M.A. from School of Economics of University of the Philippines; and PhD from Karolinska Institutet in Sweden.

He is the member of Advisory Committee of Health Policy and Management and member of the Expert Committee of Tuberculosis Control, to Ministry of Health; the former Board Member of The Alliance for Health Policy and Systems Research, WHO; and member of the Steering Committee on Social, Economic and Behaviours, TDR.

His research interests include health financing and cost-effectiveness analysis of public health programs. Over the past decades, he has led teams conducting dozens of research projects supported by WHO, the World Bank, DFID, EU, and Chinese government. He provides a number of consultancy services focusing on health policy and systems for Chinese government through the World Bank, DFID, and Ausaid-funded projects.

Ikuo Takizawa

Director of Health Division 1
Human Development Department, JICA
Japan

Mr. Takizawa graduated from University of Tsukuba, Japan in March 1992 with BA in International Relations and then obtained MSc in Population and International Health from Harvard School of Public Health, USA in June 1998.

Through his carrier with the Japan International Cooperation Agency (JICA) since April 1992, he has been involved in JICA's health and health-related projects in Asia, Latin America and Africa. He worked in JICA Philippines between 2001 and 2005 as an Assistant Resident Representative in charge of health, education and local governance. He was involved in designing and implementing JICA's project to strengthen local health systems in line with the national health policy directions and devolution which included expansion of social health insurance enrollment with contribution from provincial and municipal governments. He worked in JICA Kenya between 2008 and 2010 as a Regional Project Formulation Advisor for Health and he was involved in designing, monitoring and evaluation of JICA's health projects in various African countries. JICA developed partnerships with the African Health Leadership and Management Network (AHLMN) and the Harmonization for Health in Africa (HHA) through his coordination.

Currently he serves as Director of Health Division 1, Human Development Department and supervises JICA's health portfolio in Eastern Africa and Middle East.

Wim Van Damme

Professor of Public Health
and Health Policy
Institute of Tropical Medicine, Antwerp
Belgium

Wim Van Damme, MD, MPH, PhD, is a senior lecturer in public health, teaching health policy at the Institute of Tropical Medicine, Antwerp, Belgium *(www.itg.be)*. He has lived and worked for 10 year in primary health care development in Peru, Sudan, Guinea and Cambodia. He wrote a PhD thesis: Medical Assistance to Self-settled Refugees in Guinea, 1990–96.

His main research interests are related to health policy and health systems strengthening in fast changing societies:

- pro-poor health financing and health policy in South-East Asia, with a special focus on Health Equity Funds in Cambodia.
- international health policy, mainly new funding mechanisms, such as the Global Health Initiatives (e.g. the Global Fund to Fight AIDS, TB & malaria) and their impact on national health systems in donor-dependent countries, such as Ethiopia, Mozambique and Malawi;
- delivery models for AIDS care, especially their human resources configurations, in countries with very high HIV prevalence.

He teaches Health Policy in ITM's MPH programme and is supervisor of several PhD students from developing countries.
http://www.itg.be/wimvandamme
http://be.linkedin.com/pub/wim-van-damme/11/518/b94 .
Newsletter International Health Policies: http://www.itg.be/ihp.

Recent publications:

- Jacobs B, Ir P, Bigdeli M, Annear PL, & Van Damme W (2011) Addressing access barriers to health services: an analytical framework for selecting appropriate interventions in low-income Asian countries. *Health Policy and Planning.*
- Ir P, Bigdeli M, Meessen B, & Van Damme W (2010) Translating knowledge into policy and action to promote health equity: The Health Equity Fund policy process in Cambodia 2000-2008. *Health Policy.*

- Ir P, Horemans D, Souk N, & Van Damme W (2010) Using targeted vouchers and health equity funds to improve access to skilled birth attendants for poor women: a case study in three rural health districts in Cambodia. *BMC Pregnancy Childbirth* 10, 1.
- Noirhomme M, Meessen B, Griffiths F et al. (2007) Improving access to hospital care for the poor: comparative analysis of four health equity funds in Cambodia. Health *Policy and Planning* 22, 246-262.
- Van Damme W, Van Leemput L, Por I, Hardeman W, & Meessen B (2004) Out-of-pocket health expenditure and debt in poor households: evidence from Cambodia. *Tropical Medicine and International Health* 9, 273-280.
- Ooms G, Decoster K, Miti K, Rens S, Van Leemput L, Vermeiren P, Van Damme W. Crowding out: are relations between international health aid and government health funding too complex to be captured in averages only? Lancet 2010;375(9723): 1403-5.
- Assefa Y, Jerene D, Lulseged S, Ooms G, Van Damme W. Rapid scale-up of antiretroviral treatment in Ethiopia: successes and system-wide effects. PLoS Med 2009;6(4):e1000056.
- Ooms G, Van Damme W, Baker BK, Zeitz P, Schrecker T. The 'diagonal' approach to Global Fund financing: a cure for the broader malaise of health systems? Global Health 2008;4(1):6.
- Van Damme W, Kober K, Kegels G. Scaling-up antiretroviral treatment in Southern African countries with human resource shortage: how will health systems adapt? Soc Sci Med 2008;66(10):2108-21.
- Janssens B, Van Damme W, Raleigh B, Gupta J, Khem S, Soy TK et al. Offering integrated care for HIV/AIDS, diabetes and hypertension within chronic disease clinics in Cambodia. Bull World Health Organ 2007;85(11):880-5.
- Samb B, Celletti F, Holloway J, Van Damme W, De Cock KM, Dybul M. Rapid expansion of the health workforce in response to the HIV epidemic. N Engl J Med 2007;357(24):2510-4.

Parallel Session 2.5

Voice of the People

Statement of the 1st Pan-African Health Congress on Universal Coverage

Alisa Hotel, Accra, Ghana 15th – 17th November 2011

Theme: Creating a Movement for Universal Coverage in Health for Africa (MUCH in Africa)

By Sam Adjei

The 1st Pan-African Health Congress on Universal Coverage was held from the 15th -17th November 2011 at the Alisa Hotel, Accra, Ghana. The Congress under the theme "creating a movement for universal coverage in health for Africa" known simply as "MUCH in Africa" was attended by representatives of ministries of health, directors general, chief executives of health insurance schemes, chief directors, principal secretaries, academics, policy experts and researchers from twenty-five (25) African countries and multilateral, bilateral, regional, development partner and civil society organisations.

The ceremony was opened by the Minster of Health, Ghana, Honourable Joseph Yileh Chireh on one behalf of the Vice-President of the Republic of Ghana, HE John Dramani Mahama. The Deputy Director General of the World Health Organisation, Dr Anarfi Asamoa-Baah was the key note speaker.

At the end of the Congress participants agreed to:

1. Sustain the momentum generated by African experts and their collaborating development partners at this meeting to find practical solutions to the continent's problems to achieve universal coverage;

2. Retain the Congress as the platform for stakeholders involved in health financing and health insurance for universal coverage to:

a) Generate awareness and interest in adopting proven social health financing and comprehensive health systems strengthening mechanisms within the region;

b) Coordinate and leverage cross-learning and joint implementation activities among countries and make inputs into the Africa agenda for attaining the goal of universal health coverage;

c) Work with countries with the requisite expertise, universities, research institutions, regional and international bodies to bring technical support and mobilise resources to strengthen health systems

d) Sustain an interface between activities and outcomes of this Congress and meetings of heads of state and ministers to leverage political support for proven reform initiatives that accelerate progress in Africa;

e) Encourage a positive engagement with international partners to scale up social health financing mechanisms and systems strengthening initiatives in African countries;

f) Facilitate the publication and dissemination of African and international scientific knowledge including its translation and reproduction;

g) Identify opportunities for collaborative research and knowledge production to bring systematic evidence that support the effective implementation of different sustainable social health financing mechanisms being up-scaled as a positive intervention in Africa; and

3. Establish a international Congress coordinating mechanism to oversee the implementation of the commitments in this statement and affairs of the Congress. The Centre for Health and Social Services will serve as the interim secretariat.

4. Convene the 2nd Pan-African Health Congress on Universal Coverage in 2013 to review progress, share insights and experiences and set new agenda for accelerating universal coverage based on the evidence. Uganda has offered to host the next Congress

Voices of the People Advocacy to Provide Health for All in the United States Experiences with the Occupy Movement in New York City

By Matthew Anderson

Summary: In this paper I will examine how the Occupy Wall Street (OWS) movement catalyzed health activists in New York City in the fall of 2011. This led to health care worker involvement in teach-ins and protests. A smaller group participated in providing direct clinical care initially in Zucotti Park and later in different venues. I will summarize some of the lessons learned and possible future directions for this advocacy.

Background: Approximately one in seven US citizens have no insurance and many more have inadequate insurance (i.e., are underinsured). Health care costs are now the leading cause of personal bankruptcy by Americans. The passage in 2010 of the Patient Protection and Affordable Care Act (PPACA) will not end these problems. The fact that the running of the US health care system has now been turned over the for-profit health insurance industry doe not augur well for future reforms of PPACA that might fundamentally alter the very expensive and very dysfunctional US health care system.

During the debate leading up to PPACA a large number of advocacy groups organized to support plans for a health care system that would guarantee access to all Americans. Some groups supported the adoption of a Canadian style system, others the expansion of the existing Medicare program. These options were excluded from the political debate on the grounds that they were "not politically viable" despite polls showing they had widespread support from the American people. Advocates resorted to civil disobedience and – for those paying attention – images of doctors and (primarily) nurses getting arrested were common prior to PPACA's passage.

This debate was entirely framed in terms of health care financing and did not address the social determinants of health or the organization of clinical practice.

Occupy Wall Street: The Occupy Wall Street movement began on September 17th with the occupation of Zuccotti Park, a small park located in the heart of the Wall Street area. At the core of this movement was a protest against income inequality, the domination of the political process by corporations, and the impunity given to the Wall Street bankers responsible for the financial meltdown.

Large numbers of health care workers (associated with the Physicians for a National Health Program, the National Physicians Alliance and the Montefiore Residency Program in Social Medicine) participated in a major march on October 5th, one of several massive rallies that took place in October. These three organizations provided the impetus for the formation of Health Care for the 99% a group that organized and participated in teach-ins and protests around lack of access to health care and the problems of income inequality. The formation of Health Care for the 99% was facilitated by the fact that all three groups

had a core of experienced activists and an existing community to draw from. Protest marches often targeted the offices of health insurance companies such as Wellpoint which was located at Zuccotti Park. Doctors in white coats were given prominent play in the local media.

Other clinicians, most notably members of National Nurses United (a nurses' union) provided medical care at an improvised first aid tent in the park. Care at both Zuccotti Park and at demonstrations was also provided by Street Medics, an informal group of individuals who provide care during political protests. The involvement of licensed clinicians in this effort raised a host of legal issues including medical liability and the regulation of medical practice. These were issues that had been raised and resolved by a previous generation of physicians in the 1960's during the civil rights era.

Emerging from the OWS has been a participatory, non-hierarchical structure. Events often use the human microphone in which a speaker's words are transmitted by those closest to the entire group. Decisions are made by consensus and no-one is excluded from participation. It has been problematic for medical professionals to work in such environments at times.

Protesters were forced out of Zuccotti Park on November 15th but OWS has remained alive if dispersed. Demonstrations continue nearly every day and care is now being provided at a first-aid area near the Park and (on an individual basis) at the many sites where the occupiers are now lodged. The medical team has organized to provide care at demonstrations where there have been numerous incidents of police brutality. Health activists are in the process of forming networks to link the many occupying sites around the country.

Lessons Learned: As the political class in the US has drifted ever more the right over the past four decades progressive positions have been excluded from the political debate. One poignant expression of this is the contrast between the New York Police Department's use of pepper on peaceful protestors and the fact that none of the Wall Street financiers has even been charged for the criminal activities that provoked the financial collapse. The Occupy movement represented the first time in decades that serious questions were posed publicly about the nature of the US society and its political system. For the first time there was a space for the voices of the people to emerge.

In this context existing activists were able quickly mobilize and use the venue of Zuccotti Park as a springboard for activism. In the (re)-invention of "protest medicine" we were also able to draw on the experiences of physicians involved in the civil rights movement.

There are currently hundreds of occupying sites around the country and probably thousands of small temporary occupations. The movement has not sought to become an electoral player in the US which is probably wise given the current balance of forces in the electoral arena. Instead many see the path forward as working with local organizations and implementing local programs that challenge the existing power structures in particular neighborhoods.

These are fundamental issues in US democracy that we are working to resolve as we try to give voice and power to those who have been excluded for so long from the political debate.

Voice of People Case Study

By Orajitt Bumrungskulswat

Case 1: Assisting a Handicapped Person in accessing Healthcare Services

Miss Somboon Raksonjit, who was mentally handicapped at birth, was not been able to access any of her rights for thirty years even though her parents are of Thai extraction and citizenship. This poverty stricken family and relatives did not think that there would be any problems resulting from not registering her birth particularly since she was handicapped as in those days social welfare was nonexistent for the disadvantaged and there were no health security systems. The Kanchanaburi Province Consumer Protection and Complaint Center established in accordance with Section 50(5) of the National Health Security Act received the complaint through the district level mechanism of Tha Muang District stating that the center knew of a handicapped female living in an old rundown house in the fields in U-Tapao sub-district, Tha Muang District, Kanchanaburi Province who has not received the rights that is her due.

The Kanchanaburi Province Consumer Protection and Complaint Center proceeded to resolve the issue in accordance with the following 7 steps: 1. Accept the complaint; 2. Verify the facts; 3. Collect the evidence; 4. Coordinate with concerned agencies; 5. Implement corrective measures; 6. Forward the case; 7. Process completion.

In this case the Consumer Protection and Complaint Center focused its operations in the field in order to verify the facts and started the process for requesting an identification card by coordinating with the concerned agency and providing answers to the questions concerning Miss Somboon's background. At present, Miss Somboon Raksonjit is registered as an individual in the Thai civil registration system and has access to her rights as a handicapped person and her rights to receive healthcare under the Universal Coverage Healthcare System.

Case 2: Request to Receive No Fault Compensation due to Injuries received from Healthcare Services in accordance with Section 41 of the National Health Security Act

This complaint was submitted to the Prachuab Khirikhan Province Consumer Protection and Complaint Center established in accordance with Section 50(5). This incident occurred in 2009 and the period of prescription of one year for submitting the complaint as determined by Section 41 was almost reached. The complaint was submitted by Mr. Prachak Sukplung, the husband of the patient, Mrs. Riam Sukplung who died while pregnant.

Mrs. Riam Sukplung, aged 41, was the wife of Mr. Prachak Sukplung, aged 43, and lived in Nong Ta Taem Sub-district, Pranburi District, Prachuab Khiri Khan Province. Mrs. Riam's occupation was that of a general wage earner and with her husband, she also farmed vegetables. She had 4 daughters. She went to the prenatal clinic at Pranburi Hospital from the beginning of her 5th pregnancy and went to all her regularly scheduled appointments. There were no complications. On her due date, Mrs. Riam did not have labor pains, thus the Pranburi Hospital sent her to Hua Hin District Hospital on 25 June 2009. She spent 1 night at Hua Hin Hospital and in the late afternoon of the next day, she walked to the bathroom and passed out. The doctors and nurses revived her with CPR but she passed away with the perfect male fetus in the early evening of 26 June 2009.

After Mrs. Riam passed away with the perfect male fetus in the evening of 26 June 2009, the Hua Hin Hospital requested that Mr. Prachak, Mrs. Riam's husband, sign a document. At that moment, Mr. Prachak said that he was sad that his wife passed away and did not know what he was doing. He signed the document without reading it and did not know what it was for. He found out later that it was a document stating that the injured party would not submit a complaint in accordance with Section 41.

The Prachuab Khiri Khan Province Consumer Protection and Complaint Center in accordance with Section 50(5) verified the facts of the case of Mrs. Riam's death together with that of her fetus and then notified Mr. Prachak of his right to receive no fault compensation in accordance with Section 41 of the Health Security System and gathered the required documents and coordinated with the Provincial Public Health Office. The responsible official perceived that the case had not yet reached the period of prescription of one year for submitting the complaint as determined by Section 41 (there was still one month remaining) and the death of Mrs. Riam complied with the conditions of Section 41, thus Mr. Prachak submitted a request to the Prachuab Khiri Khan Provincial Public Health Office on 14 July 2010 in order to proceed with the case.

After the request was submitted to the Prachuab Khiri Khan Provincial Public Health Office, it was presented to the Sub-committee in accordance with the procedures of Section 41 for consideration which resulted in the approval of compensation in the amount of 200,000 baht.

The findings of the Prachuab Khiri Khan Province Consumer Protection and Complaint Center in accordance with Section 50(5):

1. The doctor responsible for this case at Hua Hin Hospital had the husband of the deceased sign the document stating that he would not file a request in accordance with Section 41 while he should have advised the injured party to request compensation for the injury in accordance with the criteria determined in the National Health Act 2002.

2. This case had almost reached the period of prescription of one year for submitting the complaint, but through the determination of the network of the Prachuab Khiri Khan Province Consumer Protection and Complaint Center in verifying the information and facts and coordinating with the concerned agencies, the injured party was able to receive the compensation for injuries from public health services

Mr. Prachak Sukplung with Mr. Jaroonwan Jindamanee, the representative of the Consumer and Complaint Center, Pranburi District, Prachuab Khiri Khan Province

Voice of the People in the National Health Security System

By Orajitt Bumrungskulswat
Bureau of Public and Private Participation, NHSO

1. Consumer Protection

To ensure that the populace is protected in accordance with the National Health Security Act and to foster understanding and good relations between service providers and consumers the implementation within the framework of **protecting the rights of the people, receiving complaints, participation by the people and prevention against infringement of rights have been initiated.**

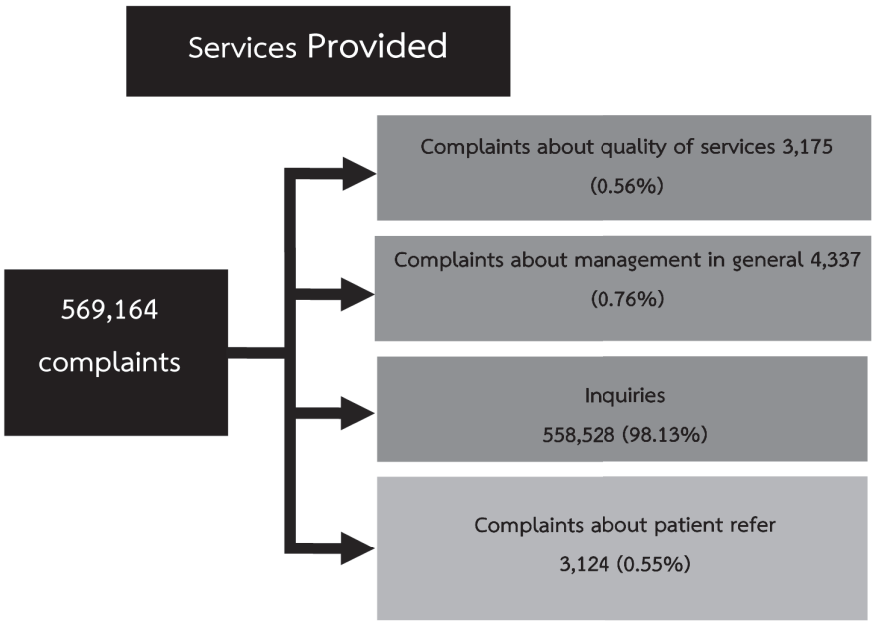
Development Guidelines for the Consumer Protection System

1. **Development of access channels in which the people may conveniently file their complaints such as:**
   - 1330 Call Center which provides 24 hours service
   - 1330@nhso.go.th website
   - Provincial branch offices of the National Health Security Office (77 provinces)
   - Regional offices of the National Health Security Office (13 regions)
   - Health Security Service Centers in hub hospitals, general hospitals and community hospitals (337 centers)
   - People's Health Security Coordination Centers (104 centers)
   - Independent Complaint Centers from the accuses that are in accordance with section 50(5) (41 units)
   - Other channels in public and private organizations

2. **Development of operational systems with standards for venues, personnel, implementation systems, information and feedback services**

3. **Development of consumer protection operations that are efficient and holistic with complaint networks**

Implementation Progress



as of June 2011

2. Independent from the accuse Complaint Center in accordance with National Health Security Act Section 50(5)

Section 50(5) stipulates that a complaint unit that is independent from the accused be established as a center to protect rights. This unit is responsible for disseminating information and knowledge in order to foster the people's understanding of their rights and the channels for accessing those rights independently. The Standard and Quality Control Board declared the criterias for registration of Independent Complaint Centers on 19 February 2009 as being responsible for receiving and recording complaints, verifying information, facts and evidence, coordinating, explaining, fostering understanding and providing assistance to ensure that those with complaints receive public health services in accordance with their rights. The centers are also responsible for submitting the complaints and their recommendations to the provincial sub-committee for further consideration. In addition, the centers are required to submit implementation progress reports to the Standard and Quality Control Board on a monthly and yearly basis.

Implementation Progress

1. **Designed training curricula and provided orientation training for Consumer Protection and Complaint Center staff;** 3 sessions for a total of 190 people
2. **Announced the registration of organizations that complied with the criteria for being an Independent Complaint Center** between 2009 -2011 for a total of 41 centers.

3. **Summarized lessons learned and provided capacity building for personnel in Independent Complaint Centers;** 1 time.

Implementation Progress of Independent Complaint Centers and Number of Grievances/Complaints

Independent Complaint Centers: Section 50(5)	Total Complaints	Types of Complaints			
		1.Explanation, foster understanding: Section 57,59	2.Submit case to Consideration Sub-committee: Section 41	3. Submit case to Quality Control Sub-committee	4.Provide other assistance
41 centers	135 issues	**82**	**12**	**7**	**34**

Source: Independent Complaint Center reports as required (from October 2009 – June 2011)
Remark: data as of June 2011

Conclusions

1. Independent Complaint Centers were able to operate in accordance with the roles and responsibilities determined in the declaration. They had implementation progress report systems for receiving individual complaints, monthly reports and annual reports. However, some centers, such as sub-district local authority offices or municipal offices, did not provide reports or provided limited reports because the people did not use their services very often.

2. Operations of approximately 50 percent of the Independent Complaint Centers could be used as models for learning exchanges and the findings could be extended to other areas in the future.

3. Information should be disseminated through various media so that the people will be aware of the existence of Independent Complaint Centers and will be able to receive advice or submit their complaints through these channels.

3. Preliminary Assistance for Customers and Service Providers (No Fault Compensation)

Section 41 of the National Health Security Act 2002 required that the National Health Security Committee earmark the amount of no more than 1 percent of the budget to be provided to healthcare centers as preliminary monetary assistance to service recipients in the case that they received damages resulting from the care provided by the healthcare centers where it is not possible to determine the **party at fault or the party at fault could be determined but the compensation could not be provided within an appropriate amount of time. As a result, it was determined that the service recipient would be provided with preliminary monetary assistance** or no fault compensation for the damages resulting from the care provided by the healthcare centers which was not a result of the histopathology of the disease or side effects that resulted from normal diagnosis or the provision of standard care including unforeseen events in the patient treatment system.

This is considered to be a mechanism to alleviate problems and reduce difficulties which may occur to concerned parties who could become the **"injured party" without having to wait for proof of wrongdoing".** A regulation with criteria, procedures and conditions for providing the no fault compensation to ensure appropriateness, fairness and efficient management came into effect as of 1 February 2006.

The rate for the no fault compensation is

(1) Death or permanent disability	no more than 200,000 baht
(2) Loss of organ or handicapped	no more than 120,000 baht
(3) Injury or chronic illness	no more than 50,000 baht

The Standard and Quality Control Board will make the final decision in providing the no fault compensation within the determined rate or may have the final consideration in refusing the appeal.

In the past, the provision of the no fault compensation to service recipients had some implementation problems and obstacles which have been compiled, summarized and analyzed and presented to the National Health Security Committee for consideration in order to adjust and improve the criteria and procedures for providing the no fault compensation to be more appropriate.

Implementation Progress for the Provision of the No Fault Compensation
According to the data from October 2010 to June 2011 a total of 728 **service recipients** have submitted requests for no fault compensation due to injuries from treatment provided by healthcare centers in the public health system. The Committee considered the requests and determined that 584 requests (80.2 %) complied with the criteria and

approved the provision of the no fault compensation in the amount of 67.87 million baht. Compensation was provided for 301 cases of death or permanent disability in the amount of 49.05 million baht, 103 cases of loss of organ or handicapped in the amount of 10.89 million baht and 180 cases of injury or chronic illness in the amount of 6.76 million baht. On the other hand, 370 service providers that received damages from providing services received compensation in the amount of 3.4 million baht.

Implementation of the no fault compensation for service recipients and providers illustrates that the National Health Security Office (NHSO) has worked to create and develop a health security system based on humanitarian principles which includes the provision of humanized health care. This is achieved by providing opportunities for stakeholders (both service recipients and providers) to participate in and become a part of the public health service system rather than simply administrating and managing the system to provide healthcare services to the people in the form of social welfare. Moreover, the NHSO is committed to assisting service recipients and providers to be provided with care and preliminary assistance to alleviate/ resolve their troubles from the effects of the care provided without having to wait for proof of wrongdoing.

4. Friendship Support Center: Patient Participation in the Healthcare System

The policy of the NHSO is to provide support for the **people and the patient networks** to participate in the development, management and administration of the healthcare system at every level since 2003. This policy is based on the belief that participation will ensure that the health security system will be able to respond to the needs of the people and increase their access to public health services. NHSO has coordinated and supported the creation of networks and volunteer communities of patients who have received high cost treatment by starting with heart disease and cancer patients. The result was the exchange of learning that was developed into recommendations beneficial to the development of the service system where patients and service recipients participated in providing humanized healthcare services leading to the tangible creation and implementation of the **"Friendship Support Center".** Emphasis is placed on enabling healthcare centers providing care for chronic patients to provide space and to establish and continuously develop a system of active patient volunteers and care providers/relatives to assist in caring for and providing services in the healthcare centers and in the community.

From 2006-2008 the Friendship Support Center received support from NHSO in the form of pilot projects in 35 healthcare centers, the majority of which were units that provided tertiary or specialized care, hub hospitals and hospitals with medical schools such

as various cancer centers both in the Bangkok and in the provinces. The implementation results were gradually extended to the healthcare centers that were ready, increasing the number of healthcare centers to 165 in 2010 and 253 in 2011 where support was provided for implementation with the participation of other patients/networks of chronic patients such as the network of heart disease patients, cancer patients and chronic renal failure patients.

The Friendship Support Center promotes the provision of humanized health care in healthcare centers **where patients and volunteers participate in the management and development of healthcare services.** The final objective is to include the operations of the Friendship Support Center within the structure of the service system of healthcare centers at every level with various partner networks such as the Friends Helping Friends Support Group, networks of patients with various chronic diseases and collaboration with various professional associations such as the Thai Cardiovascular -Thoracic Nurses Association, University Hospital Nursing Director Consortium and the Thailand Nursing and Midwifery Council participating in diverse activities.

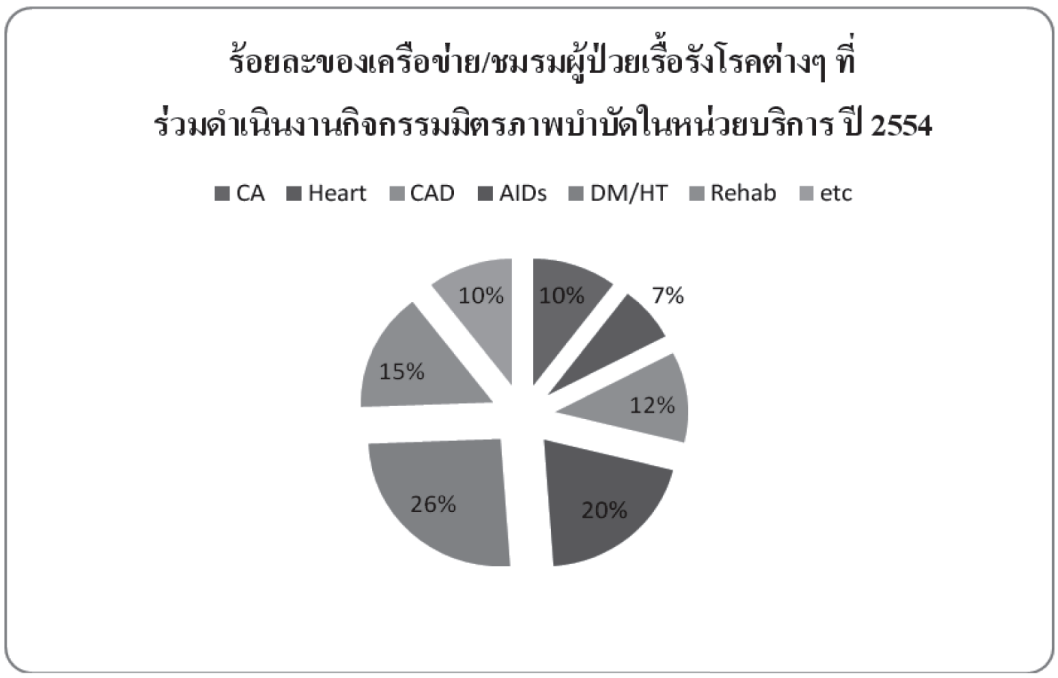
The objectives of activities implemented by the Friendship Support Center within the Universal Coverage Healthcare System are to develop patient's quality of life, to improve the quality of healthcare services and to organize healthcare for patients with chronic diseases / cancer patients with expensive treatments and / or terminally ill patients in the final stage of their illness with the participation of the patients themselves.

Implementation Progress

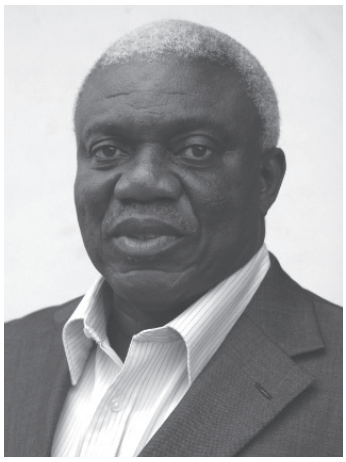
As of September 2011 a total of **253 healthcare centers** have participated in implementing Friendship Support Center activities and provided opportunities for networks of patients / the people / communities to participate in the following:

1. Establishment of chronic patient support groups/clubs with group volunteers
2. Organization of 'friends helping friends' activities where patients help patients on an on-going basis such as visiting patients at health centers, in communities and at homes.
3. Development and extension of capacities in order to establish healthcare networks for chronically ill patients in communities, villages / families.
4. Organization of activities in which patients / volunteers may participate in order to continuously develop the service system.
5. Organization of evaluations and summarization of lessons learned from working together.

Percentage of Networks/Associations of Various Chronically Ill Patients Participating in Friendship Support Activities in Healthcare Centers in 2011



In conclusion, the Universal Coverage Healthcare System has emphasized the importance of protecting the rights to participation of the people, healthcare recipients and patients, to receiving no fault compensation and to provide humanized healthcare with the objective of achieving a healthcare system that responds to the needs of the people and patients in order to improve their quality of life both physically and mentally.



Sam Adjei

President and Chief Executive Officer
Centre for Health and Social Service
Ghana

Sam Adjei, is a public health physician with skills in policy development, strategic planning and research. He has over 25 years experience in health development both public and private from the district through the provincial, national, and global levels. At the district level he was responsible for public health services including maternal and child care and worked with the local government to ensure well coordinated implementation. At the provincial level he was the specialist responsible for public health services. At the national level, he had worked in research as the Director of Research in the Ministry of Health for more than 10 years and later was appointed the Deputy Director General for the Ghana Health Service and coordinated all health programs. Later he became the Chief Consultant of the Ghana Health Service where he was the chief advisor to the Minister for Health and the Director General of the Ghana Health Service.

He spearheaded the Ghana Health Sector Reforms (Swap) and negotiated various aspects of it with development partner was a co- leader several annual reviews. In this position he led the development of three 5 Year Programs of Work (strategic plans) of the MOH.

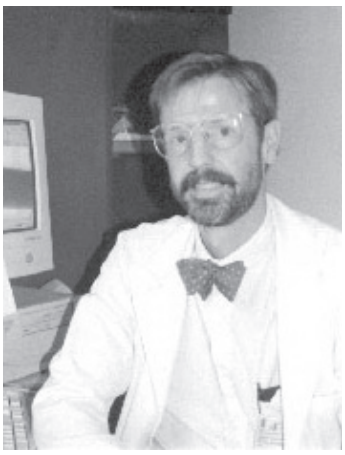
He has provided leadership in the design of health insurance at the onset in 1996, supported a district approach to evaluation of health insurance and coordinated the response of providers. He served on the first National Health Insurance Council.

At the global level he served on several committee of WHO and also as their temporal advisor of numerous occasions. He was a Board Member of the Health Metric Network of WHO and a member of the Independent Review Committee of GAVI. He is widely travelled and made several presentations at international forums.

He has worked in academia at the Department of Community Health in the University of Ghana Medical School, the School of Public Health of Ghana and at Aberdeen University where he was a visiting professor and policy advisor to the Initiative on Maternal Mortality Program Assessment (IMMPACT), a global research project on maternal mortality reduction. He has been Principal Investigator in several research programs on specific diseases as well as health systems in Ghana.

His skills include health systems and policy research, partnerships and inter-sector collaboration, health systems strengthening, donor coordination, health financing especially health insurance systems development and evidence based policy making and advocacy.

Currently he is the President and Chief Executive Officer of the Centre for Health and Social Service, a private not for profit organization he co-founded.



Matthew Anderson

Medical Doctor

Department of Family and Social Medicine,

Montefiore Medical Center

USA

Matt Anderson is a native of New York City. Before college he worked for six years in Haiti as a beekeeper for HACHO, a subdivision of CARE. He graduated from Harvard Medical School in 1990 and from Montefiore's Residency Program in Social Medicine (RPSM) in 1993. In 1999 he taught as a Fulbright Senior Scholar at the University of San Carlos Medical School in Guatemala City. In 2003 he received a Master's Degree in Clinical Research from Yeshiva University. He is board certified in Family Medicine and is certified as an HIV specialist by the American Academy of HIV Medicine.

He works as a family physician in a community health center in the Bronx. As part of his clinical work, he is co-director of a clinic caring for prisoners returning to the community. His research interests have included HIV in Guatemala, the management of vaginal complaints in primary care, health in the Bronx, and the use (or rather misuse) of race in clinical medicine. He is an active teacher on the faculty of Albert Einstein College of Medicine and is involved in the Social Medicine curriculum at the Montefiore RPSM. He participated in organizing an IPHU in the Bronx in 2010. Since October of 2011 he has been a member of the Occupy Wall Street Medical Support Working Group.

He is an editor of the online journal Social Medicine (www.socialmedicine.info and www.medicinasocial.info) and the Social Medicine Portal (www.socialmedicine.org). In 2001 he received the Service Award from Montefiore Medical Center, and in 2010 he received a Mid-Career award from the International Health Section of the American Public Health Association. He speaks English, Spanish, French, Haitian Creole and some German.

Orajitt Bumrungskulswat

Director, Bureau of Public and Private Participation
National Health Security Office
Thailand

Mrs.Orajitt Bumrungskulswat, 55 years old, was born in Bangkok, Marriage with two sons, Bachelor in Economics, Master of Science in Human Settlement Planning and development.

Present position Director, Bureau of Public and Private Participation, National Health Security Office. Social position, Assistant Secretary, Heart to Heart Foundation.

Working experience 35 years, in policy and plan analysis, urban and community development, Social Investment Fund of the World Bank, Community Development Fund, Local Health Promotion Fund, people and patient participation and Consumer Protection in Health Security System, local authority participation in Health Security System. Rehabilitation Fund Development under the Health Security Fund. Friendship Support Center Development.

Expertise local and community development /strategic planning and advocacy, local and community fund, people participate on and empowerment, civil society development/ networking, participatory monitoring and evaluation.

Douglas Munoreveyi Gwatidzo

Chairperson
Harare Hospital Management Board
Zimbabwe

Dr. Douglas Munoreveyi Gwatidzo was born almost 50 years ago. He grew up in an impoverished rural setting where the little extra money earned from the little plots was used to send his young brother and himself to school.

On completion of high school in 1982, he decided to go for a medical degree at the local university. By the way his high school was punctuated by closure of the school he attended when an all night vigil was held at the school by fighters of the liberation war in September 1978.

After internship Dr. Gwatidzo then decided to join the army in 1990 as a medical officer. This he did for four years, after which he retired at an early age of 32. He then joined a private hospital as an accident and emergency medical practitioner. It was at this hospital that he came face to face with the harsh reality of torture and various other forms of Human Rights abuses in 2000 to 2002. Together with his colleagues, they then decided to form Zimbabwe Association of Doctors for Human Rights (ZADHR) in November of 2002.

They looked at the health delivery system and identified areas of need that were never addressed by the government. This included health financing among the six building blocks of the health delivery system.

The cholera outbreak of 2008/2009 was the last straw in the collapse of what used to be the best health delivery system in sub-Saharan Africa north of the Limpopo. Dr. Gwatidzo and colleagues took the campaign to the corridors of government and forced government to admit that they had failed the nation.

As a result of the work done by the association of which Dr. Gwatidzo was the Chairperson until 2011, he was awarded with Global Health Council recognition for Health and Human Rights.

Dr. Gwatidzo has since been invited to sit on the board of Harare central Hospital as its Chairperson. This is going to be his pet project for the next three years or more. This is the Hospital for the majority poor in Zimbabwe.

David Sanders

Professor and Founding Director
School of Public Health, University
of the Western Cape
and People's Health Movement
South Africa

David Sanders, Emeritus Professor and founding Director of the School of Public Health at the University of the Western Cape, (U.W.C.), South Africa, is a specialist pediatrician with postgraduate qualifications in Public Health. He has over 30 years experience of health policy and program development in Zimbabwe and South Africa, having advised both governments as well as OXFAM,WHO,UNICEF and FAO in the areas of primary health care, child health and nutrition, and health human resources. He has published extensively in these fields as well as on the political economy of health, including on structural adjustment and development aid, having authored or co-authored three books: "The Struggle for Health: Medicine and the Politics of Underdevelopment", "Questioning the Solution: the Politics of Primary Health Care and Child Survival" and "Fatal Indifference: the G8, Africa and Global Health", as well as over 30 chapters and monographs and over 100 articles in peer-reviewed journals. In 2004/5 he was Heath Clark visiting lecturer at the London School of Hygiene and Tropical Medicine where he was also an Honorary Professor. He is also a Visiting Professor at the Centre for International Health at the University of Bergen.

He was on the Steering Committee of the United Nations Standing Committee on Nutrition from 2002 – 2006 and was actively involved in the Joint Learning Initiative on Human Resources for Health. He is on the editorial boards of and is a reviewer for several international journals. He was a member of the Knowledge Network of the WHO Commission on Social Determinants of Health. He is on the Global Steering Council of the Peoples Health Movement, was a managing editor of Global Health Watch 2 and a contributor to the recently published Global Health Watch 3. He is recipient of the Nutrition Society of South Africa award in 2002

Abhay Shukla

Coordinator
Support for Advocacy and Training to Health Initiatives (SATHI)
India

Dr. Abhay Shukla, M.D. is a Public health physician, with a postgraduate degree in Community Medicine from the All India Institute of Medical Sciences, New Delhi. Since one and half decades, he has been based in Maharashtra, working on health issues in collaboration with people's movements and grassroots NGOs. He is presently Coordinator of SATHI-CEHAT, and is a National Co-Convenor of People's Health Movement – India. He has co-edited the books 'Review of Health care in India', 'Report on Health inequities in Maharashtra' and 'Nutritional crisis in Maharashtra; he has co-authored the People's Health Movement-India booklet 'Health system in India – crisis and alternatives' and has authored the book 'The Rights Approach to Health and Health care'. He has been centrally involved in developing the framework of Community based monitoring of health services at national level (as part of the National Rural Health Mission - NRHM), is involved coordinating its implementation in Maharashtra, and is a member of the NRHM Advisory Group for Community Action. He is actively involved in development of Health rights activities at national and global level.

Parallel Session 2.6

The Role of the Private Sector in Universal Health Coverage:
a Blessing or a Curse?

The role of the private sector in achieving universal health coverage in South Africa

By Jane Doherty
Independent researcher and part-time lecturer, School of Public Health, University of the Witwatersrand

Introduction

South Africa is a country situated at the southernmost tip of Africa. Unlike other African countries, it has a relatively high GDP per capita of around $US5,800 and is therefore classified as an upper middle-income country (World Bank 2012). Yet South Africa performs poorly on many health indicators, often appearing as an outlier on graphs showing health status relative to GDP. Analysts ascribe at least some of the blame to the structure and functioning of the country's large for-profit private health sector and the contrast between the incentives driving this sector and the social objectives of the government.

It is generally assumed that the attraction of the South African private sector to paying patients is that it offers a superior quality of care and runs services more efficiently. This paper shows that, for the health system as a whole, the growth of the private sector has had disastrous consequences for equity, efficiency and sustainability.[1] This poses particular challenges when considering the potential role of the private sector under the National Health Insurance system proposed by the South African government in a recent Green Paper (National Department of Health 2011). This draft policy seeks to achieve universal health care coverage (including financial protection) and improve performance across the whole health system.

The emergence of the private health sector during the apartheid years

Under apartheid the South African for-profit private health sector developed mainly to serve the ruling white minority although in the mid-1980s the unionisation of black workers also gave them access to commercial health care through employer-based insurance. At that time, most health insurers (known as 'medical schemes' in South Africa) were 'closed,' employer-based schemes. Membership was usually a condition of employment, with premiums shared between employer and employee and adjusted according to income but not to the risk of ill-health. As benefits were standardised, schemes promoted cross-subsidisation of the ill, old and poor by the healthy and rich. Schemes themselves were not for profit, with surpluses channelled back into the scheme. Although scheme administrators might sometimes be profit-making entities, they were often part of the employer organisation, while schemes were generally overseen by a

[1] There is also some research evidence that shows that the quality gains afforded by expensive private care can be less than expected, although this paper does not pursue this issue.

Board consisting of employer and employee representatives keen to keep costs down. Schemes were aided in this by the setting of nationally negotiated tariffs for providers by the official association of schemes.

Even so, in 1992/93 the for-profit health sector captured 60 percent of total health expenditure in the country although it covered only 23 percent of the population, while medical scheme contributions amounted to 15 percent of average salaries (McIntyre, Bloom et al. 1995). These problems led to political pressure on the apartheid government to relax regulations constraining the behaviour of medical schemes. By 1994, shortly before the election of the first democratic government, new legislation had allowed schemes to differentiate benefit packages and risk-rate members, the intention being to encourage cheaper plans and extend private sector coverage.

The rapid growth of the private sector post-apartheid

The consequence of de-regulation was the proliferation of medical schemes, including the advent of a new type of scheme, the 'open' scheme. Unlike 'closed' schemes, 'open' schemes accepted individual members, were not linked to particular employers and were usually administered by for-profit entities. They also offered differentiated benefit packages, with cheaper premiums for more limited packages and low-risk members.

These developments did not expand coverage as intended (Doherty and McLeod 2003; Doherty and Steinberg 2003). Instead, existing members were 'churned' between schemes. The new open schemes 'cherry-picked' low risk members, excluding high-risk (and expensive) members. This eroded the membership base of closed schemes which were left with disproportionate numbers of older, sicker members. Financial incentives offered to brokers also encouraged the poaching of existing members from one scheme to another. Scheme administrators became adept at excluding risky beneficiaries rather than managing schemes efficiently, and costs continued to rise. This was aggravated by the fragmentation of risk pools which reduced income and health risk cross-subsidies, and led to rising premiums for the ill, old and poor. Increasingly, some form of co-payment became the norm, reducing the financial protection afforded by prepayment. This led to members 'buying down' to smaller benefit packages, the exclusion of poor or high-risk patients and the increasing 'dumping' of privately insured patients on the public sector when their benefits had expired.

In this climate of minimal regulation, some open scheme administrators were able to strip surplus from their schemes through unethical reinsurance practices and kickbacks. Another mechanism for extracting surplus was through charging high administrative and managed care costs. All of these practices became easier as the vertical integration of reinsurance companies, medical scheme administrators and managed care organisations

grew. Scheme reserves were also allowed to run dangerously low.

All through this period, providers remained largely unregulated. The number of hospital beds doubled in the decade 1989 and 1998, despite a government moratorium on the building of new hospitals (Doherty, Thomas et al. 2002). Increasingly these beds fell under the aegis of three private hospital networks which have been suspected of colluding on prices. There was also increasing vertical integration of providers (such as the ownership of private ambulance services and medical scheme administrators by private providers) (McIntyre 2010). Because of the weak bargaining power of schemes, the absence of effective price controls and exclusively fee-for-service reimbursement, together with the decline of public hospitals, private hospitals and specialists began to charge above the recommended medical scheme tariff. There were also large mark-ups on pharmaceuticals (especially by private hospitals) as well as instances of over-prescribing (particularly by dispensing doctors).

The impact of these features of the de-regulated environment on the efficiency and equity of the overall health system were the following (Doherty, Thomas et al. 2002).

- Over the two years between 1996/97 and 1998/99, per capita expenditure grew 10 times more quickly in the medical schemes industry compared to the public sector.
- By 1999 per capita expenditure on medical scheme beneficiaries was nearly four times that spent per public sector patient.
- The private sector increasingly captured government subsidies through a variety of mechanisms, including contracts with the public sector, under-charging of privately insured patients who used the public sector, tax relief to employers contributing to their employees' premiums (amounting to 20 percent of the public sector health budget) and high premiums paid by government for its civil servants belonging to medical schemes (in the 1990s, government spent 12 times as much per civil servant for medical scheme membership as it did on public sector dependents).
- The expansion of the private sector, and higher fees, attracted skilled health professionals away from the public sector. At the end of the 1990s, around 75 per cent of specialists, between 50 and 70 per cent of GPs and around 40 per cent of nurses were estimated to work in the private sector. Doctors working in academic hospitals were allowed to engage in limited private practice, a strategy which undermined the provision of care at academic hospitals.

Re-regulating the private sector in the early 2000s

In the early 2000s, new legislation was introduced to combat some of these developments. There were some hard-won achievements in regulating the practice of dispensing doctors, setting single exit prices for pharmaceuticals, enforcing generic substitution, controlling dispensing fees and re-introducing community rating and standardised (minimum) benefit packages in the medical schemes industry. As a result of these measures, some negative practices by medical schemes administrators were curtailed. Spending on medicines as a proportion of total medical schemes expenditure also decreased from 32 percent in 1992 to 17 percent in 2009 (McIntyre, Doherty et al. forthcoming). Private hospitals and

specialists remained largely unregulated, however. Other remaining problems include fragmented risk pools (both within the private sector and between the private and public sectors) and increasing concentration of the ownership of hospital beds, pharmaceutical companies and medical scheme administrators.

Apart from progress on the price of medicines medicines, cost containment in the rest of the private sector was consequently disappointing, as were the equity benefits of re-regulation (McIntyre, Doherty et al. forthcoming):

- By 2008, medical schemes funding accounted for 43 percent of total health care resources in the country (equivalent to general tax revenue). This made South Africa the country with the largest proportion of total health care finances channelled through private insurers in the world (Drechsler and Jutting 2005).
- Medical schemes covered only 16 percent of the population (although these numbers have recently picked up slightly with the introduction of a scheme for government employees, coverage is still below 1994 levels).
- Medical scheme contributions per beneficiary were double that in 1996 (after adjusting for inflation) (see Figure 1).
- Over 60% of out-of-pocket payments were made by medical scheme members showing that health insurance does not offer them complete financial protection from the costs of ill-health.
- The richest 40 percent of the population paid more towards medical schemes than they paid in tax and out-of-pocket for health care services combined.
- Expenditure on private hospitals and specialists as a proportion of total medical scheme expenditure had escalated sharply.
- Private sector expenditure per beneficiary was six times that spent on public sector dependents.

The private sector under National Health Insurance

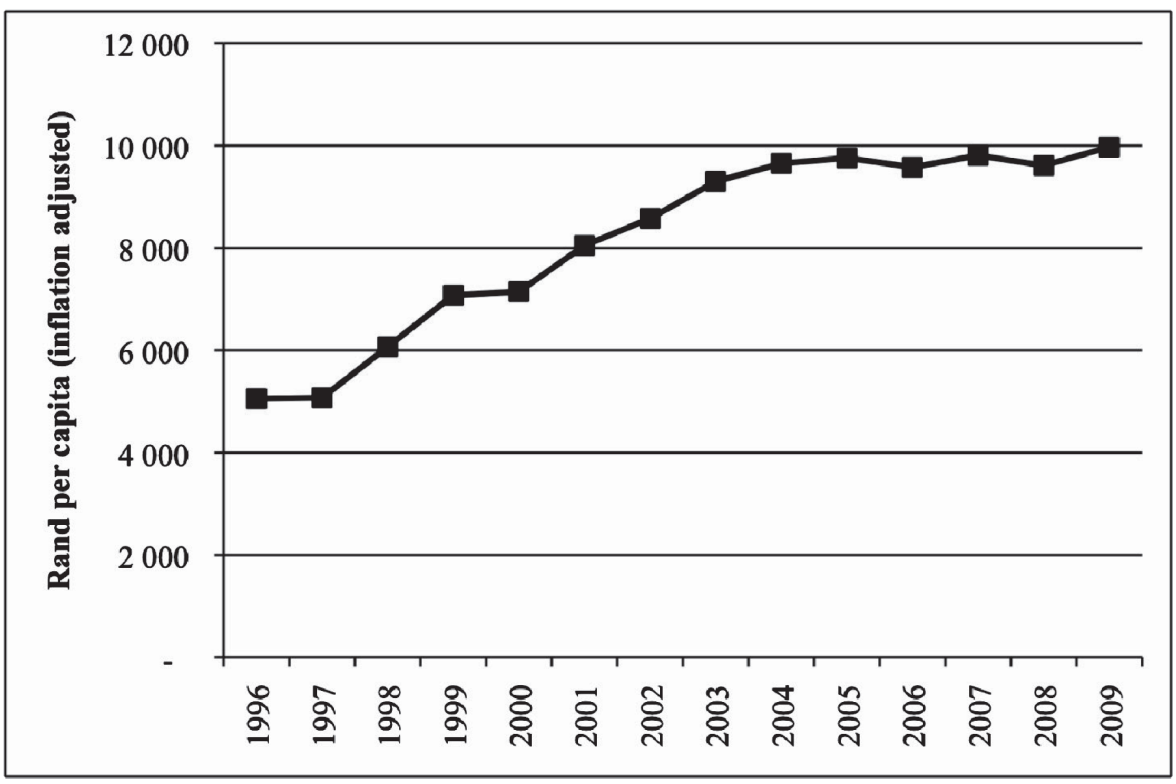
The experience of South Africa shows that promoting the private sector in the absence of appropriate regulation, price controls, efficient reimbursement mechanisms and effective competition aggravates inequity and makes quality health care increasingly unaffordable, even for the wealthier members of society. Re-regulation of the private sector is complex and difficult, particularly once providers have become disproportionately powerful. This suggests that, while the private sector has much-needed resources and skills, it may prove difficult to deploy these in ways that support the social objectives underlying universal health care coverage policies.

One of the objectives of South Africa's proposed National Health Insurance system is to address the distortions created by the private health sector through fundamental changes to its structure and functioning. It is proposed that this will be done by creating a single NHI Fund which purchases services from both public and private providers using more efficient reimbursement mechanisms (such as capitation and case-based payments) and sustainable prices. Primary level providers (including pharmacists) would probably be the initial focus for such contractual arrangements. It is intended that this would result

in human and other resources within the private sector being utilized to serve the wider population at a lower overall cost. Private voluntary insurance would continue, but probably only in the form of complementary (or 'top-up') cover.

Shifting to these new arrangements will take time and depend on the cooperation of provider groups, the development of contracting and monitoring capacity on behalf of government, and the reorientation of private practice at the primary level towards a comprehensive Primary Health Care approach.

Figure 1: Trends in real funding via medical schemes, per medical scheme beneficiary (2008 Rands)



Sources: *Council for Medical Schemes Annual Reports (1997-2010), quoted in (McIntyre, Doherty et al. forthcoming)*

Note: One United States Dollar is equivalent to roughly eight South African Rands

Acknowledgement

This paper forms part of work in progress for a chapter by Jane Doherty and Diane McIntyre, *'Addressing the failings of public health systems: should the private sector be an instrument of choice?,'* ***in a book entitled*** *'Social policy in developing world: comparative debates,'* ***edited by Rebecca Surrender, Robert Walker and Robert van Niekerk.***

REFERENCES

Doherty, J. and H. McLeod (2003). Medical schemes. South African Health Review. Health Systems Trust. Durban, Health Systems Trust.

Doherty, J. and M. Steinberg (2003). Priority health care information needs for reform: what role for BHF? Johannesburg, Board of Healthcare Funders.

Doherty, J., S. Thomas, et al. (2002). Health financing and expenditure in post-apartheid South Africa, 1996/97-1998/99. Pretoria, National Department of Health.

Drechsler, D. and J. Jutting (2005). Is there a role for private health insurance in developing countries? . Berlin: German Institute for Economic Research.

McIntyre, D. (2010). Private sector involvement in funding and providing health services in South Africa: implications for equity and access to health care. EQUINET Discussion Paper Series 84. Harare, Health Economics Unit (UCT), ISER (Rhodes University), EQUINET.

McIntyre, D., G. Bloom, et al. (1995). Health expenditure and finance in South Africa. Durban, Health Systems Trust and the World Bank.

McIntyre, D., J. Doherty, et al. (forthcoming). Health care financing and expenditure - progress since 1994 and remaining challenges. Health and health care in South Africa (2nd edition). H. Van Rensburg. Pretoria, van Schaik Publishers.

National Department of Health (2011). Green Paper on National Health Insurance in South Africa. Pretoria, National Department of Health, Republic of South Africa.

World Bank. (2012). "Country website: South Africa." Retrieved 4 January, 2012, from http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/AFRICAEXT/SOUTHAFRICAEXTN/0,,menuPK:368082~pagePK:141159~piPK:141110~theSitePK:368057,00.html.

Jane Doherty

Independent researcher and part-time lecturer
University of the Witwatersrand
South Africa

I am a South African health systems and policy researcher with over twenty years' experience. I specialise in issues affecting the equity and effectiveness of the South African public health sector. I also have an interest in using international evidence to inform the strategic direction of health systems in low- and middle-income countries.

I have a Bacherlor's degree in Veterinary Science (1985, Pretoria), a Master's degree in International Relations (1987, Cantab) and a post-graduate Diploma in Health Services Management (1991, Witwatersrand). I have also done a number of post-graduate courses in research methodology.

Between 1989 and 2001 I worked at the Centre for Health Policy at the University of the Witwatersrand (South Africa) where I eventually became Deputy Director. Since 2001 I have worked independently (mainly for universities and international agencies), although I remain a part-time lecturer in the School of Public Health at the University of the Witwatersrand.

My research interests include health financing policy, hospital planning and management, district health systems, human resource planning and production, the public-private mix and methodological issues in policy research. I use mixed research methods but have special skills in the qualitative analysis of semi-structured interviews.

I have produced around 40 research reports, 10 book chapters and 15 journal articles, amongst other outputs. I also act as a reviewer for a number of international journals.

Beyond my research interests, I am committed to developing capacity for health systems and policy research in low- and middle-income countries. I have considerable experience in designing post-graduate courses, adult learning techniques and mentoring. I act as an external examiner for Master's students and also conduct research on effective capacity-building approaches.

I am currently a member of the Purchasing Sub-Committee of the Ministerial Advisory Committee on National Health Insurance in South Africa.

My research outputs relating to the role of the private sector in achieving social objectives are:

- Doherty J. 2011. Expansion of the private for-profit health sector in East and Southern Africa. EQUINET with HEU, UCT and TARSC Policy Brief 26. Harare: EQUINET.
- Doherty J. 2011. *Expansion of the private health sector in East and Southern Africa. EQUINET Discussion Paper 87*. Harare: EQUINET.
- McIntyre D, Doherty J. 2004. Health financing and expenditure. In: Van Rensburg HCJ (ed). 2004. *Health and health care in South Africa.* Pretoria: van Schaik Publishers. (2012 revision in press)
- Doherty J, McLeod H. 2003. Medical schemes. In: Health Systems Trust. 2003. *South African Health Review, 2003.* Durban: Health Systems Trust.
- Doherty J, Steinberg M. 2003. *Priority health care information needs for reform: what role for BHF?* Johannesburg: Board of Healthcare Funders.
- Doherty J, Thomas S, Muirhead D, McIntyre D. 2003. Health financing and expenditure in the post-apartheid era. In: Health Systems Trust. 2003. *South African Health Review, 2003.* Durban: Health Systems Trust.
- Buch E, Doherty J. 2002. Public policy and the future of medical schemes. In: Board of Healthcare Funders. 2002. *Investing in the new healthcare economy*. Johannesburg: Board of Healthcare Funders in association with Deloitte and Touche Human Capital Corporation.
- Clews F, Kushlick A, Lee T, Doherty J, Rapholo G. 1998. *Non-governmental organisations serving people with profound intellectual disability and severe psychiatric disability*. Johannesburg: Centre for Health Policy.
- Beattie A, Doherty J, Price M, de Beer C. 1992. Private practice in academic medicine - a trojan horse. *South African Medical Journal*; **82:** 385-386.

My detailed CV and outputs are available on http://healthpolicysa.wordpress.com/.

Marie-Gloriose Ingabire

Senior Program Specialist
International Development Research Centre (IDRC)
Canada

Dr. Marie-Gloriose Ingabire is the Senior Program Specialist for the Governance for Equity in Health Systems (GEHS) programme at the Canada's International Development Research Centre (IDRC). An economist by training, Marie-Gloriose oversees IDRC-supported research related to health financing and health economics as well as human resources for health. Before joining IDRC, she worked at the Pan American Health Organization (PAHO) in Washington, DC, as an Associate Expert working on and advising countries in Latin America and Caribbean on human resources for health dimensions of health systems and services. She has also assisted countries in Africa for the development of their strategies for human resources for health development.

Marie-Gloriose also worked for the Canadian Federal Government as an economist and a senior consultant. She holds a PhD in economics from the Université de Montréal, where she also worked as a lecturer and professional researcher.

Gustavo Nigenda-Lopez

Research Director
Harvard Global Equity Initiative
USA

Dr. Nigenda, PhD., is the Research Director for the Harvard Global Equity Initiative. Recently, he served as the Director of Innovation Services and Health Systems and Coordinator of the Doctoral Program on Health Systems at the Mexican National Institute of Public Health. He is also a member of the research group and consultant for "Cáncer de Mama: Tómatelo a Pecho," an initiative with the goal of reducing breast cancer mortality in Latin America through early detection and effective treatment. Dr. Nigenda has published extensively on various topics including human resources for health, gender and health, social health protection and health system reforms in Mexico. Dr. Nigenda earned his PhD in Health Policy from the London School of Economics and Political Science. Since 1980, he has worked with research groups in the field of public health.

Ravindra Rannan-Eliya

Fellow and Executive Director
Institute for Health Policy
Sri Lanka

Dr. Ravi P. Rannan-Eliya, Fellow and Executive Director of the Institute for Health Policy, is a physician and economist who graduated from the University of Cambridge with degrees in Political Science and Medicine. After his internship in the United Kingdom, he specialized in International Public Health, earning a master's degree in Public Health and then his doctoral degree in Health Economics from Harvard University. From 1993 to 1997, he was a member of the research faculty of Harvard University, where he worked on a series of research projects in Latin America, Africa, and Asia. From 1996, he established and developed the leading health economics research group in Sri Lanka, at the Institute of Policy Studies, before transforming it in 2005 into a full-fledged, independent research center, the Institute for Health Policy (IHP), which he now leads. He has undertaken research and consulted in more than 30 countries, working with the World Bank, WHO, ADB, and other agencies and governments. He is recognized as a leading international expert in the areas of health equity research and health accounting. His current research focuses on issues of health systems financing, aging, equity, non-communicable disease and child under-nutrition.

Regional and international collaborations comprise a major part of his work. He is director of the IHP Hub of the recently established Asia Pacific Observatory on Health Systems and Policy, and co-director of the Global Network on Health Equity (GNHE), which brings together a number of regional health equity networks. He also coordinates two major scientific networks – APNHAN (Asia-Pacific National Health Accounts Network), and Equitap (Equity in Asia-Pacific Health Systems), and is a board member of the Asia-Pacific Health Economics Network (APHEN). He has served as a member of the Scientific, Technical and Advisory Committee of the WHO Alliance for Health Systems and Policy Research, and contributed as an author to the Alliance's 2007 Biennial Review, which focused on capacity building for health systems and policy research. He is currently a Deputy Secretary of the International Health Economics Association (iHEA), where he works on outreach to health economists in developing Asian countries.

Sakthivel Selvaraj

Health Economist

Public Health Foundation of India

India

Dr. Sakthivel Selvaraj is a Health Economist who is currently engaged in teaching and research in the area of health care financing, pharmaceutical economics and economics of tobacco. He was a Takemi Fellow (Post-Doctoral Fellow at Harvard School of Public Health, Boston, US) and a Fulbright Scholar during 2006-07. He has a Ph.D. in Health Economics (1996-2001) from Jawaharlal Nehru University, New Delhi. Earlier, he was engaged as a Health Economist in the National Commission on Macroeconomics and Health (NCMH), Ministry of Health and Family Welfare, New Delhi during 2004-05. S. Sakthivel also served as Consultant in National Commission on Enterprises in Unorganised Sector in India and as a Fellow at Institute for Human Development (2005-06). Before joining NCMH, he was engaged as Research Associate in the Institute of Economic Growth (2002-04). He has published articles in reputed national and international refereed journals, including The Lancet, Social Science and Medicine, etc..

Dr. Sakthivel Selvaraj has been involved in several research projects. During 2006-07, he was involved in a research report produced for the WHO India Country Office on disease-specific sub-accounts. The report dealt with tracking the flow of funds in the HIV/AIDS Sector in India using the NHA framework. He actively participates in the ongoing EQUITAP Phase-2 project (Equity in Health Financing and Delivery) along with other Asia-Pacific countries. The project lead is heading EQUITAP research work from India that includes examining implications of households catastrophic and impoverishment effect due to increasingly growing role of OOP (Out-of-Pocket) payments. EQUITAP also envisages an analysis of the distributive implications of public health subsidies on various segments of the population (through the methodology of Benefit-Incidence Analysis). Dr. Sakthivel Selvaraj also headed another project in relation to public health expenditure tracking exercise (Public Expenditure Tracking initiative), funded and guided by Research for Development (R4D). The project examined the following specific objectives: a) Document the framework and process of drug financing, procurement and distribution at various government levels; b) Analyse the current financing, selection, procurement, distribution and dispensing pattern of drug spending in two Indian states; c) Bring out policy suggestions and work out detailed action plan for implementing the suggestions. He is also currently part of the Secretariat at Public Health Foundation of India (PHFI), which has been entrusted with the exercise of providing overall vision and specific roadmap for achieving Universal Health Care (UHC) in India. As part of the exercise of evidence generation to policy-making in relation to UHC, he was specifically entrusted with two specific areas – health care financing and access to medicines in India.

Plenary Session 3

Pathways to UHC:
Debates on critical policy choices

Peter Berman

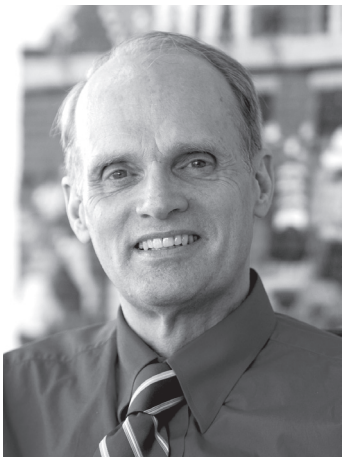
Adjunct Professor
Harvard School of Public Health
USA

Prof. Peter Berman (M.Sc, Ph.D) is a health economist with thirty years of experience in research, policy analysis and development, and training and education in global health. He recently retired from the World Bank's Washington, D.C. office and returned to Cambridge Massachusetts.

While with the World Bank, he spent three years as Lead Health Economist in the HNP anchor department and Practice Leader for the World Bank's Health Systems Global Expert Team. He also served a four year assignment in the World Bank's New Delhi office as Lead Economist for Health, Nutrition, and Population. He is Adjunct Professor of Population and International Health Economics at Harvard School of Public Health and Visiting Professor at the Public Health Foundation of India (PHFI), New Delhi. Prof. Berman is also the advisor to the China National Health Development Research Center for health care financing and health accounts.

Previously at Harvard he was Professor of Population and International Health Economics and founding Director of the International Health Systems Program (IHSP, see www.hsph.harvard.edu/ihsg/ihsg.html) in the Population and International Health Department. Prof. Berman is the author or editor of five books on global health economics and policy as well as dozens of academic articles and papers. He has led and/or participated in major field programs in all regions of the developing world.

Prof. Berman's specific areas of technical expertise include analysis of health systems performance and the design of reform strategies; assessment of the supply side of health care delivery and the role of private health care provision in health systems and development of strategies to improve outcomes through public-private sector collaboration; and the use of national health accounts as a policy and planning tool. Prof. Berman has worked extensively on health system reform and health care development issues in a number of countries, including Egypt, India, Colombia, Indonesia, and Poland, including extended periods of residency and field work in Indonesia and India. He is co-author of Getting Health Reform Right: A Guide to Improving Performance and Equity (Roberts, et al, Oxford University Press, 2003), co-editor of the Guide to the Production of National Health Accounts (World Bank, World Health Organization, and USAID, 2003), and co-editor of Paying for India's Health Care (Sage, 1993).



David de Ferranti

President

Results for Development Institute (R4D)

USA

David de Ferranti is President of The Results for Development Institute (R4D), a not-for-profit that works with African, Asian, Latin American, and Eastern Europeans countries to find and apply practical solutions that help reduce poverty.

Previously, he headed up the World Bank's vice-presidency for the social sectors (nutrition, health, education, population, and social safety net and protection programs in developing countries), and, subsequently, its vice-presidency for Latin America and the Caribbean.

He has served in the U.S. government and led research at Rand, the think tank. He has been a Senior Fellow at the Brookings Institution and the United Nations Foundation, and an Adjunct Professor at Georgetown University. He is Chair of the Board for the Center on Budget and Policy Priorities, spent ten years on the Board of the Rockefeller Foundation, and serves on numerous other boards and international committees.

He holds a Ph.D. in Economics from Princeton University, and a B.A. from Yale University, with Phi Beta Kappa and Magna cum Laude honors. His recent publications include a book on *How to Improve Governance: A New Framework for Analysis and Action and a Lancet article on Reforming how health care is paid for in China: challenges and opportunities.*

Naoki Ikegami

Professor

Keio University School of Medicine

Japan

Naoki Ikegami, MD, PhD, MA, is Professor and Chair of the Department of Health Policy and Management at the Keio School of Medicine, from which he received his MD and PhD. He also received a Master of Arts degree in health services studies with Distinction from Leeds University (United Kingdom). During 1990-1991, he was a visiting professor at the University of Pennsylvania's Wharton School and Medical School, and has continued to be a Senior Fellow at Wharton. He is a founding member of inter*RAI* (a non-profit international consortium of researchers and clinicians focused on care planning instruments), and served as a consultant to the WHO and the World Bank. He is currently President of the Japan Health Economics Association and Past-President of the Society of Healthcare Administration. He sits on various national and state government committees, including the Chair of the Investigative Specialist Sub-committee on Case-mix Based Reimbursement for Chronic Inpatient Care. His research areas are health policy, long-term care and pharmacoeconomics. His publications include "The Art of Balance in Health Policy - Maintaining Japan's Low-Cost Egalitarian System" (Cambridge University Press, 1998) with John C. Campbell, "Quality Life Evaluation Handbook for Clinicians" (Igakushoin, 2001) in Japanese with Shunichi Fukuhara et al, "Measuring the quality of long-term care in institutional and community settings" in "Measuring Up – Improving Health Care Performance in OECD Countries" (OECD, 2002) with John Hirdes and Iain Carpenter, "Games policy makers and providers play: Introducing case-mix based payment to chronic care hospital units in Japan (JHPPL, 2009).

Naoki Ikegami, MD, PhD, MA is Professor and Chair of the Department of Health Policy and Management at the Keio School of Medicine, from which he received his MD and PhD. He also received a Master of Arts degree in health services studies with Distinction from Leeds University (United Kingdom). During 1990-1991, he was a visiting professor at the University of Pennsylvania's Wharton School and Medical School, and has continued to be a Senior Fellow at Wharton. He is a founding member of inter*RAI* (a non-profit international consortium of researchers and clinicians focused on care planning instruments), and served as a consultant to the WHO and the World Bank. He is currently President of the Japan Society of Healthcare Administration and sits on various national and state government committees, including the Chair of the Investigative Specialist Sub-committee on Case-mix Based Reimbursement for Chronic Inpatient Care.

Pongpisut Jongudomsuk

Director

Health Systems Research Institute (HSRI)

Thailand

Pongpisut Jongudomsuk, MD degree at the Faculty of Medicine, Ramathibodi Hospital, Mahidol University, Master of Public Health at the Institute of Tropical Medicine Antwerp, Certificate of Preventive and Family Medicine of the Thai Medical Council. After ten years working in rural district hospital in northeastern of Thailand, he changed his career to work in the Ministry of Public Health as Deputy Director of Health Insurance Office, National Project Director of the (EU-supported) Health Care Reform Project, Director of the Bureau of Policy and Planning at the National Health Security Office, and Head of the Technical Support Team of the Thai Minister of Public Health. Currently he is the director of the Health Systems Research Institute. His main areas of interest are health financing, health care reform, primary care and health policy and systems research.

Nathaniel Otoo

Director of Administration and General Counsel
National Health Insurance Authority
Ghana

Nathaniel is the Director of Administration and General Counsel of the National Health insurance Authority of Ghana. His 20 years of work experience has spanned both the public and private sectors, with the last 9 of them being in social protection.

He holds an LLB Degree from the University of Ghana and a professional qualification in law from the Ghana School of Law. He also holds an MA degree in International Relations from the International University of Japan.

Nathaniel has attended various management and health leadership courses and participated in a number of international fora on health financing. He has played a key role in the ongoing legal reforms in Ghana's National Health Insurance Scheme and is the current focal person for the Joint Learning Network in Ghana.

Kanuru Sujatha Rao

Former Secretary
Ministry of Health and Family Welfare
India

Ms. Sujatha Rao joined the Indian Administrative Service in 1974. She had the unique privilege of being associated with the health sector directly and indirectly since 1988 -93 when she was deputed to the Ministry of Health and Family Welfare, Government of India as Director and later as Joint Secretary. Form 1998-2003. She worked as Secretary, Family Welfare in Govt. of Andhra Pradesh from 1993-06; and again during 2005. 2004 she was nominated by Govt. of India as Member Secretary of the National Commission on Macroeconomics which was co-chaired by Union Ministers' of Health and Finance. The Report of this Commission is now the basis for much of the health sector reform underway in the Ministry of Health & Family Welfare.

Ms. Rao was posted as Union Secretary, Ministry of Health and Family Welfare in 2009. Before that she was Additional Secretary and later Secretary & DG Department of AIDS Control from 2005 till 2009. She retired from government service on 30th November 2010.

Ms. Rao was nominated as Vice-Chairman of the Global Advisory Group on Nursing and Midwifery by the WHO as a public health expert for 2000-2001. She was elected as chairperson of the Portfolio Committee of the Global Fund for HIV/AIDS, TB and Malaria (GFATM) for 2 years (2007-2009) In 2008, she was invited to be a member of the six member Global Advisory Panel of the Bill & Melinda Gates Foundation, She was the Founding Board member of the Public Health Foundation of India 2005 She is currently a Board Member of the Population Council International, New York, 2011; Co-chair of the WHO's Advisory Panel on Developing a Global Health Systems Research Strategy, Geneva, 2011 and Member of the Advisory Board of the Ministerial Leadership Program of the Harvard School of Public Health, USA. She represented India on the Boards of the WHO, Global Fund and UNAIDS

Ms. Rao did her post-graduation from Delhi University and has a Master's Degree in Public Administration from Harvard University, USA in 1991-92. She was also a Takemi Fellow at the Harvard School of Public Health during 2001-2002. She has recently been invited as the Gro Harlam Brundtland Fellow for the spring term by the Harvard School of Public Health, USA.

Ms. Rao has published several papers and articles on health and public policy matters. She was a co-author of 'India Health Report' published by Oxford University Press in 2003.

Email : ksujatharao@hotmail.com

Parallel Session 3.1

Defining, Measuring and Monitoring Universal Health Coverage

Defining, Measuring and Monitoring Universal Health Coverage[1]

By Xenia Scheil-Adlung,
Health Policy Coordinator, International Labour Office,
Geneva, Switzerland

I. Introduction

Current approaches to measuring the performance of social health protection in terms of coverage frequently suffer limitations. Coverage is often measured only in terms of population coverage – based on the existence of legislation – which fails to reflect whether health services are in fact accessible e.g. in terms of availability and affordability.

Furthermore, information on external factors such as the socio-economic environment of a country that poses barriers to achieving universal coverage is often missing and thus related international comparisons on progress might be less meaningful.

In response, the International Labour Office (ILO) proposes a new approach, which utilizes a set of indicators to assess the various dimensions of universal health coverage within a framework of country groups facing similar socio-economic challenges. It is suggested that such a framework of vulnerability of countries replaces the current approach of grouping countries by national income-levels.

II. Defining Universal Health Coverage

Following the definition of the ILO, social health protection involves a series of:

> *Public or publicly organized and mandated private measures against social distress and economic loss caused by the reduction of productivity, stoppage or reduction of earning or the cost of necessary treatment that can result from ill health.*

Universal coverage of social health protection entails that all residents living in a country be able to access health care in an equitable manner at least an essential health benefit package of adequate quality if in need. It should be in line with national and internationally agreed objectives such as the MDGs on health and relevant ILO Conventions such as ILO Convention 102 (Social Security Minimum Standards).

[1] This paper is largely based on Scheil-Adlung, X., Bonnet, F., Beyond legal coverage : Assessing the performance of social health protection, ISSR, Vol. 64 3/2011.

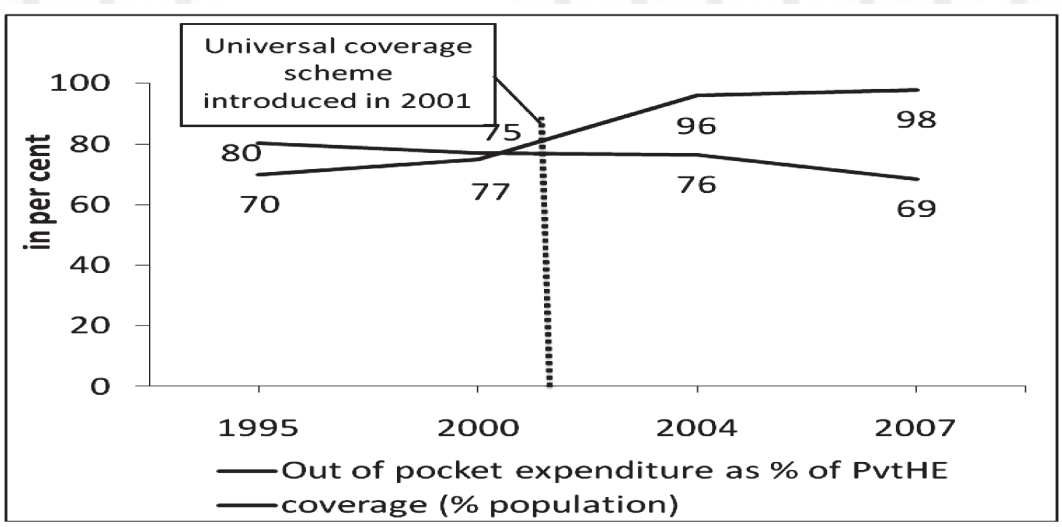
Universal health coverage should be based on inclusive legislation. In addition, legislation needs to be implemented with a view to achieving effective access to health care. Effective access to health is frequently hampered by e.g. financial barriers due to high out-of-pocket payments (OOP) or geographical barriers due to the absence of health work force, infrastructure etc. Against this background, it is suggested to define effective access as regards the following key dimensions:

- **Inclusive legislation** that covers the whole population providing rights to health care
- **Availability of health services**, e.g. the physical existence of health care services, related staff, infrastructure, medical goods and products that provide care responding to needs.
- **Affordability of health services,** particularly with regard to the absence of financial barriers to access services such as high copayments or user fees and financial contributions in relation to the ability to pay.
- **Financial protection** from high OOP, catastrophic costs, impoverishment and loss of income due to ill health
- **Quality** of health care including at the systemic and managerial level and at the service delivery level regarding infrastructure, staff, responsiveness etc.

In many countries, these dimensions do not fall together. An example is provided in Figure 1. It outlines the trends in population coverage as compared to financial barriers to access posed by OOP in Thailand: Despite the introduction of the universal coverage scheme in 2001 and a significant decrease of OOP expenditure, the overall level of OOP expenditure remains in 2007 with nearly 70 percent of total private expenditure high.

OOP thus continues to pose financial barriers to health care, a testament to the fact that the extension of population coverage alone does not necessarily lead to effective access to health care.

Figure 1. *Trends in population coverage and OOP expenditure in Thailand 2000-2009*



Source: ILO based on WHO (2011) Global Health Expenditure Database

Thus measuring coverage should be based on a broad concept that encompasses key dimensions of effective access to health care in addition to population coverage.

III. How to Measure Coverage in Terms of Access

The ILO approach to measuring coverage defined as effective access to health care aims to bring together a set of indicators to capture the aforementioned dimensions of coverage, and to interpret the results in a framework that allows for adequate international comparisons. Such a framework should reflect main socio-economic issues at country level that hinder progress in achieving universal coverage and need to be addressed. These are in particular poverty and labour market conditions:

- Both poverty and labour market structure impact significantly on the availability of funds to finance healthcare expenditures from domestic revenues such as taxes, contributions or premiums.

- Labour market structures characterised by high levels of informal economies impact on the technical feasibility to reach out to people working in the informal economy that are often poor and living in rural areas.

It is thus suggested that for the purpose of measuring and monitoring coverage, countries are grouped by poverty rates (below USD 2 per day) and the share of the informal labour market. By grouping countries in this way, peer country groups are created that are based on challenges to achieving universal coverage. Within this framework of country vulnerability, a set of indicators should be observed that reflects the key dimensions of universal coverage defined as effective access. Appropriate indicators are listed in Table 1.

Table 1. *Set of indicators and databases suggested for measuring coverage*

Population coverage	Deficit of population coverage in per cent of the population, based on data from the ILO Social Health Protection database (ILO, 2008).
Affordability and financial protection	Share of out-of-pocket payments in per cent of total health care expenditure and catastrophic health expenditure as a share of total health expenditure, based on National Health Account data and data available from various sources using WHO databases.
Availability	ILO Access Deficit Indicator using the availability of the health service workforce, based on data from ILO calculations on social health protection coverage using WHO databases.
Quality	Deficit in health spending per capita and maternal mortality ratio, based on National Health Accounts and WHO databases.

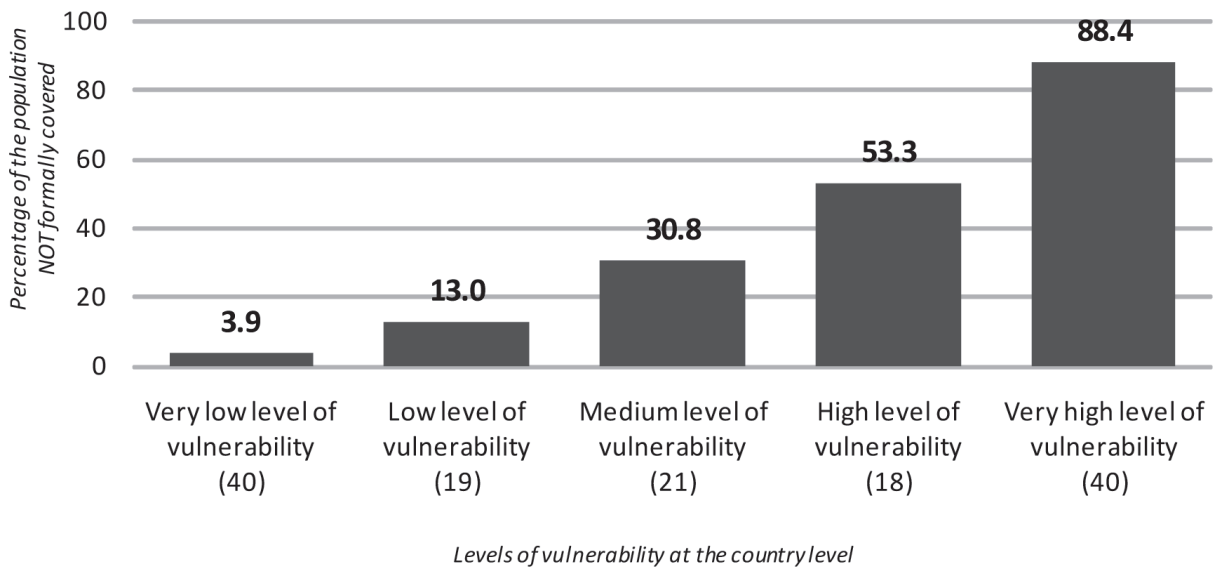
The ILO Access Deficit Indicator provides information on the shortage of a skilled health workforce using the relative difference between the density of health professionals in a given country and the median value in countries with a low level of vulnerability. Similarly, the deficits in health spending per capita are measured in comparison to the median value of the country group with a low level of vulnerability. The maternal mortality ratio is used as an indicator to reflect access and quality of maternal care services and the general health service, following the logic that pregnancy should not be a cause of death.

IV. Mapping Coverage and Deficits: Preliminary Results of the Suggested Methodology

1. Deficits in extent of population coverage and affordability/financial protection

In terms of deficits in population coverage, Figure 2 indicates that no group of countries has achieved universal coverage, as even the best performing group of countries provides coverage to no more than approximately 96 per cent of the population. The people living in the most vulnerable countries are the most hard-hit, as 88.4 per cent of their population is not covered by legislation regarding social health protection.

Figure 2. *Deficits in population coverage by countries' level of vulnerability*



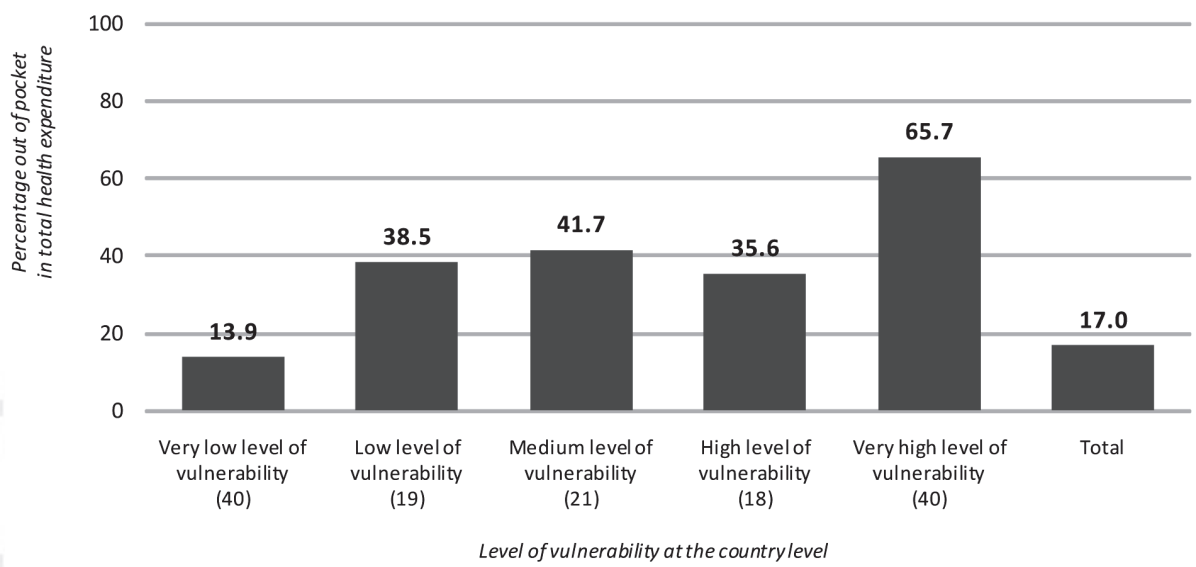
Sources: *For percentage of the population not formally covered: ILO (2008); for informality (non-wage workers as a proportion of total employment as a proxy of informality level): ILO (2009, 2007), and national statistical offices; for poverty incidence (below USD 2 per day), World Bank (2009). Numbers in brackets give the number of countries included in each group. See also http://www.socialsecurityextension.org.*

Furthermore, even when population coverage is provided, specific groups suffer from exclusion from social health protection and access to health care. Such groups include the poor (especially poor women) living in rural areas with low density and quality of services, as they must face financial and geographical barriers to access.

Affordability of health services and financial protection is measured by the share of OOP as percentage of total health expenditure. Thus, it is likely that this indicator underestimates the extent of financial burden, as it does not take into account other relevant costs such as for transportation.

Figure 3 shows the general trend: The higher the level of vulnerability, the higher the share of OOP. The high share of OOP in the most vulnerable countries demonstrates a significant gap in financial burden sharing, thus a lack of affordability of healthcare.

Figure 3. *Share of OOP as percentage of total health expenditure by vulnerability of countries*

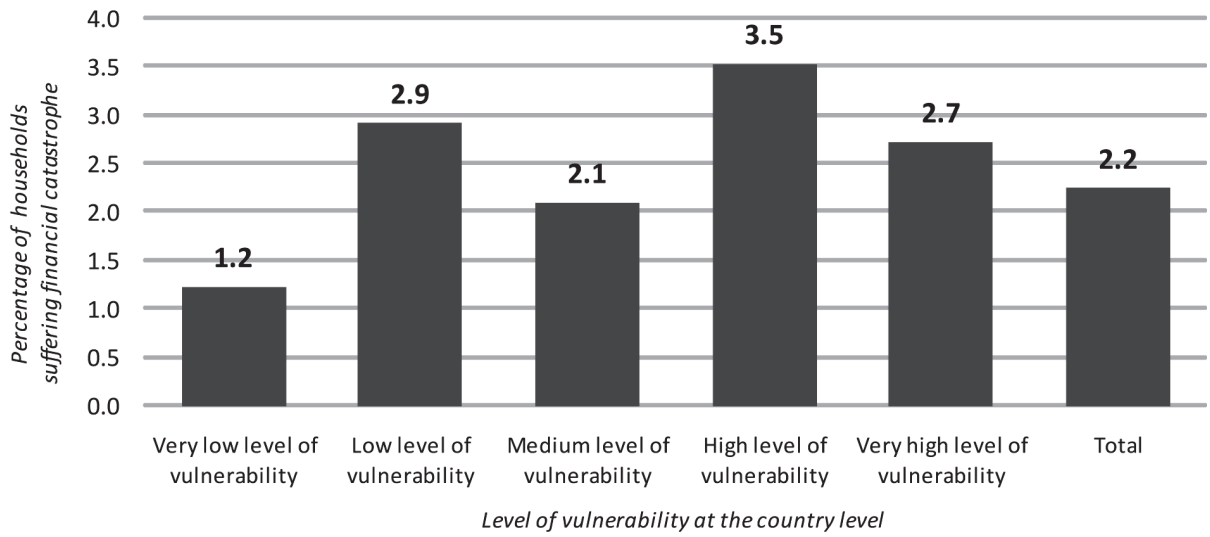


Sources: For informality (non-wage workers as a proportion of total employment as a proxy of informality level): ILO (2009, 2007), and national statistical offices; for poverty incidence (below USD 2 per day), World Bank (2009). WHO (2006). See also http://www.socialsecurityextension.org.

Figure 4 indicates the percentage of households that are pushed into poverty from catastrophic health expenditure, defined as expenditure exceeding 40 percent of subsistence household income. It ranges from 3.5 percent of households that are impoverished in countries with high vulnerability to 1.2 percent in countries with very low vulnerability. However, fewer households are concerned in country groups with low and very high levels of vulnerability than in the less vulnerable country groups. This may be a result of factors such as:

- Availability of services for secondary and tertiary care which is unavailable in countries with higher vulnerability
- The price structure of services and drugs
- Higher beliefs in formal health care as compared to traditional care and related cost impacts.

Figure 4. *Vulnerability and financial catastrophe, 2006*



Sources: *WHO, Global Health Observatory Web portal (http://www.who.int/gho/en/); and ILO (2010).*

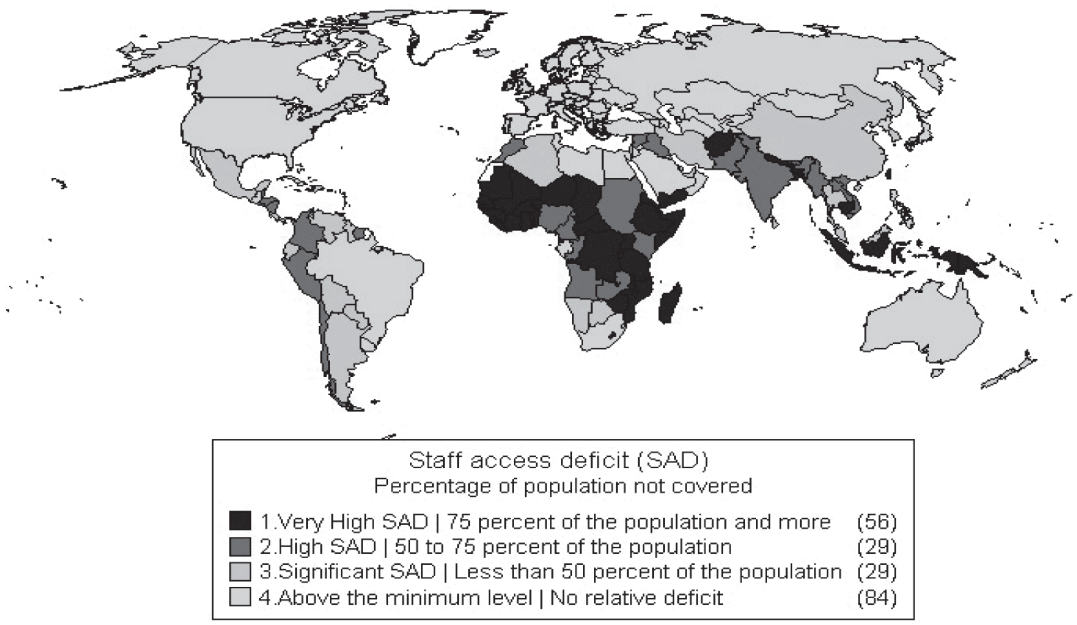
2. Gaps in availability and quality of services

Gaps in availability and quality of services are measured by the ILO Access Deficit Indicator, health spending per capita, and the maternal mortality ratio.

A global overview of the staff-related access deficit can be found in Figure 5. It shows significant gaps in availability of services due to the absence of skilled medical personnel. Further, it suggests that most severe gaps in availability of health care are found in countries of Africa and Asia that have very high and high levels of vulnerability.

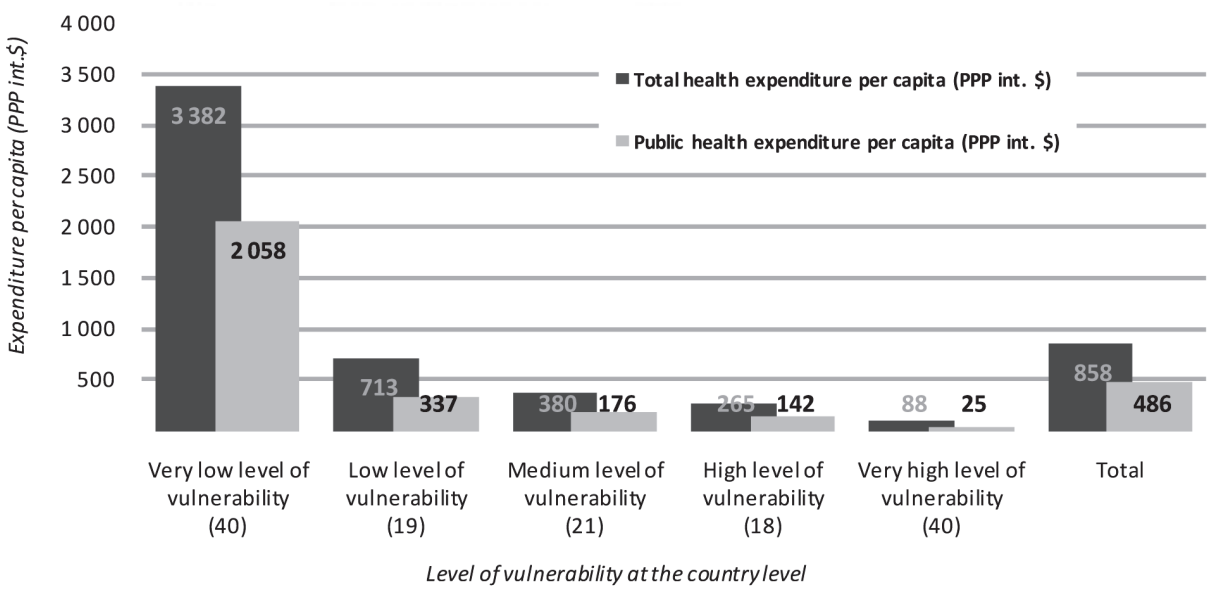
Countries with the lowest per capita expenditure are found in the group of highest vulnerability, where public health expenditure is around USD 25 per capita, as opposed to USD 2,058 in the least vulnerable countries (Figure 6). As even the most basic benefit package would cost more than USD 25 per person per year, a significant increase in funds is necessary to achieve access to and quality of healthcare.

Figure 5. A*ccess deficits based on density of health professionals, 2006 (Percentage of total population without access to health care due to lack of skilled medical personnel)*



Source: *ILO, Social Health Protection, Geneva 2008. ILO SECSOC calculations*

Figure 6. *Total and public health expenditure per capita (PPP int. $) by level of vulnerability at the country level*

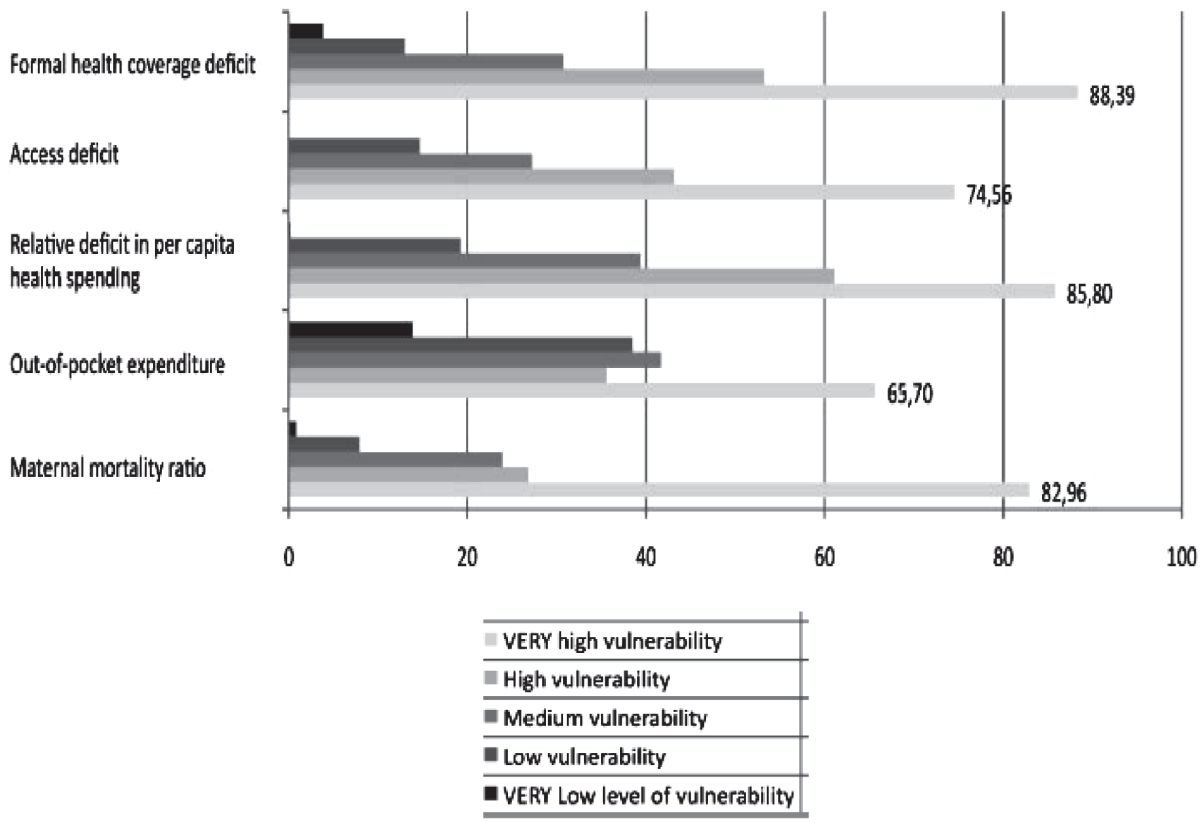


Sources: *For informality (non-wage workers as a proportion of total employment as a proxy of informality level): ILO, (2009, 2007), and national statistical offices; for poverty incidence (below USD 2 per day), World Bank (2009); WHO (2006). See also http://www.socialsecurityextension.org.*

3. *Overview of global deficits in coverage and access deficits by vulnerability of countries*

A global overview on gaps in social health protection using the proxies that reflect the key dimensions of coverage can be found in Figure 7. It suggests that the country level of vulnerability is closely associated with the level of coverage and access. In fact, decreasing vulnerability translates into greater levels of coverage and access. Globally, the gaps in universal coverage most important in countries with very high vulnerability: The deficit in population coverage amounts to nearly 90, the staff related access deficit to some 75 per cent, the relative deficit in per capita spending to more than 85 percent and OOP is about 65 percent and the maternal mortality ration nearly 83.

Figure 7. *Gaps in social health protection coverage by countries level of vulnerability*

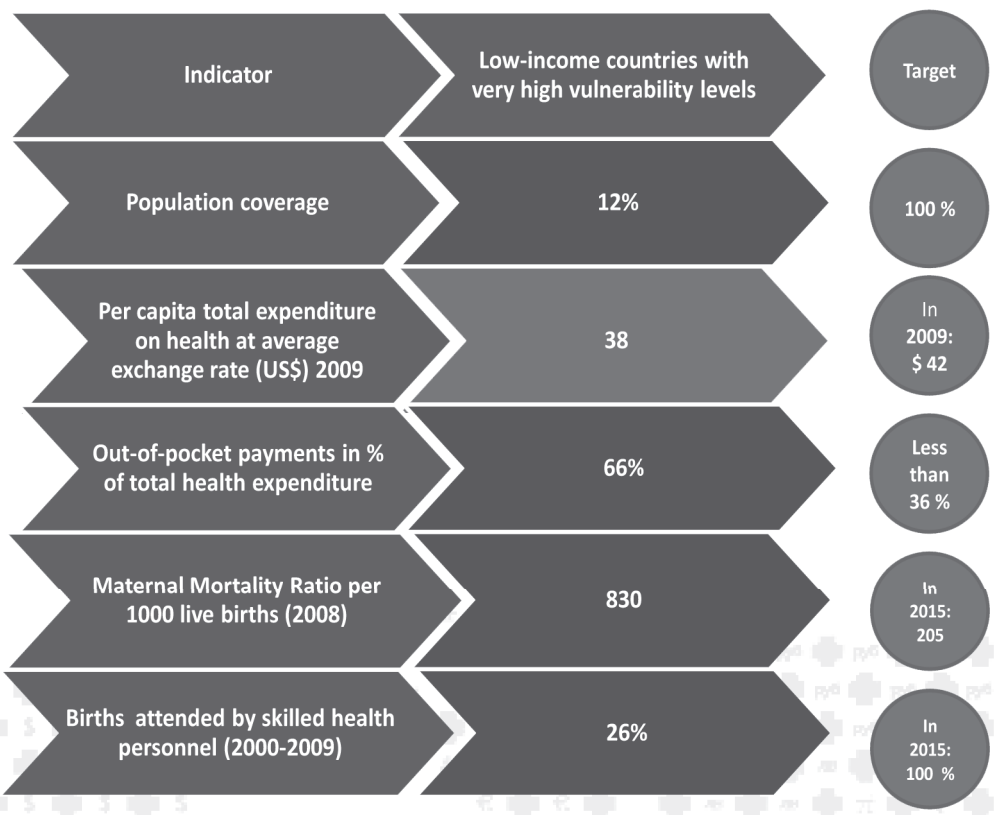


What is the situation as regards time-bound targets set by the MDGs (e.g. on maternal mortality) and absolute targets as set by the Commission on Macroeconomics and Health (per capita expenditure) and the ILO target referring to the group of low vulnerable countries (OOP)?

Figure 8 observes the achievement of these targets in the combined frameworks of county vulnerability and national income. It shows that countries with highest level of vulnerability that are considered as low-income countries are off track with regard to

all targets of universal coverage. Slow, but insufficient progress could only be observed as regards per capita expenditure. Only 12 percent of the population in these countries enjoy protection by legislation, affordability of health care is hampered by OOP of 66 percent of total health expenditure and as little as 26 percent of birth as attended by skilled personnel. Low quality of services is reflected in the high maternal mortality ratio of 830 and low per capita expenditure of 38 US$.

Figure 8. *Deficits in universal coverage defined as effective access to healthcare in low income countries with high vulnerability*



Red = Off track - Orange: insufficient progress - Green: On track

Source: *Maternal Morality ratio and per capita total health expenditure on health: WHO, Global health Observatory 2011 (online database accessed 9.05.2011, Births attended by health skilled personnel: WHO, World Health Statistics 2010, Formal coverage: ILO 2008, Social health protection. An ILO strategy towards universal access to health care, GENEVA: ILO*

Conclusion

When defining universal coverage in terms of effective access to healthcare at the national level, the following key dimensions should be taken into account: legislation, affordability/financial protection, availability, and quality of services. Related indicators suggested include percent of population coverage, per capita expenditure, OOP, maternal mortality, and attended skilled births.

Measuring and monitoring progress across countries needs to reflect challenges in funding and outreach as reflected by poverty levels and extent of informal economies in order to be compare peer countries. Grouping countries by poverty level and share of informal economies provides a useful framework for observing developments towards universal coverage.

Preliminary results of this approach show a significant global deficit in social health protection coverage and effective access to health care, particularly for the most vulnerable countries.

The suggested methodology of defining, measuring and monitoring universal health coverage provides more detailed insights into gaps at national and global level and allows for meaningful international comparisons.

Addressing the gaps requires focusing on both, deficits within social heath protection and tackling the underlying causes of access deficits that relate particularly to poverty and informal economies. Effective related policies include building national social protection floors that provide access to at least essential services and social transfers eg. to health, education, and housing for the vulnerable.

Tan-Torres Edejer

Coordinator
Health Systems Financing,
World Health Organization
Switzerland

Dr. Tan-Torres Edejer is the coordinator of the Unit of Costs, Effectiveness, Expenditure and Priority Setting (CEP) under the Department of Health systems financing in the Cluster of Health systems and services in WHO. For over 10 years, she has been primarily responsible for leading the work on defining the costs effectiveness of health interventions (WHO-CHOICE) and the costs of scaling up. Recent work has revolved around resource allocation, priority setting and explicit equity-efficiency trade-offs and the development of OneHealth, a UN interagency health sector costing and planning tool. Another major area of work in the unit is on national health accounts (NHA) which includes the annual updating of the health expenditure estimates of WHO's 193 member states and assisting countries to generate and use their own estimates. Work has just been completed on the System of Health Accounts 2011, the new global standard for reporting health expenditures. The work was done in collaboration with OECD and Eurostat.

Ainura Ibraimova

Regional Health Finance and HSS Director
USAID Quality Project
Kyrgyzstan

Dr. Ainura Ibraimova, former Deputy Minister of Health of Kyrgyzstan and Director-General of Mandatory Health Insurance Fund under MoH. She graduated from the Kyrgyz State Medical Institute and undertook further studies in cardiology under the Academy of Medical

Sciences, Moscow. She started her career in the Kyrgyz Research Institute of Cardiology and, in 1989, she joined the Kyrgyz Medical Institute. In 2001, Ainura Ibraimova became Deputy Minister of Health of Kyrgyzstan and Director-General of the Mandatory Health Insurance Fund. During her years at the Ministry of Health, Dr. Ibraimova has participated in national health reforms programmes to strengthen the capacity of the health care system. In addition to her activities at national level, Dr. Ibraimova shared her experience and takes an active part in the work of WHO's different expert groups and committees, as well as regional and international conferences. Dr. Ibraimova is an author and co-author of several publications on health reforms. She has also served as a temporary adviser for several WHO regional events. Currently she is working at the USAD Quality Health Care project for Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan as a Regional health finance and Health System Strengthening Director.

Ariel Pablos-Méndez

Assistant Administrator for Global Health
USAID
USA

Dr. Ariel Pablos-Méndez is Assistant Administrator for Global Health at the U.S. Agency for International Development (USAID), a position he assumed in August 2011. Nominated by President Obama in March, Dr. Pablos-Méndez joined the USAID leadership team with a vision to shape the Bureau for Global Health's programmatic efforts to accomplish scalable, sustainable and measurable impact on the lives of people in developing countries as envisioned in President Obama's Global Health Initiative. In his capacity as Assistant Administrator for Global Health, he will focus his efforts to further advance the goals and reformatory recommendations expressed in the Presidential Policy Directives, Quadrennial Diplomacy and Development Review, and USAID Forward. By fostering new working relationships and maintaining existing partnerships, Dr. Pablos-Méndez will direct the Bureau's activities and approach toward a standard of technical excellence in implementation science.

Dr. Pablos-Méndez is an experienced public health physician who most recently served as Managing Director at The Rockefeller Foundation where he led the Foundation's global health strategy on the transformation of health systems in Africa and Asia. He first joined the Rockefeller Foundation in 1998, spearheading public-private partnerships in research and development for diseases of poverty, the Foundation's strategy on AIDS care in Africa, and the Joint Learning Initiative on Human Resources for Health. He also served as Director of Knowledge Management at the World Health Organization (WHO) in Geneva, where he established WHO's first eHealth unit.

Dr. Pablos-Méndez is a Board-certified internist and until recently was practicing as a Professor of Clinical Medicine and Epidemiology at Columbia University. He has served in various Boards and international commissions and received his M.D. from the University of Guadalajara's School of Medicine and his MPH from Columbia University.

Apiradee Treerutkuarkul

News Reporter
Bangkok Post
Thailand

Apiradee Treerutkuarkul has been working as news reporter at Bangkok Post, one of the oldest English-language newspapers in Southeast Asia since 2001. At first her base was to cover politics at the Interior Ministry and the Parliament. Since 2004, she has been assigned to cover health issues. Covering the XIV World AIDS Conference in Bangkok was her first assignment. Later on she had opportunities to cover various health issues from AIDS, bird flu to SARS as well as the 5th International AIDS Conference 2009 in Cape Town, South Africa. In 2010, she was appointed one of the Thai delegates to participate in the 63rd World Health Assembly in Geneva, Switzerland.

Apiradee is closely monitor universal health care coverage for majority 48 million populations, mostly the poor, the elderly and the unemployed. As a result those suffering from chronic diseases which required costly treatment such as kidney failure, AIDS were not left bankruptcy from health care burden or deserted even during crisis and emergency.

Collaboration between public, non-governmental and private organisations in prioritising health benefits of the people was the key and that it could be a model for other countries to initiate national health care system for their population, he said.

The World Health Organisation also emphasised the importance of universal health care coverage for population especially during economic recession or global emerging diseases and aging society.

The study also found estimated 100 million population each year were forced to face poverty due to a lack of commitment among global communities in providing sufficient health security. European Union countries, Japan, Chile, Mexico, Rwanda and Thailand are among the countries successful in developing universal health care coverage for their population.

Xenia Scheil-Adlung

Health Policy Coordinator
International Labour Organization
Switzerland

Dr. Xenia Scheil-Adlung is the Health Policy Coordinator in the Social Security Department of the ILO. Her work focuses on extending social health protection embedded in broader social protection floors.

She also supports the work of various international partnerships in health such as IHP+ and the Providing for Health (P4H) initiative that joins multi- and bilateral partners including ILO, WHO, WB, the African Development Bank, GIZ, AFD and others.

Prior to joining the ILO she gained long-lasting experience in the Federal Government of Germany where her work focused on social security and specific groups at risk of HIV/AIDS.

Adam Wagstaff

Research Manager, DECHD
The World Bank
USA

Adam Wagstaff is Research Manager of the Human Development & Public Services team in the Development Research Group. He holds a doctorate in economics from the University of York (U.K.), and before joining the Bank was a Professor of Economics at the University of Sussex. He was an associate editor of the Journal of Health Economics for 20 years, and has published extensively in academic journals and in books on a variety of aspects of the field, especially health equity, financial protection, and health system reform. He has worked extensively on countries in Asia including China, India, Laos, and Vietnam, but has also worked on Latin America, Europe and Central Asia, and the OECD. With colleagues in the Bank's research group, he recently developed the health module of the computer software program ADePT, which automates and simplifies health equity and financial protection analysis.

Parallel Session 3.2

Voluntary insurance schemes:
what lessons for low- and middle-income countries seeking to cover the informal sector?

COMMUNITY BASE INSURANCE NOUNA HDSS, Burkina Faso

By TIAWARA YEMALE

I. STATUS

CBI designed as a volontary health insurance scheme. Started up in 2004 and was recognized under receipt n°2004-006/MATD/PKSS/HC by the government of Burkina Faso. CBI/Nouna is apolitical, non-religious and it is non profit-making.

II.OBJECTIVES

- To reduce health care inequity and facilitate health access
- To make money available for health providers
- To improve quality of health care
- To reinforce financial protection against illness risk

III. AREA OF COVERAGE

Nouna CBI operates in Kossi province, located north-west of Burkina Faso (in west Africa). The head office is located in Nouna town, which is the same with the District hospital.

Actually Nouna CBI covers 41 villages and 7 sectors in Nouna town. The target population is around 70 000 inhabitants. The main occupations of this target population are farming, breeding, artisan and small traders.

Location

- implementation of CBI in 2004
- covering popultation at district level: 41 villages, 7 sectors of Nouna

IV. REGULATIONS

1. Enrolment

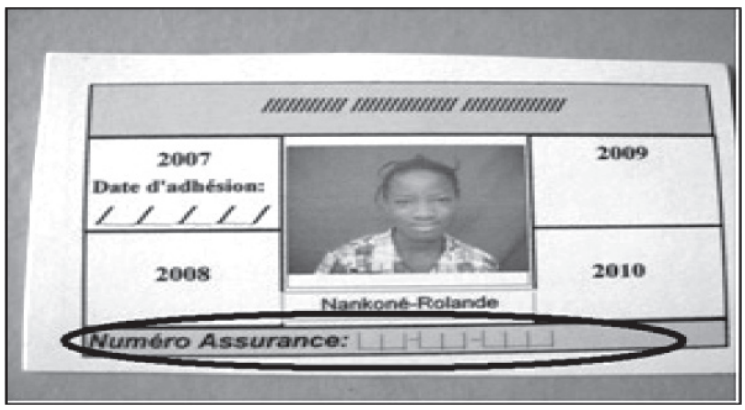
Enrolment is done at household level. Every individual at household obtains a membership card. Enrolment fees are 200 CFA (about 0,30 €) per household.

2. Premium

Premium are collected once a year after harvest which is between january and june.

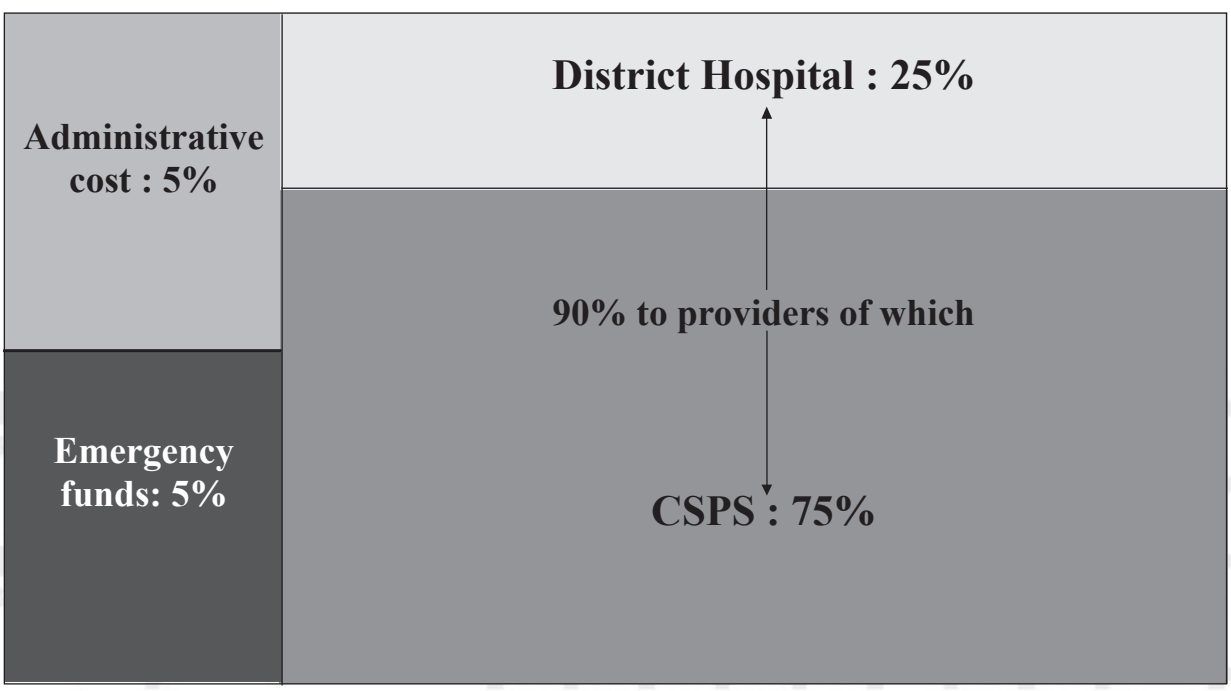
- Adults (above 15 years):1500 CFA (≈ 2,28 €),
- Children (below 15 years): 500 CFA (≈ 0,76 €)

3. Membership card



CBI gives each of the members of the household a membership card. Ownership of CBI card allows using health care services

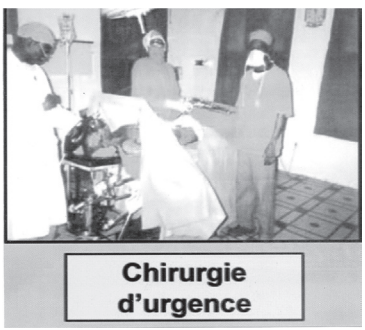
2. Resource management



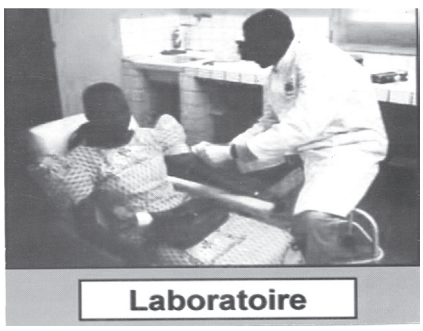
4. Service package

- ***CSPS level :***
- Consultation
- Essential and generic drugs (after formal prescription)
- Inpatient hospital stay (up to 3 days maximum)
- Emergency surgery: Stitch
- Ambulance transport
- ***Hospital level***
- Consultation

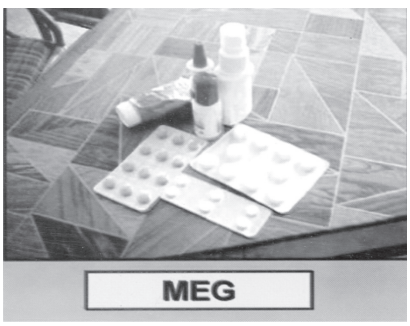
- Essential and generic drugs (after formal prescription)
- Laboratory exams
- Inpatient hospital stay (up to 15 days maximum)
- X-rays
- Emergency surgery
- Madness illness (acute)
- Chronic diseases (limited to first case and diagnosis)



Emergency surgery



laboratory



generic drug

5. Service provision

- 3 month window-period
- Provision free of charge at point of delivery for benefits in package
- Members assigned to specific CSPS
- Gate-keeping: CSPS
- Referral to District Hospital in Nouna

V. SOCIAL MOBILIZATION SYSTEM

- The CBI team members organizes every year joint sensitization programmes with health care providers and health consumers within the community to improve adherence.
- Media sensitization broadcasting
- Yearly CBI evaluation meeting with CBI members, community leaders, health care providers, government structures, technical partners and sponsors.

VI. RESULTS

Rate of target population adherence 2011 : 10.84%
Rate of premium renew: 84.62%
Growing rate 2011: 21%

Table 1 : Caracteristic of CBI since 2004

Year	household	Recipients	Adherence rate	Rate of registration renew	Abandon rate	Capitation (in CFA)	Number of health facilitation
2004	162	1201	5,2%	NA	NA	1 080 900 (1647,82 €)	6 CSPS 1 CMA
2005	311	2205	6,3%	68,51%	31,49%	2 034 450 (3101,49 €)	9 CSPS 1 CMA
2006	370	2930	5,2%	53,37%	46,63%	2 560 500 (3903,45 €)	9 CSPS 1 CMA
2007	648	4509	8,3%	74,05%	25,95%	4 184 995 (6379,98 €)	10 CPSS 1 CMA
2008	557	3929	7,1%	62,03%	37,97%	3 654 453 (5571,17 €)	11 CPSS 1 CMA
2009	705	4831	8,6%	76,30%	23,7%	4 245 525 (6472,26 €)	13 CPSS 1 CMA
2010	918	6255	8,98%	83,68%	16,32%	5 706 453 (8699,43 €)	13 CPSS 1 CMA
2011	1215	7750	10,84%	84,62%	15,37%	**11 424 818 (17417,02 €)**	13 CPSS 1 CMA

VII. LESSONS LEARNT

- The CBI shows deficit (elevated sinistrality) due the low premium paid by children despite the same demand of health care. Children under 15 years represent 50.3% of registrated members.
- More utilization of health care services by members compare to non members.
- No difference in hospital care utilization for insured and no insured.
- Quality of the care is the same for both.
- Health insurance protects household against health related cost and save their goods.
- Analyses of 2004-2005 data shows that CBI increases household income

VIII. ASSETS

- CBI is well known in Nouna and Burkina Faso
- God father is the Bishop of Nouna
- Renewing of registration is above 80%
- Good management of resources
- CRSN technical partnership (data base available)
- Availability of services
- Experience of the management team (Bureau Multiservices Consulting Groups)

IX. CHALLENGES

- Research of sponsorships to balance deficits
- Subsidise children adherence fee
- Partial or total subsidise to young children and infants to improve health equity and access
- To consider the CBI at national level by inscription in the Poverty Reduction Strategy Paper (PRSP) in Burkina Faso
- To exploit the experience of Nouna CBI for the National Health Insurance System(SNAM) implementation

X. PERSPECTIVES

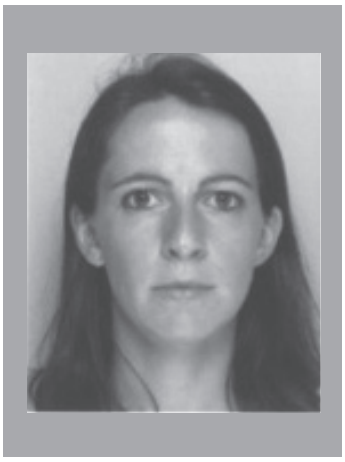
- Coverage of six new area- 15 000 new persons to register
- Coverage of the entire District by 2015
- Piloting the partnership with the National Health Insurance System(SNAM) for universal coverage

XI. CBI PARTNERS

- Bureau Multiservice Consulting Group (BMCG/Nouna)
- Nouna Health Research Center (CRSN)
- Nouna Health District
- University of Heidelberg (Germany)

XII. CONTACTS

- Nouna CBI Team
- Cellphone: (+226) 70 71 65 77/71 06 03 69
- Bureau Multiservice Consulting Group (BMCG)
- Cellphone: (+226) 70 11 04 78 / 70 12 33 23
- Fax : (+226) 20 53 70 55
- e-mail: bmcgnouna@yahoo.fr



Solène FAVRE

Project Manager, Health Insurance Project
Groupe de Recherche et d'Echanges Technologiques in Phnom Penh (GRET)
Cambodia

Solène FAVRE is a health insurance specialist. Solène has been working in the health insurance sector since 1998 when she was a board member of a French health insurance company SMEBA that is in charge of the management of social health benefits for students. From 2003 to 2009 she became a provincial branch manager in the same company. Then, she decided to enlarge her experience with community based micro-insurance project in emerging country, in India. She joined Inter Aide, a French NGO, and become the technical advisor to 5 local MFI proposing health insurance services and to UpLift India Association with a significant outreach of more than 100 000 beneficiaries. Since June 2011, Solène joined GRET (www.gret.org) to become the project manager of HIP. HIP is a micro-Health insurance Project for Cambodian Garment workers. HIP has the twofold objectives of (1) securing workers income by limiting the catastrophic expenses linked to health events and (2) preparing the health component of the Cambodian Social Security (NSSF) to be implemented in 2013. Since January 2012, Solène became the project manager of both HIP and of SKY health insurance project for GRET. SKY is the largest community based health insurance in Cambodia. SKY as a network of more than 100 public health facilities contracted where insured members have a cashless access to primary and hospital care. In November 2011, SKY employs 126 staff and protects more than 70,000 persons. In 2012, SKY health insurance project will be transformed into a local NGO and a legal micro-insurer according to the new legal context regarding micro-insurance in Cambodia.

Marty Makinen

Managing Director
Results for Development Institute
USA

Marty Makinen, Ph.D., joined Results for Development Institute (R4D) in January 2008 after 23 years at Abt Associates Inc. where he was a Vice President and Fellow. At R4D, he directs the Bill and Melinda Gates Foundation (BMGF)-funded study of new vaccine adoption by lower-middle-income countries and leads the increasing coverage track of the Rockefeller Foundation-funded Joint Learning Network for Universal Health Coverage. He also directed the BMGF-funded Ministerial Leadership Initiative; two studies of the role of the private sector in the health sector, one for the French Development Agency (AFD) in four African countries and another for the World Bank Group in Ghana; and the secretariat for the Financing Task Force of the Global Health Workforce Alliance. Makinen is a health economist with three decades of experience in more than 40 countries in all regions of the world. He serves on the GAVI Independent Review Committee for Monitoring and served on advisory panels for Gates grants focused on maternal nutrition and routine immunizations. Before coming to Results for Development, Makinen helped to start and develop Abt Associates' international health practice. At Abt he headed many initiatives, including the following worldwide USAID-funded projects: Health Financing and Sustainability, Partners for Health Reform plus, and Health Systems 20/20. Makinen speaks French fluently and is a frequent speaker at professional meetings and international forums. He received his Ph.D. and Master's Degree in Economics from the University of Michigan and his B.A. in Economics from Kalamazoo College.

Yogesh Rajkotia

Managing Director

Institue for Collaborative Development

Bangladesh

Dr. Yogesh Rajkotia, PhD., is an experienced leader in global health with extensive expertise in developing and managing large-scale health systems strengthening initiatives. He is the Founder and Director of the Institute for Collaborative Development, a health systems strengthening 'action-tank'. Prior to that, he worked for USAID, where he served as team leader for Health Systems in Rwanda and Senior Health Systems Advisor in Washington. While working for USAID, he provided leadership to the Agency's health systems work globally, and managed key programs including the $125 million Health Systems 20/20 agreement and the $1 billion TASC3 contract. He has also worked as a long-term advisor to the senior leadership of health ministries in Bangladesh and Rwanda. Dr. Rajkotia has a doctorate degree in health economics and a master's degree in health policy. He has worked on health systems strengthening issues in Peru, Angola, Senegal, Ghana, Rwanda, Malawi, Uganda, Ethiopia, Southern Sudan, DR Congo, Kenya, Yemen, Indonesia, India, Bangladesh Afghanistan, and Republic of Georgia.

Yemalé Tiawara

Social Marketing Manager
Community Base Insurance Nouna (CBI/Nouna)
Burkina Faso

TIAWARA Yemalé, Post graduted in Businesses law, obtained at the University of Ouagadougou.

Jurist with Post-graduate diploma in businesses law obtained in 1995 at University of Ouagadougou (Burkina Faso). First experienced community activities from 1996 to 2003 with the Association Tontine de Nouna (ATN). Through ATN activities I succeed to provide microfinances to the community members and them organized in group of cooperative to take their destiny in hands. I successfully developed community adapted training tools for financial management. I became successively Responsible for the Development of the Network of the "tontines", and general manager of the ATN. With this experience accessibility of the poor populations to financial products adapted to their needs have been a big challenge and the duality of health care and sustainable microfinance capacity jeopardizes the survival of the ATN programme. Base on this experience and others experiences the CBI have set to tackle health care issues. I joined the CBI team in July 2003 as a head of the social marketing team. I contribute to the research activities accompanying the implementation of the CBI and regularly provide information to the data entry clerk.

July 2003 to 2011, I am in charge of social marketing. So I worked on the aspects of sensitizing and organization of CBI for his institutionalization and of his visibility in the landscape Burkinabe mutualist. As the principle responsible of CBI, I contributed to make data available for research activity.

Currently, I am setting health insurance consultation office. The experience of CBI/Nouna will be put it at the service of other systems of Community health insurance. In addition, this office will accompany the Nouna CBI in the prospect of the coverage extension to the entire Province of Kossi which has the same limit with health District. The office of consultation will be in charge of the execution of the actors plan of competence reinforcement and the construction of an endogenous network of trainers on the level of the province.

TIAWARA Yemalé
Social marketing Manager
Community Base Insurance (CBI/Nouna)
PO Box.: 18 Nouna
Burkina Faso

Tél.: (226) 70 11 04 78
Fax: (226) 20 53 70 55
E-mail: yemale_g@yahoo.fr

Parallel Session 3.3

Beyond Bismarck and Beveridge:
Lessons from hybrid financing to cover a billion people

John Langenbrunner

Lead Economist
The World Bank
USA

John ("Jack") Langenbrunner is a Health Economist with the World Bank with both research and operations experience. He currently coordinates the new Health Financing and Health Insurance Thematic Group within the Bank and will lead the Bank's Global Expert Team for Health Systems in 2011-2012.

Since 2008 he has worked on health financing issues and health insurance design and development issues mostly in mainland China, but also Mongolia, Philippines, Cambodia, Thailand and other East Asian and Pacific countries. Prior to that, Jack worked in Eastern Europe in the EU New Member States and in other countries such as Russia, Croatia, Azerbaijan, Kyrgzstan, and Kazakhstan. He has worked as well in selected countries in the Middle East on the development of health insurance including Saudi Arabia, Bahrain, Iran, and Egypt.

Jack's most recent book is "Financing Health Care in East Asia and the Pacific: Best Practices and Remaining Challenges," released in June and co-authored with Aparnaa Somanathan. He also has recently co-authored 2 books on Resource Allocation and Strategic Purchasing by insurers and other public and private organizations, and has authored or co-authored a number of papers related to this initiative. He also led the Bank's work on a manual for National Health Accounts for low and middle income countries. This so-called NHA "Producers Guide" was published in 2003.

Previous to his work at the Bank, Jack was with the US Health Care Financing Administration, a public health insurance program for over 80 million Americans. He later went in the early 1990s to the US Office of Management and Budget where he served on the Clinton Health Care Reform Task Force for the US White House.

Toomas Palu

Sector Manager,
Health Nutrition and Population;
East Asia and Pacific Region
The World Bank
Thailand

Toomas Palu is the Health Sector Manager for the World Bank's South East Asia and Pacific Region. He has led World Bank health programs in Vietnam, Cambodia, Thailand and Laos and in several countries in Eastern Europe and Former Soviet Union. He has also served as a Director in the Estonia Social Health Insurance Fund Management Board and as a Deputy Director of the Tallinn Emergency Care Hospital in Estonia. His key qualifications and experience include health policy and health sector reforms in middle-income transition economies and health systems strengthening in developing countries. Toomas has a Medical Doctor degree from the Tartu University in Estonia and a Master of Public Administration degree from the Harvard University in the US.

Jui-fen Rachel Lu

Professor and Dean

College of Management, Chang Gung University

Taiwan

Jui-fen Rachel Lu, Sc.D., is a Professor and Dean in the Department of Health Care Management, College of Management, at Chang Gung University in Taiwan, where she teaches comparative health systems, health economics, and health care financing. She earned her B.S. from National Taiwan University, and her M.S. and Sc.D. from Harvard University, and she was also a Takemi Fellow at Harvard (2004-2005) and has been an Honorary Professor at Hong Kong University since 2007 and a guest. professor at Huazhong University of Science and Technology, China, since 2010.

Her research focuses on 1) the equity issues of the health care system; 2) impact of the NHI program on health care market and household consumption patterns; 3) comparative health systems in Asia-Pacific region. She has also been appointed to serve as a member on various government committees dealing with health care issues in Taiwan, such as National Health Insurance Supervisory Committee (DOH), Hospital Management Committee (DOH), and Hospital Global Budget Payment Committee (BNHI), etc. Dr. Lu received the Minister Wang Jin Naw Memorial Award for Best Paper in Health Care Management presented by Kimma Chang Foundation in 2002 and was the recipient of IBM Faculty Award in 2009. She has published papers in *Health Affairs, Medical Care, Journal of Health Economics, Health Economics, Social Science and Medicine, Health Economics, Policy and Law, Osteoporosis International, Health and Quality of Life Outcomes, and Taiwan Economic Review etc,* and a book *"Health Economics"(in Chinese)*. A detailed C.V. can be found at http://management.cgu.edu.tw/cm/index.php/about-us/dean

Ammar Siamwalla

Distinguished Scholar
Thailand Development Research Institute
Thailand

NAME: Ammar Siamwalla

HOME ADDRESS: 105 Soi Soon Vijai 14(5) New Petburi Road Bangkok 10310

OFFICE ADDRESS: Thailand Development Research Institute
565 Soi Ramkhamhaeng 39 (Thepleela 1)
Ramkhamhaeng Rd., Wangthonglang
Bangkapi, Bangkok 10310
Telephone: (66-2) 718-5460, Fax: (66-2) 718-5461
E-mail: ammar@tdri.or.th

DATE OF BIRTH: 29 May 1939

NATIONALITY: Thai

EDUCATION:

1967 Ph. D. in Economics, Harvard University, U.S.A.

1962 B. Sc. in Economics (First Class Honours), University of London, U.K.

ROYAL THAI ORDERS AND DECORATIONS:

2007 Knight Grand Cross (First Class) of the Most Noble Order of the Crown of Thailand

2007 Grand Companion (3rd Class, higher grade) of the Most Illustrious Order of Chula Chom Klao

2003 Companion (Fourth Class) of the Most Admirable Order of the Direkgunabhorn

1991 Knight Commander (Second Class) of the Most Exalted Order of the White Elephant

1977 Commander (Third Class) of the Most Noble Order of the Crown of Thailand

HONORS AND AWARDS:

2003 Honorary Doctoral Degree in Economics, Chulalongkorn University

1999 Honorary Doctoral Degree in Economics, Thammasat University

1999 Honorary Doctoral Degree in Development Economics, National Institute Development Administration (NIDA)

1995 Award for Best Research Work (in economics) by National Research Council (NRC), Thailand for *Compendium on Rice.* (with Viroj Na Ranong)

1986 Distinguished Researcher Award (in economics) by NRC

Sir John Crawford Exchange Award in Agricultural Economics from the Australian Agricultural Economics Society and Australian Council for International Agricultural Research

1981 Honorary Professor, Faculty of Economics, Thammasat University

POSITIONS HELD:

1 Oct.2008-present Distinguished Scholar, Thailand Development Research Institute (TDRI)

8 Mar.2007-30 Sep.2008 Acting President, TDRI

1996 – Mar.2007 Distinguished Scholar, Thailand Development Research Institute (TDRI)

1990 - 1995 President, TDRI

1984 - 1990 Program Director for Agriculture and Rural Development, TDRI

1978 - 1984 Research Fellow, International Food Policy Research Institute, Washington, D.C.

1972 - 1978 Lecturer, Faculty of Economics, Thammasat University, Bangkok

1966 - 1972 Asst. Prof. and Research Staff Economist, Department of Economics, Yale Univ.

VISITING FELLOWSHIP:

1975 - 1976 Visiting Professor, Food Research Institute, Stanford University

1970 - 1971 Rockefeller Foundation Visiting Prof., Faculty of Economics, Thammasat Univ.

COMMITTEES:

Present:	Advisory Board Member, Transparency Thailand
	Board Member, Naresuan University Hospital
	Member, Screening Committee to Recruit Lecturer for Faculty of Economics, Thammasat Univ.
	Member, Sub-committee to Study Price Intervention Measure for Agriculture Product in order to Preventing Corruption
	Advisory Board Member, the Press Council of Thailand
July 07-Oct.11	Member, National Health Security Committee, Ministry of Public Health
Sep.07-Oct.11	Chair, Sub-com. to Develop Financial and Fiscal System for Universal Health Coverage
Aug.07-Aug.10	Member, Law Reform Commission, Office of the Council of State
Oct.08-May 09	Honorary Member, Monetary Policy Committee, Bank of Thailand
2007	Senior Advisory Board Member, the Minister of Public Health
2006-2008	Honorary Member, Board of the Health Insurance System Research Office (HISRO)
2006-2008	Member, the National Legislative Assembly
2005-2008	Board Member, Sanya Thammasak Institute of Democracy
2005-2006	Member, National Reconciliation Commission (NRC)
2005-2006	Chairman of the Sub-Committee to Study Appropriate Development Directions for Human Security, NRC
2002-2005	Pridi Bhanomyong Distinguished Professor, Dhurakijpundit University
2001-2005	Member, Evaluation Committee, Thai Health Promotion Foundation
2000-2005	Board of Directors, Bank of Asia
2000-2003	Member, Appellate Committee, Department of Internal Trade, Ministry of Commerce
2000-2003	Board Member, National Health System Reform, Ministry of Public Health
2000-2003	Board Member, Health Systems Research Institute, Ministry of Public Health
1999-2000	Steering Committee on the Study of Thailand Legal Development Project
1999-2000	Sub-committee on Evaluation of the Energy Conservation Plan, National Energy Policy Office (NEPO)
1998-2002	Chairman, Social Investment Fund (SIF)
1998	Nukul Commission Tasked with Making Recommendations to Improve the Efficiency and Management of Thailand's Financial System (Sor Por Ror)
1997-2000	Economic Advisory Board, Thailand Management Association (TMA)

1996-1999	Board Member, National Statistical Office
1995-2000	Board Member, Thai Tapioca Development Institute
1995-1999	Board Member, Government Savings Bank
1995-1999	Policy Board, Biodiversity Research and Training Program (BRT), National Centre for Genetic Engineering and Biotechnology, National Science and Technology Development Agency
1995-1996	Board Member (Economics), the Thai Chamber of Commerce
1994-1998	Chairman, Committee on Credit Program for Rural Development, Government Savings Bank Chairman, Public Enquiry Committee on the Benefits of the Collector/Distributor Road for the Second Stage Expressway
1993-1997	Member, Technical Advisory Committee, Consultative Group on International Agricultural Research
1993-1996	Member, National Agricultural Credit Policy Committee
1993	Member, Public Enquiry Committee on the Benefits of the Collector/ Distributor Road for the Second Stage Expressway
1992-1994	Member, Board of Investment, Bangkok, Thailand
1992	Member, Review Committee for the International Rice Research Institute, Los Banos, the Philippines
1988	Member, Review Committee for the Department of Economics and the National Centre for Development Studies in the Research School of Pacific Studies, the Australian National Univ.
1975-1978	Member, Economics Section, National Research Council
1978	Member, Economic Advisory Council to the Prime Minister

Parallel Session 3.4

Reaching and protecting the poor in Low Income Countries:

What challenges?

HEALTH EQUITY FUND

In the frame of the Health Services Improvement Project (HSIP), Department of Planning and Finance Ministry of Health, Lao PDR

By Chansaly Phommavong
Deputy Director of the Health Services, Ministry of Health, Laos

Executive Summary
Under the guidance and supervision of Department of Planning and Budgeting, MOH, HSIP, the HEF implementing agency (HEFIA) Swiss Red Cross/Lao Red Cross was contracted to provide technical and managerial support to the central HEF Management Unit (CHEFMU). From January 2009, the HEFIA, in collaboration with CHEFMU, set up and operated HEF schemes in nine pilot districts assisted by the MOH/HSIP of: ***Champhone, Phalanxay and Sepone Districts (Savannakhet Province), Sukhuma District (Champassak Province), Taoy District (Saravan Province)*** and ***Thateng, Lamam, Kalum, Dakchung Districts (Sekong province).*** The HEFs were jointly funded by the HSIP and the SRC.

With a piloting mandate in nine districts with very different situations in terms socio-economic status, accessibility, culture and ethnicity or health service delivery across four provinces, the design of the HEF in the 9 districts relied on several strategies that evolved across the period of implementation. Geographical targeting was used in the 3.5 very poor districts, incorporating all households of all villages outside the town, while the so-called Controlled Participatory Approach was used to identify the poor in other districts. The HEF started to pay providers by reimbursing the bills and evolved rapidly towards a case-based payment on fixed fee per category of service. As requested by the MOH, the HEF purchased CBHI premium at full price for the HEF members in the two districts where CBHI was in place and paid directly the non-covered transport/food allowances. The HEF system was progressively adjusted during the period based on decisions from the Provincial/District Social Health Protection Committee meetings.

As per March 2011, **77,043 HEF members** or 13,185 households have been identified in the 9 districts representing 22% of the coverage population. The proportion of HEF eligible poor varies greatly across the districts from 1% to 92%. 77% of HEF members were pre-identified through automatic geographic exemption in the non-urban population of the poorest districts of Kalum, Dakchung, Taoy and half of Lamam. Furthermore, geographic exemption was also used for 11 very poor villages of Sepone. 22% have been pre-identified in the other 5.5 districts via "Controlled Participatory Approach" (CPA).

Provision of services for the HEF eligible members has been fully in place in April/ May 2009. In the first quarter of 2009, only Sepone district provided full services to HEF members. A quick launching strategy was chosen to start –up HEF in all the districts before the rainy season 2009 with basic services at start at district/provincial level first with progressive extension to HCs and progressive on-the-job training.

At the end of March 2011, the provision of services was effective in all **4 provincial**

hospitals, all 8 district hospitals, 1 referral inter-district and in 38 health centres. HEF coverage was complete in 7 districts. Effective implementation in all HC of Champhone (20 HCs) was still delayed. Implementation in remote HC of Kalum and Dakchung depend mainly on availability of staffing in these remote areas.
Utilization: During the roughly **2 years' period**, the HEF has assisted **76,249 out-patient cases; 6,731 in-patients cases; 2,065 observations at HC; 1,842 deliveries; 567 surgeries** (143 major, 61 caesarean sections, 113 medium and 232 minor) **and recorded 1,209 ANC consultations and 3,335 Family Planning consultations**

Average yearly utilization for the latest complete year of 2010 was as follows: **0.68 OPD**/ member (ranging 0.12 to 1.12), **0.049 IPD** (ranging 0.033 to 0.142), 0.022 observations at HC/member, **16% of the deliveries** (ranging from 5% to *30%, in Sepone 30% of the whole population*) and **0.004 surgeries** including caesarean sections. **These utilization rates of curative services for the poor substantially increased for all districts compared to before the HEF implementation and compared to 2009. Figures are well above the national average for the general population (non-poor and poor).** In the year 2010 and 2011, one experienced a **positive more homogenous utilization rate across the 9 districts, especially for admissions. The consultation rate is now at a relatively high level and may require some containing measures** as started in some districts during the first quarter 2011.

Benefits: from the start in 2009, the value of benefits to be paid amounts **LAK 5.0 billion (~US$613,000)** including around $315,000 from HSIP. This means on a yearly basis **roughly $3.32/HEF member/year** (ranging from $3.14 to $7.04) or **$0.86/capita/ year**. This amount per HEF member has significantly increased from 2010 mainly with the increase in coverage at HC, in utilization and also with the extension of the payment mechanism on fixed fees by category of services. The amount slightly deceased in the first quarter of 2011, maybe linked to the introduction of cost containment measures.
During the calendar year 2010 and 2011, the HEF paid services respectively at **$5.01/ HEF member/year** (ranging from $3.74 to $9.38) in 2010 and **$4.55 in the first quarter of 2011.** Respectively **83-86%** of the benefit costs went for **treatment costs** (51-56% for medicines, 11-9% for fees and 21-20% of surplus)**, 9-7% for transport, 8-6% for food allowances and 0.2-0.4% for other basic items and death grants.**

Detailed analysis concludes that evidences from several sources indicate that: **(a) the introduction of HEF has contributed to considerably increase the utilization of OPD and IPD, but not the maternal health services**. The increase in the utilization of curative services in the poorest districts with geographic exemption appears even more striking, but it started from very low figures; **(b) the HEF appears to have contributed to reduce the barrier of distance in the access to health services; (c) the utilization and costs pattern for HEF beneficiaries does not appear to suffer at this stage from major imbalances in terms of gender, age, ethnic group**.

The implementation design of Health Equity Funds using a specific design with an intensive role of the 3rd party implementing agency has had some key **strengths** (rapid implementation, flexibility and reactivity for design adjustments, insurance of funding

continuity in front of delays) and **weaknesses** (limited ownership by the PHO and MOH, limited potential of pressure on the health providers, higher administrative costs). The **targeting** system showed a very restrictive pre-identification of eligible poor households through Controlled Participatory Approach (CPA) and a satisfactory geographic targeting for very remote areas. The **links with Community-Based Insurance (CBHI)** has failed to prove efficient and effective. The **case-based payment system** to providers on fixed fees schedule by category of services has been satisfactory with unavoidable drawbacks calling for regular adjustments to avoid inherent coping mechanisms.

Key strategic challenges for the implementation of the HEF in the 9 districts include at least: (a) the improvement in targeting methods, with the aim of covering a much larger share of poor households in districts with Controlled Participatory Approach; (b) the piloting of simpler, less risky methods for paying for outpatient services; (c) incorporation of the policy for free delivery and under 5 services; (d) the progressive streamlining with other HEF schemes and other social health insurance schemes for a secured institutionalization; (e) the increased involvement and ownership of the PHO and Social Health Protection Committees; (f) the increased purchasing role regarding quality improvement implemented together with joint technical monitoring with PHO; and (g) the insurance of secure funding in the medium term.

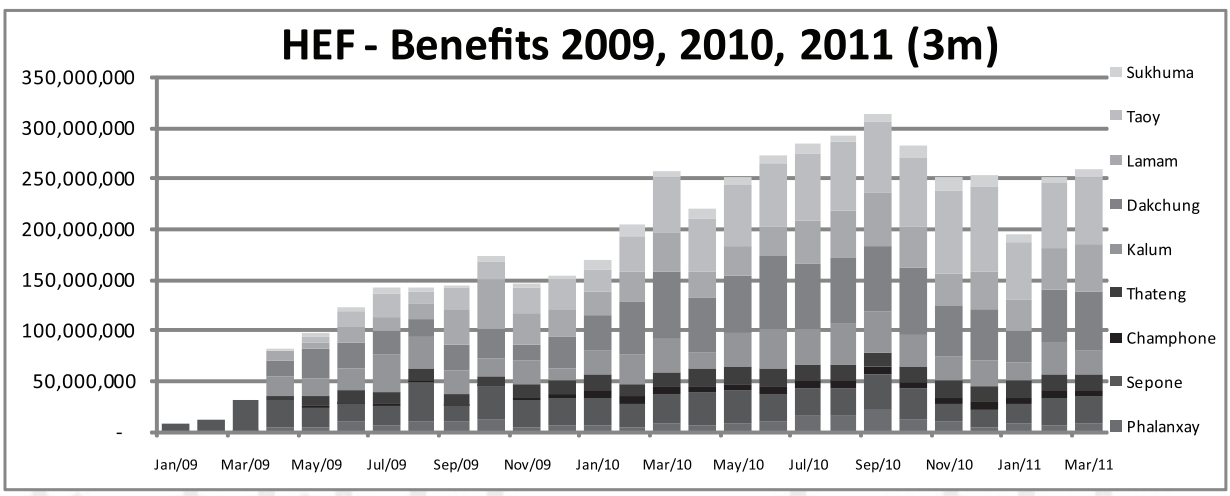
The key operational challenges ahead for the HEF Implementing Agency are to standardize and institutionalize the HEF work and become more pro-active in order to fight against the numerous access barriers. In this way, the HEF Agency should progressively focus more on its key social roles of proximity, monitoring and promotion opposed to the roles of administration and fund management.

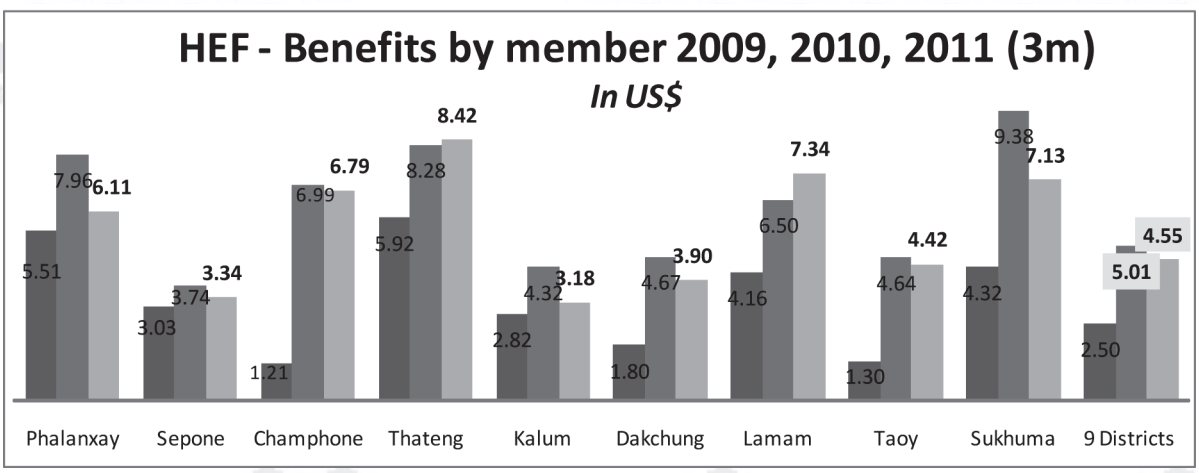
The main recommendations to the MOH and HSIP are to:

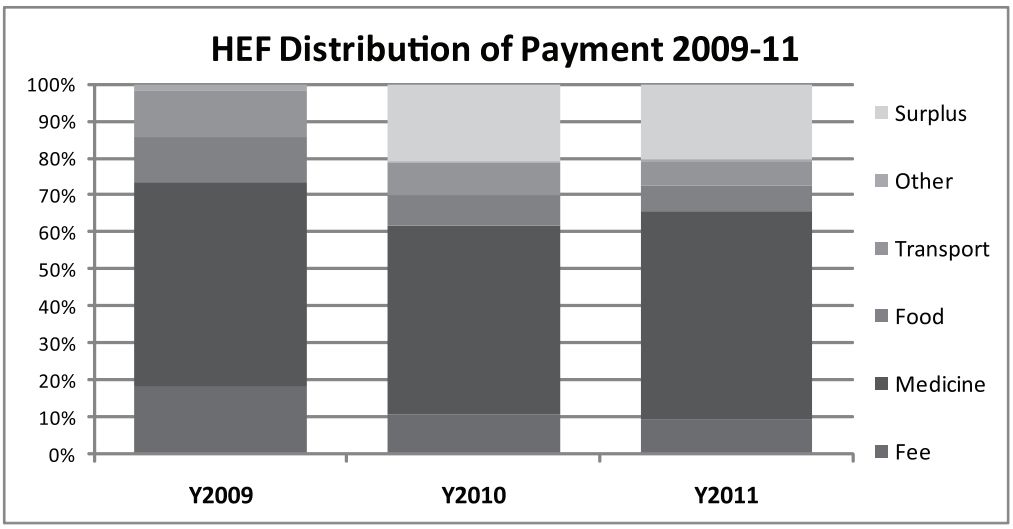
1) **Ensure timely effective implementation of the agreement between MOH-SRC/LRC for the period 04-06/2011 with minimal changes in the management.**
2) **As the implementation of HEF on a district-basis suffers from major problems (low efficiency, limited responsiveness by provincial hospital and interest of the social health protection committees, lack of critical mass, fairness, etc), the MOH and partners should consider ways to temper this weaknesses. Expanding the terms of references of the HEFIA to maximize efficiency is one option. Include more poor districts in provinces (e.g. Samouay/Toumlan in Saravan) is another alternative, especially as SRC has agreed to fund four of the nine districts.**
3) **Make operational the links between the implementation of the HEF and the free of charge policy for delivery and U5 children. The management of free delivery, HEF and other institutionalized schemes available in most of the provinces and districts would benefit from progressive alignment.**

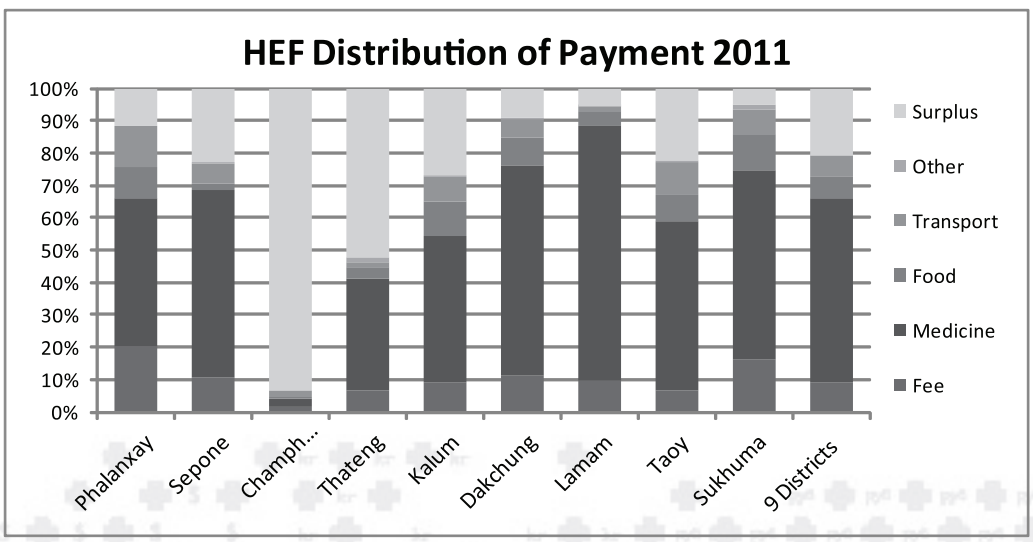
4) **As the experience with geographic targeting for very remote areas has been satisfactory, enabling a rapid implementation while allowing for sufficient critical mass to ensure public information, we would recommend this approach for the poorest areas. Progressive targeting to remote or poor villages distant from a health facility (>3km) may be more adequate than a whole district coverage. This would require modifications in the draft of MOH National HEF Guidelines**

5) **Clarify the official MOH unit in charge of the monitoring of the health equity funds, its staffing and the MOH expected role of the HEFIA technical assistance.**

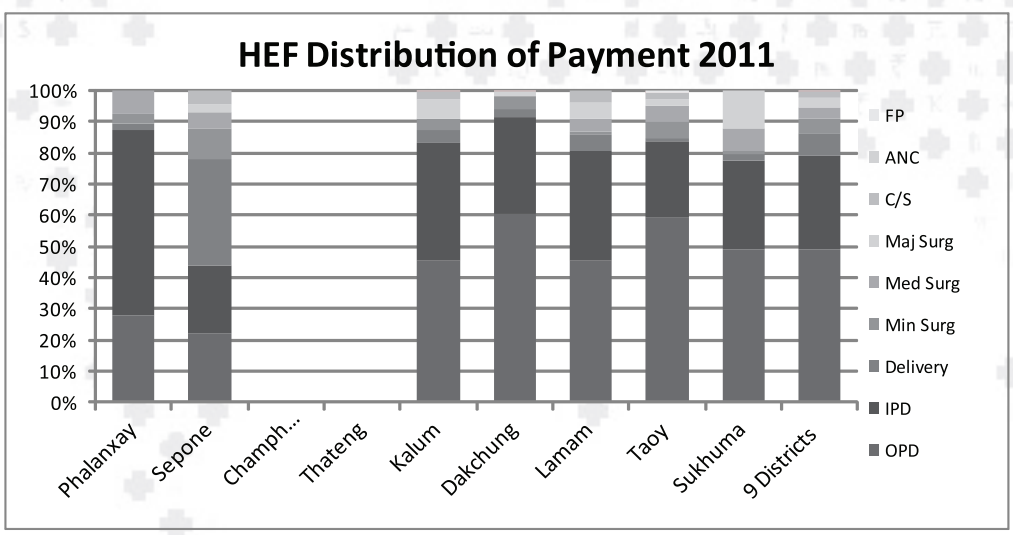








The payment of health services for OPD has largely increased in the year 2010 and 2011 to reach 48% of the medical benefits (versus 30-35% in 2009).



Discussions

The implementation of Health Equity Funds using an independent third party agency was new to the public health in Lao PDR. The triangle relation between oversight government agencies, public health providers and the HEF Implementing Agency has modified the roles of the different stakeholders.

The design with an intensive role of the 3rd party implementing agency has had some key strengths (rapid implementation, flexibility and reactivity for design adjustments, insurance of funding continuity in front of delays) and weaknesses (limited ownership by the PHO and MOH, limited potential of pressure on the health providers, higher administrative costs)

Case-Based payment

- The case-based payment system on fixed fees by category of services was implemented from the start in the very poor districts with geographic targeting and expanded to the 4 districts without CBHI from March 2010. As a whole, the implementation has been satisfactory.

- The management has revealed easier for the HEF Implementing Agency and also for the health facilities which did not have to go through the sometimes badly perceived monthly control of all invoices. With high enough negotiated rates, the system allowed in most facilities for necessary psychological "surplus" to provide adequate services to poorest patients. The system appeared, in terms of acceptability, a good compromise between capitation and bill's reimbursement. Introduction has been rather smooth with limited major complains.

- As all providers' payment mechanisms, it also showed unavoidable drawbacks and called for required regular adjustments and fix-it to avoid coping mechanisms. Some over-reporting were found mainly at remote health centers where monitoring was difficult and not yet well introduced. The level of fixed fees for consultation at HC revealed too high and the fees for medium/major surgery of referred cases at regional and provincial hospital appeared slightly too low. Using the same rates for a category of service by level of facility also showed some problems in uneven quality of services and prescribing practices among facilities. The agreed planned introduction of higher fees for higher quality of services showed difficulty and delay in the implementation as this felt outside the responsibility of the HEF IA and required formal agreement on joint monitoring with the Provincial Health Offices.

Daniel Cotlear

Lead Economist
The World Bank
USA

Daniel Cotlear is Lead Economist at the Health, Nutrition and Population Unit in the Human Development Network. He holds a PhD in Economics from Oxford University, a Master's Degree from Cambridge University and a Bachelor's Degree from the Catholic University of Peru. Prior to his current appointment, he was the Lead Economist at the World Bank's Human Development Department for Latin America and the Caribbean Region. Prior to that, within the World Bank he was Sector Leader for Human Development covering the Andean Countries. He has also served as health economist for Latin America, as macroeconomist in the Central America Department and as Agricultural Economist in the Southern and Eastern Africa Department. Before joining the Bank he was an advisor at the Ministry of Agriculture of Peru, university lecturer and author of several publications including a book on poverty reduction in the Peruvian Sierra.

Mursaleena Islam

Principal Associate/
Senior Economist
International Health Division of
Abt Associates, Inc.
USA

Mursaleena Islam, Ph.D., is a Principal Associate/Senior Economist in the International Health Division of Abt Associates, Inc., a mission-driven firm in research and program implementation, headquartered in the USA and currently working in over 75 countries. Dr. Islam specializes in the areas of health systems, health financing, and monitoring and evaluation. She has conducted economic analysis and managed implementation on a variety of projects in Asia, Africa, Central America and the Caribbean during the past 12 years; she is currently working on the Health Systems 20/20 project, funded by USAID. Through this project, Dr. Islam is working with a country team to support the development of a health financing strategy in Bangladesh. Previously, as the Deputy Director and technical coordinator for a GTZ-funded project in Bangladesh, she managed three teams to: evaluate a maternal health voucher program, cost maternal health services, and design a human resources incentive package. Health system assessments in 25 countries have been conducted using a manual whose publication Dr. Islam coordinated, *Health Systems Assessment Approach: A How-To Manual*, which covers the six building blocks of a health system. Dr. Islam received her bachelor's degree in economics from the Massachusetts Institute of Technology, her master's degree in economics from Syracuse University, and her Ph.D. in economics from the University of Illinois at Urbana-Champaign.

CHANSALY PHOMMAVONG

Deputy Director of Health Project
Ministry of Health
Lao PDR

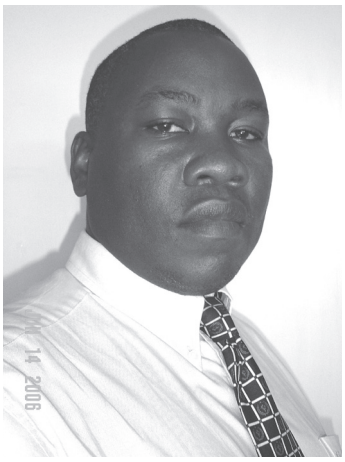
Dr. CHANSALY PHOMMAVONG Master in Primary Health Care - Flinders University , Adelaide South Australia and Master decree in Paediatric, Leningrad Medical Institute of Paediatric, Soviet Union.

Six years working as Deputy Director responsible for Health Services Improvement project supported by WB one of the main activities is HEF implementation in 9 districts of 4 provinces since 2005. Since then in Lao PDR there are only two district implement HEF by SRC (in Namback Luangprabang) and BTC (in Sepone Savanakhet). The HEF in 9 district of HSIP is the first project that came under Ministry of Health. Ministry of Health expected that the project could draw a lesson and experience for the government to expand it throughout the country. This is the top down approach implementation by forming policy and guidelines before apply it the real practice which is different from Cambodia model. Therefore, the main task is how to design a system that could be mechanism to protect the poor from catastrophic expenditure, and help them access to quality of health services. The design of HEF policy is based on 4 main components of health insurance schemes: (i) how to identify the poor beneficiaries, (ii) what kind of benefit package, (iii) organizational structure in management, oversight, monitoring, supervision, control etc, (iv) what kind of payment mechanism to be used.

Throughout the 5 year implementation, there were great lesson could be learn from success as well as challenges that we faced. The old issue is that how we can have a better mechanism to identify the poor and how we could have mechanism to verify the services provider while the new issues coming on how this HEF could be merged into existing health insurance schemes and more importantly how we could make sustainable to assist the poor access to heath services and contribute to poverty reduction. All theses question we have an answer.

Fredrick Ssengooba

Senior Research Fellow
Makerere University
Uganda



Dr. Ssengooba, is a senior research fellow and lecturer in health economics and health systems management at Makerere University. Dr. Ssengooba has worked as a Medical Doctor in a clinical setting, as a Hospital Director and as a District Health Officer in Uganda's health system. In the last 12 years Dr. Ssengooba has focused on research work about health system problems in Uganda and in the East African region. Dr. Ssengooba has led a program of research on the organizational reforms like decentralization of health services; autonomy and efficiency of hospitals; performance-based contracting and its impacts on health system in general and on the workforce in particular. For his PhD research, he studied using mixed methods the response of non-profit hospitals to performance-based contracting by trailing the pilot that was implemented by World Bank and Ministry of Health between 2003 and 2006. With Health System 2020, Dr. Ssengooba has led a multi-disciplinary team to conduct a Health Systems Assessment covering the main building blocks of the health system in Uganda. He also provided overall technical leadership for the design and preparation of Uganda's grant applications to the Global Fund for HIV TB and Malaria. He is also a member of the DFID funded knowledge programs – ReBUILD Consortium whose aim is to generate research focusing on post-conflict health systems (Acholi sub-region in Uganda) and their reconstruction. Dr. Ssengooba is well grounded in both quantitative and qualitative research methods drawing on multiple lenses such as public health, health economics, political science and system thinking. In these fields, Dr. Ssengooba has taught graduate and postgraduate courses, and published books, journal articles, working papers and Op Eds in newspapers. He has also provided technical services to WHO, DFID, USAID, World Bank, Ministries of Health, Uganda AIDS Commission and Multi-lateral and Bilateral Agencies and Foundations.

Parallel Session 3.5

Portability of financial risk protection across schemes, across borders

PhilHealth Overseas Workers Program: Accessible health care for OFWs and their families

By Alexander De Las Alas PADILLA

Background:
In 1987 Philippine Constitution, the State adopted an integrated and comprehensive approach to health development which aims to make essential goods, health and other social services available to all the people at affordable cost. In 1995, the enactment of the National Health Insurance Act established the National Health Insurance Program (NHIP) which provides all citizens with the mechanism to gain financial access to health services, in combination with other government health programs. The Program aims to achieve coverage of the entire population with at least a basic minimum package of health benefits. The Implementing Rules and Regulations of NHIA provide coverage for all Filipinos, including land-based Overseas Filipinos Workers (OFWs) and their dependents. In 2005, pursuant to Executive Order 182, the Medicare funds and the Medicare functions of the Overseas Workers Welfare Administration were transferred to Philippine Health Insurance Corporation (PhilHealth).

Overseas Filipino Workers: Number, Location and Contribution to Philippine Economy

Overseas Filipino Workers or OFWs are Filipinos who are presently and temporarily out of the country to fulfill an overseas work contract for a specific length of time or who are presently at home on vacation but still has an existing contract to work abroad. They may be land-based or sea-based workers. OFWs are considered modern-day heroes because they risk leaving their families to work abroad, not sure of what lies ahead. They sacrifice so much to earn a living to support their families back home.

In 1970s, the Philippine government considered overseas employment as a temporary measure that will be reduced over time as the economy recovered. However, the increasing demand from foreign countries for professional and technical services became too hard to resist, both for the government and for individual Filipinos in search of better employment. In addition, advancement in information technology has made it easier for Filipinos to find overseas employment contributing further to increasing number of Filipinos working abroad over the years. At present, POEA reports that for every 100 Filipinos, 1-2 leave the country to work overseas. In 2010, their number has reached around 1.5 million. The top 10 country-destinations include (1) Saudi Arabia, (2) United Arab Emirates, (3) Hong Kong, (4) Qatar, (5) Singapore, (6) Kuwait, (7) Taiwan, (8) Italy, (9) Bahrain, and (10)Canada.

Overseas employment also contributed significantly to Philippine economy. According to a 2010 report released by Asian Development Bank, Philippines did not go into recession during the global financial crisis in 2008 because of its resilient domestic economy. One of the three factors that contributed to this resiliency is the remittances of overseas Filipino workers, which fuelled personal consumption spending. This is significant because from the expenditure side of the national income accounts, personal consumption expenditure has contributed about three-fourths of the GDP growth in recent years.

PhilHealth Overseas Workers Program

Considering the number of Filipinos working abroad while their families are left behind, PhilHealth established the Overseas Workers Program (OWP) to provide OFWs and their dependents with social health insurance coverage. However, the OWP only covers land-based OFWs since sea-based OFWs are considered employed and are enrolled in PhilHealth under Employed Program. All active land-based OFWs registered at the Philippine Overseas Employment Administration must enroll to Overseas Workers program. Initial registration requirements include accomplished PhilHealth member registration form with supporting documents for declared dependents (i.e. birth certificate, marriage contract, etc) and any proof of being an active OFW. Valid and acceptable documents include Overseas Employment Certificate (OEC) or E-receipt, overseas employment contract or certificate of employment, re-entry visa and job contract. During their initial registration, OFWs are required to pay one year premium of Php 900. For succeeding premium payments, OWP members can either ask their family member to pay on their behalf at any of the accredited collecting agents with 7762 branches nationwide, or they can pay their premium themselves through PhilHealth accredited I-remit Centers located in selected countries including Taiwan, Hong Kong, Singapore, Australia, United Kingdom and Canada.

Eligible OWP members and their dependents can avail of in-patient and out-patient benefits. For inpatient care, OWP member has 45 days of hospitalization per year covering room and board, drugs and medicines, laboratories, operating room and professional fees for confinements of not less than 24 hours. A separate 45-day benefit is shared among the dependents. Outpatient benefits include day surgeries, dialysis and cancer treatment procedures such as chemotherapy and radiotherapy in accredited hospitals and free-standing clinics. OWP members and their dependents are also entitled to Out-Patient Benefit Package, Maternal Care Package, Newborn care Package, TB treatment through DOTS, SARS and Avian Influenza Package and Influenza A (H1N1) Packages.

These benefits can be availed through two mechanisms:

1. The hospital computes and deducts the OWP benefit from the total hospital bill and the claim is filed prior to discharge from the hospital.
2. PhilHealth members can file their claim directly to PhilHealth within 60 calendar days after discharge from the hospital.

For confinements abroad, the OFW can file his claim within 180 days after discharge. Requirements for filing a claim include original official receipt or detailed statement of account and medical certificate indicating the final diagnosis, confinement period and services rendered. Overseas confinements are paid based on tertiary hospital benefit rates.

OWP Achievements and Challenges

How successful is OWP in providing coverage for OFWs and their dependents? This question can be answered in several levels: Are OFWs enrolling to Overseas Workers Program? Of the OWP members, how many beneficiaries (OWP members and their dependents) are eligible to avail benefits? How much premium has been collected through the years? On average, how much benefits have been paid?

The number of OFWs registered to the Overseas Workers Program grew from half million in 2005 to 2.3 M in 2010. For every OFW enrolled in PhilHealth, 2-4 dependents are provided with social health insurance. The OWP beneficiaries increased more than two-fold from 2.6 M in 2005 to 6.9 M in 2010. Accordingly, the OWP member contributions increased over time, from PhP 507.5 M in 2005 to PhP 753 M in 2010.

However, not all OFWs enrolled in OWP can avail of benefits. They must have updated premium payments to become eligible to file claim. Eligibility becomes a problem for OFWs whose contract is more than one year but the premium they paid upon leaving the country covers only one year. Succeeding premium payments for this sector becomes a collection problem. To address this problem, PhilHealth has established accredited collecting agents abroad. In 2009, collection from overseas contributed 1% of the total OWP collection. Almost 70% of the premium collected overseas came from Hong Kong while another 20% were collected from Singapore. Overseas premium collection has doubled between 2009 and 2010.

Increasing the number of collecting agents abroad, however, does not seem to ensure that OWP members will continue to pay their premium. On average between 2005 and 2010, only 42% of registered OWP members have regularly paid their premium and thus eligible to avail benefits. Of those who are eligible to avail, only 2% have actually filed their claim.

But more than the OWP members themselves, OWP coverage means more for OFW dependents. The OWP has not only provided social health insurance for OFWs when they leave the country, but has also provided coverage for families they left behind while they are working abroad. This is evidenced by increasing number of OWP dependents filing for claim. For every OWP member who filed for PhilHealth benefits, 5 dependents have availed. The average value per claim is only PhP 7000 -8000.

Seven years into the implementation of Overseas Workers Program, challenges in enrollment, premium collection, membership services and improving benefits remain. First, ensuring that all OFWs are enrolled continues to be a problem because there is no available information on the real number of Filipinos working abroad. There are Filipinos leaving the country with the intention of working abroad but they do not register with the Philippine Overseas Employment Administration (POEA). On the other hand, the POEA report may include double counting because OFWs who left the country twice for 2 separate contracts within the year are counted twice. This is because OFWs are not given a unique number that can be tracked over time. Second, while there are accredited collecting agents or remittance centers in other countries, these facilities have not fully responded to the needs of OFWs. For instance, Saudi Arabia and United Arab Emirates are the top 2 destination for OFWs yet there are no membership and collection services available in these countries. There is also no comprehensive effort to emphasize to the OFWs the importance of continuous premium payment. Third, despite the fact that OWP is still considered a special project within PhilHealth, attempts to inform the OWP members and dependents of their benefits remain inadequate. Notwithstanding the low number of OWP members that are eligible to file claim in a given time, they must be informed of their benefits, as well as the benefits that are available for their dependents. Fourth, at 900 pesos annual premium, OFWs contribute the lowest premium to the National Health Insurance Program. This has to be increased so that better benefits and better financial protection can be provided to OWP members and their dependents. Lastly, while PhilHealth knows how many OWP members have stopped their contribution, there is no established mechanism to ensure that they have transitioned to other membership type, i.e. if they become employed, self-employed or turned 60.

Moving Forward with OWP

PhilHealth started right with the aspiration of providing social health protection to overseas Filipino workers and their dependents. But to achieve this intention, the challenges mentioned in previous section must be addressed. In the last 18 months, the current government and the leadership in health sector have started to establish the environment to achieve universal coverage. To align with this policy, the new management within PhilHealth has adopted four thrusts to achieve this commitment. These include organizational strengthening, membership expansion, better benefit packages and stronger partnership with health care providers.[1] Within this context, the OWP will be incorporated under the Individually Paying Program of the Membership Management Group and no longer be considered a special project.[2] Improving PhilHealth enrollment and membership services will ensure that all Filipinos will be enrolled regardless of their type of employment. With upgraded and unified IT system, premium collection, membership

[1] Race to UHC. Presented by Dr. EP Banzon during the Senior Officers' Meeting on Dec 5, 2011

[2] Personal communication with Ms Chona Yap, Senior Manager of Overseas Workers Program, Dec 14, 2011.

type tracking and claims processing will be more efficient. Moreover, OFWs are natural targets for PhilHealth-Private Partnership (PPP) strategies that make it easy for them to enroll but hard to drop out of NHIP because of the benefits they get from private merchants (e.g. discounts for commodities and services beyond PhilHealth benefit package). The PPP endeavor also facilitates behavioural change through information and education campaigns where the importance of PhilHealth membership is continuously emphasized. The campaign for enrolment and premium collection will be coupled with expansion of benefits that will improve the financial risk protection of PhilHealth members.

With political support and capable leadership, our aspiration of achieving universal coverage will be realized. PhilHealth will ensure that all Filipinos are PhilHealth members, regardless where they are in the world. PhilHealth will make certain that all PhilHealth members, including OFWs are protected from high cost of health care.

David B. Evans

Director, Health Systems Financing
World Health Organization
Switzerland

David B. Evans, Director of the Department of Health Systems Financing in the Cluster on Health Systems and Services at WHO, has a PhD in economics and worked as an academic and consultant in Australia and Singapore before joining WHO in 1990. His work has covered the social and economic aspects of tropical disease control, the assessment of health system performance and the generation, analysis and use of evidence for health policy. His current responsibility is the development of effective, efficient and equitable health financing systems, through technical support to countries, generation and use of evidence, capacity strengthening and partnership with other development agencies and initiatives. He was the lead author for the World Health Report 2010 (Health Systems Financing: the Path to Universal Coverage).

Qingyue Meng

Dean School of Public Health
Peking University
China

MENG, Qingyue, MD, PhD, is Professor in Health Economics, Dean of School of Public Health, Peking University, and the Executive Director of Peking University China Center for Health Development Studies (CCHDS). Prior to this position, he was Dean of Shandong University School of Public Health.

He obtained MD from Shandong University (Previously Shandong Medical University); MSc from Fudan University (previously Shanghai Medical University); M.A. from School of Economics of University of the Philippines; and PhD from Karolinska Institutet in Sweden.

He is the member of Advisory Committee of Health Policy and Management and member of the Expert Committee of Tuberculosis Control, to Ministry of Health; the former Board Member of The Alliance for Health Policy and Systems Research, WHO; and member of the Steering Committee on Social, Economic and Behaviours, TDR.

His research interests include health financing and cost-effectiveness analysis of public health programs. Over the past decades, he has led teams conducting dozens of research projects supported by WHO, the World Bank, DFID, EU, and Chinese government. He provides a number of consultancy services focusing on health policy and systems for Chinese government through the World Bank, DFID, and Ausaid-funded projects.

Alexander De Las Alas PADILLA

Executive Vice-President
and Chief Operating Officer
Philippine Health Insurance Corporation
Philippines

Atty. Alexander A. Padilla has headed various government agencies in the Philippines and an equally diverse list of private sector firms and non-governmental organizations. His public service career spans 15 years and counting. A human rights lawyer and an expert in constitutional law, Atty. Padilla's career has revolved around instituting innovative positive reforms through integrity, conscientious public service, efficient accountable management, and intelligent governance. He entered the health sector as Assistant Secretary for Legal Affairs of the Department of Health and was later promoted to Undersecretary of Health Regulations. Among his historic accomplishments include

1. Crafting the revised Implementing Rules and Regulations for the Philippine Milk Code that banned advertisements for infant milk formula to support exclusive breastfeeding for the first 6 months of life.

2. Developing Philippine policies in line with the Framework Convention for Tobacco Control and the implementation of the Tobacco Reform Act that banned advertisements of tobacco in areas deemed not points of sale;

3. Crafting the Implementing Rules and Regulations for the Cheaper Medicines Act, establishing 20,000 village drug outlets to provide essential medicines in rural areas, providing support for generic medicines and the generics only prescribing in government facilities, introducing medicine entitlements (free medicines for early stage breast cancer and leukaemia in children), and imposing 50% price reduction for a list of essential life-saving medicines (many still patented) deemed to have market failure. The transparent process in crafting these policies led to a supportive stance by industry proponents despite the mandatory and voluntary price cuts. This became the driving force for the pharmaceutical market growth to shift from high retail prices to high unit sales volume that benefitted more people, especially the poor.

4. Working along with other DOH high ranking officers in managing and preventing the entry of SARS, Avian Influenza, and other life threatening diseases as Chair of the Committee and Undersecretary-in-Charge of the Bureau of Quarantine of DOH.

5. Institutionalizing procurement reforms in DOH in line with the 2002 Procurement Reform Act that led to the recognition of DOH as the government agency with the highest integrity, low risk for corrupt practices, and high public trust rating in 2005-2009.

In response to the clarion call of achieving universal health coverage for the Philippines, Atty. Padilla accepted the position of Executive Vice-President and Chief Operating Officer of Philippine Health Insurance Corporation (PhilHealth). Concurrently, relying on his expertise and integrity, he was also tasked by His Excellency President Benigno S. Aquino III to chair the government panel to negotiate peace with communist insurgents in the country.

In his first year in PhilHealth, Atty. Padilla has introduced reforms in PhilHealth that changed the mindsets and pushed better performance from the country's social health insurance. He has introduced PhilHealth-Private Partnership (PPP) program that leveraged the fiscal influence of PhilHealth to get support from private sector in complimenting PhilHealth services to the people. This created new improved understanding of social health insurance by Filipinos. In the short 3 months, the PPP program has registered at least 700,000 new members for PhilHealth.

A lover of modern art, paintings, and badminton, Atty. Padilla graduated cum laude from De La Salle University and garnered his law degree from the University of the Philippines where he finished top 8 of his class.

Richard Smith

Head of Faculty of Public Health and Policy
London School of Hygiene and Tropical Medicine
United Kingdom

Richard Smith is Professor of Health System Economics, and Head of the Faculty of Public Health and Policy, at the London School of Hygiene and Tropical Medicine.

Richard has been a Health Economist for over 20 years, following undergraduate and postgraduate studies in economics at the University of York. Upon leaving York in 1991, he worked in Sydney, Cambridge, Bristol, Melbourne and Norwich, before joining the School in May 2007. He is also an Honorary Professor of Health Economics at the Universities of Hong Kong and East Anglia, and is an Associate Fellow at The Royal Institute of International Affairs, Chatham House.

Richard has worked in a number of areas of health economics, such as the monetary and non-monetary valuation of health, health care reform and genomics. More recently his work has focused especially upon developing the application of macro-economics to health, the economics of globalization and health, and aspects of trade in health goods, services, people and ideas. His current interests are broadly in the interaction and interface between a nation's health system and other systems - both within the nation (e.g. tourism, travel and leisure sectors) and between different countries (e.g. through movement of health professionals). This interest has been manifest in three areas: (i) macro-economic modelling of health (care), covering infectious disease and more recently nutrition-related non-communicable disease; (ii) economic analysis of the impact of trade and trade agreements; and (iii) international financing for health and health care. Within this work he has always taken a multi-disciplinary approach, and especially focussed upon the political-economy aspects of these areas.

Richard has received over £30 million in grant income, published five books and more than 100 journal papers. He is an Associate Editor of Health Economics, and Member of the editorial boards for the Journal of Public Health and Globalization and Health. He has had a long involvement with the World Health Organization (WHO), and currently sits on the WHO External Scientific Resource Group on Globalization, Trade and Health, the Panel of Experts for the WHO Genomic Resource Centre and is an Expert Advisor in trade for the WHO IHR Roster of Experts. Richard has also acted as an expert advisor for a number of other international and national bodies.

Bong-min YANG

Professor and Director
School of Public Health,
Seoul National University
South Korea

Bong-min YANG, PhD (in economics) is Professor and Director, and former Dean of the School of Public Health at the Seoul National University, South Korea. Professor Yang has led research and written many papers in health economics and health care system in Korea and East Asia. His recent publication includes, "Economic Evaluation and Pharmaceutical Reimbursement Reform in South Korea's National Health Insurance," January/February Health Affairs (2008), "The future of HTA in Healthcare Decision Making in Asia," PharmacoEconomics (2009), "The Societal Burden of HBV-related Diseases: South Korea," Digestive Diseases and Science (2010), and "Relationship between catastrophic health expenditure and household incomes & expenditure patterns in South Korea," Health Policy (2011).

In addition to his research and publication, Professor Yang served as co-editor for Value in Health, Asia Special Issue No.2 (2009) and Asia Special Issue No.3(2012), and is currently co-editor-in-chief of Value in Health Regional Issues, a member of editorial board of Journal of Medical Economics. Associate Editor, Journal of Comparative Effectiveness Research, and a member of Editorial Board of The Oncologist.

He also has worked as short-term consultant at WHO, ADB, UNDP, and the World Bank. For the Korean government, he served as Chairperson of Health Insurance Reform Committee, and Chairperson of the Drug Pricing and Reimbursement Committee. He currently is serving as Chair of ISPOR-Asia Consortium, and member of Board of Directors of ISPOR (International Society of Pharmacoeconomics and Outcomes Research).

Parallel Session 3.6

Universal Health for the Working Poor:

Barriers to Access

UNIVERSAL HEALTH SCHEMES AND THE WORKING POOR: BARRIERS TO ACCESS

Purpose of the Panel
Chairperson: Prof Francie Lund
WIEGO Programme Director: Social Protection and
School of Development Studies, University of KwaZulu-Natal, South Africa

WIEGO (Women in Informal Employment: Globalizing and Organizing) is a global research and policy network that seeks to assist organizations of informal workers, especially poorer women, to improve their conditions of work. Homenet Thailand, a WIEGO affiliate, is the coordinating centre of a network of homebased producers, homeworkers and other occupational groups of informal workers.

Through their work with membership-based organizations (MBOs) of informal workers, WIEGO and Homenet Thailand know that access to health services is a high priority for the working poor, especially women, in the informal economy. Their most immediate concern is to get back to good health in order to continue earning an income for themselves and their families. In this respect the introduction of inclusive health schemes could be an important step forward in terms of ameliorating some of the more significant health problems faced by informal workers.

In this panel, WIEGO and Homenet Thailand present three case studies of the extension of health care and health insurance in three countries: Ghana, India and Thailand. These three countries have recently introduced inclusive health/health schemes as a means by which to increase access to healthcare. All three policy reforms had a specific intention to include informal workers. The Ghana and Thai schemes have been relatively well documented; the access of informal workers, however, has not yet been a focus of evaluation. The case studies approach the evaluation of the schemes through the lens of informal workers, including data from interviews and focus groups with informal workers on their experiences with trying to access the schemes. The aim of the studies is to create greater clarity around the specific barriers poorer women workers face in trying to access health care, and thereby how to develop an effective policy response to address the barriers.

India's Rashtriya Swasthya Bima Yojana (RSBY): Access for Informal Workers

A case study by Kalpana Jain for WIEGO

Ninety three percent of the workforce in India comprises informal workers, the majority of whom are poor. Informal women workers have special needs and poor health: Their work hours are long and income small. Their health deteriorates over time due to their working conditions which may involve long hours of needlework in poor light and ventilation, or the collection of hazardous waste. As informal workers, they do not get any work-related benefits or protection under labor laws. Family needs take priority and when it comes to allocating resources, the health of a male or a child takes precedence over their own (Shah 2008). As a result, women workers do not see a doctor even when they suffer from health problems, which often worsens their condition. Moreover, informal workers are often not able to access care if the health facility is too far, and if the queues are long, as they risk losing income. Their lack of education and marginalization may prevent access to reliable information about available health care.

The National Commission for Enterprises in the Unorganized Sector (NCEUS) estimates about 836 million or 77 percent of the population, who constitute most of India's informal economy, are living below USD 0.4 a day (NCEUS, 2007). Yet, one of the big challenges of the India's healthcare system is the financial burden it puts on households in terms of out-of-pocket spending. The share of out-of-pocket spending on private healthcare is very high in India compared to most other developing countries (Berman et al, 2010). About 39 million additional people fall into poverty each year as a result of this expenditure (Balarajan et al, 2011). Until recently, only 10 percent of Indians had some form of medical insurance and that too was highly inadequate (National Rural Health Mission Document 2005-2012).

In the past, Central government schemes provided health insurance only to formal sector workers. Recognizing this gap, several state-based and Central health insurance initiatives have been launched in recent years. The largest of these initiatives is the national health insurance scheme, the Rashtriya Swasthya Bima Yojana (RSBY) which was launched in April 2008 and is being implemented in 25 of India's 28 states and seven union territories. It is the first serious national effort at health insurance for informal workers and those living below poverty line (BPL).

The scheme is largely funded by the Central government, with the Centre financing 75 percent, and state governments putting in 25 percent. The scheme covers hospitalization charges up to about USD 634 (Rs 30,000) for up to five members of a family for a year. Beneficiaries are required to pay only about USD 0.63 (Rs. 30) as registration fee while

the government pays up to USD 16 (Rs 750) per family per year. The scheme also provides transport allowance, up to USD 21 (Rs 1,000) per year. However, it does not cover outpatient care or the cost of medicines. The scheme works through a good IT system. Beneficiaries are issued a smart card that stores their name, age, photograph and thumb impression. This smart card needs to be presented to participating hospitals to avail treatment.

Health insurance schemes designed for informal workers need to take into consideration the various barriers to access. This case study, based on a desktop review, examines how the RSBY scheme has worked so far for informal workers, especially poorer women. The complete case study covers two other state schemes. Yeshasvini, in Karnataka, provides health care to agricultural workers, through the co-operatives which have a strong tradition in that state; Rajiv Aarogyasri in Andhra Pradesh targets the absolute poor. It compares them with the VimoSEWA scheme, active in nine states, that was built by SEWA (the Self-Employed Women's Association), a labor union of over 1.1 million women workers in the informal economy.

In the three years since its launch, the RSBY has helped provide access to hospital-based care to a large number of poor, informal sector workers. By the middle of 2011, 23.5 million smart cards had been issued, and these covered 100 million people with health insurance (Swarup, 2011). An IT-enabled network of hospitals and insurance companies has ensured efficient and cashless delivery of healthcare. The scheme's design has been well considered and well applicable to the needs of the poor. For instance, the RSBY's coverage for a family of five matches with India's average family size of 5.3. Overall, RSBY has performed commendably in providing health insurance coverage to extremely poor people. At this stage, the focus has been on expanding coverage and rightly so. However, it is also a good stage now to assess where informal workers face barriers to accessing healthcare. This case study identified the following barriers:

1. Inclusion procedures risk leaving out many BPL workers: The criterion for inclusion in RSBY is based on a below poverty line list of people drawn up through the Planning Commission of India. BPL is an economic benchmark the Indian government uses to identify families in dire poverty. However, the BPL list has several problems and in many places BPL families have been left out. Some states do not have the list. States had to devise their own criteria for inclusion in the scheme. In some areas, people felt they were unjustly left out, while their neighbors with the same or higher socio-economic status were included. This led to social divisions and serious tensions. In some cases, the name of the head of the household, required for issuing the smart card, was missing from the list. Such households were not allowed to register using another member as head of family. In families where the head of the household was ill or deceased, the members were unable to register. These rules make the scheme beyond the reach of the poorest workers, who need it most.

Moreover, the scheme requires families to register in their home states on the basis of BPL list (Range, 2008). This means that migrant workers, who have been unable to return home for long periods of time and therefore are not registered, cannot avail of the scheme even during times of illness.

2. High cost of out-of- pocket payments: A big part of healthcare expenses in India are out-of-pocket payments. About 79 percent of impoverishment through health service use is a result of outpatient care, which involves several small but frequent payments, and only 21 percent is a result of inpatient care (Peters et al, 2010). The benefit package under RSBY is mainly focused on the provision of secondary care. It does not include outpatient visits or the cost of drugs.

In the absence of coverage for outpatient visits, people delay going to a doctor for as long as they can. Such delays could not only lead to longer hospitalization but also income loss for informal workers. The impact on women's health is more severe as they are the last to visit a doctor if they have to pay for the services.

3. Fewer women avail services: RSBY's data from 145 districts shows that far more men than women were issued the smart cards: of the nearly 27 million cards that were issued, only about a third, or nearly ten million, were women.

4. Information dissemination is inadequate: Available literature shows that much of the information that people received was through word of mouth. The RSBY survey shows that 69 percent of RSBY patients first learnt of RSBY through a friend or family member and even learnt of about the hospitals that were empanelled through family members or friends. Under the scheme, state governments are responsible for creating effective programs for spreading awareness. However, many states have handed over the function to insurance companies and there is a gap in terms of a clear and effective strategy of information dissemination. In Karnataka, the question of how to create awareness was left to the district administration.

5. Lack of regulations and varied quality: There are large variations in the quality of healthcare, and both the public and the private sector function without much accountability. The poor are more likely to suffer from this lack of oversight of the quality of care. The scheme is being implemented by the ministry of labor, with little involvement of the ministry of health that would or should have more expertise in quality issues. Some studies show the number of empanelled high quality private sector hospitals is low and in some places patients had to seek services outside of network hospitals (RSBY evaluation Jaunpur, 2010, sourced from http://www.rsby.gov.in/Documents.aspx?ID=14).

As mentioned earlier, RSBY is in its early stages of implementation and has achieved remarkable success in a relatively short period of time. RSBY cannot be expected to

fix the larger problems of the health system in the short term. However, this study has identified key areas where action could be initiated over the short term. Some of the lessons for RSBY can be drawn from the experiences of other schemes such as VimoSEWA, Yeshasvini or Rajiv Aarogyasri.

1. Process of issuing smart cards: RSBY issues the smart card in the field itself, but the head of the household needs to be present. This has led to lower enrolments in areas where either the name of the head of the household was incorrect or he was not present, as he was at work. Informal workers would find it difficult to give up a day's wage to be available at a certain place. In many places, people were not given adequate information in advance, which again led to poor enrolment. This process could be streamlined. The government has already ensured smart card portability across states. It should also look at process of issuance of the card easier for informal and migrant workers. In Rajiv Aagroyasri's system, smart cards can be issued on the spot.

2. Provide primary care coverage: Benefits under RSBY are mainly focused on providing secondary care coverage. Primary care is not provided under the scheme. This case study found how the poor often do not seek treatment for minor illnesses if they have to pay for it. Coverage of outpatient visits may require much larger investments by the government at this stage. However, RSBY could take some learning from VimoSEWA in the way it integrates the scheme with a comprehensive health care package, providing preventive and curative services through its health centres. RSBY too could integrate the scheme with voluntary or not for profit health centres for primary health centres, in places where primary care is weak.

3. Better information dissemination: The RSBY could strengthen the process of information dissemination, which, in some places, has been left to insurance companies, who may have an interest in better enrolment, but necessarily in more claims. In this initial phase of the scheme it needs a much stronger information dissemination system to reach the poorest people. In the case of VimoSEWA, dedicated community health workers have been very effective. RSBY could also do so. This may also encourage a better participation of women and help reduce the gender gap.

4. Set up mechanisms for quality monitoring: Adequate quality monitoring mechanisms are yet to be set up by health insurance schemes in India. It is especially important to do so when the poor population are involved and the risks of medical malpractice may be high (VimoSEWA for example found a high rate of hysterectomies being performed on very young women). RSBY could start this process by building in inspections and quality monitoring mechanisms.

5. **Coverage for cost of drugs:** There is no simple answer to the complex issue of providing for cost of drugs, especially in countries such as India where all medicines can

be purchased over the counter. However, this is an important issue and does require some thought on how best insurance schemes can cover cost of essential medicines, especially for the poorest population.

References:

Balarajan, Y, Selvaraj, S. and Subramanian SV (2011)"Health Care and Equity in India" The Lancet, Volume 377, Issue 9764, February 2011. pp 505 -515

Berman, P, Ahuja, R, Bhandari, L (2010) "The Impoverishing Effect of Healthcare Payments in India: New Methodology and Findings" Economic & Political Weekly, April 17, 2010 vol xlv no 16.

Range, J (2008) "India's Poor Get Health Care in a Card", Wall Street Journal, August 26, 2008

Rashtriya Swasthya Bima Yojana(2010): "Rashtriya Swasthya Bima Yojana: Studying Jaunpur (Uttar Pradesh)", A Study by Amicus Advisory Private Limited. Pp 1-40

Rajasekhar D, Erlend, B, Maitreesh, G, Manjula, R, Roy, S, Implementing Health Insurance (2011) "The rollout of Rashtriya Swasthya BIma Yojana in Karnataka", May 14, 2011, Economic & Political Weekly, Vol XLVI no 20. Pp 56-63

Reddy, S; Selvaraj, S; Rao, K D; Chokshi, M; Kumar, P; Arora, V; Bhokare, S; Ganguly, I. (2011) "A Critical Assessment of the Existing Health Insurance Models in India" Public Health Foundation of India.

Sengupta, Arjun, Kannan, KP, Srivastava, RS, Malhotra, VK, Papola, TS, Yugandahr BN.(2007)" Report on Conditions of Work and Promotion of Livelihoods in the Unorganised sector". August 2007.Pp 1- 394

Shah, Mittal (2008) "Health System Strengthening using Primary Health Care Approach. Protection for Poor Women Workers: SEWA's Experience with Health Insurance". Working paper. Regional Conference on "Revitalizing Primary Health Care" Jakarta, Indonesia.

Swarup, A (2011) "RSBY – Scheme With a Difference", Ministry of Labour and Employment, Government of India, New Delhi

Websites

www.rsby.gov.in

A Case Study of the Ghana National Health Insurance Scheme and Informal Workers

Laura Alfers
WIEGO (Women in Informal Employment: Globalizing and Organizing)

Most workers in the developing world are informal workers, and most informal workers are poor. Attempts to mitigate poverty in the developing world therefore need to focus on informal workers. Over 90 percent of Ghana's workers work informally. Informal work is not homogenous and can include a variety of work statuses. The majority of informal workers in Ghana are self-employed, own-account workers[1], rather than waged employees. Few have ever had access to national social security or healthcare schemes.

In 2003 the Ghanaian government introduced a National Health Insurance Scheme (NHIS). Ghana's NHIS is an innovative and large scale attempt to extend social protection to informal workers. It may hold important policy lessons for other countries where the informal economy is large and growing, and where informal workers are excluded from formal social protection.

Several studies have focused on the impact of the NHIS on poor people, but few have specifically focused on its impact on informal workers. Although the problems poor people may face in accessing the NHIS may be similar to the problems informal workers face, informal workers may encounter specific barriers to access related to the nature and context of their work.

This case study concentrates on female informal workers in particular and has three main objectives: to describe the background, structure, implementation and context of the NHIS in Ghana, to assess the barriers faced particularly by female informal workers in terms of accessing the scheme, and to determine how much participation these workers have had in the development of the scheme. It is based on a desktop review of existing literature on the NHIS, as well as a small, qualitative study conducted in Ghana in 2009 and 2010 with informal traders, chop bar operators (who run informal eating houses), and Kayayei (headload porters, usually migrants from the rural northern areas of Ghana), and also semi-structured interviews with several key informants.

The Ghanaian NHIS was developed in consultation with a wide range of stakeholders, including the Secretary-General of the Ghana Trades Union Congress (GTUC) who representated both formal and informal labour. It is an interesting fusion of Social

[1]*Own account workers are self-employed workers who do not employ any regular employees.*

Health Insurance (SHI) and Community Based Health Insurance (CBHI) models. The basic structure is described as a "hub-satellite" or "hub-spokes" system. The hub, which is essentially based on the SHI model of pooled public tax resources, is the National Health Insurance Fund (NHIF) which is administered by the National Health Insurance Authority (NHIA). The sources of funding for the hub are varied, but come mainly from an extra VAT levy of 2.5 percent imposed on almost all goods in Ghana. The spokes are made up of a country wide network of CBHI schemes known as District Wide Mutual Health Insurance (DWMHI) schemes which are monitored, subsidised and re-insured by the hub.

This model was chosen because it was considered unrealistic, in a country with such high levels of informal employment, to implement a statutory SHI scheme, which would rely on deductions from employee wages. CBHI schemes are non-profit schemes based on voluntary membership, low premiums, and flexible payment schedules (Coheur et al., 2007). These schemes are better suited, in theory, to contexts in which informal employment and poverty are high. However, CBHI schemes usually encounter problems of financial sustainability – high drop-out rates, small risk pools, and low premiums all contribute to this problem (Coheur et al., 2007). They also tend to work best in small community settings, and it has proved difficult to scale them up to facilitate national coverage (Atim et al., 2009). By combining a network of CBHI schemes with a centralised authority and source of funds (the SHI component) to ensure nationwide coverage and to guarantee the financial sustainability of the schemes, the NHIS is an attempt to adapt aspects of these health financing models to fit the particular socio-economic situation of Ghana.

Figures on the scheme's coverage supplied in June 2010 by the NHIA – showing that 66 percent of the population are registered with the NHIS – suggest that this strategy has been successful. However, coverage figures supplied by the NHIA have been questioned by Apoya and Marriott (2011), who argue that the actual coverage rate is closer to 18 percent of the population.

Informal workers who were interviewed for this study generally welcomed the idea of the NHIS as an alternative to the previous system, which was based on out-of-pocket cash payments at the point of service. Participants who were members of the scheme clearly felt that it had increased the quality of their lives. Particularly noteworthy was the mention by several women that they had used the NHIS to have regular blood pressure checks. In 2008 the Government extended free care to all pregnant women, regardless of their NHIS status, and this has also been warmly welcomed.

However, a number of barriers to access meant that the majority of informal workers interviewed in this study (32 out of 40) were not NHIS members. The main barriers were:

1. ***The cost of premiums:*** Although all Ghanaian contribute to the NHIF through the VAT levy, they are only able to access the scheme's benefits once they have paid a once-off registration fee and an annual premium. The official premium levels are set between GH□7.2 ($5) and GH□48 ($32), depending on income, and district schemes are meant to judge on a case-by-case basis what premium people qualify for. Evidence suggests that many urban schemes have now set their minimum premiums well above GH□7.2 – numbers mentioned range from GH□15 ($10) to GH□25 ($17). This is far out of reach for many of the poorest workers, particularly rural migrants such as the *Kayayei* who on average earn just over $1 a day.
2. ***Registration fees for children:*** In 2008 the Government declared that all children under the age of 18 would have free NHIS membership. In reality, however, a registration fee of GH□2 per child is charged by the district schemes. This can add up to a significant amount for women with many children, who also often tend to be among the poorest.
3. ***Poor administration in the District schemes:*** A considerable number of the better off workers interviewed had at one point tried to join the scheme, or had tried to renew membership, but had failed because of poor administration at the district level. Some workers had paid premiums, but had not received membership cards; others had tried to renew their cards, only to find that the offices had moved. A number complained that their work commitments meant that they did not have time to follow up further with the schemes, and so they had given up.
4. ***Lack of detailed information on the NHIS:*** Leaders of the worker associations felt that the NHIS had not made enough effort to spread detailed information about the scheme in the market areas in which a significant number of Ghana's informal workers work. Many Kayayei women, for example, do not know that they qualify for free pre- and post-natal treatment at health facilities. There is no easily available information on whether premium payments can be made in instalments, and many traders were unaware that they may be able to qualify for lower premiums depending on their earnings.
5. ***Long waiting periods for NHIS members at healthcare facilities:*** NHIS card holders are reportedly being made to wait for treatment in favour of cash paying patients at health facilities. This appears to be a consequence of overcrowding at the facilities and the late payment for health services by the NHIS. Again, for most informal workers, time is very literally money.
6. ***Out of pocket payments for medication:*** Many of the workers interviewed felt that there was little point in joining the NHIS, because they said that the drugs covered by the NHIS are often inadequate, and members still have to pay extra for medication.

Apoya and Marriott (2011) have recently argued that, despite its intention of increasing equity in healthcare provision, the NHIS is a deeply unfair system. The authors give

evidence that coverage figures have been grossly inflated by the NHIA, and point out that the scheme results in poorer people subsidising healthcare for those who are richer. While everyone must pay the NHIS VAT levy, only those who can afford to pay premiums are able to access the service. Apoya and Marriott (2011) argue that instead of spending money on a chaotic, over complicated, inefficient NHIA, a far more equitable approach would be to use the funds to bolster the health system and to institute non-insurance based universal healthcare. It should be noted here that Thailand is one country where a low cost health insurance scheme was later converted into a universal healthcare system.

Whatever health financing route the Ghanaian government ultimately decides to take, it is important for now that the scheme begin to address some of the specific barriers to access that informal workers face. Some of these barriers are related to the wider functioning of the healthcare system and of the scheme itself, and may not be simple to solve. This study has identified some areas, however, where focused action could be taken in a relatively straightforward manner. These include:

1. ***Regulation of urban premium levels:*** Anecdotal evidence suggests that the minimum premiums in urban areas are set well above GH□ 7.2 because urban areas are considered to be wealthier than rural areas. It is not always easy to draw a clear geographical line between the rural and the urban in Ghana – there are significant populations of very poor, rural migrant workers, such as the Kayayei, living and working in cities like Accra. Ideally for workers as poor as the Kayayei, there should be some form of premium exemption. Failing this, there should be regulations which force urban district schemes to at least offer the lowest premium (GH□7.2) to such workers.

2. ***Better dissemination of information in informal workplaces:*** Awareness of the NHIS amongst Ghanaians is high – no one interviewed in the research was unaware of the scheme's existence. However, there is a difference between a general awareness about the scheme's existence, and the wide availability of accurate information on the details of the scheme. The market areas could be strategic places to provide this kind of information. The market women themselves suggested that health booths could be installed in the markets to act as information points. They could also be used as a central space in which to conduct targeted, detailed education campaigns for market workers and customers alike. Using worker organizations to spread accurate information about the scheme may also be a good idea.

3. ***Better representation of informal workers at all levels of the NHIS:*** The NHI Act makes provision for a representative of organised labour to sit on the National Health Insurance Council (NHIC). This position has been filled, since the inception of the scheme, by the Secretary-General of the Ghana Trades Union

Congress (GTUC). As the GTUC represents both formal and informal workers, informal workers are technically represented on the governing body of the scheme. However, the interests of formal and informal labour are not always the same, and may often clash. This means that, whatever good intentions are present, it is likely to be very difficult for one individual to truly represent the interests of both groups. In this case, it is important that provision is made for an additional person representing the interests of informal organised labour to sit on the NHIC.

It is also important that such representatives of informal workers be included in the governing bodies of the district schemes. All levels of the NHIS need to keep in touch with what is happening on the ground, and including representatives of informal labour in these bodies is a necessary part of doing that, especially considering the central role these workers play in Ghanaian social and economic life.

References

Apoya, P. and Marriott, A. 2011. 'Achieving a Shared Goal: Free Universal Health Care in Ghana.' [Online]. Retrieved 24 June 2011, from www.oxfam.org.

Atim, C., Fleisher, L., Hatt, L., Masau, S. and Arur, A. 2009. Universal Access to Quality Health Services: Improve Maternal, Neonatal and Child Health. Paper presented at the Fourth Session of the African Union Conference of Ministers of Health, Addis Ababa, Ethiopia, 4-8 May 2009

Coheur, A., Jacquier, C., Schmitt-Diabate, V. and Schremmer, J. 2007. 'Linkages between statutory social security schemes and community-based social protection mechanisms: A promising new approach'. Technical Report 09. Geneva: International Social Security Association.

UNIVERSAL HEALTH COVERAGE AND THE INFORMAL SECTOR IN LOW INCOME COUNTRIES

By Chris Atim

One of the most compelling issues facing Sub-Saharan African countries embarking on the road of universal coverage via some form of health insurance is how to cover the informal sector, usually the most dominant population in low income countries. The challenges arising here are usually related to two inter-connected factors: the first is due to the characteristics of informal sector itself, and the second is do with the macroeconomic, or more accurately, the fiscal space, context of these countries.

The informal sector in these countries is typically large (over 60% in most countries) and has range of income categories from the very poorest to some of the richest. Moreover, for the vast majority, their revenues are mostly irregular and unstable, making it difficult to assess income levels and to collect income-based taxes (including regular premiums in the case of insurance agencies). This is reinforced by the fact that people working in the informal sector are not readily visible to state institutions, through lack of organization and regular contact with such institutions.

The macroeconomic, or fiscal space, factor, relates to the fact that the revenue bases of low income countries are usually insufficient to provide cover for the large numbers in the informal sector on the basis of general tax revenues. This is partly a result of the difficulty of collecting taxes from the informal sector, although other factors such as a limited total income base, uneven and slow or negative growth, inefficient tax collection and 'leakages' are also important.

Methods of raising revenues:

1. General taxation (NHS, Thailand with earmarked sin taxes as well)
2. Payroll taxes? (Colombia but with cross-subsidization)
3. Donor funding and community contributions (Rwanda)
4. Special earmarked taxes (VAT - Ghana but with exemptions for items consumed by poor; mobile phones and foreign exchange transactions -Gabon)
5. Health equity funds (Cambodia, Senegal, and Mali?)

Key issues involved in raising revenues for informal sector coverage

From members of informal sector and/or by other means?

1. Historical context of informal sector coverage in Africa African countries inherited Euro style social security systems, based on formal sectors, generous but very limited size /proportion of population

Formal sectors tended to grow after independence (statist development) Until economic crisis in late 70s, 80s/90s, undermining revenue base and viability of those systems
Restructuring /user fees in 90s – also private sector growth, civil society rise Context that led to development of CBHI/MHOs for formal sector; hence a model for raising revenues and covering informal sector /social protection for informal sector; state exemption schemes for vulnerable CBHI/MHOs limited in population coverage, and could not cover poorest 2000s onwards: Agenda of universal coverage (no more just formal sector): New context: post structural adjustment. But how exactly to attain such coverage?

Formal sector first, or
Informal sector first, or
Both together from start

Related directly to revenue question: how is revenue to be raised, from informal sector itself, or by other means, to cover those populations?

2. Some countries with good experience of CBHI /mutuelles going for last of the 3 options – both sectors from start (Ghana/Rwanda), avoids fragmented pools Compare Nigeria, Tanzania starting with informal sector
Mali, Burkina projects?
While Gabon shows that, even if you choose a phased approach out of prudence, or due to resource limitations, you can start with the most vulnerable in a phased approach (not exactly informal sector but an important portion of it), by focusing new taxes raised on those populations.

3. Covering formal sector first – Equity issue: Repeat of post-independence injustice? But also crucial: decreasing or increasing quality perceived with expansion to informal sector? From whose point of view? Ghana, and some Maghreb countries have national pool for all; Rwanda has separate schemes for formal and informal sectors but has legislated that all citizens should be covered from the start, and also maintains a single national pool for costly or above-PHC health care. Tanzania, Nigeria, Kenya do not have high population coverage as result of focusing in easy-to-cover formal sector first.

4. Not against phasing: Gabon counter example to starting with the formal sector first because it is easy

5. But history matters – Thailand, Kenya had strong formal sector schemes to start with – extending coverage with adequate resources and efforts to ensure quality does not suffer may not be a problem?

6. Issue is how to exempt the very poor while taxing those who can afford to pay?
7. Contributions (premiums) from members is the fundamental principle of insurance but acknowledged that such direct contributions under current revenue levels, will not be enough to cover the cost of their care when pooled, so needs subsidy or complementary contributions – mainly Govt but also donors and special taxes

8. But also helps to pool contributions across from formal sector to informal sector (Ghana) – creates national pool, helps equity in contributions if formal sector paying more but not benefiting more (reversing also historical situation of the opposite)

9. But expanding to informal sector as Ghana and Rwanda have done also has challenges: Problem with special earmarked taxes, unlike either general budget and premium contributions, is that it breaks the link between numbers of insured population and revenues- there is no necessarily between what is collected from these taxes and the number of people insured (true to some extent with general taxes too but generally the budget allocated is in principle expected to correspond to expected costs so there is some link); Perverse situation possible with Ghana's tax-base for instance. Also problem of adequacy and sustainability of funding sources.

10. Phasing a la Gabon, ie with vulnerable and informal sectors first (though Gabon has not added informal sector as a whole in first category) may be a way forward in such a context.

Universal Healthcare Scheme in Thailand: Barriers to Access By Informal Workers

By Boonsom Namsomboon, Ph.D.
HomeNet-Thailand, for WIEGO

Before the "30-baht healthcare scheme" was introduced, the Thai government provided several healthcare schemes with different objectives. For example: the Medical Service Welfare for the People Project focused on providing services for the poor, the elderly and children. However, it was not be able to serve the poor as expected due to the budget limitations. The Ministry of Public Health (MoPH) was the core agency that implemented the universal healthcare scheme[1], beginning on a pilot scale in six provinces in April 2001 and later expanded to another 15 provinces on 1 June 2001, finally to all provinces in January 2002. As a result, in 2003, 47.7 million Thai citizens or 74.7% of all 63.8 million people nationwide were covered by the universal healthcare scheme. When we include those who already have health insurance coverage by social security, this leaves only 3.2 million people or 5% of total population without any health insurance coverage.

On May 1, 2010, National Labor Day, Deputy Public Health Minister Pansiri Kulanartsiri said the following:

> Two thirds of Thai workers - 23 million of the 37 million workforces - are not covered by the social security system. More than half of all workers are at risk of occupational hazards, with about 2.9 million injured or sick annually.[2]

Under the 30-baht healthcare scheme (universal healthcare scheme) patients paid only 30 baht (USD 0.75) per healthcare intervention, and since 2007, it has become a totally free health service. Puenpatom and Rosenman (2008) claimed that 90% of the population is covered by the universal health care scheme. The results of a survey conducted by the National Statistical Office Thailand in June 2003 revealed that most people, as high as 97 % of the sample, were satisfied with the Universal Healthcare Coverage Scheme. Similarly, almost 91% wanted to see this scheme continued (Doane, et al., 2006:127). The National Economic and Social Development Board also reports that "95.7% of the population has health security" (National Economic and Social Development Board, Development News Bulletin, Vol. 20, No. 06: June 2003). However, even though it is

[1]Initially, it was called the '30-baht healthcare scheme'. However, since October 1, 2007, it has become free, and now called universal healthcare scheme. To avoid confusion, in this paper, it will be called universal healthcare scheme except in quotes.

[2]http://www.nationmultimedia.com/home/2010/05/02/national/Millions-lack-welfare-coverage-govt30128409.html Viewed May 2, 2010

claimed to cover all people, there are many low income workers, especially informal sector workers, who are not able to access universal health care services even though they do have the rights to access.

In this study, the researcher interviewed 415 working poor women by using a structured questionnaire in order to examine how they were able to access the universal healthcare scheme, and to know the reasons for not being able to access it. In addition to individual interviews, a variety of other methods were used. There were 13 focus group discussions, 10 group representatives were interviewed as key informant, and 10 life stories were done. Secondary data were also collected in a literature review.

The results of this study shows that 297 (71.6%) out of the 415 respondents were able to access the 'Universal Healthcare scheme' at the hospital. 385 (92.8%) accessed health care centers[1] while 303 (73.0%) used community health centres[2]. The reason might be because health care centres were more effective compared to community health centres and closer to their homes when compared to the hospital.

The study also found that those who were married, separated or widowed had poorer health while less than half of those who were separated were able to access the healthcare centre and about half of them (12, or 57.1%) went to hospital. The reason might be that because of their poorer health, they needed to get better treatment from the hospital.

On the positive side, regarding satisfaction with the universal healthcare scheme, the results of this study showed that although only a few working poor women appreciated this service; these were especially those who experienced using the universal healthcare scheme when they had serious sicknesses. Their reaction was:

> It really surprised me when I paid nothing for having the operation.

The results from the focus group discussions and in-depth interviews with those who used universal healthcare scheme showed that some of them were highly satisfied with this service. There were two important aspects to this. First, satisfaction depended upon the type of treatment received. Those who received treatment in serious cases (e.g.

[3] Health care centre are established and run by the government, and have doctors and nurses stationed there. Health centres aim to provide primary health care services to the people living near the centre. Thus most of the health centres are located near communities and villages.

[4]Community health centres are mostly set up at the volunteers' homes or the community centre. The trained local health volunteers in each community work in the centre on a rotation basis and receive 140 Baht per day as their honorarium. Some communities have agreed to deduct 40 Baht from each honorarium as a saving for group activities.

operations, childbirth, etc.) were satisfied because they clearly could see the difference between the expenditure for medicine and treatment before and after having the universal healthcare scheme.

Second, the universal healthcare scheme provided an alternative way for working poor women to have better healthcare services than in the past. In the past they had to cover the whole expenditure when they got sick. After the universal healthcare scheme was set up, it provided free medical care and treatment.

On the negative side, the lack of use of the scheme was due to the following barriers:

1. Administrative discrimination

These were related to the respondents' perception of superior treatment being provided for those who did not use the 'universal healthcare card (golden card)'.
As Mrs. A said:

> I used to use universal healthcare card (golden card) and I saw the nurse changed my medicine when she knows that I use golden card.

2. Travel expenses

There were big distances between poorer women workers' residential areas and their registered hospitals. Although the 'universal healthcare scheme' itself is free of charge, many women working poor did not have enough money for transportation to the hospital.

Because of transportation and other costs incurred to go to hospitals to use the universal healthcare scheme, buying drugs over the counter is considered cheaper. That is, those who use private clinics/ hospitals are more likely to use the universal healthcare scheme as well. It should be noted that those who used private clinic/hospital services usually belonged to a relatively better-off group among the home-based workers. These women would have better information about the universal healthcare scheme and also could afford to pay for the costs to use hospitals, which allowed them to access both private hospitals as well as the universal healthcare scheme.

3. Hospital subsidies

There were only low government subsidies to the private hospitals that joined the universal healthcare scheme. This resulted in several private hospitals withdrawing from the universal healthcare scheme and in an increasing number of patients using the government hospitals, affecting management and treatment.

4. Distrust in services provided

Through using life stories of some leaders, the researcher found that even group leaders did not use the universal healthcare scheme due to their distrust of the services of state

hospitals and managements, as in the case of Mrs. A[1]. She told the researcher that:

> Most of the members in Urban Poor Group have the 'universal healthcare card' but many of them did not use this card. They prefer to pay for their treatment fee and medicine since they did not trust that they would get the same standard of treatment if they used the 'universal healthcare card'. Some of them who had experienced the 'universal healthcare scheme' complained that they had to wait for very long times before getting this service and getting to know the results of the examination as well.

All the above costs might have been considered worth it, if they were satisfied with the services provided under the universal healthcare scheme. However, their long experiences in exclusion from state schemes have developed a deep mistrust towards the government services.

This finding shows that 85.5% out of the 228 interviewees who did not use the universal healthcare scheme used the clinic/private hospital. At the same time, 62.1% (out of 87) who did not use the clinic/private hospital used the universal healthcare scheme. These statistics indicate that working poor women who were unable to access universal healthcare scheme had tried to access non-state healthcare services.

5. Lack of correct information

During home visits, the researcher found that some working poor women were unable to use the universal healthcare scheme because they did not know that they had the right to use it in Bangkok, in spite of their family registration being in their home town. The results from this study also found that 1.2% of the respondents had no 'universal healthcare card' yet. Some were not accessing the universal healthcare scheme since they did not have their household registration in Bangkok, and thus understood wrongly that they cannot access the services, although this was a minority among the respondents (1.2%). The survey also showed that many members of the public were unaware of the benefits to which they were entitled. For example, only 10% of those with disabilities in the survey group knew that they were entitled to physical therapy, while only 2% of the elderly were aware that they could claim for dentures.

6. Time constraints

Many of the hospitals that provide the universal healthcare scheme are crowded, and the waiting time is very long. This has been aggravated since a number of private hospitals withdrew from the scheme because of low government subsidies. This has led to more time needed to go to hospitals in the scheme, and the waiting time in these hospitals had become very long.

---

[5] Mrs. A is a vice-president of the "Urban Poor Group". She is living in *Runmai Pattana* Community, *Bangkaen* District, Bangkok, Thailand.

7. Need for other support to access universal healthcare scheme:

The working poor women who were able to access the universal health service had to get monetary and other support from their own social network. Help was needed to get through the bureaucratic procedures to access these services, such as writing registration forms, queuing etc.

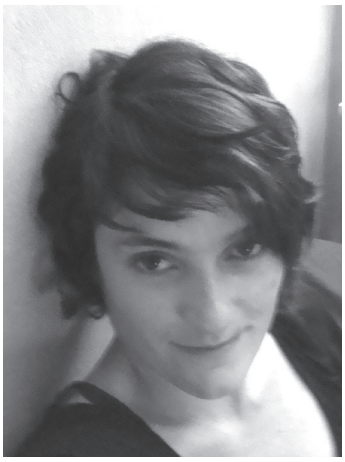
The history of healthcare in Thailand shows improvement of both state and non-state services, as well as traditional provision. However clarity is still needed about the mechanisms available for working poor women to access healthcare services.

References:

Doane, D., Ofreneo, R., Jirapatpimol, B. and Research Teams of PATAMABA and HomeNet Thailand, (2006), "Social Protection for Homebased Workers in Thailand and the Philippines", REGAN, Quezon City, Philippines.

National Economic and Social Advisory Council, (2003), "Result of Economic and Social Assessment Indicate a Stronger Economy and Continued Well-being of the Thai", Development News Bulletin, Vol. 20, No. 06: p. 4.

Puenpatom, R.A. and Rosenman, R. (2008), Health Care Management Science, Vol. 11, No. 4, pp. 319-338.



Laura Alfers

Researcher

WIEGO

United Kingdom

Laura Alfers has worked with Women in Informal Employment, Globalizing and Organizing (WIEGO) since 2009 on the Social Protection Programme. She conducted a study of the Ghana National Health Insurance Scheme and its ability to reach poorer informal workers in 2009. Laura has also worked in Ghana on WIEGO's Occupational Health and Safety (OHS) Programme, conducting several rounds of participatory research with market and street traders in Accra, as well as writing up an institutional analysis of Ghana's OHS system. Two forthcoming research reports have come out of this, both of which explore regulatory issues around urban informal workers and health systems at local government level. Laura is currently registered for a PhD at the School of Development Studies, University of KwaZulu-Natal, South Africa under the supervision of Francie Lund. Her PhD is an historical study of worker's health policy in Africa, with a particular focus on Ghana and Tanzania. Laura holds an MA in Political Studies from Rhodes University (South Africa), and an MPhil in Development Studies from Cambridge University (UK).

Chris Atim

Senior Health Economist
The World Bank
Senegal

Dr. Atim received his PhD on an economic development thesis from the University of Sussex in the UK in 1993. He specializes in health care financing in Africa and has taught for many years in health economics masters courses at the West African regional training institute (CESAG) based in Senegal. He is currently working as senior health economist on the World Bank's health systems strengthening program based in Dakar, Senegal, where he leads on the World Bank's health financing support to several countries in the region.

Between 2004 and 2009, Dr. Atim worked for a number of international organizations in the areas of cost effectiveness and evidence-based decision making in introducing new technologies in GAVI-eligible countries; costing of HIV/TB/Malaria programs; analyses of the financial factors relating to the achievement of key international health targets such as the Millennium Development Goals (MDGs); analyses of the international aid architecture, aid effectiveness, global health initiatives as well as various aid modalities and fiscal space issues for low income countries.

Between 1999 and 2004, he worked as a senior health economist for Abt Associates Inc and served as their West and Central Africa Regional Advisor for USAID's Partnerships for Health Reform (PHR) Project. In that role, he led and supervised technical assistance for the PHR project's program on community-based health insurance schemes in West and Central Africa.

A pioneer in research, development and analysis of Mutual Health Organizations (MHOs, or *mutuelles de santé*) in West Africa, Dr. Atim has authored a number of papers on community financing and mutual aid insurance. In 1996-1997, his work involved field research in Ghana and Cameroon and resulted in a paper published in *Social Science and Medicine* on health insurance systems in those countries. During this time, he also did research on health care financing in Ethiopia, Tanzania, Zimbabwe and South Africa. In 1995 - 1996, he led a technical team based at the International Labor Organization (ILO) in Dakar to produce a training handbook for the leaders and promoters of MHOs in Francophone Africa. In 1993-1994, Dr. Atim carried out research in seven African countries on health care financing with particular reference to community financing and MHOs.

Dr. Atim is currently serving also as the Executive Director of the African Health Economics and Policy Association (AFHEA).

Mirai Chatterjee

Director of Social Security
Self Employed Women's Association (SEWA)
India

Mirai Chatterjee is the Director of the Social Security at Self-Employed Women's Association, (SEWA), a union of 1.3 million women workers in the informal economy. She is Chairperson of the SEWA-promoted National Insurance VimoSEWA Cooperative and the Lok Swasthya Health Cooperative. She is also a member of the National Advisory Council, appointed by the Prime Minister of India.

Mirai Chatterjee serves on the boards of several organizations, including the Public Health Foundation of India and Friends of Women's World Banking. She also serves on several advisory committees of the government, including a committee to develop universal health coverage, set up by the Planning Commission of India. She also advises the National Rural Health Mission.

She was the General Secretary of SEWA between 1997-1999. She was also a Commissioner in the WHO's Commission on Social Determinants of Health (2005-2008) and an advisor to the National Commission on Enterprises in the Unorganised Sector (2006-2007).

She has written several papers on women's health and development, social protection, child care, microinsurance and organising women for collective action.

Mirai Chatterjee has a B.A. from Harvard University and a Masters in Health Sciences from Johns Hopkins University, USA.

Kalpana Jain

Health Journalist

India

Kalpana Jain is an award-winning senior journalist whose reporting played a significant role in elevating public health as an important topic of news coverage. She is currently based at Harvard Kennedy School, where she has been working with the faculty in identifying and writing case-based teaching material, writing policy papers and assisting with the teaching of a course on mobilization of social movements. She came to the Kennedy School in 2010, after being selected as a Mason Fellow from India, to complete a mid career Masters in Public Administration. She is also a senior fellow at Brandeis University, US, where she is working on the cross-border problems of modern-day slavery issues.

Jain was health editor with the largest circulating English daily, The Times of India, where she reported on development issues and exposed the many concerns in the public health sector through well-researched articles. Her stories in The Times of India led to several policy changes in public health and to the resignation of the minister for health. She was the first journalist in India to give a face to the epidemic of HIV/AIDS in her book "Positive Lives," published by Penguin in 2002; chapters from her book are now included in course work at an Indian university. Jain traveled across India, painstakingly documenting the ground realities of the epidemic and bringing out stories of how people were dealing with the stigma of the epidemic in remote parts of India. Jain has been on several ethics-based and policy-based committees at key institutions as well as with the health ministry in India.

Public health has been a neglected area in India and low on political agenda, even though healthcare costs are the main reason for indebtedness. Jain sought to raise the public discourse on these issues through her consistent reporting. Her articles highlighted issues of gender inequality, poverty and continuing economic disempowerment for a majority of people despite the economic reforms. Jain has also trained journalists in identifying and reporting these issues. She started the first online health magazine in India, highlighting serious public health issues. In 2008, in recognition of her work, she was selected as a Global Health Fellow for the prestigious Nieman fellowship at Harvard University. Jain is actively engaged in working for change through the media. She is particularly interested in how health policy reforms can be initiated through an active and vigilant media. In her current work at Harvard and Brandeis University, she is engaged in finding a pathway to bring academia and journalism together in a way that can make a deeper and longer lasting contribution to the process of social change.

Francie Lund

Director, Social Protection

WIEGO

United Kingdom

Francie Lund is the director of WIEGO's Social Protection Programme, and has worked part-time with WIEGO (Women in Social Protection: Globalizing and Organizing) since 2000. A sociologist and community worker by training, she was involved in social policy reform through and after the move to democracy in South Africa. She specialized in the impact of government spending on patterns of poverty and inequality, and in particular the impact of spending on women and children. She is also intensely interested in comparative research methods, and the different ability of different methods to capture for example incomes, associational memberships, and intra-household distribution of resources.

Francie Lund has been directly involved in policy interventions at local, national and international levels. In 1996 she chaired the Lund Committee on Child and Family Support which led to the introduction of the Child Support Grant. In 1999 – 2001 she and Caroline Skinner were involved in policy development for the informal economy in Durban metropolitan city. In 2008 – 2010 she participated in the UNRISD six-country study on the political economy of paid and unpaid care work, focusing specially on effects of government withdrawal of state spending on health and welfare on women's participation in the labour markets, and as volunteers. She is at present involved with Oxford Policy Management in South Africa in a study of how to include informal workers in plans for reform of retirement provision. A major current research interest is a five country study (Brazil, Ghana, India, Peru, and Tanzania) exploring how to develop an inclusive occupational health and safety discipline and practice that could include places of work of poorer informal workers.

She has worked as a researcher and policy consultant for a wide range of international organizations (such as the DfID, ILO, SIDA, UNIFEM, UNRISD, World Bank, the WHO).

Selected Recent Publications

Lund, Francie. 2010. 'Hierarchies of care work in South Africa: Nurses, social workers and home-based care workers. In Razavi, S. and Staab, S. (eds.): 'Underpaid and overworked: a cross-national perspective on care workers', International Labour Review 149(4) December.

Lund, F. 2011. 'A step in the wrong direction: linking the South Africa Child Support Grant to school attendance,' Journal of Poverty and Social Justice, 19(1): 5 – 14.

Lund, F. 2009. Social protection, citizenship and the employment relationship. PLAAS Working Paper No. 9. Cape Town: Programme for Land and Agrarian Studies, University of the Western Cape. (www.plaas.org.za/publications/wp/wp9)

Lund, F. 2009. 'Welfare, development and growth: lessons from South Africa', In Townsend, Peter (ed.): **Building Decent Societies.** Geneva: International Labour Office and London: Palgrave MacMillan.

Lund, F. 2008. **Changing social policy: the Child Support Grant in South Africa.** Cape Town: HSRC Press. 144 pages

Boonsom Namsomboon

Secretary General
HomeNet Thailand
Thailand

EDUCATION:

Suan Dusit Teachers College, Bangkok	1971
Sri Nakharinwirote University, Bangkok -- B.A. Education	1975
Asian Social Institute, Manila, Philippines -- M.S. Sociology	1979
Asian Institute of Technology, Thailand. – Ph.D.	
Doctoral of Philosophy (Gender and Development)	2011

1998-Present Chairperson and Founder
Forward Foundation (Thailand)

Provide organizational guidance to successfully carry out active community development project including income generating program, Children and youths development and reproductive health especially for women's group. Carry out activities planning; fund raising, proposal writing and arrangement of seminars and training for our target groups- - community committee, women and youth groups. Responsible for overall project administration including budgeting, staff supervision, coordination between NGO's and GO's acting as a spokewomem on behalf of Forward Foundation and briefing local and international visitors on current projects.

2007-Present Vice President of Associazione di Maria Auxiriatrice (ADMA) Thailand

2003-Present Secretary General of Foundation for Labour and Employment Promotion

2003-Present Board Committee Member of World Confederation of FMA Past-Pupil

RESEARCH AND PAPER:

2011 "Social Security for Women Home-based Workers in Thailand", Requirement for Doctoral Degree on "Gender and Development Studies", Asian Institute of Technology, Bangkok, Thailland.

2010 "Social protection for women homeworkers: a case of healthcare services in Thailand", published in International Journal of Sociology and Social Policy

2006 "Social Protection for Homebased Workers in Thailand and the Philippines" on researcher planning and designing.

AWARD:

Received "St. John Bosco Award" on December 3rd 2000
"St. John Bosco Award" was given to the alumni in the Salesian Family schools who works continuously for the poor children.

Plenary Session 4

Achieving universal coverage:
a key role of health systems

Evelyn Korkor Ansah

Public Health Specialist and the Deputy Director Research and Development Division, Ghana Health Service

Ghana

Dr. Evelyn Korkor Ansah is a Public Health Specialist and the Deputy Director of the Research and Development Division of the Ghana Health Service. She holds a PhD (Clinical Epidemiology) from the London School of Hygiene & Tropical Medicine (2006). She studied medicine and obtained MB ChB and BSc (Human Biology) from Kwame Nkrumah University of Science & Technology, Kumasi, Ghana. She later obtained an MPH from the School of Public Health, University of Ghana. Dr. Ansah has extensive experience in Health Research specifically in the area of Malaria and Health Systems Research. She has collaborated with a various International Consortia especially in the area of Malaria research, some of which are published in peer reviewed journals. She worked as the District Director of Health Services in the Dangme West District directing all public health and clinical activities in the district as well as conducting health research from 2004 until September 2011 and is very conversant with the operations of the health system in Ghana. She was a member of the team that set up and managed the first district-wide health insurance scheme in the southern part of Ghana from the year 2000 to 2004. She has also been a part-time lecturer in epidemiology at the School of Public Health, University of Ghana, from September 2009 to date.

Narayanan Devadasan

Director

Institute of Public Health

India

Dr. N. Devadasan is a medical graduate from the renowned CMC Vellore, India. After graduation, he and his wife worked for 10 years with indigenous groups in Nilgiris District of Tamil Nadu. Here they helped the adivasi community set up a health system that was accessible, affordable, and acceptable. This ranged from village health workers to a 30 bed hospital providing secondary care. While working here, he developed a community health insurance programme so that the adivasi community could access health care without any financial burden. The main objective of the health programme was to empower the adivasi community (one of the poorest in the country) so that they have choices vis-à-vis their health care.

Subsequently, Dr Devadasan joined the WHO at Delhi. He was in charge of the communicable disease cluster and is one of the authors of the Integrated Disease Surveillance Programme that is being implemented by our country today. He also had the opportunity to investigate a plague outbreak as well as the Nipah virus outbreak both in India and Bangladesh.

He resigned from the WHO to return to his first love - the field. He was the co-founder of the Institute for Public Health, whose main vision is to carry out research, training, and advocacy activities on public health issues. He has been researching on ways to improve access to quality care for the poor – hence his interest in health financing. He also teaches health management for the district level government staff. He is a visiting faculty at the SCTIMST, Trivandrum as well as at the Manipal University.

He is currently involved in research projects on governance, social exclusion in health care and district health management.

He is the author of 13 articles in peer reviewed journals and 9 books on public health issues.

Latest relevant publications:

Devadasan N, Criel B, Van Damme W, Manoharan S, Lefevre P, Van der Stuyft P. *Community health insurance schemes and patient satisfaction: evidence from India.* Indian Journal of Medical Research. Jan 2011.

Devadasan N, Criel B, Van Damme W, Manoharan S, SankaraSarma P, Van der Stuyft P. *Community health insurance in Gudalur, India, increases access to hospital care.* Health Policy and Planning (in press).
Devadasan N, Criel B, Van Damme W, Ranson K, Van der Stuyft P. *Indian community health insurance schemes provide partial protection against catastrophic health expenditure.* BMC Health services research. 2007. 7:43

Devadasan N, Van Damme W. *Payments for health care in India*. Lancet; 368: 2209. 2006

Devadasan N, Ranson K, Van Damme W, Acharya A, Criel B. *The landscape of Community Health Insurance in India: an overview on the basis of ten case studies*. Health Policy; 78; 234 - 244. 2006

Devadasan N &Nagpal S. Government initiated health insurance schemes in India. IRDA Journal, Dec 2007. Vol 6, No1

Criel B, Waelkens M-P, Soors W, Devadasan N, Atim C. *Community health insurance in Developing countries*. In: Kris Heggenhougen and Stella Quah, Eds; International Encyclopedia of Public Health. Vol 1: Academic Press. 2008: 782 – 791.

Devadasan N et al: Planning and Implementing health insurance programmes in India: WHO. 2006

Carissa Etienne

Assistant Director-General,
Health Systems and Services
World Health Organization
Switzerland

Dr. Carissa F. Etienne assumed the role of Assistant Director-General for Health Systems and Services in February 2008. Prior to that, she was the Assistant Director of the Pan American Health Organization. As Assistant Director in PAHO from July 2003, she directed five technical areas - health systems and services; technology and health services delivery; health surveillance and disease management; family and community health; and sustainable development and environmental health.

A national of Dominica, Dr. Etienne began her career as a medical officer at the Princess Margaret Hospital in her country, where she eventually became the Chief Medical Officer. Other high-level posts she has held include the Coordinator of Dominica's National AIDS Programme, Disaster Coordinator for the Ministry of Health of Dominica, Chairperson for the National Advisory Council for HIV/AIDS and the Director of Primary Health Care for Dominica.

Dr. Etienne received her MBBS degree from the University of the West Indies, Jamaica, and her M.Sc. degree in community health in developing countries from the University of London.

Samrit Srithamrongsawat

Director
Health Insurance System Research Office (HISRO)
Thailand

Dr. Samrit Srithamrongsawat, MD. PhD. is a director of Health Insurance System Research Office (HISRO) which is a network of the Health System Research Institute, Thailand. He got his MD from Chulalongkorn University, Thailand, in 1984, MPH from Mahidol University, Thailand, in 1989, MSc. in Health Service Management from London School of Hygiene and Tropical Medicine (LSHTM) in 1995, and PhD in Health Policy and Financing from LSHTM in 2005.

Dr. Samrit started working as a practitioner and director of two district hospitals during 1984-1991. He was working as a deputy Provincial Chief Medical Officer in Phuket Province during 1991 – 1997 before moving to the Health Insurance Office, Ministry of Public Health, Thailand, in 1997. After getting PhD in health policy and financing, he was at the National Health Security Office (NHSO) for a year before turning to HISRO since 2006.

He got experiences in public health insurance systems more than 10 years and has been substantially doing research and development of health insurance systems. HISRO mission is to do research, monitoring and evaluation of the Universal Health Coverage in Thailand. He also took lead in doing research on assessment of a decade of Thai Universal Coverage Scheme.

Andrei USATII

Minister

Ministry of Health

Republic of Moldova

Dr. Andrei USATII is a medical graduate from Chisinau State Medical and Pharmaceutical University, Republic of Moldova, in 1997 being awarded the title of Doctor in Medicine at the same University, for the research on the peculiarities of family planning in rural area.

After the graduation he served for a long time respectively as a director, a deputy director and again as a director of the Anenii-Noi District Hospital, Republic of Moldova. His responsibilities were to organize and administrate the hospital and emergency medical services delivery, to develop and implement regional integrated health programmes on promoting health and preventing chronic diseases.

Between June 1998 and May 2001 he served as Prime Deputy Minister of Health of the Republic of Moldova, taking care of the process of National Health Care System financing and reformation, of policy development in the field of primary health care, coordinating the activity of national agencies and the cooperation with international organizations.

From May 2001 to October 2003 Dr. USATII served as a Coordinator of Health Programmes at Swiss Development and Cooperation Agency in the Republic of Moldova, coordinating the programmes for health promoting as well as those in the field of mother and child health.

He also, served as a stagier in the filed of Public Health at the Department for Public Health of Nova Scotia, Canada, being responsible for coordinating epidemiological researches and data analysis on communicable and non communicable diseases, as well as for revising and updating the guide for communicable diseases in Nova Scotia Province. For a period of one year he served as a Coordinator of Research Partnership, at Nova Scotia Foundation, developing research strategy and its implementation.

Between July 2006 and October 2009 Dr. USATII served as a senior counselor at the Ministry of Health of Ontario Province, Canada, being in charge with developing health care system strategies, modernizing the hospital sector and primary health care assistance, assessing the world tendencies of health systems development.

Before being appointed as Minister of Health of the Republic of Moldova, in January 2011, Dr. USATII served as the General Director at Republican Clinical Hospital, in Chisinau, one of the main hospitals of tertiary level in our country.

Besides his core health education, Dr. USATII has been trained in different particular fields of health such as health policy development (JICA Program, Tokio, Japan,), public health system management and financing (Michigan University, USA), health system reformation (Washington Dc, USA), public health and healthcare services administration (Moscow, Russia). His command of English and Russian is excellent.

Parallel Session 4.1

Measuring the impact and outcome of universal coverage

Impact of Universal Health Coverage Scheme on Thai populations

By Supon Limwattananon

Background

Two major features of the 2001 Universal Health Coverage Scheme (UCS) in Thailand that can have an impact on individual members of the Scheme are (1) tax-based financing mechanism and (2) close-end provider payment methods. As majority of the UCS members lived in households with relatively lower economic status, this paper aimed first to determine if this tax-financing health reform could maintain the pro-poor government subsidy for health services using a benefit incidence analysis. Second, the paper examined poverty impact of the UCS by comparing health-impoverished households between the informal employment sectors who were majority of the UCS members and the formal public and private sectors.

The close-end payment methods employed by the UCS would shift the financial risk to health care providers. Whether the providers accommodated such a pressure in a way that service quality was compromised and less responsive to people expectation is the third issue examined by this paper. In the worst case, whether the financial burden eventually jeopardized the population health was also explored.

The main approach in this paper was a quantitative analysis of large-scale, secondary data that were readily available for several years around the UCS implementation period. Table 1 summarizes data sources and analysis approaches used for fulfillment of the four objectives.

Table 1. Data sources and analysis approaches

Objective	Data source	Analysis	
		Numerator	Denominator
1. Benefit incidence (Net public subsidy for health services)	HWS 2003-2009	Costs of outpatient visits and inpatient admissions net of out-of-pocket payment per health facility type	Quintiles of UCS members according to household asset index
2. Health impoverishment	SES 1996-2009	Consumption expenditure net of health payment	Households with economically inactive and informal sectors
3. Responsiveness (UCS insurance uptake and service satisfaction)	HWS 2003-2009 and ABAC Poll 2003-2010	Insurance uptake and satisfaction levels	UCS members who were health care users
4. Mortality and hospitalization	National IP data sets 2004-210	- Deaths at hospital discharge and within 30 days after admission - All-cause mortality and time to death - Admissions with ACSC	Hospital admissions with deadly diseases and those of which death amenable to care

Note: *HWS –Health and Welfare Survey; SES –Socio-Economic Survey; IP –Inpatient; ACSC –Ambulatory care sensitive conditions*

Results

1. Benefit incidence

At the national level, government net subsidy for the OP service used by the poorest and richest quintile UCS beneficiaries, accounting for 23-24% and 12-13% of the whole-country population was 27-30% and 7-11%, respectively throughout the UC period (figure 1). Similarly, the IP service subsidy disproportionately concentrated among the UCS poor more than the rich. This indicates a pro-poor public subsidy, especially at the district health system that included health centers and district hospitals (figure 2).

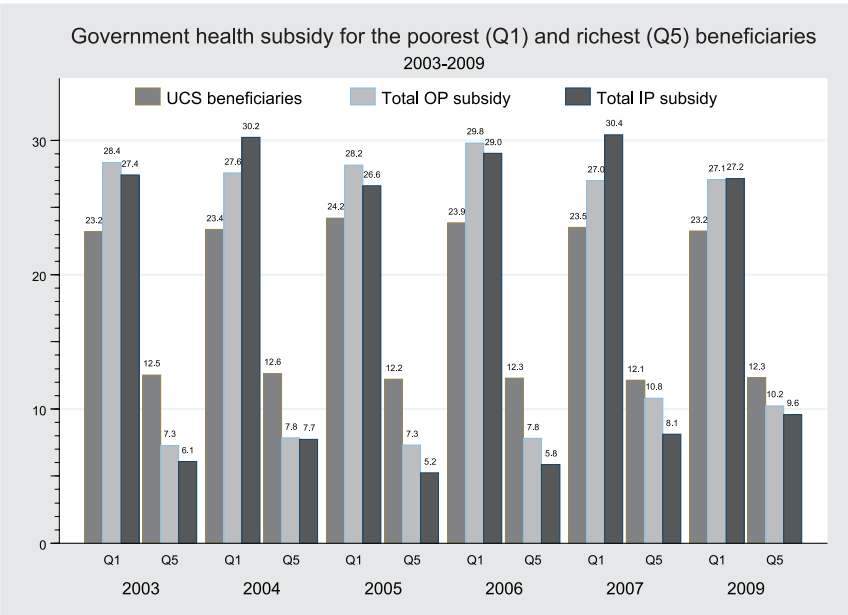


Figure 1. *Distribution of OP and IP government subsidies by economic quintile as compared with the UCS beneficiary distribution*

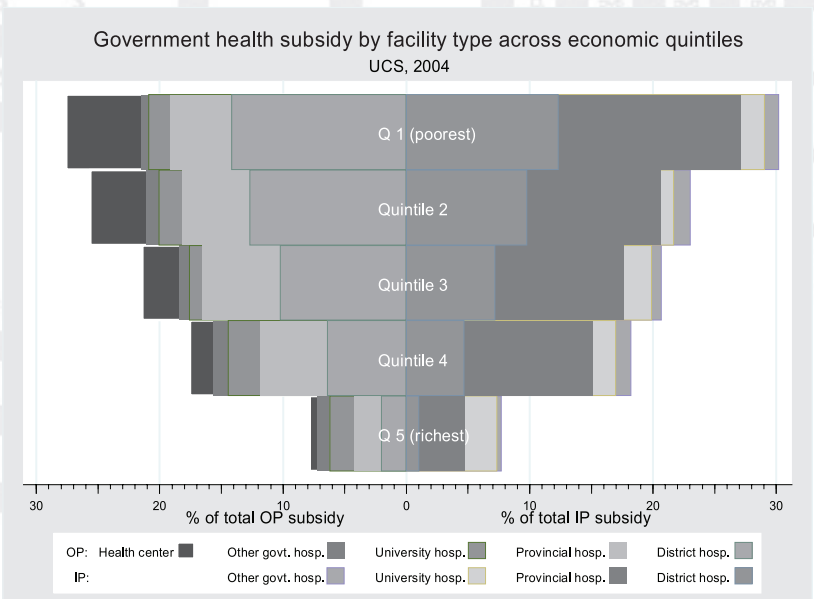


Figure 2. *Distribution of OP and IP subsidies by facility type for each economic quintile*

The pro-poor government subsidy for health services was largely driven by two major factors. First, the poor UCS members had the frequencies of OP visits and IP admissions disproportionately more than the rich counterparts (figure 3). Second, the poorer members were less exposed to health payments in terms of any payment and an average amount being paid (figures 4A and 4B).

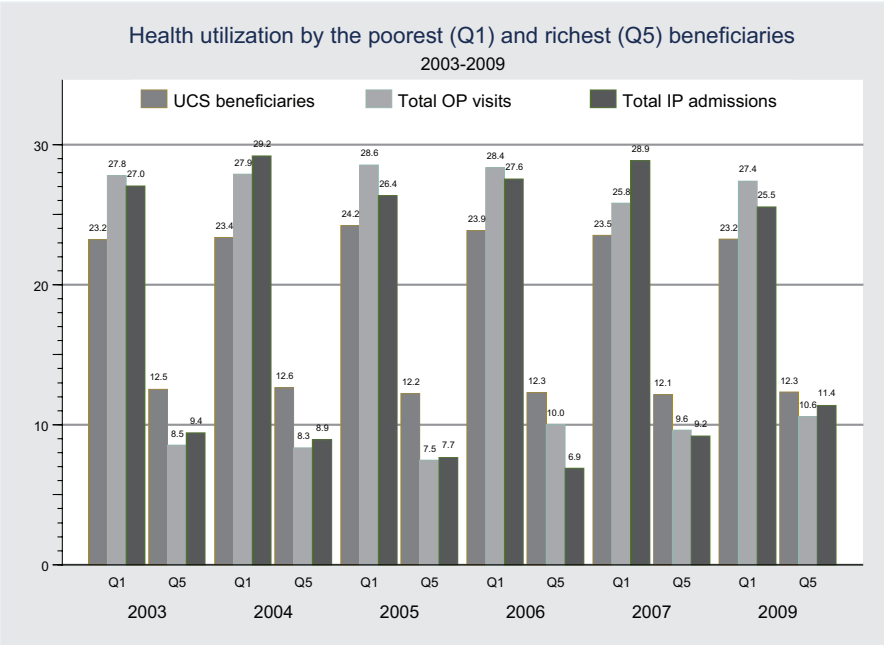


Figure 3. *Distribution of OP visits and IP admissions by economic quintile as compared with the UCS beneficiary distribution*

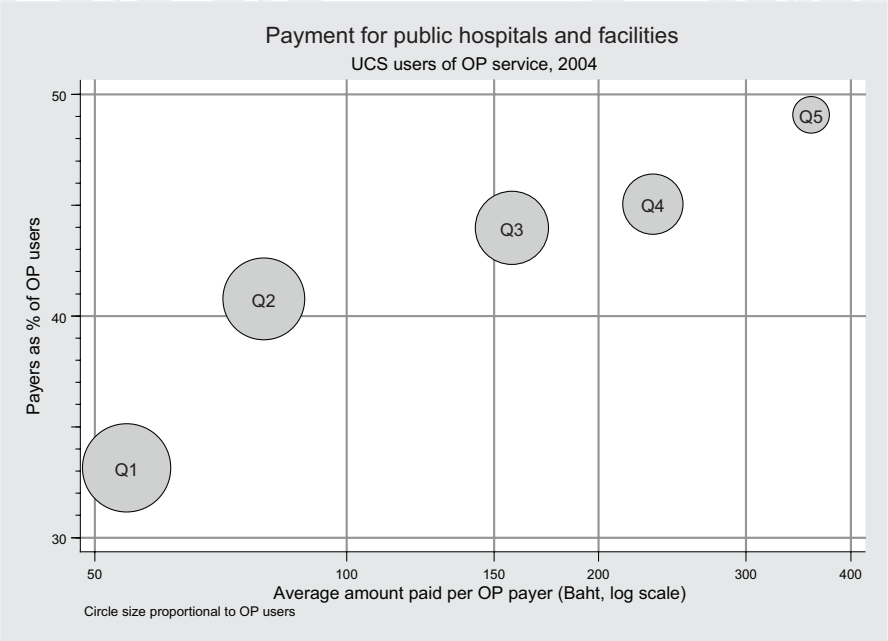


Figure 4A*. Payers and payment amount for OP public facility by economic quintile, 2004*

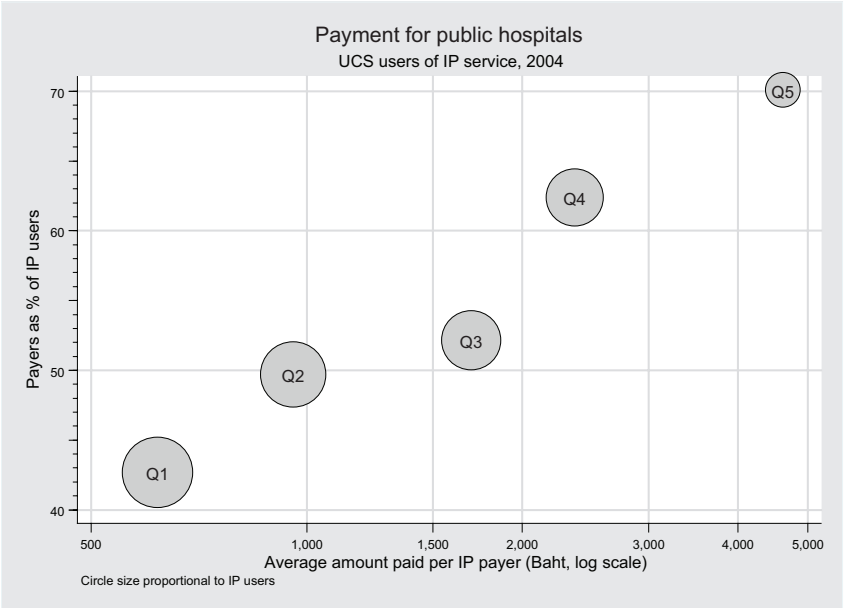


Figure 4B. Payers and payment amount for IP public facility by economic quintile, 2004
Note: Q1 –poorest 20% of population, Q5 –richest 20% of population

2. Health impoverishment

Regardless of employment status of household members, there was a decreasing trend in health impoverishment of households at the national level over the period of 1996-2009. Almost one-fifth of households with all adult members were unemployed, self employed or employed by those other than formal private or public sectors faced with health impoverishment in 1996 (figure 5). After the UC achievement, the proportion of informal sector households impoverished by health payment per 1,000 reduced to 12 in 2002-2004, 8 in 2006 and gradually to 5 in 2009.

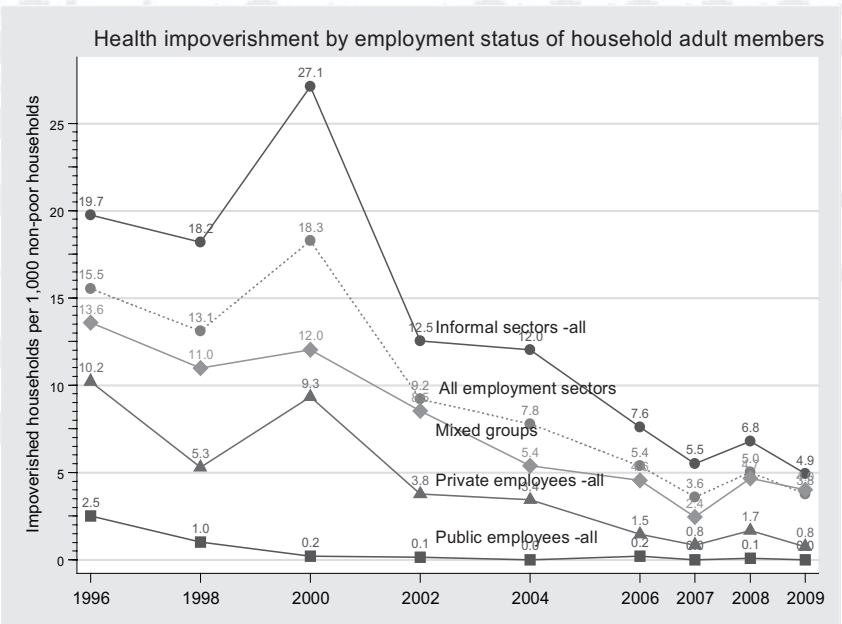


Figure 5. *Trend in health impoverishment of households in various employment sectors*

Table 2 reveals magnitude of a reduction in health impoverishment for the non-poor households in informal, mixed, and private employment sectors, as compared with the public employment. Health-impoverished households in the informal sector reduced from 1996 by a 5-per-1,000-higher than those in the public sector in 2002-2004. The degree of poverty reduction was even stronger in 2006-2009 with the absolute reduction of 10-12 per 1,000. Households in the mixed group experienced the health impoverishment reduction by 3-9 per 1,000 more than the public sector after the UCS implementation.

Table 2. Health-impoverished households as compared with 1996 and all-public employed households (per 1,000 non-poor households)

Employment sector	1998	2000	2002	2004	2006	2007	2008	2009
All-informal	-0.09	9.65	-4.85	-5.23	-9.87	-11.73	-10.56	-12.32
Mixed	-1.13	0.75	-2.68	-5.70	-6.73	-8.62	-6.50	-7.07
All-private employed	-3.46	1.40	-4.07	-4.27	-6.47	-6.86	-6.12	-6.95

Using the provincial poverty lines as the thresholds, the degree of health-impoverishment in the informal employment sector in each of the 76 provinces during 1996-2009 was illustrated by maps of Thailand in figure 6. Provinces with darker shaded colors had a greater proportion of impoverished households. Evident by the color fadeout in most of the provinces, the impoverishment due to direct household payment declined after the UCS implementation.

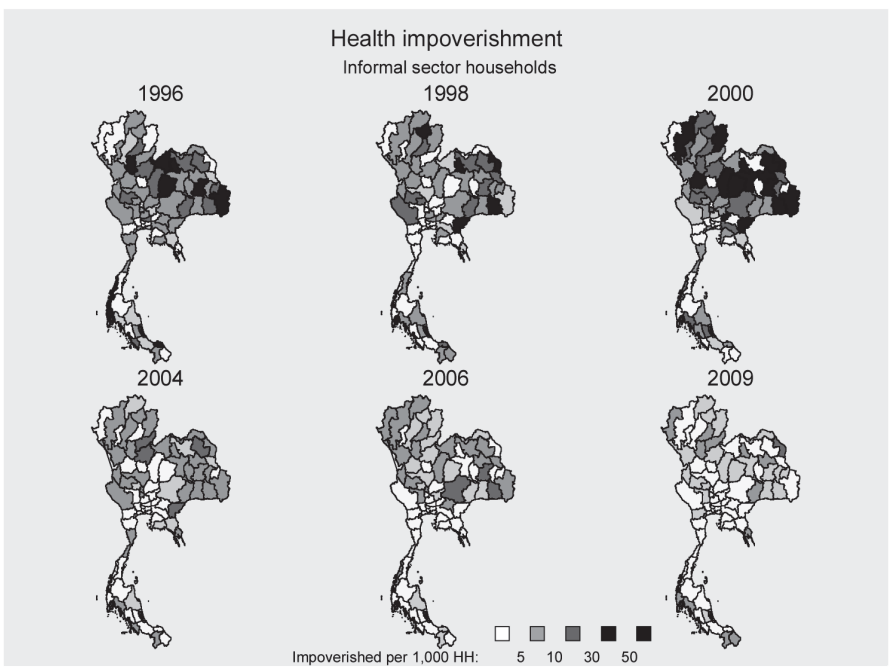


Figure 6. *Health impoverishment of households of informal employment sector by province*

3. Responsiveness to people expectation

3.1 Use of UCS insurance

Based on HWS 2003-2009, 88-96% of the UCS beneficiaries who reported any OP visits (or IP admissions) to public hospitals and facilities during one (or 12) months prior to the interview dates used their insurance entitlement, more often in health centers and district hospitals than in provincial hospitals.

The 2004-2009 ABAC Poll revealed a similar high use rate of the UCS entitlement, every time when having OP or IP services (85-98%) and an intention to use the UCS on the next health care visit (89-99%).

3.2 Overall satisfaction with UCS

Figure 7 illustrates an average (with 95% CI) of the overall satisfaction with UCS on the 1-10 Likert scale as rated by the UCS members over the period of 2003-2010. It showed an increasing time trend from the average of 7.8-8.1 in 2003-2006 to 8.2-8.5 in 2008-2010. There was again a drop in the score of 7.7 in the year 2007.

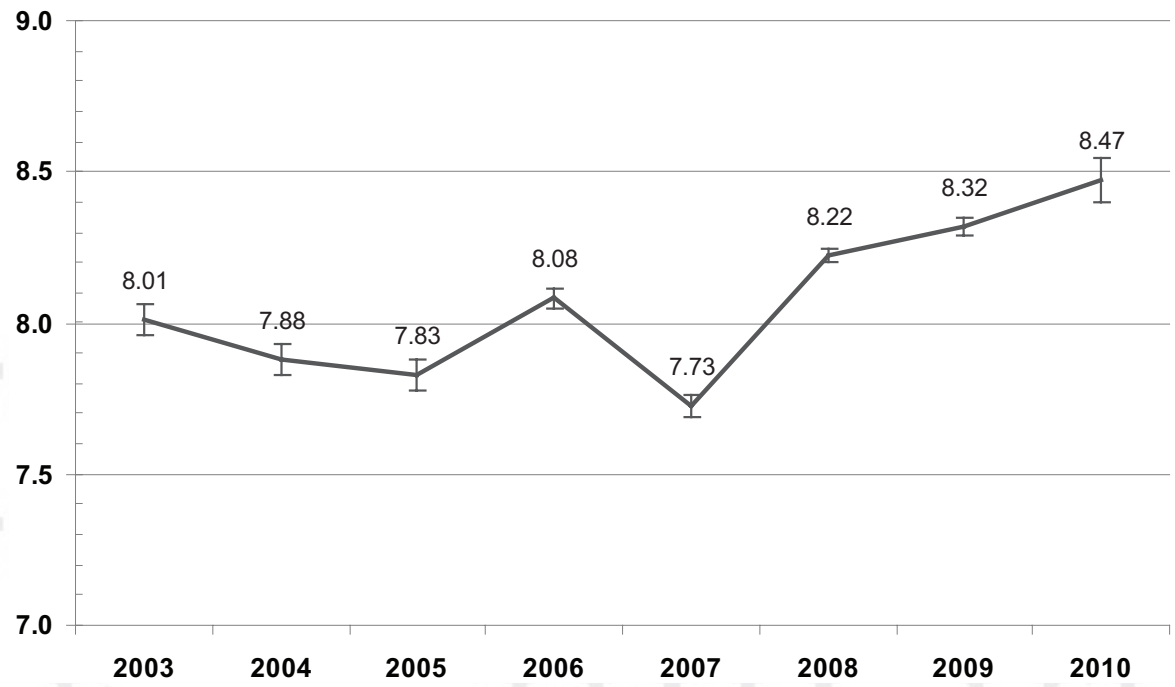


Figure 7. *Satisfaction scores towards UCS (mean and 95% CI) –Overall*

4. Health outcomes

4.1 In-hospital and 30-day mortalities

Case fatality of the UCS patients admitted to public hospitals due to the diseases with top 80% in-hospital deaths was relatively stable, on average at approximately 7%

over the periods of 2004-2010. For 30-day mortality, a temporary increase of the rate at the national level from 12.2% in 2005 and 12.9% in 2006 to 13.4% during 2007-2008 was driven largely by those admitted to district and provincial hospitals (figure 8). The 30-day mortality rate subsided to 12.9-13.0% afterward as the deaths of those admitted to the district and provincial hospitals gradually dropped, whereas those in the university hospitals had a continual decreasing trend.

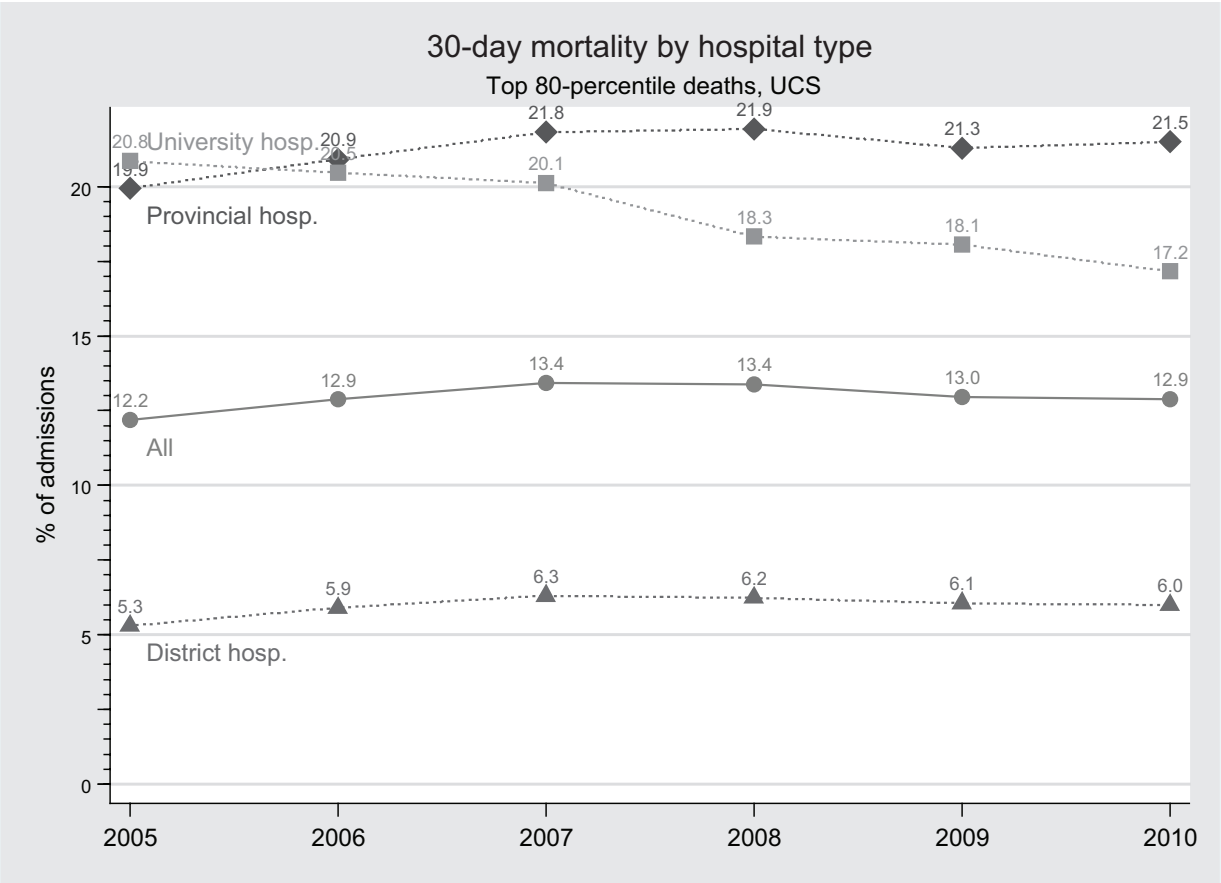


Figure 8. *30-day mortality of the diseases with top 80% deaths*

For the UCS patients admitted to hospitals due to the diseases of which death considered amenable to health care, the in-hospital mortality gradually dropped on average from 5.4% in 2004 to 5.0% in 2010. The 30-day mortality of the UCS patients admitted with death avoidable diseases peaked in 2007-2008 at 8.3-8.4% (figure 9). Then it declined to 7.8% in 2009 and 7.6% in 2010.

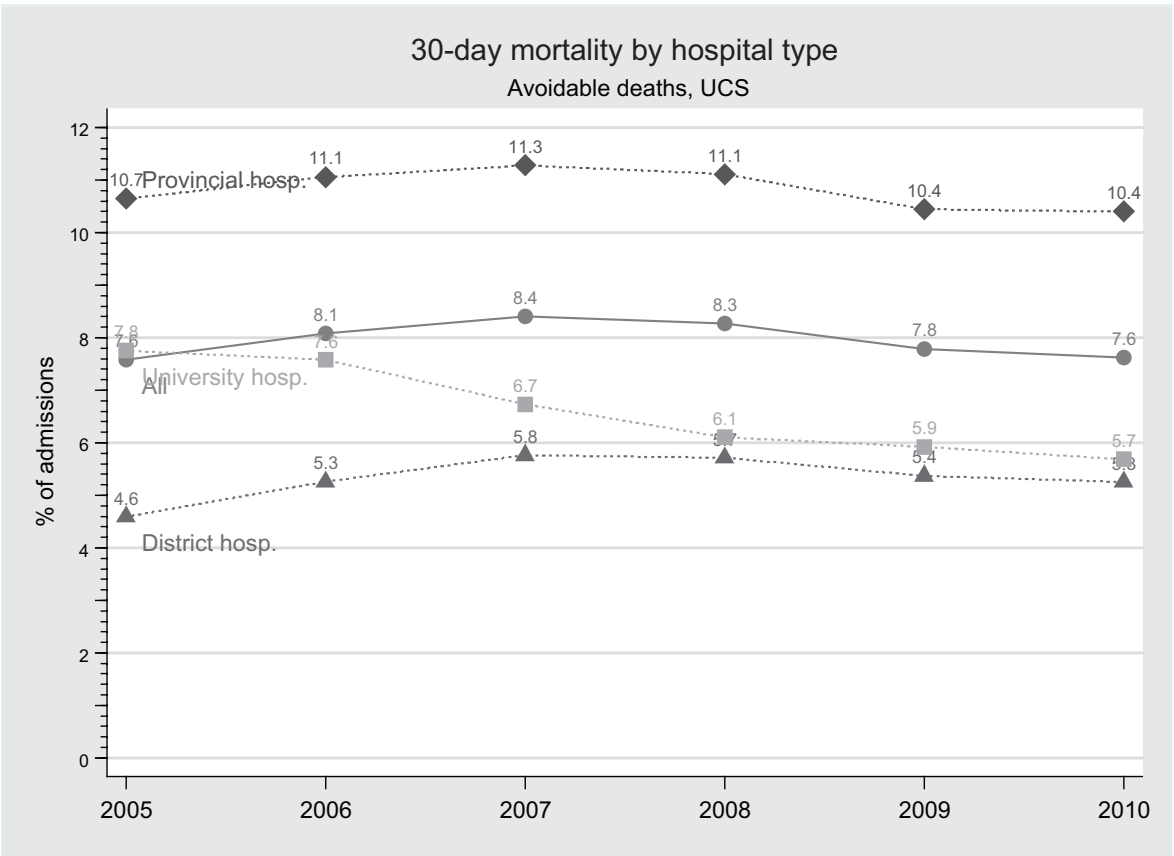


Figure 9. *30-day mortality of the diseases of which death amenable to health care*

4.2 Overall survivals for common cancers

Overall survivals of the UCS patients first admitted during 2006-2010 with 7 types of common cancers were determined. For breast cancer (N=32,591), the survival of those admitted in 2008-2010 was statistically (P<0.001) higher than that in 2006-2007 (figure 10). The patient survivals for cervical cancer (N=25,161) and colon cancer (N=23,075) were statistically (P=0.039, 0.003, respectively) different across the first hospitalization years. However, no obvious time trends were observed.

For the deadly solid tumor like lung (N=42,474) and liver (N=67,094) cancers, those admitted in 2007-2010 shared a comparable lower survival, whereby those in 2006 had a statistically (P<0.001) higher survival.

For hematological neoplasm, the survival for non-Hodgkin's lymphoma (N=11,116) seemed to be worse off over time. Those first admitted in 2008-2010 had a statistically (P<0.001) lower survival than those in 2006-2007. Difference in the patient survival across years of hospitalization with myeloid leukemia (N=7,189) was less statistically significant (P=0.021).

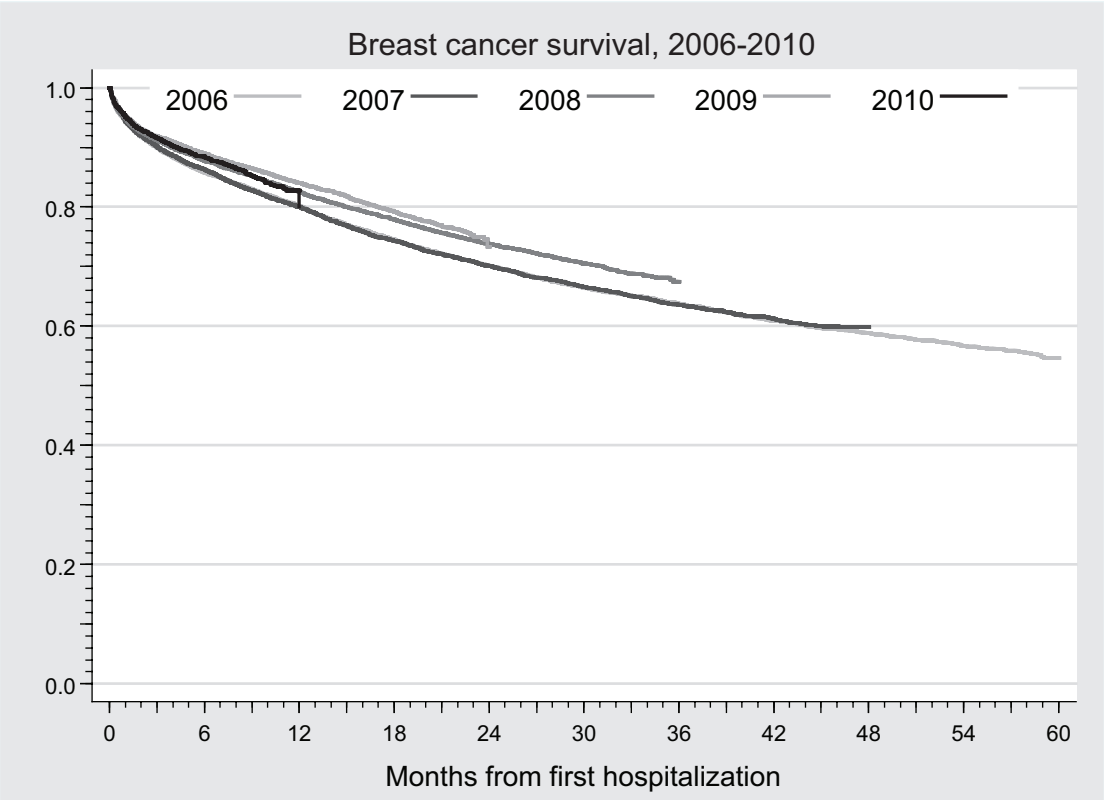


Figure 10. *Survivals of UCS patients admitted in 2006-2010 with breast cancer*

4.3 Admission with ambulatory care sensitive conditions

Even though there were the signs of non-increasing and decreasing trends in the hospital mortality for the UCS patients admitted with the top deadly diseases and the diseases of which death considered amenable to health care, the hospital admissions due to certain diseases controllable with ambulatory care were observed.

Among the six ambulatory care sensitive conditions (ACSC), the per capita admissions due to COPD increases substantially from 176 in 2004 to 281 in 2010 per 100,000 UCS members (figure 11). The hospital admissions with diabetes, HF/PE and epilepsy per 100,000 populations increased from 87, 75 and 35 to 148, 136 and 60, respectively over the same period. Only asthma had a decreasing trend in the per capita admission, whereby hypertension admission was relatively stable.

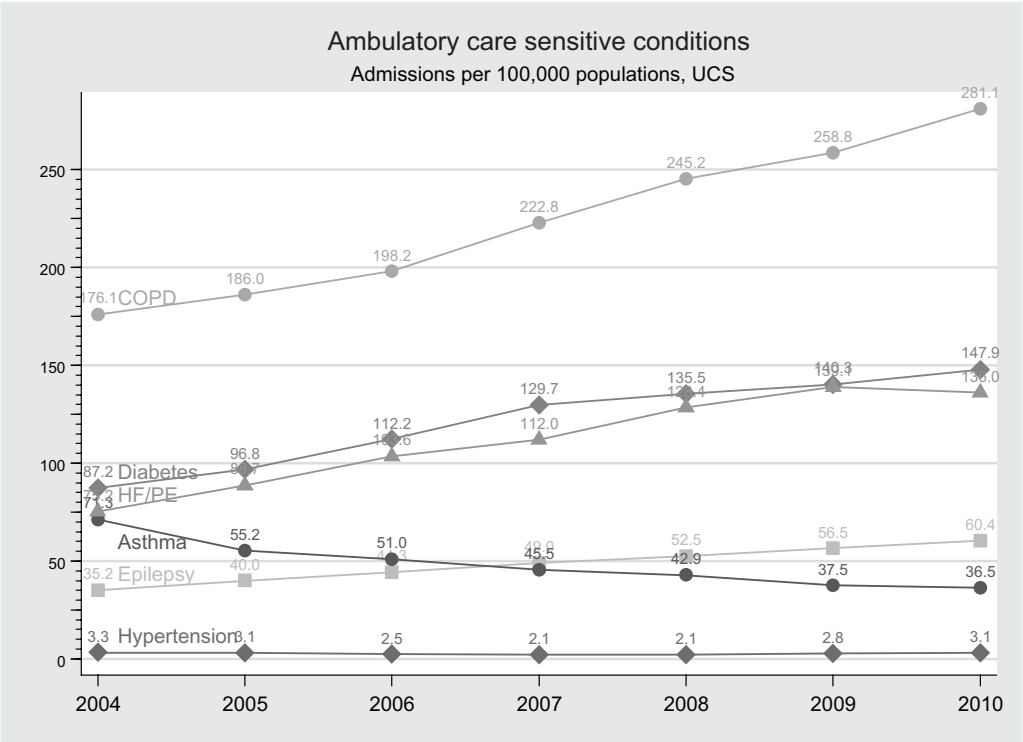


Figure 11. *Hospital admissions with six ambulatory care sensitive conditions*

Conclusion

Results of the benefit incidence analysis confirm the pro-poor public subsidy for two important curative health services covered by the UCS. The pro-poor benefit has been maintained through out the UCS period of 2003-2009. Finding in this report nullifies a major argument that the rich UCS members will crowd out health services from the poor.

The UCS was able to mitigate the poverty impact of direct health payment on households that are the primary target of the Scheme. Consistent finding on a reduction in the number of health-impoverished households, especially in the informal employment sector at national and provincial levels after the UCS implementation confirms such a conclusion.

Level of overall satisfaction with the Scheme itself and the covered health services among the UCS members was relatively high without an attenuate trend. Use of the UCS insurance eligible when exposed to health services followed the same pattern with attitude towards the UCS.

For health outcomes, in-hospital and 30-day mortalities for hospital admissions with the top 80% in-hospital deaths were without an increasing trend. For the admissions with the diseases of which death considered amenable to health care, the in-hospital mortality gradually dropped over time, whereas the 30-day mortality did not show an increasing trend. The overall survival for seven common cancers showed no obvious time trends, except for breast cancer with a better survival in 2008-2010 as compared with 2006-2007. The hospital admissions with three common conditions sensitive to the ambulatory case (i.e., diabetes, COPD and HF-PE) increased over time.

Peter Annear

Senior Research Fellow
Nossal Institute for Global Health,
University of Melbourne
Australia

Dr. Peter Leslie Annear is a Senior Research Fellow at the Nossal Institute for Global Health, University of Melbourne, Australia, and an Associate of RMIT University in the School of Global Studies, Social Science and Planning.

Dr. Annear is a health economist and health financing specialist who has worked in international development in various capacities since the 1970s. He has more than 15 years experience working in the health sector in Cambodia, Laos and a number of Asian countries as a consultant and advisor for Ministries of Health, the World Health Organization, the World Bank, AusAID and other international agencies.

He completed his PhD in Health Sciences with a study of Health Reform in post-conflict Cambodia, and has published many articles, commentaries and reports on health and development with particular attention to issues of equity and access to health services for the poor.

Dr. Annear is the Principal Investigator on an Australian-government funded research project investigating pro-poor health financing strategies with the Ministries of Health in Cambodia and the Lao PDR. He has particular interest in demand-side health financing issues.

David B. Evans

Director, Health Systems Financing
World Health Organization
Switzerland

David B. Evans, Director of the Department of Health Systems Financing in the Cluster on Health Systems and Services at WHO, has a PhD in economics and worked as an academic and consultant in Australia and Singapore before joining WHO in 1990. His work has covered the social and economic aspects of tropical disease control, the assessment of health system performance and the generation, analysis and use of evidence for health policy. His current responsibility is the development of effective, efficient and equitable health financing systems, through technical support to countries, generation and use of evidence, capacity strengthening and partnership with other development agencies and initiatives. He was the lead author for the World Health Report 2010 (Health Systems Financing: the Path to Universal Coverage).

Supon Limwattananon

Associate Professor, Khon Kaen University
Senior Researcher,
International Health Policy Program (IHPP)
Thailand

Supon Limwattananon is an Associate Professor at Khon Kaen University. He is also a part-time senior researcher at the Ministry of Public Health International Health Policy Program (IHPP), Thailand. He earned Bachelor of Pharmacy from Chulalongkorn University in 1982, Master in Primary Health Care Management from ASEAN Institute for Health Development in 1991, and Doctor of Philosophy in Social and Administrative Pharmacy from University of Minnesota in 2000. He was a Fulbright Scholar during 1993-1996 and received the US Health Care Financing Administration Dissertation Award in 2000. In 2008, he was seconded to the World Bank head office in Washington, DC as a Senior Health Specialist in the Human Development Network. His expertise is in the areas of health economics and micro-econometrics.

Masato MUGITANI

Assistant Minister for Global Health
Ministry of Health, Labour and Welfare
Japan

Dr. Masato MUGITANI, Assistant Minister for Global Health, Ministry of Health, Labour and Welfare, Japan, is the Chair of the Board for the Global Health Workforce Alliance. Dr. Mugitani is a medical doctor with professional and profound engagement in the global health, pandemic Influenza response, cancer policies, medical system and public health policies at global, regional and national level.

Dr. Mugitani has demonstrated strong and committed leadership in global health, including Chair of the Committee A at the 63rd World Health Assembly in 2010, Chair of the 2010 APEC Health Working Group (1st and 2nd meeting), and Vice-chair of the Open-Ended working group of Member States on Pandemic Influenza Preparedness from 2010. He has also been serving as a board member of the International Agency for Research on Cancer (IARC) and a senior official member of Global Health Security Action Group (GHSAG).

He has been keenly interested in Health System Strengthening with special emphasis on Health Workforces, demonstrating his capacity to liaise with global health partners and achieve consensus on difficult public health issues through his strong public speaking and health diplomacy skills. He has an excellent management ability and strategic visions to ensure effective functioning and performance-focused decision making to find solutions to health workforce crises.

Yogesh Rajkotia

Managing Director
Institue for Collaborative Development
Bangladesh

Dr. Yogesh Rajkotia, PhD., is an experienced leader in global health with extensive expertise in developing and managing large-scale health systems strengthening initiatives. He is the Founder and Director of the Institute for Collaborative Development, a health systems strengthening 'action-tank'. Prior to that, he worked for USAID, where he served as team leader for Health Systems in Rwanda and Senior Health Systems Advisor in Washington. While working for USAID, he provided leadership to the Agency's health systems work globally, and managed key programs including the $125 million Health Systems 20/20 agreement and the $1 billion TASC3 contract. He has also worked as a long-term advisor to the senior leadership of health ministries in Bangladesh and Rwanda. Dr. Rajkotia has a doctorate degree in health economics and a master's degree in health policy. He has worked on health systems strengthening issues in Peru, Angola, Senegal, Ghana, Rwanda, Malawi, Uganda, Ethiopia, Southern Sudan, DR Congo, Kenya, Yemen, Indonesia, India, Bangladesh Afghanistan, and Republic of Georgia.

Peter C. Smith

Professor of Health Policy and Co-Director
of the Centre for Health Policy
Imperial College Business School
United Kingdom

Peter C. Smith is Professor of Health Policy in the Imperial College Business School, and co-director of the Centre for Health Policy. He is a mathematics graduate from the University of Oxford, and was formerly Director of the Centre for Health Economics at the University of York. He is author of many academic papers on the financing and efficiency of health systems, and is with Sherry Glied joint editor of the *Oxford Handbook of Health Economics*. Particular research interests include health system performance assessment, value for money, financial protection and the equitable financing of health services. Smith has advised many overseas ministries and international agencies on health reforms, including the World Health Organization, the International Monetary Fund, the World Bank, the European Commission and the Organization for Economic Cooperation and Development.

Parallel Session 4.2

Resource scarcity, efficiency and coverage with health services

Tan-Torres Edejer

Coordinator
Health Systems Financing,
World Health Organization
Switzerland

Dr. Tan-Torres Edejer is the coordinator of the Unit of Costs, Effectiveness, Expenditure and Priority Setting (CEP) under the Department of Health systems financing in the Cluster of Health systems and services in WHO. For over 10 years, she has been primarily responsible for leading the work on defining the costs effectiveness of health interventions (WHO-CHOICE) and the costs of scaling up. Recent work has revolved around resource allocation, priority setting and explicit equity-efficiency trade-offs and the development of OneHealth, a UN interagency health sector costing and planning tool. Another major area of work in the unit is on national health accounts (NHA) which includes the annual updating of the health expenditure estimates of WHO's 193 member states and assisting countries to generate and use their own estimates. Work has just been completed on the System of Health Accounts 2011, the new global standard for reporting health expenditures. The work was done in collaboration with OECD and Eurostat.

Kara Hanson

Reader, Health System Economics
London School of Hygiene and Tropical Medicine
United Kingdom

Kara Hanson is Reader in Health System Economics and Head, Department of Global Health and Development at the London School of Hygiene and Tropical Medicine. She holds degrees from McGill University, Canada; University of Cambridge, UK; and Harvard University, US. She has over 20 years' experience of researching health systems in low- and middle-income countries. Her focus is on the financing and organization of health services, and has included research on scaling up health services, health insurance, user fees, and expanding domestic fiscal space. She has worked extensively on the role of the private sector in health systems, identifying the opportunities and limitations of the private sector in improving the efficiency, quality and responsiveness of health systems. Her work in this area includes developing innovative methods for studying private sector supply chains for antimalarial medicines. She has also researched hospital sector reforms in Uganda and Zambia, focusing on the implications of two-tier pricing for equity of access to hospital services. She is co-Research Director of RESYST - Resilient and Responsive Health Systems, which is a UK-DFID funded research consortium bringing together researchers from South Africa, Nigeria, Kenya, Tanzania, Thailand, India, Vietnam and the UK. The RESYST programme includes research on health financing, health workers and governance and leadership in the health sector, together with a focus on encouraging the uptake of research findings into policy and practice.

Rozita Halina Tun Hussein

Deputy Director,
Unit for National Health Financing (NHF)
Planning and Development Division,
Ministry of Health
Malaysia

Dr. Rozita Halina currently heads the Unit for National Health Financing (NHF) under the Planning and Development Division of Ministry of Health (MOH) in Malaysia. She holds a Master in Public Health (MPH) degree from Harvard School of Public Health with emphasis on Health Policy and Management.

After clinical medicine, Dr. Rozita started her Public Health career as a health systems researcher, focusing mainly in the areas of health financing and health economic research as well as training. She has been involved in various health expenditures estimates and projections, benefits incidence analysis, health care demand analysis and costing of health services. She planned and initiated the Malaysia National Health Accounts (MNHA) which is now institutionalized under the MOH.

For more than a decade, Dr Rozita has been involved in various plans to improve and reform the Malaysian health system. As the head of NHF, she spearheaded the plans to transform Malaysia's health system through major changes over a mid-horizon time-frame. These changes involve service delivery reforms, organizational reforms and health financing reforms. The concept called 1Care for 1Malaysia has been accepted by the Government of Malaysia. Currently Dr. Rozita and other colleagues in MOH works and communicates with various stakeholders of the health system are developing the blueprint for phased implementation to improve the health system of the country.

Naoki Ikegami

Professor

Keio University School of Medicine

Japan

Naoki Ikegami, MD, PhD, MA, is Professor and Chair of the Department of Health Policy and Management at the Keio School of Medicine, from which he received his MD and PhD. He also received a Master of Arts degree in health services studies with Distinction from Leeds University (United Kingdom). During 1990-1991, he was a visiting professor at the University of Pennsylvania's Wharton School and Medical School, and has continued to be a Senior Fellow at Wharton. He is a founding member of inter*RAI* (a non-profit international consortium of researchers and clinicians focused on care planning instruments), and served as a consultant to the WHO and the World Bank. He is currently President of the Japan Health Economics Association and Past-President of the Society of Healthcare Administration. He sits on various national and state government committees, including the Chair of the Investigative Specialist Sub-committee on Case-mix Based Reimbursement for Chronic Inpatient Care. His research areas are health policy, long-term care and pharmacoeconomics. His publications include "The Art of Balance in Health Policy - Maintaining Japan's Low-Cost Egalitarian System" (Cambridge University Press, 1998) with John C. Campbell, "Quality Life Evaluation Handbook for Clinicians" (Igakushoin, 2001) in Japanese with Shunichi Fukuhara et al, "Measuring the quality of long-term care in institutional and community settings" in "Measuring Up – Improving Health Care Performance in OECD Countries" (OECD, 2002) with John Hirdes and Iain Carpenter, "Games policy makers and providers play: Introducing case-mix based payment to chronic care hospital units in Japan (JHPPL, 2009).

Naoki Ikegami, MD, PhD, MA is Professor and Chair of the Department of Health Policy and Management at the Keio School of Medicine, from which he received his MD and PhD. He also received a Master of Arts degree in health services studies with Distinction from Leeds University (United Kingdom). During 1990-1991, he was a visiting professor at the University of Pennsylvania's Wharton School and Medical School, and has continued to be a Senior Fellow at Wharton. He is a founding member of inter*RAI* (a non-profit international consortium of researchers and clinicians focused on care planning instruments), and served as a consultant to the WHO and the World Bank. He is currently President of the Japan Society of Healthcare Administration and sits on various national and state government committees, including the Chair of the Investigative Specialist Sub-committee on Case-mix Based Reimbursement for Chronic Inpatient Care.

Manuel Inostroza Palma

Director of Clinical Campus and Director of MPA

Andrés Bello University

Chile

Manuel Inostroza Palma. I am a physician 45 years old, I am married to Cecilia and I have four wonderful children, I am M.Sc.(c) in Health Administration from the University of Chile and Master of Public Health in Financing and Management of the Johns Hopkins University. In my career I have excelled as manager in the Health Superintendence, the Isapres (private health insurance in Chile) Superintendence, Director of the Health Reference Center and East Peñalolén Cordillera, Regional Ministerial Secretary of Planning of the Metropolitan Region. Currently I work as Director of Clinical Campus, Director of the Master of Public Administration (MPA), academic and consultant to the Institute of Public Policy and Management, Health and Future of the Andrés Bello University. Furthermore, as an expert in management and public health, I worked as Advisor to the Ministry General Secretariat of the Presidency in the Division of State Modernization and the Executive Secretariat of the Committee of Ministers of the Modernization of Public Administration and was head of Cabinet of Ministers of Health of Chile, Carlos Massad, and Alex Figueroa and consultant of the Pan American Health Organization in Washington D.C..

PERSONAL DATA:

Name	:	*MANUEL ADRIAN INOSTROZA PALMA*
ID Number	:	*9.231. 042-6*
Birthdate	:	*October 19th 1966*
Age	:	*45 years old*
Marital Status	:	*Married, 4 children*
Nationality	:	*Chilean*
Particular address	:	*La Vendimia Sur 7781, Peñalolén-Santiago-Chile*
Office phone	:	*56-2-7587559*
Cell phone	:	*56-9-81982660*
E-mail address	:	*minostroza@unab.cl*

STUDIES:

Basic Education	:	*Public school D N° 628, Puerto Montt*
High School	:	*Jesuit school "San Francisco Javier", Puerto Montt.*
University studies	:	*Admission at School of Medicine, University of Chile (1984)*
Academic degree	:	*Bachelor in Medicine, University of Chile (1988)*
Professional Title	:	*MD, in August of 1992 University of Chile*

Other studies	:	*Master(c) in Health Administration of the Health Administration Interfaculty Program (PIAS), University of Chile (1993-1994). Master of Public Health in Financing and Management, Johns Hopkins University (2000-2001).*
Scholarships	:	*Fulbright fellow and scholar President of the Chilean Republic 2000-2001*

LABOUR RECORD:

- **From January 2011 to date** I work as Director of the Master of Public Administration (MPA), Andrés Bello University.
- **From April 2010 to date** I work as Director of Clinical Campus, academic and consultant to the Public Policy Institute of Health and Future of the Andrés Bello University.
- **From January 2005 to March 2010** I served as Superintendent of Health
- **From March 2003 to December 2004** I worked as Superintendent of Isapres
- **From February 2002 until March 2003** I worked as Director of the Health Reference Center pilot Peñalolén Cordillera East.
- **From June until November 2001** I worked as a consultant to the Pan American Health Organization in Washington DC, United States.
- **From November 1998 until May of 2000** I worked as a Regional Ministerial Secretary of Planning and Coordination of the Metropolitan Region.
- **From January 1997 until October 1998** I worked as Advisor to the Ministry General Secretariat of the Presidency in the Division of State Modernization and the Executive Secretariat of the Committee of Ministers of Modernization of Public Administration.
- **From August 1996 until January 1997** I worked as Chief of Cabinet of the Minister of Health Dr. Alex Figueroa.
- **From March 1994 until August 1996** I worked as Chief of Cabinet of the Minister of Health Don Carlos Massad Abud.
- Physician of the Service Emergency Care of the Municipality El Bosque, in Metropolitan Region, **between 1992 and 1993.**
- I worked as Director of Student Affairs at the University of Chile **in the years 1992 and 1993** under the leadership of Dr. Jaime Lavados Montes.
- **I served between 1991 and 1992** as a consultant in social policy and youth of the Mayor of the Municipality of Santiago, Don Jaime Ravinet De la Fuente

Poonam Khetrapal Singh

Deputy Regional Director
World Health Organization,
South East Asia Regional Office
India

Dr. Poonam Khetrapal Singh is the WHO Deputy Regional Director for South-East Asia for the last eleven years. She has overall responsibility for managing all technical departments in WHO South-East Asia Region, and supervises all financial and human resources in this regard. Before joining WHO SEARO, Dr. Singh was Executive Director in WHO's Headquarters in Geneva and a member of the Director General's Cabinet.

Dr. Poonam Singh has held several important portfolios in India including Secretary, Health, Family Welfare and Medical Education; Chairperson, Health Systems Development Corporation; Secretary, Finance; Managing Director, Punjab Financial Corporation among others in the Government of Punjab, India. She has also worked as a Specialist in Health, Nutrition and Population in the World Bank.

Dr. Poonam Khetrapal Singh has three masters degrees including one in Health Management and another in Population Studies. Dr. Singh has a Ph.D. in Public Health and is a Fellow of the Royal College of Physicians, Edinburgh.

Winai Sawasdivorn

Secretary General
National Health Secretary Office
Thailand

Name Dr. Winai Sawasdivorn
Presentation Position Secretary- General
Date of Birth Jan 3, 1954
Place of Birth Suphanburi, Thailand
Nationality Thai

Office address National Health Security Office
The Government Complex Commemoration, His Majesty the King's 80th Birthday Anniversary 5th December, B.E. 2550 (2007) Building B,
120 Moo 3,Chaengwattana Rd., Lak Si District, Bangkok 10210 Thailand
Tel (662) 141-4000 Fax (662) 143-9731www.nhso.go.th

Education Qualification

1979	Medical Doctor Siriraj Hospital Mahidol University
1986	MPH (Urban) Mahidol University
1985	(FETP) Field Epidemiology Training Program
1986	Certificate in Preventive Medicine (Epidemiology)

Academic Assignment

1980-1983	Director of Community Hospital Leengnokta, Yasothorn
1986-1989	Chief of Social Medicine Section, Mahasarakham Hospital
1989-1993	Deputy Provincial Chief Medical Officer (PCMO) Mahasarakham Provincial Health Office
1993-1998	Yasothorn Provincial Chief Medical Office
1998-2000	Nakornsawan Provincial Chief Medical Office
2000-2003	Deputy Director General, Department of Medical Services, Ministry of Public Health
2003-2008	Deputy Secretary-General, National Health Security Office
2008-Present	Secretary-General, National Health Security Office

Parallel Session 4.3

Provider payment:
aligning proper incentives and efficiency

Country experiences in implementing new provider payment methods in Ghana

By Irene Akua Agyepong[1]

Objectives

The objective of this background paper and accompanying presentation is to present Ghana's experiences with its current efforts to pilot the feasibility of a per capita payment system for primary care outpatient services while retaining the already existing Ghana Diagnostic Related Groupings (G-DRG) for services and Fee For Service (FFS) for medicines payment systems for specialist OPD and inpatient services under its National Health Insurance Scheme (NHIS).

Socio-economic Background on Ghana

Ghana is estimated (2010) to have a GDP per capita at current prices of US$ 1,542 and PPP of US$ 2,930 – international dollars[2]. It is an agricultural country and its main exports are cocoa, timber and gold. Oil in commercial quantities was discovered offshore in 2007 and drilling started in 2011. Most of the estimated twenty four million population are employed in the non-formal sector. About half the population is below 15 years. Approximately 13 – 15% of the public sector budget is allocated to health. The 2006 Ghana Living Standards Survey measured total consumption expenditure using an upper poverty lines of approximately US$ 390[3], expressed in constant prices of Accra, January 2006, and compared it with the results of previous surveys. The proportion of the population of Ghana below the upper poverty line fell from 51.7% in 1991/92 to 39.5% in 1998/99 and 28.5% in 2005/06. The poverty declines were however not even distributed geographically, and poverty in Ghana remains predominantly a rural phenomenon. The most recent Ghana Demographic and Health Survey (2008) estimated an Infant Mortality Rate (IMR) of 50 /1000 live births and an under five mortality rate of 80 /1000 live births.

The Ghana NHIS

In 2003 Ghana passed a health insurance law (Act 650) with the aim of improving equity in financing and access to health services by eventually replacing out of pocket fees at point of service use in the health sector with prepayment. The Ghana NHIS is 70 – 75% funded by a 2.5% value added tax, 20 – 25% by a percentage of social security contribution of fund contributors and 5% by out of pocket premiums paid by non SSNIT contributors and registration fees paid by all. Apart from the registration fees that are kept

---

[1] Regional Director Ghana Health Service (GHS), Greater Accra and Chair Provider Payment Mechanism Technical Sub-Committee (PPM TSC) National Health Insurance Authority (NHIA) /World Bank Health Insurance Project (HIP)

[2] http://www.gfmag.com/sources-for-country-economic-reports-and-gdp-data.html#5

[3] January 2006 exchange rates

by the district schemes that collect them, all funds are centrally pooled in the National Health Insurance Fund.

Provider payment systems evolution under the Ghana NHIS

At the start of NHIS implementation in 2004 provider payment for all services whether outpatient or inpatient was by itemized fee for service. Providers filed claims through the district schemes to the national insurance office and received payment back through the same route. Overtime it was clear this was not sustainable. The provider administrative burden of filling claims forms as well as the scheme burden of vetting them was huge; and costs kept escalating. In 2007/8 the itemized fee for service system was replaced by the Ghana Diagnostic Related Groupings (G-DRG) for services with itemized fee for service (FFS) for medicines.

Rapidly increasing service utilization rates clearly showed the value of the NHIS to subscribers. However the exponential growth in utilization and total claims even after the move to DRG for services, particularly outpatient (OPD) claims, were a challenge for cost containment and sustainability of the NHIS.

The Primary Care Per Capita payment system reform

In 2010, the National Health Insurance Authority (NHIA) took a decision to pilot test a per capita provider payment system for primary care outpatient services under the NHIS in the Ashanti region of Ghana to inform proposals for nationwide implementation of such a system. The pilot was to be financed by the NHIA as well as by part of the World Bank Health Insurance Project (HIP) funds. In parallel and as an important part of the provider payment reform process, terms of reference were also developed, and a consulting firm recruited under the HIP project to carry out an external evaluation of the experiences under the DRG system.

A Provider Payment Mechanism Technical Sub-Committee (PPM TSC) was established to design and oversee the implementation of the capitation pilot. The PPM Technical Sub-Committee includes members of key stakeholder groups, including NHIA, the Ministry of

---

[4] PPM TSC members (by agency and surname alphabetical order):

• Providers

Charles Adjei-Acquah, Irene A. Agyepong (Chairperson) Philip Akanzinge, Eric Boachie Agyeman (Chair Ashanti region Regional Implementation Committee) Eben Boadi, Caroline Jehu-Appiah (GHS),

Col Francis Kwashie (37 Military),

Alex Ofori-Mensah, Patrick Owusu-Bonsu (CHAG)

Ben Abrokwah (K'Bu Teaching Hospital)

• NHIA

Osei B. Acheampong (Dir. Research), Winfred Agbeyibor (Dir. Social and Cooperate affairs), Imoro Ahmed (Dir. Finance), Rockson Atakloe (Operations division /Secretary to the PPM TSC), Anthony Ginggong (Coordinator World Bank Health Insurance Project), Ben Kusi (Dir. ICT), Perry Nelson (Dir. Claims), Nicholas Tweneboa (Dir. Operations), Ben Yankah (Dir. Actuarial), Kofi Ntim, Rebecca Akatue, Adjetey Annan (Deputies supporting their directors)

• International

Karimah Saleh (World Bank) Cheryl Cashin (World Bank /Joint Learning Network) Evelyn Awittor (World Bank)

Health (MOH), Ghana Health Service (GHS), the Christian Health Association of Ghana (CHAG), and Korle Bu Teaching Hospital and 37 Military Hospital (quasi-government facility), the country Health Sector lead of the world Bank and an international consultant[1].

The pilot aimed to test the overall effectiveness of a capitation payment system in achieving the objectives identified by the PPM Technical Sub-Committee; identify key features of implementation that are essential for success; and make recommendations for scale-up of the capitation system after the pilot period. Specific objectives were to:

1) Improve cost containment
2) Share financial risk between schemes, providers and subscribers
3) Introduce managed competition for providers and choice for patients (compatible with portability) to increase the responsiveness of the health system
4) Improve efficiency and effectiveness of health services through more rational resource use
5) Correct some imbalances created by the G-DRG (e.g. OPD supplier-induced demand)
6) Simplify claims processing
7) Address difficulties in forecasting and budgeting

To determine the effectiveness of the capitation payment system in achieving its stated goals, manage unintended consequences, and make recommendations for scale-up a robust Monitoring and Evaluation system was considered to be a critical part of the pilot and beyond and making sure such a system was set up and functional was also a key objective of the PPM TSC.

In the first 6 months of the work, the national level PPM TSC focused on technical decision making and formulating of key policies and implementation arrangements, with frequent stakeholder consultations at the national level and in the Ashanti region to inform the process. Once the process was advanced enough and there was the need to move into implementation (Dec 2010 /Jan 2011), a regional Implementation Committee (RIC) was set up in the Ashanti region and within each district in the Ashanti region, District Implementation committees (DIC). All of 2011 has been spent in a process of refining policy and implementation arrangements based on feedback and experience from the ground, progressively putting in place sequential steps towards full scale implementation and constantly using feedback to monitor and fine tuning the process towards the ultimate goal.

Key steps carried out have been:

1. Defined per capita package of primary health care services with list of diagnosis and medicines. The per capita package comprises
   a. General OPD consultation with a trained primary care prescriber for
      i. Most common PHC diagnosis (see list in appendix)
      ii. Routine maintenance care for non insulin-dependent diabetes and hypertension (ambulatory care sensitive chronic conditions) once clients have been stabilized at a specialist clinic and instructions provided by the specialist clinic. Periodic specialist review and related laboratory tests will be covered by DRG with a referral from the PHC providing giving maintenance care.
   b. Maternity consultation and services with a midwife or doctor
      i. Antenatal care
      ii. Postnatal care
      iii. Normal delivery (including episiotomy)
   c. Selected basic laboratory examinations that match the selected primary care conditions and can be carried out even where there is no laboratory because rapid test kits are available
      i. Urine routine examination
      ii. B/F for Malaria parasites
      iii. Hb
      iv. Blood Sugar
      v. Pregnancy test
   d. Selected medicines based on the most current version of the Ghana STG that are appropriate to the diagnosis at PHC level and maternity conditions
2. Mapping of providers in the Ashanti region and designation of providers to provide the PHC services as Preferred Primary Providers (PPP)
3. Development of guidelines and commencement of education to providers unable to deliver all the per capita services to form a group practices
4. Calculation of the per capita rate
5. Enrolment regulations
6. Stakeholder education – ongoing and will continue since education is not a one off activity
7. Selection of PPP by subscribers
8. Modification of the NHIS computerized registration data base to take data on enrolment of clients to PPP
9. Establishing a functional routine data M&E system
10. Commencement of per capita payments to providers and service delivery under capitation is set for 1st January 2012.

Facilitating factors and Challenges

Factors that facilitated the work have been:

1. The locally driven nature of the agenda setting, formulation and implementation processes
2. The major backing and proactive support of the top leadership i.e. CEO NHIA Mr. Sylvester Mensah and the NHIA council. The PPM TSC had an always open communication line to the CEO and prioritization of the process that empowered it to move the process forward in a way that would otherwise not have been possible
3. The cross stakeholder composition of the PPM TSC
4. The high quality and experience, understanding and commitment of the Ghanaian membership of the PPM TSC
5. The high quality and experience, understanding and commitment of the international TA/consultant
6. The openness and transparency of PPM TSC proceedings and communications by email, phone, text as well as face to face
7. The creation of a Regional Implementation committee and District implementation committees
8. The strong links created and maintained between formulating the policy, design of implementation arrangements and actual implementation through the links and interactive working relationships between the PPM TSC, RIC and DIC.
9. The decision to reinforce routine data systems, prioritize and strengthen M&E and integrate the strengthening into the routine system

Challenges have included:

1. Understanding the political as well as technical nature of the process; actor/ stakeholder interests and concerns at all levels and effectively harnessing / addressing them for successful policy formulation and implementation
2. Related to the political as well as the technical nature of the process, how to carefully listen to, think through, understand and sort out genuine concerns that needed to be addressed to improve the process and outputs versus self interested ones in the sometimes conflicting interests of actors /stakeholders and the objectives of the pilot
3. The concerns, suspicions, fears and mistrusts of stakeholders – sometimes accompanied by major high level lobbying and other efforts to stop the

process – if not understood and addressed. When listened to, understood and concerns collaboratively addressed, sometimes opponents become supporters.

4. The challenges of being innovative, rapidly responsive and flexible within the operating constraints of the World Bank and NHIA bureaucratic systems, rules and regulations
5. Getting past system inertia, some of which was related to the bureaucratic obstacles e.g. things needed urgently could get stuck in procurement or financial clearance without a sustained effort to remind to treat as urgent (few weeks / days) rather than routine (months or never)
6. Getting major reform underway in a resource (human, infrastructure, equipment, tools and supplies as well as money) constrained setting; and being pragmatic to design what would work in the actual rather than the ideal context
7. Public education to ensure adequate stakeholder understanding and buy is a critical part of implementation but an expensive long term processes needing to use multiple channels, media and approaches at multiple levels. It was consistently inadequate given the resource constraints.
8. Data availability and quality to inform decision making

Country experiences in implementing DRG: Germany

By Martin Edgar Braun

Due to the limited resources available in the in-patient sector the question of the type of financing arises. However, this is always embedded in the structure of the health system as a whole. Therefore, a brief look at these conditions is made first.

In Germany, the Bismarckian health system exists, which means that basically all Germans are statutory health insured (90%) and thus in the event of illness, the costs will be covered by the statutory health insurance. An exception is made only for self-employed, civil servants or employees with very high incomes who are insured by a private health insurance (10%). All Germans have access to necessary health care services regardless of income, age or sex.

In the year 2009, out of the total of 1,649 German hospitals 33% were in public, 42% in non-profit/charitable and 25% in private ownership. The hospital's clinicians are employees of the hospital and they do not work outside the hospital in parallel. In 2009, approximately 20 million patients were admitted to hospital.

By the year 2003 the way of financing the in-patient care was a per-diem payment which had a negative impact on the length of stay and from an economic point of view on the efficiency of service delivery. In 2003, the form of financing was changed to a DRG system. This applies to all in-patients, regardless of whether they are insured statutorily or privately. It also applies to all hospitals, regardless of the ownership. Each patient treated in hospital is billed by DRG, no matter because of which disease he was treated. Exceptions are not provided. The introduction of the DRG system aims to reduce the length of stay, to achieve a performance based remuneration, to provide services more efficiently and to create more competition among hospitals.

Therefore in Germany a DRG system for the in-patient sector was established in 2003, which is based on the Australian AR-DRG system. Over the last nine years this system was adapted for Germany and developed further, in order to use it as a prospective payment system. After a five year period all hospitals in the same state should be remunerated equally. Therefore, a remarkable modification of the DRG system was necessary. This explains the drastic increase of the number of DRG groups and the redefinition of many existing groups. Furthermore, additional fees were implemented. The classifications of diagnoses and procedures were developed further by means of establishing new or differentiating codes. Besides this, the data collection of costs and services was improved. With the aid of a standardised cost calculation manual the data quality could be enhanced essentially.
The G-DRG system is used as a billing system, which means that each case will be charged within a week after the patient's discharge by a DRG-based accounting between

health insurance and hospital. Each DRG group shows for cases within their lower and upper margin of length of stay (inlier) a cost weight, which is multiplied with a base rate. The same base rate now applies to all hospitals within a state (Germany has 16 states). In the next few years, these base rates will be adjusted on a national level.

For the financing of highly expensive services (e.g. chemotherapy or endovascular implantation of aortic prosthesis), there are about 150 different additional fees. These are paid in addition to the revenue of the DRG groups. Under certain conditions medical innovations can be negotiated between the local hospital and health insurances as additional charges as well.

Since by the G-DRG system the revenue for each DRG group is known before the treatment (equivalent to a price system), an extensively expansion of the amount of services must be avoided. This is achieved by the prospective bargaining of the amount of services for each DRG group and for the additional fees. This negotiation is conducted annually between representatives of all health insurances and the respective local hospital.

Exceeding the negotiated amount of services, the predominant share of the already received revenue has to be returned. Falling below the agreed amount of services, the too little service providedis paid in a small proportion anyway. This rule takes the financing of fixed costs and variable costs into account. In doing so, the incentive of unbridled expansion is kept in check, without preventing a medically necessary treatment. In addition it is currently being discussed, to counter the incentive to the expansion of elective services, that the insurance companies can negotiate discounts with hospitals.

Since the G-DRG system is used as a billing system, it has been shown that the review of hospital bills by the insurance companies is necessary. Basically, the coding of diagnoses, operations and interventions affect the assignment to a DRG group and therefore the revenue of the case. Accordingly, it is necessary that the compliance with the coding guidelines is reviewed. On the other hand, the annual revision of the G-DRG system has to ensure that no perverse incentives exist in the system, leading to an escalating upcoding. Hereby, the consideration of secondary diagnoses (particularly on PCCL splits – patient clinical complexity level) plays a major role.

Since a DRG system is a flat-rate remuneration system, previously existing quality assurance measures were further expanded to prevent a negative influence of the financing system on the quality outcome. For example, all hospitals were required to publish quality reports. In addition, various forms of quality assurance are carried out.

Overall, the introduction of the G-DRG system, both from the political side and on the part of insurers and the hospitals, consistently received a positive response. The length of stay decreases annually. The remuneration is performance oriented, equal performance

is paid the same, independent of the respective hospital. This creates competition among the respective hospitals and a corresponding efficient service delivery. The transparency of the services provided increased enormously because of the data available, which has significant implications for all involved. Thus, the previous objectives have been achieved. Problems related to the quality of the services provided are not apparent up to now. The frequent coding audits are perceived negatively from the physicians. Similarly, the incentive on the expansion of elective services appears not fully resolved yet.

Based on the positive experiences with the introduction and development of the G-DRG system in Germany by now Switzerland, Cyprus and Slovakia have decided to introduce a DRG system based on the German G-DRG system. Other countries (e.g. China) are in close contact with the German DRG institute.

Country experience in implementation capitation for primary health care providers and other provider methods in Kyrgyz Republic

By Ainura Ibraimova

The health system Kyrgyzstan inherited from the Soviet period was built on the premise of universal access to free health services, but it was also characterized by a rigid and highly centralized management structure, a high level of bureaucracy, inflexibility, fragmentation and duplication of health care delivery, inefficient methods of financing, and an excessive health care infrastructure. All of these ultimately undermined the declared principle of free and universal access.

Prior to independence, Kyrgyzstan devoted 3.5% of its GDP to health. This diminished following rapid economic decline—creating a substantial funding gap between the level of financing needed by the health system and the resources available.

In response to these challenges, Kyrgyzstan introduced a systemic reform to address: organisational complexity; excess infrastructure and human resources; allocative inefficiency and inequities in financing; inefficient service provision; limited incentives and low pay levels for health personnel.

The main directions of the health strategies are:

- reforming the health care delivery system with the aim of strengthening primary health care, developing family medicine and restructuring the hospital sector;
- reforming health financing, including introduction of outcome-based payment methods;
- improving medical education and developing human resources;
- improving quality of care;
- strengthening public health; and
- introducing new health management methods in the context of greater autonomy of health facilities.

The goals of the health financing component were to develop a sustainable, effective and integrated system of health financing based on increasing funding, to ensure an equitable distribution of resources, to meet state commitments within the SGBP and other priority programmes, to decrease the financial burden of the population, especially the poor, to improve access to health services, and to use health resources more effectively and rationally.

The introduced health financing model has become widely known locally and internationally as the "Single Payer System". This name captures the key idea of the Kyrgyz model which is the creation of single payer oblast (regional) level purchasing pools under the Mandatory Health Insurance Fund. In each oblast, there is one purchaser of health services, for those services that are part of the State Guaranteed Benefit Package (SGBP). These purchasing pools are called Territorial Departments of the Mandatory Health Insurance Fund (TDMHIF). All oblast and sub-oblast tax revenues are transferred to and pooled in these oblast purchasing pools. Providers covering services in the SGBP receive payment from the MHIF and its territorial departments on the basis of their outputs. These new methods of paying public providers mean a complete break from the previous historical line-item payment method which contributed to inefficiencies and quality problems.

The Programme of State Guarantees for the entire population was introduced in 2000. It defines the health services and entitlements of various categories of the population. The Programme of State Guarantees provides free PHC services for all citizens, regardless of their insurance status and enrolment. Referral care for outpatient specialist care and hospital care is provided against co-payment with the exception of certain exempt categories. Citizens not covered under the MHI scheme are subject to higher co-payments for referral services than insured patients.

To address allocative inequities, political decision has been made to gradually increase the share of PHC budget. By 2009, share of PHC had increased to almost 37. 7%.

New provider payment methods have been successfully introduced in the all regions for FGPs, based on simple per capita mechanism. Per capita payment mechanisms are much more equitable way of allocating resources to PHC level, as compared with budgets based on historic activity, provider activity or historic input levels. Per capita payment mechanism establishes an excellent platform for need-based resource allocation methods to be introduced through incorporation of 'weights' or 'coefficients' —reflecting determinants of need—to the simple per capita formula.

Direct and indirect contracts have been introduced for FGPs, including partial fundholding for pharmaceuticals (Additional Drug Package). Citizens insured under the MHIF receive additional benefits of access to an outpatient drug package which provides certain drugs at reduced rates. Contracts provide an opportunity to the purchasing authorities to become 'strategic purchasers' to develop care packages that reflect the need of the country but also to continually improve the quality levels in provider institutions through modification of the contract specifications and introducing quality/outcome based targets, with appropriate incentives.

Changing payment systems at PHC level required organizational and legal changes, which included: (i) creating providers with increased managerial autonomy, such as stand-alone FGPs or autonomous hospitals able to contract with the Mandatory Health Insurance Fund (MHIF); (ii) Restructuring of PHC to develop FGP units and larger PHC centres with FGPs as structural units; (iii) Rationalization of outpatient polyclinics (for children, adult and women consultation) by establishing multi-profile policlinics, as a first step, to establish FGP centres; (iv) Defining an essential package of services to be provided by FGPs, and; (v) Developing a referral and counter-referral system.

Hospitals are paid per case according to clinical cost groups, a type of diagnosis-related groups. The phased introduction of the SGBP and patient co-payments in 2001–2004, the re-classification and re-calibration of clinical cost groups in 2003 and the transition to the classification of cases based on the 10th revision of the *International Classification of Diseases* (WHO, 1992) required a thorough analysis of hospital payment methods to find solutions for cases above the volumes set in the contracts with the MHIF.

Overall, the introduction of case-based payment has created incentives to increase the effectiveness of hospital performance, reduce the average length of stay and increase the share of direct treatment expenses. It also introduced payment for services rather than infrastructure or buildings and required an alignment of payments with the SGBP. The use of modern information technology permits in-depth analyses to be conducted of the scope and structure of health services provided to different population categories, and to plan measures that aim to improve effectiveness and the rational use of funds (Kutzin et al., 2002; Kutzin, 2003)

There are documented improvements in the efficiency and quality of the Kyrgyz health system. The new provider payment methods under the Single Payer system triggered the tremendous downsizing that occurred in the hospital sector between 2000 and 2003. The large reallocation of expenditures to the primary level and to direct patient expenses would not have been possible without significantly downsizing the infrastructure of service delivery. The introduction of strategic purchasing has also led to improved quality of PHC, with tremendous benefits associated with the Additional Drug Package in terms of availability and affordability of drugs for primary care sensitive conditions also documented. These achievements are due in large part to the adoption of "strategic purchasing" using output-based payment mechanisms, sophisticated incentives for referrals and exemptions, and regular monitoring of quality. The MHIF also has been able to fulfill its functions with remarkable efficiency, keeping administrative costs significantly lower than required by Kyrgyz law and lower than most social insurance-based health systems in Europe.

Irene Akua Agyepong

Regional Director of Health Services
Accra Regional Ghana Health Service
Ghana

Irene Akua Agyepong is currently Regional Director of Health Services, Ghana Health Service in the Greater Accra Region of Ghana. She also teaches part time in the Health Policy Planning and Management department of the School of Public Health of the University of Ghana, Legon. She is a member and Chair of the Scientific and Technical Advisory Committee (STAC) of the Alliance for Health Policy and Systems Research, WHO Geneva. She was Professor to the Prince Claus Chair in Equity and Development 2008 – 2010 in Utrecht University in the Netherlands. Her areas of research and publication are related to Health Policy and Health Systems. She has a Medical degree (MBChB) from the University of Ghana Medical School, a Masters in Community Health from the University of Liverpool, School of Tropical Medicine and a Doctorate in Public Health (Health Policy and Administration) from the University of North Carolina at Chapel Hill.

Martin Edgar Braun

Expert and Consultant for Public Health
Health Care Management
Germany

Curriculum vitae
Dr. med. Martin Braun, M.Sc.

Education
Specialist for Internal Medicine/Gastroenterology/Diabetology DDG
Master of Science in Healthcare Management
Advanced Training in Quality Management (German Medical Association)

Medical career

until 2000	Senior physician, Ansbach Clinic
2000	Head of Staff Unit Medical Controlling/Quality Management, Worms City Hospital
2001	Consultant of Medical Department, German Hospital Association, Düsseldorf
2002	Deputy Head of Medical Department, German Hospital Association, Düsseldorf
2003 until 2010	Head of Medical Department, InEK GmbH (German DRG Institute), Siegburg
since 2011	Expert and Consultant for Public Health DR MARTIN BRAUN Health Care Management, Mannheim

Cheryl Cashin

Lead, Provider Payment Track, Joint Learning Network for Universal Health Coverage
Results for Development Institute
USA

Cheryl Cashin, Ph.D., is a health economist with more than 20 years of experience in the design, implementation and evaluation of health financing policy. Dr. Cashin is a Senior Fellow at Results for Development Institute and is currently serving as the Lead for the Provider Payment Mechanisms technical track of the Joint Learning Network for Universal Health Coverage. She is a co-author of the World Bank's "Designing and implementing health care provider payment systems: a how-to manual."

Previously, Dr. Cashin served as an advisor to the Government of Albania on health sector monitoring and evaluation, as the director of a health financing policy program in the Republic of Georgia, and as the deputy director and health financing specialist for a health reform program in the Central Asian Republics.

Ainura Ibraimova

Regional Health Finance and HSS Director
USAID Quality Project
Kyrgyzstan

Dr. Ainura Ibraimova, former Deputy Minister of Health of Kyrgyzstan and Director-General of Mandatory Health Insurance Fund under MoH. She graduated from the Kyrgyz State Medical Institute and undertook further studies in cardiology under the Academy of Medical

Sciences, Moscow. She started her career in the Kyrgyz Research Institute of Cardiology and, in 1989, she joined the Kyrgyz Medical Institute. In 2001, Ainura Ibraimova became Deputy Minister of Health of Kyrgyzstan and Director-General of the Mandatory Health Insurance Fund. During her years at the Ministry of Health, Dr. Ibraimova has participated in national health reforms programmes to strengthen the capacity of the health care system. In addition to her activities at national level, Dr. Ibraimova shared her experience and takes an active part in the work of WHO's different expert groups and committees, as well as regional and international conferences. Dr. Ibraimova is an author and co-author of several publications on health reforms. She has also served as a temporary adviser for several WHO regional events. Currently she is working at the USAD Quality Health Care project for Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan as a Regional health finance and Health System Strengthening Director.

Christopher D. James

Technical Officer
in Macroeconomics and Health
WHO Western Pacific Regional Office
Philippines

Christopher D. James is an economist with the Western Pacific Regional Office of the World Health Organization. He works on health financing issues in Asia and the Pacific, with this work including regional level analyses, development and application of policy tools, and extended support to specific countries on a needs basis. Some recent examples of his work include coordinating a 5-country project that analysed the financial burden of health payments on households; co-developing MacroHealth, a health expenditure projection tool; and the provision of in-depth technical support to the current health financing reform initiatives in Lao PDR. Before joining the Western Pacific Regional Office of the WHO, he worked at the WHO in Geneva and for the Overseas Development Institute in Rwanda. He was also a consultant for Save the Children UK, UNICEF and the WHO. He has published articles on various aspects of health systems, such as on user fees, social health insurance, priority setting and supply-side incentives in healthcare. He received his PhD from the London School of Hygiene and Tropical Medicine, and his MSc in health economics from York University.

Joseph Kutzin

Coordinator
Health Financing Policy
World Health Organization
Switzerland

Joseph Kutzin is a health economist with over 25 years' experience in health financing policy and health system reform, working in Africa, Asia, the Caribbean, and Europe. He has published numerous conceptual and empirical articles as well as co-authored and edited books on health financing in Europe as well as in low and middle-income countries elsewhere. Notable among these was a chapter in the book *Achieving Universal Coverage of Health Care,* edited by Sanguan Nitayarumphong and Anne Mills, published in 1998. His most recent work is as lead editor of a book entitled *Implementing Health Financing Reform: Lessons from Countries in Transition,* published in 2010.

Following the completion of a Master's Degree in Development Economics from Boston University in 1985, he worked in a private health foundation and for the World Bank before joining WHO Headquarters in Geneva in 1994. In 2000 he became WHO's Senior Resident Policy Advisor to the Ministry of Health of Kyrgyzstan, where he established and managed a health policy analysis unit that has since become an integral part of the health system. He moved to Copenhagen in 2003 as the WHO European Region's Advisor for Health Systems Financing, a role he continued when he became Head of the WHO Barcelona Office for Health Systems Strengthening in 2007. In Barcelona, he led a team responsible for providing support, guidance, and capacity strengthening on health financing policy and health policy analysis for the 53 countries of the European Region. He also supported WHO's work on health financing globally, including contributing to the World Health Report 2010 entitled *Health Systems Financing: the Path to Universal Coverage.* In July 2011, he moved to WHO Headquarters in Geneva where he is leading the Health Financing Policy Team within the Division of Health Systems Financing.

Qingyue Meng

Dean School of Public Health
Peking University
China

MENG, Qingyue, MD, PhD, is Professor in Health Economics, Dean of School of Public Health, Peking University, and the Executive Director of Peking University China Center for Health Development Studies (CCHDS). Prior to this position, he was Dean of Shandong University School of Public Health.

He obtained MD from Shandong University (Previously Shandong Medical University); MSc from Fudan University (previously Shanghai Medical University); M.A. from School of Economics of University of the Philippines; and PhD from Karolinska Institutet in Sweden.

He is the member of Advisory Committee of Health Policy and Management and member of the Expert Committee of Tuberculosis Control, to Ministry of Health; the former Board Member of The Alliance for Health Policy and Systems Research, WHO; and member of the Steering Committee on Social, Economic and Behaviours, TDR.

His research interests include health financing and cost-effectiveness analysis of public health programs. Over the past decades, he has led teams conducting dozens of research projects supported by WHO, the World Bank, DFID, EU, and Chinese government. He provides a number of consultancy services focusing on health policy and systems for Chinese government through the World Bank, DFID, and Ausaid-funded projects.

Sudha Pillai

Member-Secretary
Planning Commission, Government of India
India

Name	:	(Mrs.) SUDHA PILLAI Indian Administrative Service 1972 Batch Kerala Cadre 2nd in the Batch
Date of Birth	:	1st May, 1950
Education	:	BA (Hons – English Literature), 1968 Punjab University, Chandigarh. Awarded University Gold Medal for securing first rank Master of Arts (Psychology), 1970 – Punjab University, Chandigarh. Awarded University Gold Medal for securing first rank Masters in Public Administration (MPA), 1985 Kennedy School of Government, Harvard University, USA
Languages known	:	English, Hindi, Punjabi, Malayalam, French

Important senior positions held in Government of India and State Government of Kerala:

- District Collector, Trivandrum
- Director, Ministry of Industry, Dept. of Industrial Development, Government of India
- Joint Secretary, Ministry of Law, Justice & Company Affairs, Department of Company Affairs, Government of India
- Secretary, Higher Education, Government of Kerala
- Chairman-cum-Managing Director, Kerala Finance Corporation, Trivandrum
- Joint Secretary, Ministry of Rural Development, Government of India
- Principal Secretary, Finance, Government of Kerala
- Addl. Secretary, M/o Mines, Government of India
- Addl. Secretary, M/o Panchayati Raj, Government of India
- Secretary, M/o Labour & Employment, Government of India
- Secretary, Planning Commission
- Currently Member-Secretary, Planning Commission(in the rank of Minister of State), Government of India

Hobbies : Painting

Marital Status : Married

****

Parallel Session 4.4

Using financing as a platform for quality improvement

Antiretroviral Drugs in the Cupboard Are Not Enough: The Impact of Health Systems' Performance on Mother-to-Child Transmission of HIV

By Pierre M. Barker, MBChB, MD,† Wendy Mphatswe, MBChB, MPH,‡ and Nigel Rollins, MB, MD‡§*

Objective: To model the effect of health systems performance on rates of mother-to-child HIV transmission.

Methods: We modeled the effect of variation in performance of the multiple steps of different prevention of mother-to-child transmission (PMTCT) protocols using hypothetical and reported data.

Setting: Data from a PMTCT program in a large province in South Africa was used to compare model predictions with reported outcomes for mother-to-child HIV transmission. Main Outcome Measure: Perinatal HIV transmission was predicted for infants of 6 weeks of age.

Results: HIV-infected pregnant women who fulfill eligibility criteria are initiated on lifelong antiretroviral treatment, whereas noneligible HIV-infected women and their infants receive single-dose nevirapine in a health system functioning at reported performance levels, and the overall vertical transmission rate would be 19.5%. Adding azidothymidine for women not eligible for lifelong treatment would further decrease the overall transmission rates only marginally to 17%. If the same steps were accomplished at 95% reliability, then the overall transmission rates would be 9.4% and 4.1%, respectively.

Conclusions: Introduction of more effective combination antiretroviral interventions will yield only marginal reductions in childhood HIV infections and mortality unless health systems achieve high

Received for publication August 15, 2010; accepted September 21, 2010.

From the *Institute for Healthcare Improvement, Cambridge, MA;
†Department of Pediatrics, University of North Carolina, Chapel Hill, NC; ‡Department of Child Health, University of KwaZulu-Natal, Durban, South Africa; and §Department of Adolescent Health and Development, World Health Organization, Geneva, Switzerland.

All authors have contributed to the development of the models and writing of the manuscript. The data for the models were obtained through literature review. Data for the South African health system performance was obtained from the South African District Health Information System.

The model was presented at a WHO internal technical consultation in October 2009.

N. Rollins is a staff member of the World Health Organization.

The authors alone are responsible for the views expressed in this publication

and they do not necessarily represent the decisions, policy, or views of the
World Health Organization. The authors have no funding or conflicts of interest to disclose. Correspondence to: Nigel Rollins, MB, MD, Department of Child and
Adolescent Health and Development, World Health Organization, Avenue
Appia 20, 1211 Geneva, Switzerland (e-mail: rollinsn@who.int).

levels of performance at each step of the PMTCT pathway. Investment in and support for the mechanisms of delivering and sustaining PMTCT interventions at scale are required if gains in maternal and child survival are to be realized in countries highly affected by HIV.
Key Words: PMTCT, health system, performance, transmission, antiretroviral drugs
(J Acquir Immune Defic Syndr 2010;00:000–000)

INTRODUCTION

Antiretroviral (ARV) drugs used for the prevention of mother-to-child transmission (PMTCT) of HIV can virtually eliminate the risk of childhood HIV infection and improve maternal survival.[1] Yet failure of any of the multiple sequential steps of PMTCT care results in cumulative losses of pregnant mothers from PMTCT services, with increased risk of HIV transmission to their infants. Among infants attending immunization clinics in South Africa, 21% of HIV-exposed infants were HIV infected by 6 weeks, despite single-dose nevirapine (sdNVP) being offered through antenatal clinics (ANC).[2] The transitioning of PMTCT protocols in high HIV prevalence countries, from sdNVP to combination ARV drug regimens[3] and ''optional'' eligibility criteria for initiating maternal antiretroviral treatment (ART),[4] offer the prospect that HIV transmission rates and maternal mortality will decrease. However, these new interventions are likely to have minimal effect unless primary health care systems that deliver PMTCT services in these countries are improved. The PMTCT ''cascade'' identifies the sequence of steps needed to deliver ARV interventions to HIV-infected women and their infants: counseling, HIV testing, CD4 testing, dispensing of ARVs at ANC and labor wards, and testing of infants at 6 weeks. However, the output of this sequence, prevention of HIV transmission, is significantly affected by the reliability of the health system to deliver each step in the sequence.[5]

If the entire multistep PMTCT care pathway is reduced to just 3 steps (ANC access, HIV/CD4 testing, and ARV treatment), the profound effect of even small losses in reliability is evident. If each step is delivered at 95% reliability, then a 5% loss that is compounded at each subsequent step means that only 86% of women will receive the ARV intervention. If the system delivers each step at 80% reliability (20% loss at each step), then only 51% of women

will receive the final intervention and at 60% reliability, only 22% will receive ARVs. In real life, the multiple occasions when mothers are ''lost'' result in failure of interventions that under controlled research conditions, effectively decrease HIV transmission.[6,7] It is estimated that in 2008, PMTCT programs in eastern and southern Africa provided ARVs to only 58% of HIV-infected pregnant women (45% in all low-and middle-income countries) who needed them.[8]

METHODS

We developed a model that estimated the effect of ARV interventions for PMTCT on population-based vertical transmission rates in infants, taking into account health systems' performance. The proportion of women accessing each point of service delivery could be independently varied. These steps reflect activities that are largely within the control of health systems and are points of potential failure or improvement.

The model was restricted to antenatal and peripartum interventions, and the primary outcome was defined as HIV status of infants born to HIV-infected mothers at 6 weeks of age. It is assumed that the HIV status of all infants is determined at 6 weeks, whether they were part of the PMTCT program or not. The model did not include postnatal transmission due to breast feeding, primary infection of pregnant women, or situations when a pregnant woman might not test positive, such as during the ''window period'' of a newly acquired HIV infection.

The model assumed vertical transmission rates, measured in infants at 6 weeks, associated with different (or no) ARV interventions as described in published literature[9,10] and could adjust transmission rates depending on maternal CD4 count. At each step of the PMTCT process, women who ''fell out'' of the ideal treatment stream were entered into default streams. For example, if a service offered ART to women meeting either immunological (CD4 count) or clinical criteria, then women who missed this opportunity because of impaired system performance could be designated to receive either nothing or a default intervention such as sdNVP or azidothymidine (AZT)/sdNVP.

We explored 6 scenarios that reflect actual PMTCT practices in different settings:

1 No intervention to HIV-infected women or HIV-exposed infants;

2 HIV-infected women receive sdNVP in labor. HIV-exposed infants receive sdNVP after delivery;

3 HIV-infected women receive AZT any time from 28 weeks of gestation and sdNVP in labor. HIV-exposed infants receive sdNVP and AZT for 1 week after delivery;

4 A 2-tier system in which HIV-infected women who do not fulfill criteria for lifelong ART and their infants receive sdNVP as in setting #2, whereas HIV-infected women who do fulfill criteria are initiated on ART by 34 weeks of gestation. Eligibility for ART was initially set at CD4 count,200 cells per milliliter;

5 A 2-tier system in which HIV-infected women who do not fulfill criteria for lifelong ART and their infants receive AZT and sdNVP as in setting #3, whereas HIV-infected women who do fulfill criteria (CD4 count ,200 cells/mL) are initiated on lifelong ART by 34 weeks of gestation;

6. A 2-tier system in which HIV-infected women who do not fulfill criteria for lifelong ART receive triple ARV prophylaxis (eg, AZT/3TC/Kaletra) for the duration of pregnancy, whereas HIV-infected women who do fulfill criteria (CD4 count,200 cells/mL) are initiated on lifelong ART by 34 weeks of gestation.

These intervention scenarios were tested in a model that used reported performance data from South Africa (SA)[11,12] for each of the 3 core steps (Fig. 1). The model assumes that CD4 testing is available at all sites. Infants born to HIV-infected women who had not been tested or treated were considered to be at unimpeded risk of transmission. We also ran the model using CD4 count,350 cells per milliliter as the eligibility criteria for initiating ART.

RESULTS

When PMTCT interventions are delivered in a health system functioning at reported SA performance levels for each step, then only one third of mothers and their infants would receive sdNVP or ART interventions (scenario 4) that should reduce HIV vertical transmission rate to about 8% (Fig. 1). The other two thirds of mothers would be lost along the PMTCT pathway, and their infants would be subjected to an unimpeded HIV transmission rate of 25%. When combined, the overall vertical transmission rate would be 19.5% (Surveillance data from SA in 2006 estimated population-based transmission rates to be 20.8%.[2]). If the same steps were accomplished at 95% reliability, then the overall transmission rate would be 9.4%. Using the reported SA levels of system efficiency, introduction of AZT to a PMTCT protocol in addition to sdNVP/ART (scenario 5) would further decrease the overall transmission rates only marginally, that is, from 19.5% to 17%. Improving reliability of the system at all steps to 95% efficiency would result in a fall in the transmission rate to 4.1%.

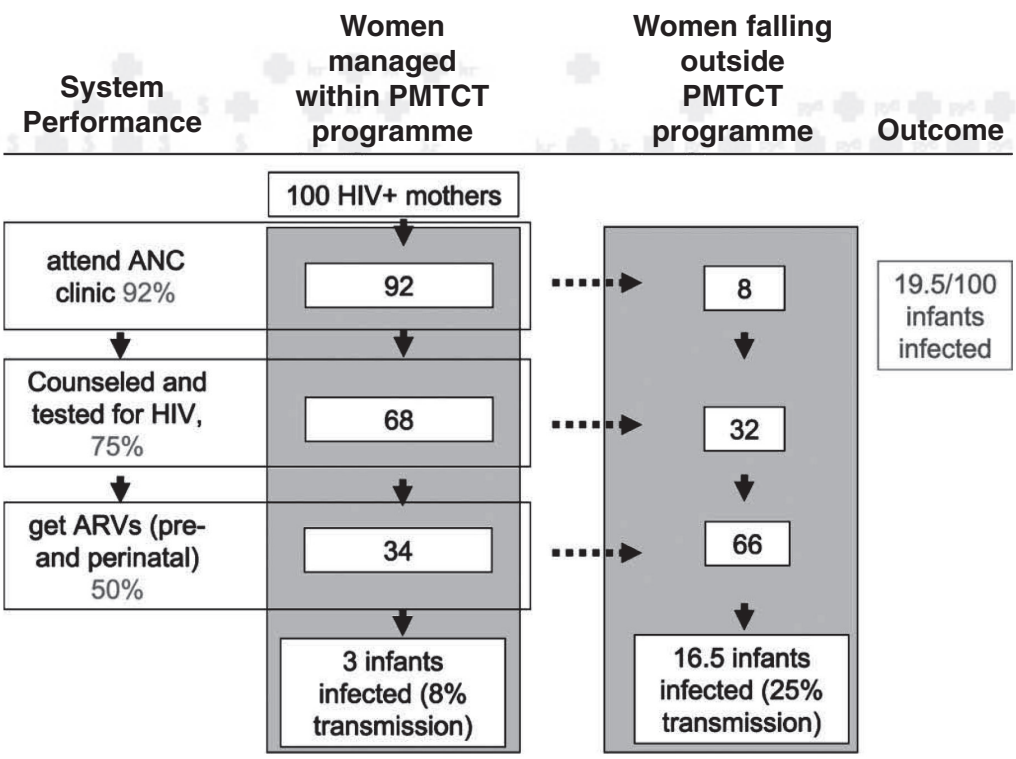


***FIGURE 1**. Effect of poor system performance on PMTCT outcomes.*

In models of system-wide performance levels that ranged between 60% and 95% (Table 1), a high-performing system (95% reliability at all steps) that provides only sdNVP to all HIV-infected women, irrespective of CD4 count, would achieve population-based transmission rate similar to a low-performing (60%) system that provided ART to all HIV-infected women. In systems that function below 60% efficiency, there is limited impact of any ARV intervention on infant HIV transmission rates when measured at population level.

When performance was varied at different steps of the pathway, failure in the early steps of the PMTCT pathway such as poor access to ANC services or failure of counseling services has a greater impact on overall transmission rates than later losses in efficiency such as at initiating ARVs. In this model, if all steps in the system were delivered with 100% efficiency except HIV testing, which was delivered at 80%, the HIV transmission rate would be 8.2%. By contrast, if all steps were at 100% efficiency except delivery of ARVs (80% efficiency), then the overall transmission rate would be 5.7%. The effect is most significant if women with low CD4 counts are not identified and referred for ART, as infants born to these mothers are at much higher risk of transmission than those with higher (ie, CD4.200 cells/mL) counts.

Finally, when ART is provided at the reported current performance levels from SA in the 2-tier models, changing the eligibility criteria for ART from CD4 ,200 to CD4 ,350 has little effect on the number of infants becoming infected (18.2% vs. 15.3%, respectively), although would benefit the additional mothers who would receive ART.

DISCUSSION

The principal finding is that to reduce the number of infants who become infected with HIVand ensure that mothers receive interventions that will save their lives, each step of the PMTCT pathway needs to be delivered with greater than 90% reliability. Equally important to recognize is that introducing more effective drug interventions, or raising the CD4 threshold at which ARTwould be offered, will have limited effect unless health system performance is addressed. Nor is it good enough to focus on 1 step of the pathway or only those women who come through the door of the antenatal clinic. Unless the overwhelming majority of pregnant women in the community are reached, the goal of minimal infant transmissions (eg, to less than 5%)[13] cannot be reached.

As stated in the Methods section, neither the effects of breastfeeding on later postnatal transmission or acute maternal HIV infection are included in the analyses. The World Health Organization now recommends the provision of ARVs to prevent postnatal transmission, which has the potential to significantly improve HIV-free survival of infants born to HIV-infected mothers.[14] However, this opportunity also depends on consistent delivery of specific interventions over an even longer period than antenatal care, that is, approximately 12 months and emphasizes the need for health systems' interventions to improve the reliability and quality of care provided through primary health facilities.

The model helps explain global estimates that only about 45% of HIV-infected women living in low-and middle-income countries ever receive PMTCT interventions.[8] With poor reliability for the 3 main steps of the PMTCT pathway, it is hard to envision how new therapies could have any impact on HIV transmission rates or maternal mortality. As PMTCT interventions are directed at HIV-positive women, increasing the number of women who know their status will have the greatest impact on the number of infant infections that can be averted. This will require different strategies as, in some settings, access to any ANC service will be the dominant constraint, while elsewhere, it will be that counseling services are failing to offer testing to all women. Interventions to improve the quality of services within the health system need to be matched by initiatives to increase the demand for services. Simplification of protocols and methods to monitor and improve local performance will help.

Although the magnitude of these tasks seems overwhelming, especially knowing the physical and human resource constraints that prevail in many countries, quality improvement methods[15] and other innovations such as task shifting[16] can yield significant benefits relatively quickly. However, unless strategies to improve PMTCT delivery are energetically and resolutely pursued, then ARVs will remain in cupboards. Such interventions would not just improve PMTCT services but could strengthen essential maternal and child health services and related health information systems.

The 2008 World Health Report[17] calls for reforms so that health systems contribute to health equity, social justice,

TABLE 1. *HIV Transmission Rates in Infants At 6 Weeks According to Intervention Delivered by Health System Functioning at Different Levels of Performance*

	Intervention				
12345 6					
System Efficiency (%)	No intervention (%)	sdNVP (%)	AZT/sdNVP 2-Tier or ART (%)	sdNVP 2-Tier or ART (%)	AZT/sdNVP 2-Tier ARV + ART (%)	Triple
100	25	11.5	4.1	8.7	2.9	1
95	25	12.8	6.1	9.4	4.1	3.8
90	25	14.1	8.1	10.3	5.3	4.8
80	25	16.4	11.6	12.1	8.0	6.8
60	25	20.1	17.5	16.4	14.0	11.2

This model assumes 100% ANC attendance and ART initiated when CD4 count ,200 cells per milliliter.

and the end of exclusion; reforms that acknowledge the complexity of contemporary health systems as they strive to secure healthier communities. This call could not be more timely or appropriate when considering the urgent need to reduce HIV infections and mortality in infants and mothers in southern Africa. Reform means changing the way things are done—not simply exhorting these countries to ‘‘try harder’’ using current strategies. If mothers and infants in the countries most heavily afflicted by the HIV epidemic are to gain the benefit of interventions that have almost eradicated HIV transmission in the North, then immediate and exceptional efforts are needed to harness methods that could improve the quality and reliability of services delivered.

REFERENCES

1 Paintsil E, Andiman WA. Update on successes and challenges regarding mother-to-child transmission of HIV. Curr Opin Pediatr. 2009;21:94–101.

2 Rollins N, Little K, Mzolo S, et al. Surveillance of mother-to-child transmission prevention programmes at immunization clinics: the case for universal screening. AIDS. 2007;21:1341–1347.

3 WHO. Towards Universal Access: Scaling up Priority HIV/AIDS Interventions in the Health Sector. Geneva, Switzerland:/UNAIDS/ UNICEF; 2008.

4 WHO. Antiretroviral drugs for treating pregnant women and preventing HIV infection in infants in resource-limited settings. Towards universal access. Recommendations for a public health approach. 2006. Available at: http://www.who.int/hiv/pub/guidelines/en/index.html. Accessed November 10, 2010.

5 Nkonki LL, Doherty TM, Hill Z, et al. Missed opportunities for participation in prevention of mother to child transmission programmes: Simplicity of nevirapine does not necessarily lead to optimal uptake, a qualitative study. AIDS Res Ther. 2007;4:27.

6 UNICEF. Evaluation of United Nations-supported pilot projects for the prevention of mother-to-child transmission of HIV. Available at: http:// www.oecd.org/dataoecd/22/14/35160441.pdf. Accessed March 6, 2009.

7. Manzi M, Zachariah R, Teck R, et al. High acceptability of voluntary counselling and HIV-testing but unacceptable loss to follow up in a prevention of mother-to-child HIV transmission programme in rural Malawi: scaling-up requires a different way of acting. Trop Med Int Health. 2005;10:1242–1250.

8. WHO. Towards Universal Access. Scaling up Priority HIV/AIDS Interventions in the Health Sector. Progress report. Geneva, Switzerland: WHO/UNAIDS/UNICEF; 2009.

9. Stover J, Johnson P, Zaba B, et al. The Spectrum projection package: improvements in estimating mortality, ART needs, PMTCT impact and uncertainty bounds. Sex Transm Inf. 2008;84;i24–i30.

10. Halima D, Mofenson LM, Ekpini R, et al. International recommendations on antiretroviral drugs for treatment of HIV-infected women and prevention of mother-to-child HIV transmission in resource-limited settings: 2006 update. Am J Obstet Gynecol. 2007;197(3 suppl): S42–S55.

11. South African Health Review, Health Systems Trust, 2004 Data. Available at: http://www.hst.org.za/healthstats/92/data. Accessed April 23, 2009.

12. Day C, Barron P, Monticelli F, eds.The District Health Barometer 2007/ 08. Durban: Health Systems Trust; 2009.

13. South African National AIDS CouncilHIV & AIDS and STI National Strategic Plan for South Africa 2007-2011. Pretoria, South Africa: SANAC; 2007.

14. WHO. Antiretroviral Drugs for Treating Pregnant Women and Preventing HIV Infection in Infants: Towards Universal Access. Recommendations for a Public Health Approach. Geneva, Switzerland: WHO; 2010. Available at: http://www.who.int/hiv/pub/mtct/antiretroviral 2010/en/index. html. Accessed September 17, 2010.

15. Barker PM, McCannon CJ, Mehta N, et al. Strategies for the scale-up of antiretroviral therapy in South Africa through health system optimization. J Infect Dis. 2007;196(Suppl 3):S457–S463.

16. Zachariah R, Ford N, Philips M, et al. Task shifting in HIV/AIDS: opportunities, challenges and proposed actions for sub-Saharan Africa. Trans R Soc Trop Med Hyg. 2009;103:549–558.

17. WHO. The World Health Report 2008. Geneva, Switzerland: WHO. Available at: http://www.who.int/whr/2008/en/index.html. Accessed March 6, 2009.

Pierre Barker

Senior Vice President,
Low and Middle Income Countries Program,
Institute for Healthcare Improvement (IHI)
USA

Pierre Barker, MD, MBChB serves as the Senior Vice President for the Low and Middle Income Countries program within the Institute for Healthcare Improvement (IHI). He is also a pediatric pulmonologist and Professor of Pediatrics at the University of North Carolina at Chapel Hill, where he held many practice and research positions before joining IHI. Dr. Barker has a broad background in the design, execution, evaluation and leadership of programs that use quality improvement methods. As Medical Director of the University of North Carolina at Chapel Hill (UNC) Children's Hospital outpatient services, he led a large scale re-organization of patient care programs, using Quality Improvement (QI) approaches and subsequently led a health-system-wide sub-specialty access initiative for state-wide referrals. In 2004, Dr. Barker used a sabbatical year to test QI approaches to improve access to ARVs for South Africa's emerging HAART program, and that work initiated an Africa-wide multi-country program that he now leads for IHI. His 10 year background in leading NIH-funded basic science research (prior to 2002) provided him with a strong foundation in an array of scientific methods, and he now works closely with the research and development unit at IHI to design innovative approaches to implementation and evaluation of health programs. Dr. Barker earned his MBChB degree and his MD from the University of Cape Town in South Africa.

Kalipso Chalkidou

Director
National Institute for Health and Clinical Excellence
United Kingdom

Kalipso Chalkidou, is the founding director of NICE's international programme, helping governments build technical and institutional capacity for using evidence to inform health policy. She is interested in how local information, local expertise and local institutions can drive scientific and legitimate healthcare resource allocation decisions. She has been involved in the Chinese rural health reform and also in national health reform projects in Colombia, Turkey and the Middle East, working with the World Bank, PAHO, DFID and the Inter-American Development Bank as well as national governments.

She holds a doctorate on the molecular biology of prostate cancer from the University of Newcastle (UK), an MD (Hons) from the University of Athens and is an honorary senior lecturer at the London School of Hygiene and Tropical Medicine (UK), a senior advisor on international policy at the Center for Medical Technology Policy (USA) and visiting faculty at the Johns Hopkins Berman Institute for Bioethics. Between 2007 and 2008, she spent a year at the Johns Hopkins School of Public Health, as a Harkness fellow in Health Policy and Practice, studying how comparative effectiveness research can inform policy and US government drug pricing policies.

Gerard La Forgia

Lead Health Specialist
The World Bank
USA

Gerard La Forgia is a Lead Health Specialist at the World Bank, currently assigned to the South Asia Region. He specializes in health finance and management. His major areas of interest and research are hospital governance and management, quality of care, performance-based financing, health insurance, and public-private partnerships for health service delivery. He has worked in these areas in Afghanistan, Argentina, Belize, Brazil, China, Colombia, Dominican Republic, Ecuador, El Salvador, Guatemala, India, Maldives, Mexico, Nicaragua, Panama, South Africa and Uruguay. Gerard has maintained an active agenda in research, evaluation and policy analysis, and has made an effort to publish in refereed journals or Bank publications. His most recent publications include a book (2008) and articles (2009; 2011) on hospital performance in Brazil. He is currently working on a book on health insurance in India. He formally was a Research Associate at the Urban Institute and a Senior Health Specialist at the Inter-American Development Bank. He has a Sc.D degree in Health Service Administration from the University of Pittsburgh.

Mei-Shu Lai

Professor
College of Public Health,
National Taiwan Univesity
Taiwan

Mei-Shu, M.D., MPH, Ph.D., received her undergraduate training in Medicine at National Taiwan University, School of Medicine. During 1975-79. She was a resident in Department of Internal Medicine in the National Taiwan University. In 1979 she moved to Pittsburgh to train in hepatitis research and got her MPH degree in University of Pittsburgh, USA. She also finished her Ph.D. degree in Epidemiology in Taiwan. From 1982-1987 She practiced as lecture and staff physician in Department of Family Medicine, school of Medicine, National Taiwan University.

Since 1989 she devoted to national policy work as administrator in National level Department of Health. At the beginning her main job was focused on Health Promotion Project, especially the tobacco control act was promulgated in 1997. She served as CEO and president of Bureau of National Insurance during 1998-2001. She lead the global budget scheme and insurer IC card to implement and designed the pay-for-performance payment scheme.

Dr. Lai's research has been devoted to the study of quality cancer care and safety of drug utilization since 2002 back to the College of Public Health, National Taiwan University where she is currently professor of Epidemiology and Preventive Medicine.

She was appointed as principle investigator of 3 year 2nd generation reform of National Health Insurance plan in 2002. By her study and planning is now being applied to our new National Health Insurance Law in 2011. She focused on equal access to quality of care after original objective in equal access to health care. Besides the health indicators, healthcare core measure in cancer care was first designed and adapted by National accreditation program. By now performance indicators is quite a concept and system to overview the quality in Taiwan. Through her effort, transparency to the public of those indicators is published on the web periodically since 3 years ago.

From April 2010-December 2011 she was appointed as Chairperson, Taiwan National Advisory Council for Healthcare Quality and Policy. By setting the roadmap, there is going to publish a White Paper on National Healthcare Quality and Disparity on February 2012.

Yogan Pillay

Deputy Director General
National Department of Health
South Africa

Dr. Pillay is the Deputy Director-General responsible for the following health programmes: HIV & AIDS, TB and MCWH. In addition, he is currently overseeing the strengthening of the district health system as well as communicable diseases, non-communicable diseases and nutrition programmes. He has recently co-authored the 'Textbook of International Health: global health in a dynamic world (with Drs Anne-Emanuelle Birn and Tim Holtz).

Anuwat Supachutikul

Chief Executive Officer
Healthcare Accreditation Institute
Thailand

Dr.Anuwat Supachutikul has been working with the Thai Hospital Accreditation (HA) program since 1997. The program started as a pilot project under the Health Systems Research Institute (HSRI) and then institutionalized to be a Public Organization, one form of independent state agencies, in 2009. He also chairs the Technical Subcommittee of the Thailand Quality Award Program, be a member of the Medical Committee of the Social Security Scheme and a member of the Quality and Standard Committee of the National Health Security Office.

He has a background as an orthopedic surgeon with experience in hospital management and information system. After receiving a master degree of Health Planning and Financing from LSHTM in 1992, he served the Health Card Project, a voluntary health insurance program, and then the HSRI. Experience of working with hospitals for quality improvement ranges from quality management, hospital standard development, to a full Hospital Accreditation program.

With the universal coverage program in 2001 that demanded access to quality of care nationwide, he proposed a stepwise recognition program to assist small hospitals with limited resources on the journey of quality. The results of recognition and accreditation are used by 2 major 3rd party payers, i.e. The Social Security Office and The National Health Security Office, to create incentive for quality improvement.

He uses the concept of accreditation as an educational process rather than inspection, evaluation with appreciation for empowerment and improvement. The standard for accreditation combines requirements of healthcare organization standards with health promotion concepts and quality of management according to the Thailand Quality Award criteria.

He advocates the science of improvement to the context of Thailand and eastern wisdom, especially spiritual dimension of healthcare and improvement. He also seeks effective tools for hospitals to improve their quality and safety, for example, patient safety goals, the use of triggers to identify adverse events, human factor engineering, lean concepts in healthcare, KPI comparison among hospitals with the same context.

Parallel Session 4.5

Ageing populations:
What challenges for health financing?

Healthcare financing system for the elderly; Lessons from Japan's eclecticism policy

By Hideki Hashimoto, MD DPH.
Professor in health economics and epidemiology research
University of Tokyo School of Public Health

Corresponding to; 7-3-1 Hongo, Bunkyo-ku
Tokyo, 131-0033, Japan
Phone; +81-3-5841-1887
Fax; +81-3-5841-1888
E-mail; hidehashimoto-circ@umin.ac.jp

1. Introduction

Financing healthcare and long-term care in the face of population ageing and stagnated economy is a common challenge to health policies in developed and developing countries today. Controversies have been over dichotomies such as private vs. public, social insurance vs. tax base, family vs. state, and contract-base vs. market driven system. Japan is in the very front of this policy choice; its proportion of population 65+ already reaches 23% as of 2010, economy has been for long stagnated with increasing financial deficit. In spite of this, Japan provides healthcare at relatively low cost, and enjoys one of the longest life-expectancy and health-adjusted life years over the globe. Japan has been seeking its policy solution in the ad hoc mix of dichotomies under a long lasted administration by then conservatism party, which as I argue later in this paper did help Japan's equity system. However, this eclecticism policy only allows incremental reform in the system, resulted in recent challenge of deadlock in financial difficulties and eroding equity. By presenting Japan's experience, this paper will argue that discussion for healthcare financing in aged society needs go beyond dichotomies and should seek for solution in ageless scheme of policy.

2. Japan's choice

Japan started its public healthcare coverage through social insurance system in 1927, gradually expanded its coverage until it finally achieved universal coverage in the year of 1961. Since then more than 3000 public insurers covered its population, which were largely categorized into community-based insurers driven by municipal government and firm-based insurers by company affiliated NPOs for large business and by the central government for small business (since 2008, it was transferred to prefectural NPOs)(Ikegami,et al., 2011). Premium rates are varied across insurers within the range that the central government decides, while reimbursement price to providers are strictly standardized by the central government. Service benefit generously covers

outpatient, inpatient, pharmaceutical, rehabilitation, and dental services, and is also common across insurers.

At the time of universal coverage introduction, benefit rate was only 50% except for employees who enjoyed 100% benefit until 1984. Community based insurance, which covered self-employed, their dependent family, and the retired in the community, had limited premium revenue due to low income status of beneficiaries, and could cover only a half of the whole expense. In fact, the community-based insurance has never been actuarially-fair since its beginning until today. Instead, the central government subsidized community-based insurance with transfer from tax revenue.

During late 60s and early 70s, backed up by ever booming economy and increasing tax revenue, political dispute between then leading conservative party and the opposition socialist party sought for generous welfare program as a critical election campaign (Shinmura, 2011). The government gradually expanded the benefit rate from 50% to 70% by the year of 1973. In the same year, medical care for the elderly aged 70 and over became free of charge with government subsidy, and another new subsidy program to compensate for catastrophic copayment over limit according to household income was introduced. This naturally resulted in drastically rapid increase in medical care utilization and expenditure by the elderly. However, since the world economy went into uncertainty since late 70s, the government regarded skyrocketing healthcare expenditure as financial threat to the nation's economy. In 1983, the government changed the policy by introducing a new elderly medical care system in which the elderly was asked to pay fixed copayment per visit and hospital day. Since the contribution by copayment was quite limited, the elderly care was financed by half from central and local government general revenue, and for the rest by pooled contribution from public insurers. The system repeated amendment by raising copayment rate to control over excess utilization due to ex post moral hazard, which is currently set at 10% for lower income household, and up to 30% for high income elderly household. In spite of this, the medical care expenditure per capita among those aged 65 and over is 4 times larger than that of younger beneficiaries. The government further amended to introduce premium contribution from the elderly themselves, and discriminating payment to elderly care since 2009, though political dispute accusing of "ageism policy" prevents its full implementation until today.

During 90s after bubble economy collapse, the government's health sector successfully contained the growth of healthcare expenditure at the level of GDP growth by macro and micro cost control (for details, see Ikegami & Campbell, 2004), though decreased tax revenue due to decreased wage rate pushed the government's financial sector to serious concerns against relatively increasing burden of tax transfer to healthcare.

During the same period, another theme on the political table was the introduction

of public long-term care system. Care for the frail elderly had long been dependent on informal care by family, based on Confucianism norm of traditional family system and seniority culture (Campbell and Ikegami, 2000). Otherwise, municipal governments provided free homecare and institutionalized care through welfare program selectively to those household with limited income and capacity for informal care provision. Demand for private provision of formal care had been limited due to its high price for middle income households. Instead, post-acute inpatient services in medical institutions, which were covered by public medical insurance, were often used as default nursing homes, leading to long length of stay and increasing medical expenditure.

In the late 80s, then leading conservative party launched a new program to extend the provision of long-term care to middle to high income household as an election campaign, though the program was poorly planned and standardized for wider implementation. This led to a national debate over public system for long-term care provision. Then ministry of health used this opportunity to shift long-term care component of medical care to long-term care payment scheme with lower price, and introduced a new "social insurance" to raise a financial source because tax raise was not a politically feasible choice (Campbell and Ikegami, 2000).

The public mandate Long-term Care Insurance (LTCI) has been launched since 2000, which has been operated by municipal government insurers with different community premium rates under a nationwide standardized benefit package and service price. Beneficiaries, once approved as eligible for care, could purchase any combination of services up to monthly limit with 10% copayment. Again, the LTCI is not an actuarially fair insurance, but is financed by half from tax revenue of local and central governments.

Japanese LTCI provides service provision only, without cash benefit to informal caregivers, to the contrast to Germany system where cash allowance is widely used. There was a debate against the introduction of cash allowance in 90s, both by left and right wing political parties; the left opposed cash allowance because it would oblige women with lower wage rate to give informal care at home, while the right criticized that allowance would disregard and spoil the tradition of family system based on Confucianism norm s of care for fragile parents. While Germany system provides an incentive for informal care provision, Japanese system complements informal care with formal care. In other words, Japanese system already presumes informal care provision by household (Tamiya, et al. 2011).

Since the introduction of LTCI, the growth of the official "medical expenditure" has been suppressed, suggesting successful transfer of medical expenditure to LTCI service scheme. However, introduction of LTCI fueled the demand for LTC in middle

to high income households that have been out of coverage by previous welfare LTC program, resulting in rapid and drastic increase in LTC expenditure of itself since its introduction (Tamiya, et al. 2011). In 2006, the government amended benefit conditions to exclude those with mild care needs, though the growth of care demand could not be under control until today.

3. Consequence of explicit finance mechanism for elderly care in Japan

As mentioned, Japan's healthcare financing comprises an ad hoc mixture of social insurance and tax. Despite of income regressive nature of out-of-pocket payment, social insurance premium, and indirect tax, progressiveness of direct tax balanced it, resulting in fair contribution to healthcare spending for household's ability to pay (Ikegami, et al., 2011 web appendix). However, ad hoc mixture of tax and social insurance makes it difficult to drastically amend the system when tax subsidy becomes no longer feasible after economic stagnation.

Decreased copayment rate for elderly medical care has contributed to almost perfect horizontal equity in access to care (Watanabe and Hashimoto, 2011). Recent study further identified that decreased copayment rate significantly and positively impacted physical and mental health of the elderly (Nishi, et al. 2011).

Introduction of LTCI evoked a rapid increase in LTC demand, especially in middle-high income households (Tamiya, et al., 2011). Recent analysis using propensity-matched difference-in-difference approach using pre-post cross-sectional nationwide datasets did not reveal significant change in health and functional status of care recipients and care givers. Instead, the analysis identified a significant increase in the likelihood of labor participation by female care givers, and decrease in hours for informal care giving, again the trend was most obvious in high-income households (Tamiya, et al., 2011).

4. Lessons from Japan; finance of elderly healthcare

Decreased tax revenue and consequently increased burden to government financial status becomes even more problematic today. The current cabinet and leading party announced to raise the rate of consumption tax from current 5% to 10% in 3 years, and to introduce negative tax to compensate for increased burden in lower income household. However, the introduction of earmarked tax may not necessarily stabilize the finance of expanding social security due to population ageing. Besides, ad-hoc introduction of indirect tax may further complicate and break the currently achieved balance of financial contribution.

Since increasing public transfer from tax revenue becomes less feasible, remained choice may be the shift to more dependence on social insurance premium contribution, which is also not politically feasible before a large interest party of elderly population, as well as large business that must pay for employer's contribution to the public

insurance. It is not technically plausible either, because pay-as-you-go nature of social insurance system burdens younger generation who recently tend to refuse mandate contribution, with less trust in sustainability of the public insurance.

Private purchasing of private insurance to cover healthcare is another choice. However, since the risk of elderly healthcare is naturally high on average, and is extremely varied and unpredictable across individuals with different genetic, socioeconomic, and functional conditions, risk pool equilibrium will not be obtainable without reliable risk information (Stiglitz and Rothschild, 1976). Finally, private saving and/or mandated saving such as Medisave come up to the choice list, though balance with financial equity will be a key challenge.

Since any choice of financing mechanism seems difficult, price and volume control over elderly healthcare is imperative. Again, Japanese recent failure to introduce discriminating payment scheme and increased copayment rate specifically for elderly shows ageism policy is hardly accepted by the population, especially with seniority culture tradition.

These Japanese lessons suggested there is no definitely best combination of dichotomy policy choice for financing elderly healthcare, as long as it is debated in the context of "elderly care" policy making. The best mix is dependent on the value attached to healthcare among the people in the country. Intergenerational conflicts emerging in the national debate over elderly care financing will not reach a political solution. The risk of healthcare use is diverse even among the elderly. This new challenge must be solved as a problem of risk pooling under information uncertainty, shifting to ageless scheme. The solution should be sought for improvement of risk information and risk pool management, and purchasing efficiency.

References:

- Campbell JC, Ikegami N.(2000) Long-term care insurance comes to Japan. Health affairs (Project Hope). May-Jun;19(3):26-39.
- Ikegami N, Campbell JC.(2004) Japan's health care system: containing costs and attempting reform. Health affairs (Project Hope). 23(3):26-36
- Ikegami N, Yoo BK, Hashimoto H, Matsumoto M, Ogata H, Babazono A, Watanabe R, Shibuya K, Yang BM, Reich MR, Kobayashi Y.(2011) Japanese universal health coverage: evolution, achievements, and challenges. Lancet. Sep 17;378(9796):1106-15.
- Nishi A, McWilliams JM, Noguchi H, Hashimoto H, Tamiya N, Kawachi I.(2012) Health gains from lower patient cost sharing: Japan's health insurance natural experiment. Manuscript prepared for submission.
- Rothschild M, Stiglitz J. Equilibrium in competitive insurance market; an essay on the economics of imperfect information.(1976) QJE 90(4);629-849.
- Shibuya K, Hashimoto H, Ikegami N, Nishi A, Tanimoto T, Miyata H, Takemi

K,Reich MR.(2011) Future of Japan's system of good health at low cost with equity: beyond universal coverage. Lancet. Oct 1;378(9798):1265-73.
- Shinmura T.(2011) The Era of Universal Coverage (Kokumin Kai Hoken no Jidai) Hosei University Press, 2011
- Tamiya N, Noguchi H, Nishi A, Reich MR, Ikegami N, Hashimoto H, Shibuya K, Kawachi I, Campbell JC.(2011) Population ageing and wellbeing: lessons from Japan's long-term care insurance policy. Lancet. Sep 24;378(9797):1183-92.
- Watanabe R, Hashimoto H.(2010) Horizontal inequity in healthcare access under the universal coverage in Japan; 1986-2007. Paper presented at Annual Meeting of the Japanese Health Economics Association.

Aging Populations: What challenges for health financing? Focus: Long Term Care in Germany

By Dr. Christian Peters

The beginning of the development of Germany's social security systems for the coverage of health related risks dates back to the year 1883, when health insurance became mandatory for employees nationwide. The newly introduced "statutory health insurance" covered hospital and out-patient treatment, drugs, support of women in childbed and death benefits. Benefits in kind and cash payments were financed by proportional contributions from mandatory and voluntary members (1/3) and their employers (2/3). After many changes in the course of the history of this insurance, the contribution for 2011 has been appointed to 15.5% of the insured's gross income, with employees contributing 8.2% and employers adding 7.3%.

In addition a compulsory accident insurance, introduced in 1885, covers medical treatment, preventive measures and salary compensation for employees in case of job related accidents. This compulsory accident insurance is funded solely by employers on the basis of a supplementary allocation procedure whereby the amount of the contribution is calculated based on the employee's salary as well as on a "danger level", into which the company or organisation has been classified.

In 1995, the "long term care insurance" was introduced in Germany. Until then, long term care (LTC) had been financed either privately or through tax-funded public welfare institutions. The introduction of the new insurance was preceded by intensive political and public discussions over the key question whether the new insurance should be fully funded, based on coverage capital, or if it should operate with pay-as-you-go funding. A fully-funded system was regarded to be more sustainable considering the background of Germany's specific demographic challenges, but on the other hand some stakeholders argued that a pay-as-you-go approach promised to be more stable against long-term cycling developments on the fiscal markets. The public authorities had been responsible for major parts of LTC financing up and until 1995. Since pay-as-you-go financing guaranteed a faster relief for the public sector, this eventually became the basic principle of the new LTC insurance. Entrepreneurs claimed for a private mandatory LTC, whereas labour unions and social associations favoured an LTC insurance model that would follow the principles of a shared premium, corresponding to the example of Germany's statutory health insurance. After an intensive, controversial debate, the new LTC insurance was set up as a system of equal contributions from both employees and employers. As of

July 1st 1996, the total contribution rate was set to 1.7% (employers/employees: 0.85% respectively) of the employee's gross income. As a compensation for the employers, a religious national holiday was disestablished.

Germany's LTC insurance covers assistance for all assured who become dependent on support and the degree of assistance depends on the degree of the individual's need for support. The assistance depends upon the degree of individual need of nursing care and is granted for each case either by payment of a cash entitlement in cases of voluntary, honorary care or by assumption of the care costs as soon as professional ambulatory or partly in-patient care are involved. The costs for care aides and residential environment-improving measures are covered as well. The carriers of the LTC insurance are the LTC insurance funds, which were established within the statutory health insurance companies. However, they fulfil their tasks in own responsibility as legally responsible public corporations. All members of the statutory health insurance are insured by the LTC insurance by law (approx. 92% of the German population). The members of a private health care insurance have to close a separate contract for an LTC insurance scheme offered by their health insurance company.

Benefits from the LTC insurance are only granted upon request. As soon as an insurant's application for LTC insurance benefit is filed, the LTC insurance assigns the medical service of the health insurance in order to determine the degree of care needed as well as its expected expenditure in detail – usually by a house call from a consultant. The consultant determines the time requirements for personal care (hygiene, nutrition, mobility) as well as for domestic help. National guidelines define the time requirements for each individual activity in comparison with a virtual "average citizen". Based on the estimated need for nursing care, the consultant determines a certain "level of care" according to national guideline standards:
Care level I – Considerable need of nursing care (need for help for 90 min per day)
Care level II – Severe need of nursing care (need for help for 180 min per day)
Care level III – Massive need of nursing care (need for help for 300 min per day and night)

If the need for nursing care exceeds care level III, the LTC insurance may grant in-patient care at a nursing home. In 2009, the "advisory board of the Federal Ministry of Health to review the concept of care dependency in the long term care insurance" suggested to change the system for measuring the need of nursing care from a time-based towards a points-based system, in order to better express the individual level of disability of the patient [1]. The result would be a scale of five "levels of need": an approach which has not been implemented so far.

The German Federal Ministry of Health publishes a triennial "Report on the Development of Long Term Care Insurance". The fourth issue of this report, in 2008, gave an overview on the development of nursing care mainly between 2004 and 2006 [2]. During that period, approx. 2.1 million insurants received grants out of the LTC insurance every month (1.4 m out-patient, 0.7 m in-patient care services). Less than 5% of patients, who had been granted out-patient care and no more than 25% of all patients of nursing homes had to claim for additional support from public social welfare institutions. Since the implementation of the LTC insurance in 1995, about 300,000 jobs have been created in the course of the development of nursing infrastructure. An annual amount of approx. 900 million Euro have been spent for more than 450,000 insurants in 2004, 2005 and 2006. In that report the ministry suggested an increase of the contribution to the LTC insurance by 0.25% and referred to the 11. "Coordinated Population Development Forecast", issued by the Federal Statistical Office of Germany in 2006 [3]. In that forecast, life expectancy for male newborns is estimated to be 83.5 years in 2050 (10. forecast in 2003: 81.1 years), for female newborns 88.0 years (2003: 86.6 years). The average remaining life expectancy for 60-year-old men and women is expected to increase by 5 years until 2050 (men: 25.3 years, women: 29.1 years in 2050). Along with higher life expectancy, the proportion of the elderly population is continuously growing: The number of persons older than 60 years is expected to be 28.8 million in 2050, representing 38.9% of the population (2005: 20.5 million, 24.9% of the population).

With increasing age, the need for nursing care grows rapidly. According to the Fourth Report on the Development of LTC Insurance, only 0.6% of the people below the age of 60 years are in need for nursing care. This demand rises to 3.9% in the age group between 60 and 80 years, and it reaches of a total of 28.3% among persons older than 80 years [2]. In 2003, the "Commission for Financial Sustainability of the Social Security Systems" (aka "Rürup-Commission") estimated an increase of persons in need of nursing care from then 1.97 million in 2002 to 3.4 million in the year 2040 [4]. Although demographic development has been identified as the main factor for the number of persons in need of care, the Fourth Report on the Development of LTC Insurance considered a long-term financial prognosis uncertain and arguable.

With the "Long-Term Care Further Development Act" of 2008, the contribution for the LTC insurance was set to 1.95% of the employee's gross income (persons without children: 2.2%) to safeguard financing until late 2014. Until 2030, the contribution is expected to increase to 2.3% of the individual gross income. A simulation calculation of the German Council of Economic Experts estimated the contribution with 2.5% in the year 2050 [5].

Against this background, the German government discusses a general reform of financing the LTC insurance. Although the coalition agreement of the governing parties ascertains the need for a complimentary capital cover to the existing pay-as-you-go principle, which would have to be obligatory, individually adjustable and fair for all generations–until now there have been no activities in this direction.

Reference

1 Bundesministerium für Gesundheit/Federal Ministry of Health: Beirat zur Überprüfung des Pflegebedürftigkeitsbegriffs/Advisory Board to review the concept of care dependency in the long term care insurance: Bericht/Report. Berlin, 2009

2 Bundesministerium für Gesundheit/Federal Ministry of Health: Vierter Bericht über die Entwicklung der Pflegeversicherung/Fourth Report on the Development of Long Term Care Insurance. Berlin, 2008

3 Statistisches Bundesamt/Federal Statistical Office of Germany: 11. koordinierte Bevölkerungsvorausberechnung/11. Coordinated Population Development Forecast. Wiesbaden, 2006.

4 Bundesministerium für Gesundheit und Soziale Sicherung/Federal Ministry of Health and Social Security: Kommission für die Nachhaltigkeit in der Finanzierung der sozialen Sicherungssysteme/Commission for Financial Sustainability of the Social Security Systems: Bericht/Report. Berlin, 2003

5 Sachverständigenrat zur Begutachtung der gesamtwirtschaftlichen Entwicklung/ German Council of Economic Experts: Jahresgutachten 2008/09/Report 2008/09. Wiesbaden, 2008.

Daniel Cotlear

Lead Economist
The World Bank
USA

Daniel Cotlear is Lead Economist at the Health, Nutrition and Population Unit in the Human Development Network. He holds a PhD in Economics from Oxford University, a Master's Degree from Cambridge University and a Bachelor's Degree from the Catholic University of Peru. Prior to his current appointment, he was the Lead Economist at the World Bank's Human Development Department for Latin America and the Caribbean Region. Prior to that, within the World Bank he was Sector Leader for Human Development covering the Andean Countries. He has also served as health economist for Latin America, as macroeconomist in the Central America Department and as Agricultural Economist in the Southern and Eastern Africa Department. Before joining the Bank he was an advisor at the Ministry of Agriculture of Peru, university lecturer and author of several publications including a book on poverty reduction in the Peruvian Sierra.

Hideki Hashimoto

Professor

School of Public Health, University of Tokyo

Japan

Corresponding to;

7-3-1 Hongo, Bunkyo-ku
Tokyo, 131-0033, Japan
Phone; +81-3-5841-1887
Fax; +81-3-5841-1888
E-mail; hidehashimoto-circ@umin.ac.jp

Hideki Hashimoto, MD, DPH is currently the professor in health economics and epidemiology research at the University of Tokyo School of Public Health, where he teaches methodology and theories on clinical epidemiology and health services research. He received his MD in the Graduate School of Medicine at the University of Tokyo, and his DPH in Harvard School of Public Health. His research interests cover technology assessment of healthcare, its impact on quality of life in chronically ills, evaluation of health systems performance, and socio-economic determinants of health and health equity. He is a certified internist and cardiologist in Japan. He serves as a technical advisor for the Statistics Committee in the Japanese Ministry of Internal Affairs and Communication. He recently joined the project of Japan Series in the Lancet issued in September 2011, as a co-lead author and coauthor in 4 papers, where the politico-historical analysis of universal coverage on medical care since its introduction in 1961, and empirical analysis on its achievement were presented with reform proposal. He also joined as a medical-epidemiological specialist the Japanese Study on Ageing and Retirement, which is a sister panel survey with U.S. Health and Retirement Study (HRS), England Longitudinal Survey on Ageing (ELSA), and Survey on Health, Ageing, and Retirement in Europe (SHARE). He is the primary investigator of the Japanese study on Stratification, Health, Income, and Neighborhood (J-SHINE), a panel study on younger generation and their spouses and children to elucidate physiological and social mechanism of socioeconomic conditions onto health inequity. He is an active member of Asian Pacific Health The Global Action for Health Equity Network (HealthGAEN) led by Prof. Sharon Friel at Australian National University, which is an global alliance for health equity through action on the social determinants of health to build on the momentum, expertise and partnerships generated through the WHO Commission on Social Determinants of Health (CSDH).

Photo attached.

Ajay Mahal

Alan & Elizabeth Finkle Chair of Global Health and Professor
School of Public Health
Monash University
Australia

Dr. Mahal is the Alan and Elizabeth Finkel Chair of Global Health and Professor at Monash University in Melbourne (Australia) and an Adjunct Associate Professor of International Health Economics at Harvard University. Until August of 2010, he was an Associate Professor of International Health Economics in the Department of Global Health and Population at the Harvard School of Public Health. Dr. Mahal holds degrees from Columbia University (Ph. D in Economics, 1995) and the University of Delhi (M.A. (Economics), 1986; B.A. (Economics), 1984). Prior to his appointment at Harvard, Dr. Mahal was a senior researcher at the National Council of Applied Economic Research (NCAER) in New Delhi, a non-government household survey and economics research organization. Dr. Mahal's research has focused on a range of economically relevant questions pertaining to household impacts of health, HIV, ageing, human resources for health and human rights, with a specific focus on India although much of his recent work has been on the financing of health systems. His experience on international health systems practice has included (a) being a resident advisor to the Ministry of Health of the Palestinian Authority (1996-98); (b) being a technical advisor to the Indian National Commission on Macroeconomics and Health (2004); and (c) participating as a key member in donor funded health sector reform projects in the state of Andhra Pradesh, India. He has, in addition, experience in working on health economics and policy research projects in Bangladesh, Botswana, Dominican Republic, Guatemala, Jamaica, Nigeria, Sri Lanka and Ukraine. He has been a consultant to the World Bank, the WHO, the UNDP, the ADB, UNCTAD, and a number of other government and non-government organizations.

Christian Peters

Head of the Department for Ambulatory Care
Federal Association of AOK
Germany

Dr. Christian Peters, MBA, is head of the Department for Ambulatory Care of the Federal Association of AOK – German Local Health Insurance Funds, Berlin.

He was born in 1970 in the city of Spremberg. Dr. Peters studied human medicine at the University of Leipzig and the Humboldt University of Berlin and received his MD from the Martin Luther University of Halle-Wittenberg after collecting practical medical experience at hospital departments for surgery and intensive care in Potsdam and Berlin.

From 2002 to 2008, he held various positions as a registered manager at the Berlin-based company ID, which develops and distributes DRG groupers, coding systems, hospital management information systems and semantic terminology servers for the German, Swiss and Austrian health care systems. In 2004, Dr. Peters received his MBA from the Danube University Krems on behalf of the Fresenius University Foundation for Healthcare Management.

Dr. Peters' professional interests focus on health economics and politics, medical reimbursement systems, contracting and health care financing.

Parallel Session 4.6

Giants Racing Towards UHC:
Health Financing Reforms in China and India

Robert Hecht

Managing Director
Results for Development Institute
USA

Robert Hecht joined Results for Development in April 2008, and is currently managing a growing portfolio of projects analyzing policy barriers and solutions related to AIDS and health financing and improving R&D and access to new health technologies in developing countries.

Before coming to Results for Development, he spent four years as vice president for Policy and Advocacy at the International AIDS Vaccine Initiative. Prior to this, he had a 20 year tenure at the World Bank, where he occupied a number of senior posts including manager of the Bank's central unit for Health, Nutrition, and Population, with oversight for global strategies, knowledge, technical services, and partnerships; chief of operations for the Human Development Network; principal economist in the Latin America region, and member of the core team and a lead author of the 1993 World Development Report, "Investing in Health." From 1987 to 1996, he was responsible for World Bank sponsored studies and projects in health in Africa and Latin America, most notably in Zimbabwe and Argentina.

He served as a director of the Joint United Nations Program on HIV/AIDS (UNAIDS) from 1998 to 2001, where he managed technical units based in South Africa, Cote d'Ivoire, and Thailand, as well as in Geneva. He led UNAIDS efforts to portray AIDS as a development and poverty issue impacting a wide range of social and economic goals, and published a number of papers advancing this view.

He is the author of more than 50 articles and other publications. He received his undergraduate degree from Yale and his doctorate from Cambridge University.

K. Srinath Reddy

President

Public Health Foundation

India

Prof. K. Srinath Reddy is presently President, Public Health Foundation of India (PHFI) and formerly headed the Department of Cardiology at All India Institute of Medical Sciences (AIIMS). He has recently been appointed as the First Bernard Lown Visiting Professor of Cardiovascular Health at the Harvard School of Public Health and is also an Adjunct Professor of the Rollins School of Public Health, Emory University. PHFI is engaged in capacity building in Public Health in India through education, training, research, policy development, health communication and advocacy.

Having trained in cardiology and epidemiology, Prof. Reddy has been involved in several major international and national research studies including the INTERSALT global study of blood pressure and electrolytes, INTERHEART global study on risk factors of myocardial infarction, national collaborative studies on epidemiology of coronary heart disease and community control of rheumatic heart disease. Widely regarded as a leader of preventive cardiology at national and international levels, Prof. Reddy has been a researcher, teacher, policy enabler, advocate and activist who has worked to promote cardiovascular health, tobacco control, chronic disease prevention and healthy living across the lifespan. He edited the National Medical Journal of India for 10 years and is on editorial board of several international and national journals. He has more than 300 scientific publications in international and Indian peer reviewed-journals.

He has served on many WHO expert panels and chairs the Foundations Advisory Board of the World Heart Federation. He is a member of World Economic Forum's Global Health Board. He also chairs the Core Advisory Group on Health and Human Rights for the National Human Rights Commission of India. He is a member of the National Science and Engineering Research Board of Government of India. He is presently chairing the High Level Expert Group on Universal Health Coverage, set up by the Planning Commission of India. He also serves as the President, of the National Board of Examinations which deals with post-graduate medical education in India.

His contributions to public health have been recognized through several awards and honours. They include: WHO Director General's Award for Outstanding Global Leadership in Tobacco Control (World Health Assembly, 2003), Padma Bhushan (Presidential Honour, India, 2005), Queen Elizabeth Medal (Royal Society for Health Promotion, UK, 2005), Luther Terry Medal for Leadership in Tobacco Control (American Cancer Society, 2009), Membership of the US National Academies (Institute of Medicine, 2005), Fellowship of the London School of Hygiene and Tropical Medicine (2009), Fellowship of the Faculty of Public Health, UK (2009), Cutter Lecture (Harvard, 2006), Koplan Lecture (CDC, 2008), Gopalan Oration (2009), Ramalingaswami Oration (2010) and Paul sDudley White Lecture (AHA, 2010), Doctor of Science *(Honoris Causa)* by University of Aberdeen, Scotland (2011) and Dr. NTR Medical University (2011).

Mirai Chatterjee

Director of Social Security
Self Employed Women's Association (SEWA)
India

Mirai Chatterjee is the Director of the Social Security at Self-Employed Women's Association, (SEWA), a union of 1.3 million women workers in the informal economy. She is Chairperson of the SEWA-promoted National Insurance VimoSEWA Cooperative and the Lok Swasthya Health Cooperative. She is also a member of the National Advisory Council, appointed by the Prime Minister of India.

Mirai Chatterjee serves on the boards of several organizations, including the Public Health Foundation of India and Friends of Women's World Banking. She also serves on several advisory committees of the government, including a committee to develop universal health coverage, set up by the Planning Commission of India. She also advises the National Rural Health Mission.

She was the General Secretary of SEWA between 1997-1999. She was also a Commissioner in the WHO's Commission on Social Determinants of Health (2005-2008) and an advisor to the National Commission on Enterprises in the Unorganised Sector (2006-2007).

She has written several papers on women's health and development, social protection, child care, microinsurance and organising women for collective action.

Mirai Chatterjee has a B.A. from Harvard University and a Masters in Health Sciences from Johns Hopkins University, USA.

Wen CHEN

Professor of Health Economics
and Deputy Dean
School of Public Health, Fudan University
Shanghai, China

Professor CHEN received his Ph.D. from Shanghai Medical University in 1998 and completed research fellowship at School of Public Health, University of California at Berkeley from August of 2000 to May of 2001.

He also served as consultant for World Health Organization and World Bank programs, greatly contributing to HPSP Pilot research study in Ning Xia Hui Autonomous Region from March of 2008 till December of 2009, and World Bank AAA project from May to August of 2004.

Prof. Chen is often invited as investigator and advisor by national and municipal governments for various research programs in the field of Chinese healthcare system, national and provincial health insurance, pharmacoeconomics, pharmaceutical price regulation, national essential medicines policies, health financing, and etc. He had more than 70 publications on key international and Chinese health economics and management journals.

He is currently also lecturing in Fudan University with graduate courses on advanced health economics, health insurance, and health financing and health care reform.

John Langenbrunner

Lead Economist
The World Bank
USA

John ("Jack") Langenbrunner is a Health Economist with the World Bank with both research and operations experience. He currently coordinates the new Health Financing and Health Insurance Thematic Group within the Bank and will lead the Bank's Global Expert Team for Health Systems in 2011-2012.

Since 2008 he has worked on health financing issues and health insurance design and development issues mostly in mainland China, but also Mongolia, Philippines, Cambodia, Thailand and other East Asian and Pacific countries. Prior to that, Jack worked in Eastern Europe in the EU New Member States and in other countries such as Russia, Croatia, Azerbaijan, Kyrgzstan, and Kazakhstan. He has worked as well in selected countries in the Middle East on the development of health insurance including Saudi Arabia, Bahrain, Iran, and Egypt.

Jack's most recent book is "Financing Health Care in East Asia and the Pacific: Best Practices and Remaining Challenges," released in June and co-authored with Aparnaa Somanathan. He also has recently co-authored 2 books on Resource Allocation and Strategic Purchasing by insurers and other public and private organizations, and has authored or co-authored a number of papers related to this initiative. He also led the Bank's work on a manual for National Health Accounts for low and middle income countries. This so-called NHA "Producers Guide" was published in 2003.

Previous to his work at the Bank, Jack was with the US Health Care Financing Administration, a public health insurance program for over 80 million Americans. He later went in the early 1990s to the US Office of Management and Budget where he served on the Clinton Health Care Reform Task Force for the US White House.

Anne Mills

Vice Director for Academic Affairs
and Professor of Health Economics and Policy
London School of Hygiene and Tropical Medicine
United Kingdom

Professor Anne Mills is known globally for her contributions to health economics and health systems research. Following a long career as researcher and teacher at the London School of Hygiene and Tropical Medicine, she took up the position of Head of the Faculty of Public Health and Policy between 2006 and 2011, and recently became the School's Vice Director for Academic Affairs. She is Professor of Health Economics and Policy and holds degrees from the Universities of Oxford, Leeds and London.

Her research expertise is built on nearly 40 years' experience of the health systems of low and middle income countries, which started with a position as health economist in the Ministry of Health in Malawi between 1973 and 1975. Since joining the LSHTM in 1979, she has researched and published widely in the fields of health economics and health systems. Between 1990 and 2005 she directed the LSHTM's Health Economics and Financing Programme, which together with its many research partners, undertook an extensive programme of research focused on increasing knowledge of how best to improve health systems in low and middle income countries. Her main research contributions lie in the areas of health financing, including strategies for achieving universal coverage; the organisation of health systems including evaluation of contractual relationships between public and private sectors and related questions of the role of the private sector; economic analysis of disease control activities, especially with respect to cost-effectiveness analysis of malaria control interventions and scaling up of malaria control efforts; and economic analysis of maternal and child health programmes including tracking donor funding to such programmes in high burden countries.

Professor Mills has had extensive involvement in supporting capacity development in health economics in low and middle income countries, for example through supporting the health economics research funding activities of the WHO Tropical Disease Research Programme, and Chairing the Board of the Alliance for Health Policy and Systems Research between 1999 and 2009. She has taught generations of LSHTM masters' students, and more than 25 research degree students have completed their degrees under her supervision.

Professor Mills has advised multilateral, bilateral and government agencies on numerous occasions; acted as specialist advisor to the House of Commons Select Committee on Science and Technology's enquiry into the use of science in UK international development policy; was a member of WHO's Commission on Macro-economics and Health and co-chair of its working group 'Improving the health outcomes of the poor'; co-chaired one of the two Working Groups for the 2009 High Level Taskforce on Innovative Finance for Health Systems co-chaired by Gordon Brown and Robert Zoellick; and most recently chaired one of the two working groups for WHO's Commission on Accountability and Information for Women's and Children's Health. In 2006 she was awarded a CBE for services to medicine and elected Foreign Associate of the US Institute of Medicine. In 2009 she was elected Fellow of the UK Academy of Medical Sciences and received the Prince Mahidol Award in the field of medicine. She is President of the International Health Economics Association for 2012-2013.

Plenary Session 5

Ministerial Round Table:
Advancing UHC Agenda

Lincoln Chen

President
China Medical Board
USA

Lincoln Chen is President of the China Medical Board. Started in 1914, the CMB was endowed by John D. Rockefeller as an independent American foundation to advance health in China and Asia through strengthening medical education, research, and policy. Earlier at Harvard, Dr. Chen was the Founding Director of the Global Equity Initiative, the Taro Takemi Professor of International Health, and Director of the Harvard Center for Population and Development Studies. Dr. Chen also served as Executive Vice-President of the Rockefeller Foundation and Representative of the Ford Foundation in India and Bangladesh. Dr. Chen currently serves on the board of many UN, academic, alliance, and non-governmental organizations, including Chair of BRAC/USA. He is a member of the Institute of Medicine, the American Academy of Arts and Sciences, the World Academy of Arts and Sciences, and the Council on Foreign Relation. He is a graduate of Princeton University, Harvard Medical School, and the Johns Hopkins School of Hygiene and Public Health.

Enrique T. Ona

Secretary of Health
Department of Health
Philippines

Secretary Enrique T. Ona was born on June, 4 1939 in Sagay City, Negros Occidental. His parents hail from Pagadian City, Zamboanga del Sur where his father became the first Provincial Health Officer and his mother served as a puericulture nurse.

He graduated from medical school at the University of the Philippines in 1962. He further extended his medical and nephrology training abroad where he earned a medical license at the State of Massachusetts, USA.

Sec. Ona belongs to the DOH family having served as the Executive Director of the National Kidney and Transplant Institute (NKTI) from 1998 until his appointment on July 1, 2010 as the new health chief. He is recognized as one of the top surgeons in the field of vascular surgery and organ implantation. He is also a dedicated advocate of preventive nephrology in the country. He is currently the President of the Transplantation Society of the Philippines, a position he holds since 1989 and also the President of Maria Corazon Torres Javier Foundation from 2009 to present.

Because of his dedication and contribution to health, Secretary Ona has been the recipient of various prestigious awards including the Ten Outstanding Young Men (TOYM) awardees for Medicine in 1979, The Presidential Award of Recognition in Organ Transplantation in 2000 and the Outstanding Health Research Award by the Philippine Council for Health Research and Development presented last July 19, 2010.

It was during his residency abroad that he met his beloved wife, Dr. Norma Martinez, an equally successful and nationally renowned hematologist. They are blessed with four boys namely, Arsenio Kenneth, Enrique Stanley, Victor Gabriel, and Manolo Steven.

As a family man, Dr. Ona spends most of his time off at home playing with his grandson or indulging himself in a game of tennis or golf. Family and friends fondly call him Manong Ike, and they describe him as kind and generous.

NKTI staff describe the Secretary as a "strict but lenient chief." They recall that during his tenure at NKTI, he arrives between 8-9 am and leaves around 7 pm. At the end of the day he sees to it that everything is accomplished and every paper signed before leaving for home. "No stone is left unturned," they say.

With his job as Secretary of Health, he promises to develop action plans with measurable and verifiable targets for the next six years, including estimated annual resource requirements and performance benchmarks.

Peter Anyang' Nyong'O

Minister
Ministry of Medical Services
Kenya

PROF. PETER ANYANG' NYONG'O

B.A., Political Science and Philosophy (First Class Honors), Makerere University, Kampala, 1971
M.A., Political Science, University of Chicago, 1974
Ph.D., Political Science, University of Chicago, 1977
Minister for Medical Services
Afya House
Cathedral Road
P.O. Box 30016-00100
Nairobi, Kenya
Tel. 254-020-2271077
Fax.254-020-2719008
Mobile: +254-724-264703

Present Positions

- Minister for Medical Services, Government of Kenya (2008 to date)
- Secretary General, Orange Democratic Party (ODM)
- Member of Parliament, Kisumu Rural Constituency
- Member, Committee of Experts on Public Administration (CEPA) of the Economic and Social Council (ECOSOC) of the United Nations Organization
- Member, Board of Directors of the Nelson Mandela Institution for Science, Technology and the Advancement of Knowledge in Africa
- Director, African Research and Resource Forum (ARRF), Nairobi, Kenya.
- Fellow of the African Academy of Sciences
- Member, Board of Directors of the *African Monitor*

Previous Positions

- President, Makerere Students Guild, 1969/70
- Special Lecturer, University of Nairobi, Department of Government, 1971
- Rockefeller Fellow, Universities of Nairobi and Chicago, 1971-1977.
- Lecturer and Senior Lecturer, Political Science and Political Economy, University of Nairobi, 1977-82.

- Associate Research Professor, Center for African and Asian Studies, El Colegio de Mexico, Mexico D.F., 1981-84.
- First Officer (P4), Department of Special Political Affairs, Office of the Under-Secretary General for Special Political Affairs, UNO, Dec. 2003-June 2004.
- Associate Professor, College of Social Sciences, Addis Ababa University, Ethiopia, 1984-86.
- Research Professor, East and Southern Africa Management Institute (ESAMI), Arusha, Tanzania, June 1986-July 1987,
- Head of Programs, African Academy of Sciences, 1987-1992.
- Member of Parliament, 1993-present.
- Minister for Planning and National Development, Kenya, 2003-2005.

Honors

- German-African Award for contribution to scholarship and democratization, 1995.
- Africa Brain Gain Award, by Kenyan American Professional Association and Career Nation, 2005.
- Fellowship of the African Academy of Sciences, 1989.

Major Publications

Articles in Journals

- "The Civil Servant in Uganda," *East African Journal,* (April 1971).
- "The Agrarian Question in Kenya", guest editor and contributor, *Review of African Political Economy No. 20,* 1981.
- "An African Perspective on Peace and Development in Africa", *International Social Science Journal,(UNESCO: Paris,* 1986).
- "Military Intervention in African Politics", *Third World Affairs,* (London: Third World Foundation,1986).
- "Democracy and Political Stability in Africa," *Africa Development ,XII,1986*
- **"**Political Stability and the Prospects for Development in Africa," *Africa development, XIII, 1988*
- **"**Crises and Conflicts in the Horn of Africa," *Geneve-Afrique, Vol. XXVII, No.2,* 1989
- "State and Society in Kenya: The Disintegration of the Nationalist Coalitions and the Rise of Presidential Authoritarianism, 1963-78," *African Affairs, Vol. 88* (1989).
- "Africa: The Failure of One-Party Rule," *Journal of Democracy Vol. 3, No. 1 (*January 1992).
- "Comprehensive Solutions to Refugee Problems in Africa: Bilateral, Regional and Multilateral Approaches," *International Journal of Refugee Law* (Special Issue), 1995.

- "Governance, Security and Conflict Resolution in Africa," *Diogenes, No.184, Vol. 46/4,* 1998.
- "Parliaments, Parliamentary Democracy and Building Democracy in Africa," *United Nations Economic Commission for Africa,* Special Consultative Paper (Addis Ababa, 2000).

Chapters in Books

- "South Africa and Israel as Settler Regimes," in I. Abu Lughod (ed.) *Settler regimes in Africa and the Arab World: the Illusion of Endurance* (The Medina University Press International, 1975).
- "The Possibilities and Historical Limits of Import Substitution Industrialization in Kenya," in P. Coughlin and G. Ikiara (eds.), *Industrialization in Kenya: In Search for a Strategy (*Nairobi: Heinemann, 1985).
- "The Military and Counterrevolution in Liberia: 1980-85," in P. Anyang' Nyong'o (ed.) *Popular Struggles for Democracy in Africa,* (London: Zed Books, 1987).
- "Alliances Populaires, militaries et counter-revolution au Liberia, de 1980 a 1985," dans
  P. Anyang' Nyong'o (dir.), *Afrique: La Longue Marche vers la Democratie,* (Paris: Editions Published, 1988).
- **"**Regional Integration in Africa" in P. Anyang' Nyong'o (ed.) *Regional Integration: An Unfinished Agenda,* (Nairobi: Academy Science Publishers, 1990).
- "The One-Party State and Its Apologists," in P. Anyang' Nyong'o (ed.) *Thirty Years of Independence in Africa: The Lost Decades?* (Nairobi: Academy science Publishers, 1992.
- "Regional Integration, Security and Development in Africa," in Olusegun Obasanjo and Felix Mosha (eds.) *Africa: Rise to Challenge, (*Lagos: Africa Leadership Forum, 1992).
- La participation popular y el desafio de la autosuficiencia en Africa, in Celma Ahuero Dona (ed.) *Africa: Inventando el Futuro (*Mexico: El Colegio de Mexico, 1992).
- "Privatization in Africa: the Kenyan Experience in a Comparative Perspective," in P. Anyang' Nyong'o (ed.) *The Context of Privatization in Kenya* (Nairobi: Academy Science Publishers, 2000).
- "Issues and Problems in the Implementation of Privatization," in Anyang' Nyong'o (ed.), ibid.
- "Challenges for Transitional Politics in Kenya," in A. Ghirmaizon (ed.) *In Quest for a Culture of Peace in the IGAD Region* (Nairobi: Heinrich Boll Foundation, 2006).

Books

- *Popular Struggles for Democracy in Africa* (ed.) (London: Zed Books, 1987).
- *Afrique: La Longue Marche Vers la Democratie* (Paris: Editions Publisud, 1988).
- *Economic Integration in Africa: An Unfinished Agenda* (Nairobi: Academy Science Publishers, 1989).
- *La Politica Africana y la Crisis del Desarrollo* (Mexico: El Colegio de Mexico, 1988).
- *Estado y Sociedad en el Africa Actual* Mexico: El Colegio de Mexico, 1988).
- *Industrialization at Bay: African Experiences* (Nairobi: Academy Science Publishers, 1990).
- *Thirty years of Independence in Africa: The Lost Decades* (Nairobi: Academy Science Publishers, 1992)
- *Arms and Daggers in the Heart of Africa: Studies on Internal Conflicts* (Nairobi: Academy Science Publishers, 1993)
- *The Context of Privatization in Kenya (*Nairobi: Academy Science Publishers, 2000).
- *The Study of African Politics: A Critical Appreciation of an Intellectual Heritage* (Nairobi: Heinrich Ball, 2002).
- (With A. Ghirmazion and D. Lamba) *NEPAD: A New Path? (*Nairobi: Heinrich Boll Foundation, 2006).
- (With Michael Chege)*Winning the Peace and Starting (Re)construction in Southern Sudan (N*airobi: ARRF Conference Series No. 3, 2004).
- *The Political Economy of Corruption in Kenya* (Nairobi: ARRF, 2006).
- *A Leap into the Future: A Vision for Kenya's Socio-Economic Transformation* (Nairobi: ARRF Press, 2007).

INTERNATIONAL ORGANIZING COMMITTEE
Prince Mahidol Award Conference 2012
Moving towards Universal Health Coverage: Health Financing Matters

1. **Dr. Vicharn Panich** — Chair
Chair, International Award Committee and Scientific Advisory Committee,
Prince Mahidol Award Foundation
Chairman, Mahidol University Council
Thailand

2. **Dr. Carissa F. Etienne** — Co-chair
Assistant Director-General, World Health Organization
Switzerland

3. **Dr. Cristian Baeza** — Co-chair
Director, Health, Nutrition & Population,
Human Development Network, The World Bank
United States

4. **Mr. Kiyoshi Kodera** — Co-chair
Vice President, Japan International Cooperation Agency
Japan

5. **Dr. Lincoln Chen** — Member
President, China Medical Board
United States

6. **Dr. Ariel Pablos-Mendez** — Member
Managing Director, The Rockefeller Foundation
United States

7. **Dr. David de Ferranti** — Member
President, Results for Development Institute
United States

8. **Dr. Keizo Takemi** — Member
Research Fellow, Japan Center for International Exchange
Japan

9. **Dr. Xenia Scheil-Adlung** — Member
Health Policy Coordinator, The International Labor Organization
Switzerland

10. **Dr. Athula Kahandaliyanage** Member
Director of Health Systems Development, WHO/SEARO
India

11. **Dr. Matthias Rompel** Member
Head of Section, Social Protection, GIZ
Germany

12. **Dr. Kalipso Chalkidou** Member
Director, National Institute for Health and Clinical Excellence
United Kingdom

13. **Ms. Bridget Lloyd** Member
Coordinator, People's Health Movement
South Africa

14. **Dr. Paijit Warachit** Member
Permanent Secretary, Ministry of Public Health
Thailand

15. **Mr. Theerakun Niyom** Member
Permanent Secretary, Ministry of Foreign Affairs
Thailand

16. **Dr. Supat Vanichakarn** Member
Secretary-General, Prince Mahidol Award Foundation
Thailand

17. **Dr. Winai Sawasdivorn** Member
Secretary-General, National Health Security Office
Thailand

18. **Dr. Piyasakol Sakolsatayadorn** Member
President, Mahidol University
Thailand

19. **Dr. Teerawat Kulthanan** Member
Dean, Faculty of Medicine Siriraj Hospital, Mahidol University
Thailand

20. **Dr. Suwit Wibulpolprasert** Member
Senior Advisor on Disease Control, Ministry of Public Health
Thailand

21. **Dr. Viroj Tangcharoensathien** Member
Senior Public Health Expert (Health Economics),
Ministry of Public Health
Thailand

22. **Dr. Pongpisut Jongudomsuk** Member
Director, Health Systems Research Institute
Thailand

23. **Dr. Sopida Chavanichkul** Member
Director, International Health Bureau, Ministry of Public Health,
Thailand

24. **Dr. David Evans** Member & Secretary
Director, Health Systems Financing, World Health Organization
Switzerland

25. **Dr. Churnrurtai Kanchanachitra** Member & Secretary
Vice President for Collaboration and Networking, Mahidol University
Thailand

26. **Dr. Toomas Palu** Member & Secretary
Lead Health Specialist, The World Bank
Vietnam

27. **Dr. Achra Sumboonnanonda** Member & Secretary
Deputy Dean for Academic Affairs,
Faculty of Medicine Siriraj Hospital, Mahidol University
Thailand

28. **Mr. Yojiro Ishii** Member & Secretary
Deputy Director General, Human Development Department,
Japan International Cooperation Agency
Japan

Conference Co-hosts:
Prince Mahidol Award Conference
World Health Organization
The World Bank
Japan International Cooperation Agency

Conference Partners and Sponsors
China Medical Board
Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH
International Development Research Centre
National Institute for Health and Clinical Excellence
Results for Development Institute
Thai Health Promotion Foundation
The Rockefeller Foundation
World Health Organization Regional Office for South-East Asia

Printed by :

The Graphico Systems Co., Ltd.

119/138 Moo 11, The Terrace, Soi Tiwanon 3, Tiwanon Rd.,
Talad Kwuan, Muang Nonthaburi, Nonthaburi 11000, Thailand.
Tel: +66 2525 1121, +66 2525 4669-70 Fax: +66 2525 1272
E-mail : graphico_sys@yahoo.com