

SEA-HSD-265  
Distribution: General

# Social Health Insurance

*Report of a Regional Expert Group Meeting  
New Delhi, India, 13-15 March 2003*



World Health Organization  
Regional Office for South-East Asia  
New Delhi  
June 2003

© World Health Organization (2003)

This document is not a formal publication of the World Health Organization (WHO), and all rights are reserved by the Organization. The document may, however, be freely reviewed, abstracted, reproduced or translated, in part or in whole, but not for sale or for use in conjunction with commercial purposes.

# CONTENTS

	<i>Page</i>
1. BACKGROUND .....	1
2. SPECIFIC OBJECTIVES.....	2
3. OPENING SESSION .....	2
4. BUSINESS SESSION.....	3
4.1 Summary of Presentations.....	3
4.2 Discussions .....	21
4.3 Recommendations.....	24

## **Annexes**

1. Programme of Work.....	28
2. List of Participants.....	31
3. Working Papers.....	33



## 1. BACKGROUND

Social Health Insurance (SHI) is a form of financing and managing health care based on risk pooling. SHI pools both the health risks of the people on one hand, and the contributions of individuals, households, enterprises, and the government on the other. Thus, it protects people against financial and health burden and is a relatively fair method of financing health care. Desirable though it is, not many least-developed and low-middle-income countries have succeeded in adequately expanding coverage of SHI. Most countries rely primarily on tax-funded finance, which is also relatively fair.

Japan and the Republic of Korea are amongst the countries in Asia and the Pacific, which have universal coverage of SHI, while lower middle income countries like Thailand and Philippines have a high proportion of SHI coverage. Developing countries with stronger economies like China, Indonesia, and India have lower population coverage through SHI schemes. SHI implementation depends on the level of socio-economic development, financial sector development (mainly banking) and, employment conditions, especially the existence of a larger proportion of formal sector organized establishments.

Countries with higher socio-economic status and a high employment ratio tend to have large SHI coverage. Countries which have reached almost universal coverage are grappling with cost containment, quality of care, equity issues, regulation, and policy re-definition. Countries without universal coverage of SHI are trying to attain substantial population coverage, through mutual health insurance and community- based schemes. Many of these efforts are frequently hampered by lack of national consensus on policy framework, poor regulation and inadequate administrative capacity.

The 48<sup>th</sup> session of the WHO Regional Committee for South-East Asia held in Colombo in September 1995 discussed the issue of alternative health care financing and urged Member Countries to undertake various alternative financing reforms, within the framework of solidarity, equity and expanding essential coverage. In 1999, the health ministers of the Region participated at the Ministerial Round Table on "Finding the money: dilemmas facing

ministers", held during the 52<sup>nd</sup> World Health Assembly. The Ministers agreed on the need to assess the consequences of their health care financing reforms, through an update of national health accounts and related studies.

At the 6<sup>th</sup> Meeting of the Health Secretaries held at Yangon, Myanmar, in February 2001, the regional experience of health care financing reforms was discussed. Even though these reforms were undertaken by each country based on respective socio-political and health systems development contexts, there were a lot of similarities. Thus, they requested WHO to share various evidence-based policy options.

Subsequently, the 55<sup>th</sup> session of the Regional Committee held at Jakarta, Indonesia, in September 2002, having expressed its concern on the high level of out-of-pocket health expenditure and the low level of public spending on health in almost all countries, decided to hold the Technical Discussions on the topic of "Social Health Insurance" in conjunction with the 40<sup>th</sup> meeting of the CCPDM preceding the 56<sup>th</sup> session of the Regional Committee in September 2003. This consultative meeting of technical experts is part of the preparation for the Technical discussions.

## **2. SPECIFIC OBJECTIVES**

The main objectives of the Regional Expert Group Meeting were to:

- (1) Review the SHI schemes in the Region, particularly those of India, Indonesia and Thailand;
- (2) Develop the outline and content of the working paper for Technical Discussions on "Social Health Insurance" to be held in conjunction with the 40<sup>th</sup> meeting of the CCPDM; and,
- (3) Review the policy options for promotion and expansion of SHI schemes in the Region.

## **3. OPENING SESSION**

The Regional Director, Dr Uton Muchtar Rafei, in his inaugural address, highlighted the policy context for the development of Social Health Insurance in the Region. He emphasized the value of developing health systems that protect the people financially in the fairest way possible, and the need to undertake reform measures in three interrelated functions of health

care financing; namely, (a) collection of revenue, (b) pooling of financial resources, and (c) purchasing of interventions. He stressed the need to examine the feasibility of SHI in the ongoing efforts in reforms in many countries. A major policy challenge, he said, was to accelerate development of community-based risk-sharing schemes and to expand the coverage of people at local levels. This required continuous and sustained support and incentives from national and local governments. He highlighted the efforts by some countries in expanding universal coverage with a combination of SHI and other risk sharing measures. He urged adoption of SHI in countries with a high proportion of employed people both in the formal and informal sectors. He, however, cautioned that introduction of SHI could face rough weather in countries where Governments are providing health care free of cost at the point of use. There could be resistance to compulsory/voluntary contributions in such cases. There is also a danger that rapid expansion of health insurance coverage without appropriate safeguards could result in health systems moving away from its basic goals. Citing experiences around the world, he also cautioned that SHI faced a difficult road ahead in low middle income countries.

## **4. BUSINESS SESSION**

### **4.1 Summary of Presentations**

#### **4.1.1 Health care financing and social health insurance**

In his presentation, Dr U Than Sein, Director (EIP), SEARO, provided a brief overview of health care financing and social health insurance schemes including the regional health situation. He stated that the South-East Asia Region was undergoing a rapid phase of socio-economic, demographic and epidemiologic transitions. While the total fertility rate in most countries had declined from its high level (more than 4) in 1950-55 to reach the replacement level (less than 2), most countries had not reached stable population growth. Rapid, uncontrolled urbanization was being witnessed in most countries. The Region was also making steady progress in expanding the life span and improving child survival. The Region carried a disproportionately large share of global disease burden, accounting for around 30% of overall global morbidity and mortality in any disease condition either as a single disease or in groups. The Region had over

370,000 reported AIDS cases and an estimated 6 million HIV-positive people. Despite steady gains in total life expectancy in all countries of the Region, only four countries exceeded the global average of 65 years. The estimated healthy-life expectancy {HALE} in the Region is around 52.7 years as against a global average of 56 years.

Total estimated global spending in health was around \$3.1 trillion in 1998. More than 95% of this money came from four major sources, viz., taxation, social health insurance, private out-of-pocket (OOP) payments, and private health insurance. The relative level of health spending in the Region was very low, with a few exceptions in countries where spending was a little more than 6% of their GDP on health. Moreover, the Region as a whole had a higher level of OOP expenditure (around or above 75% of total health spending) than in any other region. The major expenditure source was from general taxation. The externally funded health expenditure was also relatively low. In general, most countries of the Region had a higher private expenditure on health compared with the government (public) health expenditure. The OOP expenditure was exceptionally high in many Asian countries. This was usually in the form of user fees and costs for drugs and diagnostics, and formed a part or full cost of getting health care. This mode of payment was always regressive. In many countries, there was a large component of invisible 'informal' payments in addition to formal user fees.

"Risk pooling" referred to the sharing of risks across individuals/households who were willing to pool funds to deal with the financial burden of health care in times of need. Thus, SHI pooled the funds from all contributors and not just one's own accrued contribution which was available for an individual's health care. There were several methods of pooling risks, including: (a) social health insurance, (b) private (voluntary) health insurance, (c) community health financing, and (d) others including trust funds and saving accounts. The mechanism of pooling funds involved the definition of *contributions*, *fixing payment schedules* and *identifying beneficiary populations*, who thereby become entitled to the defined benefits of the fund. This required a fair formula to determine the amount of contributions for each insured unit. It also required effective management of the pooled funds. In order to ensure fair financial protection, there was a need to identify those who were unable to contribute and to find a way of extending protection to them.



Several groups of people stand to benefit from pooling both financial and health risks. The first group includes employers, ordinary people, health care providers and the government. There are other groups who may not perceive any benefit or sometimes even feel they stand to lose. The latter group includes very rich families, people who consider themselves at low health risk, employers who do not register workers, established health insurance schemes with "selective" membership and providers who fear limitations posed by cost-control measures of the pooled funds.

Effective pooling mechanisms require prepayment to the health fund, on a regular basis before any health problem, regardless of the level of income of the contributor. The contribution levels are usually pre-determined and the funds are collected in different ways but channelled to the health systems. Since the estimated funds are known in advance, it enables more efficient purchasing from health care providers. Prepayment can be applied so as to maximize cost control and reduce administrative overheads. The very poor and some economically non-active groups may still need subsidies from other sources, e.g. government, through social security, etc.

While there is no standard definition of SHI, it can generally be perceived as "a financial protection mechanism, for health care, through health risk sharing and fund pooling for a larger group of population". It can also be thought of as a part of broader "social security" framework, covering all contingencies which need financial protection and risk sharing. To be characterised as "social", SHI must have certain characteristics. Countries need to adopt a broad social policy and legislative framework, normally covered under "State Constitution" and also determined by "the society consensus" ensuring:

- solidarity across the population;
- responsibility for paying contributions with proper organizational arrangement to collect the regular income-related contributions from individuals and to allocate these funds [i.e. the payment of contributions for health care according to economic means (non-risk-related payments) and the choice of health care according to the needs], and
- rendering social assistance to cover vulnerable populations.

A country can be categorized as having Social Health Insurance, only if the majority of the population are legally covered with a designated (statutory) third-party payer through non-risk-related pre-payment (contributions) that are separate from general taxes or other legally mandated payments.

With this definition, a few countries in the Region, such as India, Indonesia, Myanmar and Sri Lanka fall into the category of SHI countries. Thailand has reached the highest coverage (95%) of total population by various SHI schemes, followed by Indonesia (27%), India (12%), and Myanmar (3%). Thailand started expanding the various SHI schemes over a decade ago from just over 30% in 1990 to its present level. The major effort in Thailand was in expanding the social health insurance scheme through government subsidy. Indonesia started with civil-service benefit schemes, followed by employees' health insurance and later expanding to community and private health insurance schemes. India implemented the employees' social health insurance for many decades and later added other schemes. It is not yet expanded to cover a larger proportion of the population. Myanmar also implemented social health insurance under the social security scheme for employed workers in the formal sector. SHI schemes in the Region are a heterogeneous mix of schemes that vary widely in terms of population coverage, range of benefits, quality of health services and patterns of risk sharing and cost sharing between the government, beneficiaries and the private sector.

A few policy directions can be developed based on the following options.

- (1) **Increasing Public Revenue for Health:** Most countries of the Region have a low investment in health from public resources. This can be increased through allocation from general revenue in each budget year; to promote earmarked indirect tax (sin-tax); to mobilize external resources both in grants and loans; and to mobilize internal resources including foundations, trust funds, saving accounts.
- (2) **Promote pooling of financial risk:** Except Thailand, almost all other countries have a low coverage of risk pooling in financial risk. Various mechanisms for pooling financial risk can be introduced in order to expand the coverage of existing health insurance schemes (mandatory and voluntary). Establishing or promoting other risk and resource

pooling schemes including community-based risk-pooling schemes and public trust funds can be considered.

- (3) **Strategic Purchasing.** Countries should also adopt various financial and managerial incentives and instruments in order to implement strategic budgeting; service-based purchasing; and appropriate technology and cost-effective interventions; promoting essential public health functions; and establishing various competition and contracting (in/out) mechanisms. Countries should establish a national quality assurance and accreditation policy and procedure, in order to provide incentives for public and private health care providers.

There may be some key issues that might hinder or enhance implementing the above policy options. These include:

- Lack of nation-wide consensus between stakeholders (solidarity);
- Inadequate resources for long-term financial viability and sustainability (relative size of formal and informal sectors and the level of income);
- Inadequate provision of health care to insured members (essential packages, reimbursement schemes, capitation);
- Lack of technical, managerial or institutional arrangements;
- Globalization and trade liberalization (expansion of private insurance and other financial and commercial markets);
- Decentralization (governance and financing);
- Expanding risk pools (single or multiple pools);
- Capacity strengthening (actuarial scientists, economists, fund managers, banking, communication);
- Time implications for expansion of SHI schemes (most countries took more than 30 years.); and,
- Low political stability

#### 4.1.2 Social health insurance in Thailand

Dr Viroj of the Ministry of Public Health, Thailand, in his presentation, stated that the objective of the health systems is to improve the health of the population with equity and social justice. Health system development of each country must ensure a fair financial contribution mechanism, where the contribution is based on ability to pay and the utilization of services based on health needs. The financing mechanism has to ensure protection from

catastrophic expenses for health problems. It would also ensure the pooling of risks among a large population and the prudent purchase of cost-effective interventions. It will also encourage efficiency among health care providers and consumers.

Many developed countries have financed their public health care expenditure predominantly through social health insurance or from general taxation with little or no role for out-of-pocket payments. In contrast, most developing countries have financed their public health care expenditure from meagre public resources with a higher proportion being out-of-pocket payments. There is an inequitable burden on the poor. While there have been attempts to give exemption to the poor, most often these have failed. Health care financing through general taxation is relatively fair. However, most developing countries had failed to invest public health finance as they do not have enough revenue from general taxation. SHI schemes in these countries usually cover a small proportion of the population, with little prospect of expanding coverage.

From developed countries' perspective, there are six characteristics of SHI:

- (1) Contributions independent to health risks;
- (2) Sickness funds as payers/ purchasers of health care;
- (3) Solidarity;
- (4) Pluralism in actors and organizational structures;
- (5) Participation in terms of shared governance arrangements; and
- (6) Individual choice of providers and sickness funds

Most of these characteristics might not be applicable to developing countries. For example, developed countries had established multiple mutual funds several decades ago and had developed national social health insurance or social security schemes, based on economy of scale and variations in the benefit packages. Tim Ensor<sup>1</sup> had made an analysis on the structural characteristics that were important in determining the feasibility of SHI, using a composite index of four quantitative indicators: (a) Population density, (b) Percentage of urban population, (c) Percentage of workforce

---

<sup>1</sup> Tim Ensor, *Developing health insurance in transitional Asia*, *Social Science & Medicine* 48 (1999) 871-879

working in industry, and (d) Per capita income. Using these indicators, a composite score was calculated for a country in the range of (-4) to (+4). The higher scores reflect a higher feasibility for implementing SHI schemes. Many American and East Asian countries are on the high score list, while very poor African and Asian countries are at the bottom. Accordingly, Indonesia, Sri Lanka, and India have scores of minus 1, while Thailand and Bangladesh have scores of minus 2.

There are different methods available for reimbursing service providers. These include salary, fee for service, capitation/block contract, fixed budget, daily allowance and case payment. As the following table shows, each of these methods is associated with certain negative behaviours by service providers:

Payment method	Provider behaviour
Salary	Restrict number of patients, services
Fee for service	Expand the number of cases, service intensity, expensive services, drugs
Capitation / block contract	Attract more registered persons, more healthy, minimize contacts per patient, service intensity
Fixed budget	Reduce number of patients, services
Daily allowance	Expand number of bed days, longer stay, more admissions
Case payment, DRG	Expand number of cases, less serious, decrease service intensity, less expensive services

**Philippines**, a low middle-income country, expanded its national SHI scheme in 1995 with the introduction of the National Health Insurance Act. The national SHI now covered around 50% of the total population and efforts are being made to reach universal coverage as soon as possible. The Government had made SHI coverage mandatory for all employees and their family members, both in the formal and informal sectors. The Government provided the finance for SHI through the payroll and general taxation. Another factor was the strong involvement by local governments and their

commitment to the subsidized indigent program. A few important limitations and challenges learnt from Philippines' SHI experiences were: a marginal increase of 1.8 times between the assessed contributions of the highest (10,000 peso/month) and minimum wage earners (454 peso/day), leaving ample room for making it more progressive; coverage expansion to the informal sector and the self-employed became difficult and expensive, particularly in collecting contributions. Payment was based on the conventional-fee-for service reimbursement model, resulting in cost escalation, overcharging, excessive admissions, irrational use of drugs and investigations. There was a limited package for inpatient care. Co-payment was high, with average support ranging from 30-70% of billing. Awareness, and thus utilization rate was low, resulting in fund surplus. There was an enormous workload on claim reviews, resulting in high admin cost (12% of total spending) and ineffective filtering of frauds. Fee-for-service (FFS) indicates inefficiency in health systems.

**Thailand**, another low middle-income country, introduced the National Social Welfare Scheme for low-income households in 1975. The scheme originally covered the working population and was later extended to people over 60 years and children under 12 years. The budget was allocated through capitation but was inadequate. The scheme was poorly designed with no provision to ensure accountability or quality of care. It had no effective mechanism for means testing and excluding the non-poor. Often, it was the real poor who were excluded.

In 1978, Thailand introduced the "Civil Service Medical Benefit Scheme-CSMBS" to extend social health insurance to all government employees, retirees and their dependents. The CSMBS was based on a fee-for-service reimbursement model, and resulted in longer hospital stay, and frivolous use of drugs and investigations. The capacity of the scheme to monitor fraud and overcharging was poor. The only source of funds for CSMBS was from the general government tax, thus it was a non-contributory fringe benefit scheme. Following various studies and due to the economic crisis in the late 1990s, the Government reformed the CSMBS to include capitation for ambulatory care, and DRG for inpatient care. An electronic disbursement system was introduced for in-patients using DRG.

Following the enactment of the "Social Security Act, 1990", the national social health insurance scheme became mandatory for all private companies with more than 20 employees using a capitation low-cost contract model. In 1994, the SHI coverage extended to companies or private

commercial establishments with more than 10 employees and by 2002, it included even small enterprises with more than one employee. The SHI scheme for the formal employees had certain strengths as it was based on contract models. Employees had the choice of consulting any registered public or private contractor. The administrative costs were low while maintaining a decent quality of care. The financial contribution was progressive with a five-fold gap between the contribution of the highest and the lowest wage-earners. There were some drawbacks, as only the employees and not the family members were included. There was some reluctance to expand to the self-employed sector. Preventive and promotive health services were not adequately addressed.

The Voluntary Health Card (VHC) Scheme started modestly in 1983, covering initially MCH care, and expanded in 1994 to cover the village health volunteers and local leaders with 100% government subsidy. The VHC scheme had several important issues. It was a voluntary insurance with adverse selection and limited risk sharing. The sick usually joined while the healthy opted out. The financial viability was a major issue and there was also inequitable access between the urban and rural members. The referral system was inefficient, with frequent bypassing of primary care.

The Universal Coverage Scheme (UCS), notably the "30 Baht Scheme" was introduced in October 2001, with the idea of replacing the "Social Welfare Scheme" and the "Voluntary Health Card Scheme". It was aimed at incorporating the 30% uninsured population into the "Single SHI Scheme". The UCS plans to provide comprehensive health care coverage with virtually no co-payment, apart from a nominal fee of just "30 Baht" per each health visit or hospital admission. The scheme is financed from overall general taxation. The coverage of the "30 Baht scheme" by the end of 2002 was around 76% of the total population. The remaining population is still covered by the CSMBS (11%) and SHI for employees (13%).

Reforms related to the UC scheme are expected to provide several benefits, such as favourable cost containment (around 1500 Baht per capita), overall systems efficiency and almost no financial impact on catastrophic illnesses. The prepayment component would probably increase to 90%, leaving less than 10% for OOP. This will help to ensure progressivity of total health financing contributions. There would be convergence of benefit package and expenditure across the three public schemes. The Government laid down the legal framework for universal coverage by promulgating the

National Health Insurance Act in November 2002; The National Health Insurance Office is fully operational. There are many important tasks ahead such as the need for standardizing the benefit package, the payment methods, and the level of budget subsidy across the three public schemes. Currently, the UC scheme is looking into amending the benefit package and seeking sources other than general tax revenue. The time line for expansion of SHI schemes in Thailand is:

- 1975:** Targeting the poor, drawing lessons, gradual expansion and health systems amendments;
- 1983:** Voluntary health insurance-transitional measures, building up the social capital and institutional capacity to manage the insurance fund;
- 1990:** Introduction of SHI - capitation, the predecessor for current UCS design;
- 1992:** Reform of CSMBS towards close-end expenditure - not very successful;
- 2001:** Political will to adopt universality - general tax revenue financed.

#### **4.1.3 Social health insurance in Indonesia**

Professor Hasbullah Thabrany, University of Indonesia, Jakarta, presented a brief historical perspective of SHI schemes in Indonesia. The Dutch colonial government implemented a reimbursement scheme for civil servants, originally covering only the European employees, and later expanded to Indonesians. After independence in 1948, the scheme continued under reimbursement for health care (fee for service). It had several drawbacks such as high moral hazards and discrimination between high and low rank employees. In 1960, the Government initiated a pilot SHI project to cover the cost of inpatient care but not medical fees. The scheme suffered a huge budget deficit, and later the pilot project was abandoned. Since then, several landmark initiatives have been taken as shown in the following time-line. Up to end-2002, only 8.5% of the population was covered under various SHI schemes.

- 1966:** Minister of Health establishes a Sickness Fund for civil servants, with contribution from civil servants. It fails.
- 1968:** Ministry of Labor establishes a Civil Servant Welfare Team, a forerunner of Askes. Reimbursement based on FFS system; contribution 5% of salary.



- 1984:** *Perum Husada Bhakti* (PHB), a public corporation, formed to be responsible for the scheme.
- 1988:** A pilot project implemented for private employee health insurance
- 1992:** PHB transformed into ***PT Askes***, a for-profit state-owned company; National Insurance Act passed. Social insurance programmes must be managed by state-owned companies. Social Security Act (***Jamsostek***) passed, prescribing provident fund, death benefits, occupational injury coverage, and health insurance.
- 1993:** Government decree (PP14/93) undermines mandatory health insurance coverage by providing opt-out option, and leads to adverse selection to ***Jamsostek***.

A few community health insurance schemes and nationally managed health care (JPKM) schemes have started in the late 1980s and early 1990s. The Dana Sehat (Community Risk Pooling) scheme was introduced on a small scale in various parts of the country, but a majority of these schemes could not expand the geographical or population coverage for various reasons. Many local, community-based schemes have stopped functioning after the wide introduction of SSN in the health sector in late 1990s. The managed care model (JPKM) scheme was introduced by the Ministry of Health in 1992 and became effective on a large scale in 1995. There are 24 licensed JPKM (Managed Care organizations) now operational.

The ASKES is mandated to cover civil servants and retirees including retired military personnel. Employees have to contribute 100% of the contribution, usually paying 2% of basic salary with no ceilings. It is managed by PT Askes, "For-profit Parastatal Company". Its coverage is comprehensive with no specific exclusion. Drugs are covered if prescribed on the national formulary. Coverage of beneficiaries includes the spouse and two children less than 21 years old, not working and not married. Services are provided, mostly public health centres and public hospitals. Special fee schedules were set by the government, 40-70% of public fee schedules. The ASKES covers about 16 million employees, belonging mostly to the upper income deciles. Contribution is about 4000 Rupiah (Rp) per capita. This figure has not been revised since 1993 and has depreciated due to inflation. Currently, it is equivalent to just about Rp 1000 - compared to the 1993 value. The ASKES suffered from many drawbacks:

- Too ambitious benefits for small contributions
- Historically high cost sharing due to small contributions. Currently efforts are being made to reduce cost sharing by adding government contribution
- Relatively low reimbursement levels to providers. It creates perception of bias and low quality of services by public providers. New reimbursement levels are closer to public prices
- Relatively richer individuals covered by very low premiums, creating gaps in expectations and satisfaction
- Adverse selection from retired military personnel
- For-profit operation creating jealousy among providers.

PT Jamsostek or SHI for employees is mandatory for all private employers with 10 or more employees or monthly payrolls exceeding Rp 1 million. Employers contribute 100% of the finance, paying 3% of salary for unmarried and 6% of salary for married employees. There is a ceiling of Rp 1 million per month. This scheme is also a "For-profit parastatal Company".

The benefit package is comprehensive, with some exclusion such as cancer treatment, cardiac surgery, haemodialysis, and congenital diseases. Drugs are covered if prescribed on the formulary. Coverage of beneficiaries includes the spouse and 3 children under 21 years, not working and not married. Services are provided by a combination of public and private providers. Fees are negotiated. The Jamostek scheme covers about 2 million employees. Contribution is about Rp 5000 per capita. The Jamsostek Scheme suffers from several drawbacks:

- Adverse selection due to opt out provision
- Low income employees enrolled, higher income opted out
- Large employers are less likely to enroll in SHI Jamsostek
- Retired employees are not covered
- Expensive procedures are not covered
- Low enforcement → low enrollment
- Integration with long-term programme → lack of incentives to focus on SHI programme
- For-profit operations, creating perception of mismanagement

There are a few policy and managerial actions required to improve current SHI schemes in Indonesia. They are:

- (1) Improve benefits, to be more reasonable and acceptable
- (2) Increase premium, share employer:-employees
- (3) Increase payment levels to acquire better quality and access of health services
- (4) Take out "opt out" option of Jamsostek
- (5) Change the carrier status → not for profit, to be consistent
- (6) More transparent management
- (7) Expand coverage to retired private employees, the poor, and self-employed
- (8) Expand coverage to small employers and self-employed
- (9) Benefits must be the same for every body, comprehensive + cost sharing (subject to ceiling of cost sharing).

The President of the Republic of Indonesia established a Presidential task force on Social Security which would also look into SHI in 2002, with various policy options: (a) to integrate public and private employee schemes into one scheme, creating specialized SHI management under a National Social Security System, uniform benefit for all; (b) to merge the PT Askes and PT Jamsostek into one single independent SHI agency at national level (National Health Insurance); (c) to make the new carrier independent, not-for-profit, controlled by tri- partite (representative of employees, employers, and the government).

At the moment, there are two alternatives:

- A model for National Health Insurance:
  - Simplicity, uniformity, portability, efficiency
  - Intersectoral commitment and supported by many parties
  - Very ambitious and large program
  - Unequal distribution and quality of providers
  - Oppositions from existing insurance companies and bapels
  - Oppositions from local governments
- A model for Oligo Insurers

- Accommodates some interests (insurer, region, sector)
- Unequal distribution and quality of providers
- Less efficient and less portability
- Oppositions from existing insurance companies and bapels
- Oppositions from local governments

In conclusion, Indonesia has extensive experience in implementing social health insurance on national scale. It is growing very slowly due to inconsistent implementation of SHI principles. Current SHI implementation needs improvement in benefits, premiums, management, and payment to providers. There is also a need to improve and expand SHI to cover at least employees in the informal sector and the poor rural population. National Health Insurance is the alternative model proposed by the Presidential Task Force and the Oligo Insurers by the Ministry of Health.

#### **4.1.4 Social health insurance in India**

Ms. Sujatha Rao, Joint Secretary (Family Welfare), Ministry of Health and Family Welfare, Government of India, New Delhi, provided a brief on social health insurance in India. While India has a multitude of systems of medicine with mixed ownership patterns and different kinds of delivery structures, the private sector dominates in health care. Broadly, India had adopted four mechanisms for financing health care: (a) General tax revenue; (b) Community financing; (c) Out-of-pocket payment; and (d) Social and private health insurance schemes. India, with GDP less than US\$1800 per capita, spent about 5.2% of the GDP on health, of which less than 17% was accounted for by the public sector (hospitals, clinics and preventive establishments). Social health insurance was available only to civil servants and a certain proportion of employees in the organized sector. Private health insurance was negligible, but growing rapidly. Out-of-pocket payments to the private clinics, hospitals and pharmacists including traditional medicine practitioners accounted for 83% of health care spending.

The financial burden on the national health system had increased in recent decades with spiraling health costs aggravated by the increasing burden of new and emerging diseases and also by the rising demand for health care. Hospitalization for major illnesses like CVD, diabetes and renal diseases was a cause of indebtedness for all income groups, especially those

living below the poverty line. A large section of the population, especially from the lower income groups, did not have easy access to good quality health care. Under a resource crunch in recent years, the Federal government was not in a position to increase health budgets. Governments at state levels too were facing financial crisis and were unable to meet recurring expenditure of the health sector. In this scenario, health insurance is seen as an alternative mechanism for financing health care.

The General Insurance Corporation (GIC), public-sector undertaking, along with four of its subsidiaries, offer voluntary health insurance (*Mediclaim Plan*). These schemes mainly covered hospital care and domiciliary hospitalization benefits (specified outpatient care provided in lieu of inpatient treatment). In addition, certain private insurance companies also offer health insurance. The GIC recently introduced new health insurance packages to extend the coverage of health care needs to middle and low-income groups. Both public and private sector companies offer employer-based insurance, through employer-owned facilities, by way of lump-sum payments, reimbursement of health expenditure of employees, or coverage of employees under group health insurance policies. The population coverage under these schemes is low and is estimated to be, about 30-40 million people.

The Government of India had implemented the Central Government Health Scheme (CGHS) since 1954, aimed at providing comprehensive medical care to central government employees (both in service and retirees) and their families. The scheme is mainly funded by central government funds. The benefits include all OP facilities, preventive and promotive care in dispensaries, inpatient care at both government and approved private hospitals. The premium contribution is progressive with salary scales (ranging from Rs. 15 to Rs. 150 per month). Beneficiaries under this scheme at present total around 4.5 million.

The central government also has another social health insurance scheme called the Employee's State Insurance Scheme (ESIS) instituted under the ESI Act in 1948, essentially to cover compulsory social security benefit to workers (employees) in the industrial sector. It provides financial and other social protection measures to employees due to sickness, maternity, disability and death caused by employment injuries. The scheme has its own facilities

for providing medical care to the employees and their family members, free of cost.

Originally, ESIS scheme covered all power-using, non-seasonal factories employing 10 or more people. Later, it was extended to cover employees working in all non-power using factories with 20 or more persons. While persons working in mines and plantations, or an organization offering health benefits as good as or better than ESIS, are specifically excluded, service establishments like shops, hotels, restaurants, cinema houses, road-transport and newspapers are now covered. The monthly wage limit for enrolment in the ESIS is Rs. 6500, with a prepayment contribution in the form of a payroll tax of 1.75% by employees, 4.75% of employees' wages to be paid by the employers, and 12.5% of the total expenses borne by the state governments. The number of beneficiaries covered are more than 33 million spread over 620 ESI centres across states. Under the ESIS, there were 125 hospitals, 42 annexes and 1450 dispensaries with over 23,000 beds facilities. The scheme is financed by the Employees State Insurance Corporation (a public undertaking) through the state governments, with a total expenditure of Rs. 3300 million or Rs. 400/- per capita insured person.

The National Health Policy 2002 of India acknowledged that access to the public health care systems were inequitable between the better endowed and the more vulnerable sections of society. The policy thus aimed to evolve a new system which would reduce the inequities and enable the disadvantaged sections of the population a fairer access to essential health care. The NHP, 2002 also aimed to increase the aggregate health investment from public sources through increased contribution from the Central (Federal) and State Governments. It also suggested trying out on a pilot basis health insurance models to enable the poor and near poor access to secondary and tertiary sector.

The national budget of India for 2002-03 had introduced an insurance scheme called '**Janraksha**' which was designed to provide financial protection to the needy population. With a premium of just Rs. 1.- per day, it promised a benefit package that would include (a) inpatient treatment up to Rs. 30,000.- per year at selected and designated hospitals, and (b) outpatient treatment up to Rs. 2000 per year at designated clinics and hospitals, including civil facilities, medical colleges, private trust hospitals and other NGO-run institutions.

During the budget period of 2003-04, another initiative called "Community-based universal health insurance scheme" was introduced. This scheme is aimed to enable easy access of underprivileged citizens to quality health care. With a premium equivalent to Rs. 1.- per day for an individual, Rs. 1.50 per day for a family of five, and Rs. 2.- per day for a family of seven, the insured will be eligible to claim (a) reimbursement of medical expenses up to Rs. 30,000 towards hospitalization, (b) a cover for death due to accident for Rs. 25,000 and (c) compensation due to loss of earning at the rate of Rs. 50.- per day up to a maximum of 15 days. To ensure the affordability of the scheme to below-poverty-line (BPL) families, Government would contribute Rs. 100.- per year towards their annual premium.

There are a few issues of concern or barriers in implementing a social health insurance scheme.

- India is a low income country with 26% population living BPL and 35% illiterate population with skewed health risks and health facilities.
- Insurance is limited to only a small proportion of people in the organized sector covering less than 10% of the total population.
- There is insufficient and inadequate information about various health insurance schemes. Data gaps also prevail.
- Much of the focus of the existing schemes is on hospital expenses.
- There is lack of awareness amongst people about health insurance.
- Health insurance suffers from problems like adverse selection, moral hazard, "cream skimming" and high administrative costs.

There is an urgent need to document the global and Indian experiences in social health insurance. Different financing options would need to be developed for different target groups. India as a heterogeneous country needs to undertake several pilot projects to provide a wide range of evidence-based experience on various health insurance schemes including other alternative risk-sharing mechanisms, and to develop options for different population groups. Health Policy and Health Systems Research Institutions, in collaboration with economics policy study institutes, need to gather information about the prevailing disease burden at various geographical areas; develop standard treatment guidelines; undertake costing of health services to enable one to develop benefit packages to determine the premiums to be levied and subsidies to be given; and map health care

facilities available and the institutional mechanisms which need to be in place for implementing health insurance schemes.

A multitude of community-based health insurance schemes including those variances of community-based health financing with some form of risk-pooling, have been established. These schemes mainly serve the people living in particular localities or communities, with main benefits in terms of preventive care. In some cases, ambulatory and in-patient care are also covered. The premiums are financed by fee-for-service at the time of providing care, government subsidies and community donations. Some schemes have introduced premium based on regular income level; some are fixed on a flat rate. Provider payments are mainly fee-for-service.

Some examples of community-based health insurance or risk-sharing schemes include: (a) **Chhatisgarh:** Raiqarh, Ambikapur Health Association (RAHA): Established in 1972; Enrolment of about 72,000 (1993); and acting as a third party administrator; (b) **Gujarat:** Self Employed Women's Association (SEWA): Established in 1992; provides health, life and assets insurance to women working in the informal sector and their families; enrolment in 2002 around 93,000, health insurance is purchased from the National Insurance Company; (c) **Gujarat:** Tribhuvandas Foundation (TF), Anand: Established in 2001, Enrolment >100,000 households, membership restricted to members of the AMUL Dairy Cooperatives, acting as a third-party insurer; (d) **Karnataka:** Mallur Milk Cooperative: Established in 1973, covers 7,000 people in three villages, outpatient and inpatient health care are directly provided; (e) **Maharashtra:** Sewagram, Wardha: Established in 1972, covers about 14,390 people in 12 villages; members are provided with outpatient and inpatient care directly by the facilities owned by the NGO itself; (f) **Tamil Nadu:** Action for Community Organization, Rehabilitation and Development (ACCORD), Nilgiris: Established in 1991, covers around 13,000 under a group policy purchased from New India Assurance; (g) **Tamil Nadu:** Kadamalai Kalanjia Vattara Sangam (KKVS), Madurai: Established in 2000, enrolment in 2002 around 5,710, covers members of women's self-help groups and their families, and acts as third-party insurer; (h) **Tamil Nadu:** Voluntary Health Services (VHS), Chennai: Established in 1963. In 1995, its membership was 124,715, offering sliding premium with free care to the poorest. The benefits include discounted rates on both outpatient and inpatient care, VHS is both insurer and health care provider. It suffers from low levels of cost recovery due to problems of adverse selection.



## **4.2 Discussions**

The following sections provide the highlights and conclusion of the discussions on various issues of relevance to health care financing and social health insurance.

### **4.2.1 Definition and scope**

National social health insurance (SHI) schemes traditionally include the following characteristics:

- (1) Compulsory or mandatory membership usually limited to the formally employed from small or large commercial, semi-commercial, industrial and agricultural establishments;
- (2) Earmarked deduction as prepayment contribution from regular payroll;
- (3) Premium based on income and not risk related;
- (4) Cross subsidization;
- (5) Benefit based on need;
- (6) Cover a large proportion of the population;
- (7) Contributions administered by some type of quasi-independent public body that acts as the third party payer or purchaser of health care.

If the above principles and scope of SHI are applied, the scheme would exclude a large proportion of people working in the informal sector in many countries of the Region, particularly those who cannot afford to make regular pre-payment contributions. Thus, expansion of SHI schemes based on traditional principles might not by itself be able to achieve the goal of universal coverage. Discussions at the Technical Discussions should therefore address the broader aspects of health care financing with a view to achieve universal coverage. One option that could be considered is the possibility of the governments subsidizing the premiums for those not able to pay.

Another issue for consideration is whether one should go slowly, introducing SHI initially to cover the formal sector and then gradually opt for others. This may take decades to achieve universal coverage.

Most SHI schemes in the countries of the Region cover mainly the protection of financial risk for hospital care and usually, inpatients only. According to empirical evidence, the cost of health care for hospitalization is only a proportion of other opportunity costs (such as transportation, cost of

medicines and consultation, under-the-table payments, etc.). There is a need to consider covering such risks as well.

Experience from countries with high coverage of SHI schemes shows that there has been a gradual development over decades from single-funded SHI to multiple-funded SHI, later and national health insurance. Countries considering expansion of SHI schemes need to study how they would go from the SHI stage to NHI within a specified time frame, say 30-50 years.

#### **4.2.2 Role of SHI as alternative health financing**

- The ultimate goal of health care financing is to achieve universal coverage. Health care financing based on general tax source is the fairest way.
- Some countries with a high proportion of salaried workers in the formal and informal employ sectors may consider implementing or expanding SHI schemes.
- Even in countries where governments are providing free health care utilizing general tax revenue, they may consider SHI as an alternative means for health financing because health ministries have limited budgets, competing as they are with other sectors. In situations where basic services are already free, SHI has an added advantage to ensure access to health services, especially from private providers.
- SHI is not a panacea or remedy that can replace other mechanisms or forms of health care financing, particularly finances based on general tax revenue. Governments should not shirk its responsibility to provide essential health care and public health functions.
- There are several limitations of SHI making it inappropriate to fund certain health functions. For example, people are generally not happy sharing the cost of public goods such as public health programmes and infrastructure. People are also unwilling to share costs of highly personalized treatment such as cosmetic surgery.
- There are a lot of information gaps on evidence for policy. Most countries have not yet established or updated their national health accounts. While many countries may have regular socio-economic surveys, the results are not properly analyzed for policy trends.

#### 4.2.3 Role of the private sector in development of SHI

- Development and expansion of the SHI scheme should be seen in the context of globalization and rapid liberalization of international trade including opening markets for the private sector. Private health insurance schemes need to be regulated to ensure the basic principles of solidarity, cross-subsidization and control of exclusion.
- In some cases, there is a mismatch between funds and services. In Thailand, a majority of accident and injury cases go to public sector facilities thereby placing a burden on public funds. The third-party insurance money handled by the private insurance companies does not go to the public sector facilities. Thus, the private companies benefit making huge profits with fewer claims.

#### 4.2.4 Community-based health insurance (CHI)

- Social capital is a pre-requisite to implement CHI. Since social capital varies among states and even among localities, the design and action programmes are very local-specific. This condition makes it difficult to replicate the schemes in other areas.
- There should be a strong stewardship from the government in enhancing CHI and, if possible, its funding.
- Many community-based financing schemes have a limited scope, as they are often expensive, considering the high hidden costs which are covered by donors and governments. Once donor funding dwindles, only 10% of such schemes survive.
- Existing CHI schemes in most countries cover limited packages of benefit that generally include, preventive health care including very basic medical and diagnostic services. It is possible that if a comprehensive package is introduced these schemes would collapse.
- CHI schemes with a small pool of participants will not be viable financially. Experience abroad has shown that HMOs with less than 100,000 participants are not viable.
- Many CHI schemes are related with, or part and parcel of, national or sub-national poverty reduction programmes including those related to micro-financing. Usually, SHI schemes are carried out as sideline benefit packages. This has hampered sustainability. In order to overcome this, CHI should be implemented as a 'core business' addressing the poor, as

shown historically in Germany and the Netherlands where the CHI schemes were initially established as sickness funds.

- For various reasons, involvement of NGOs' in social health insurance development is relatively marginal compared to other development areas. This issue needs to be addressed.
- The experience gained in implementing various models of CHI schemes, especially in ensuring consensus on solidarity and contribution, community management of collecting and allocating funds, could play a useful role in expanding the national SHI schemes.

## **4.3 Recommendations**

### **4.3.1 Development of working paper for technical discussions**

Keeping in view the limited public funding and high proportion of out-of-pocket expenditure for health, the Regional Committee had selected the topic of "Social Health Insurance" for the Technical Discussion. With this background, the working paper prepared for the Technical Discussions should not be restricted to a narrow discussion on traditional SHI, but should cover the broader health financing issues and policy options.

The working paper should dwell upon the concerns of decision makers and the reason for considering Social Health Insurance as a means of solving health financing problems. The paper should bring out clearly the message that SHI is only an instrument and not an end by itself to achieve universal coverage, and to improve the efficiency and quality of the health systems. The paper should provide evidence-based, practical approaches applicable to Member Countries, rather than mere theoretical concepts.

An expert group in WHO-HQ will soon publish a series of technical papers on health care financing including social health insurance that could also be shared at the time of the Technical Discussions. Close collaboration with WHO-HQ, ILO, the World Bank and other regional financial institutions, and bilateral and multilateral agencies and international NGOs, is therefore needed to ensure consistency and to avoid confusion.

Although the paper will focus on SHI, there should be a section highlighting the impact of private commercial health insurance by providing balanced information for decision-makers in selecting available options.

Keeping the above in view, the Expert Group adopted the draft framework, originally proposed by Dr. Viroj of Thailand, for preparing the working paper for Technical Discussions with the following modifications.

The suggested title of the working paper is, "The role of Social Health Insurance in expanding health care coverage in countries in South-East Asia Region". The main purpose of the working paper is (i) to highlight the current situation on health care financing affecting the health status and access to health care by the poor and vulnerable populations, and on progress towards achieving the societal objective of health systems, namely equity, quality and efficiency (EQE); (ii) to exchange experience in pro-poor financing mechanisms, CHI and SHI among SEAR Member Countries; (iii) to identify the potential roles of CHI and SHI in coverage expansion and financing health care, taking into account the context of emerging private-for-profit health insurance; and (iv) to provide ways and means of identifying of major obstacles in coverage expansion.

The background section in the working paper should cover: (a) the health financing situation in all Member Countries, magnitude and profiles; (b) a brief review on strengths, weaknesses and potential of health financing reforms; and (c) excerpts from the most recent World Health Reports and other reports on health financing options including promotion and development of social health insurance.

The major areas covered by the paper should include:

**(1) Demand side analysis**

- Who are the insured and the uninsured?
- What is their magnitude?
- Socio-economic characteristics of the insured and uninsured
- Illnesses, health care utilization and expenditure by the insured and uninsured.

**(2) Protecting the poor**

- Experience in providing access to the poor and giving exemptions
- Experience in pro-poor financing schemes in Asia and Pacific countries (use the World Bank Paper) – China, India, Philippines, Thailand and Vietnam.

**(3) SHI in SEAR**

- Experience in SHI and lessons on good practices
- Potential role of SHI, considered as part of the overall strategies to expand coverage and to generate health resources
- Build up a converging environment for the development of coverage expansion
- Role of private for-profit insurance.

**(4) CHI in SEAR**

- Use examples from reference papers of Carrin et al, ILO Micro-insurance units (MIU), World Bank documents on CHI, etc.
- Experience on CHI and lessons drawn and good practices
- Capacity for coverage expansion

**(5) Design of SHI and CHI**

- Take principles and steps for SHI [Reference: Weber and Normand 2000]
- Contribution collection, basis for calculation of premium
- Design of CHI, opt-out allowed or not allowed for high income earners, design of benefit package (comprehensive or selective e.g. exclude ambulatory care), exclusion and inclusion list, drug list), design of cost effective interventions in the benefit packages and value for money, purchasing mechanism and health care provider payment modes, role of co-payment
- Competing role of private-for-profit insurance
- Cost-containment strategies

**(6) Policy environment**

- Current debate and policy discussion on expansion of SHI schemes within the context of health financing reforms
- Stewardship function of the government ensuring proper regulatory framework and institutional building
- Development of social capital including capacity strengthening on policy analysis, planning, management, and evaluation of SHI

schemes, e.g. actuarial scientists, insurance mathematicians, fund managers, health economists, epidemiologists.

### **(7) Conclusions**

- Regional stances on the role of SHI in health care financing coverage expansion
- Lessons on strength and weakness of SHI, recommendations on good practices
- Strategies to expand coverage especially to the poor and most vulnerable population
- Need for technical support and expertise from international organizations such as WHO, ILO, the World Bank and other agencies.

#### **4.3.2 Process for preparation of situation report for regional consultation**

Countries with SHI and CHI schemes will be requested to prepare a situation report based on a common template provided by SEARO. The Department of Evidence and Information for Policy (EIP) of the Regional Office will prepare a template and send to countries with SHI and CHI schemes, giving guidelines on quantitative and qualitative information. The report will be drafted and prepared by a team, mainly from the Regional Office, with the close involvement and collaboration of some participants of this expert group meeting.

Each country will produce its own report, for self-analysis and policy debate. Simultaneously, it will send the completed template to the Regional Office. EIP Department will prepare the regional working paper by synthesizing the country situational reports, adding relevant perspectives from international literature reviews, especially on the design of SHI and CHI and private insurance. This working paper will serve as an input for the regional consultative meeting, scheduled to be held during the second week of July 2003. The Regional Office will solicit comments and recommendations from the regional consultation to finalize the working paper for the Technical Discussions to be held in September 2003 during the 40<sup>th</sup> meeting of the Consultative Committee for Programme Development Management. The working paper will be sent to Member Countries by the first week of August 2003.

**Annex 1**  
**PROGRAMME OF WORK**

<b>Day 1: Thursday, 13 March 2003</b>	
08.30-09.00	<b>Registration</b>
09.00-09.15	<b>Inaugural Session</b> <ul style="list-style-type: none"><li>➤ RD's Inaugural Address</li><li>➤ Introduction of participants</li></ul>
09.15-10.15	<b>Policy Brief on Social Health Insurance – Clarification and Discussion</b> (Dr Than Sein, Director, EIP-WHO/SEARO)
10.15-10.45	Tea Break
10.45-12.30	<b>Review of Social Health Insurance Schemes in the Region</b> (Moderator: Dr Indrani Gupta, Reader, Institute of Economic Growth, New Delhi, India) <ul style="list-style-type: none"><li>➤ Presentation of country experiences<ul style="list-style-type: none"><li>• Thailand</li><li>• Indonesia</li><li>• India</li></ul></li><li>➤ Clarification and discussions</li></ul>
12.30-13.30	Lunch Break
13.30-15.45	<b>Review of Social Health Insurance Schemes in the Region</b> (Moderator: Dr Indrani Gupta, Reader, Institute of Economic Growth, New Delhi, India) (Continued) <ul style="list-style-type: none"><li>➤ Discussions:<ul style="list-style-type: none"><li>• Concept and definition of Social Health Insurance</li><li>• Types of SHI schemes</li><li>• Issues in implementing SHI</li></ul></li></ul>
15.45-16.00	Tea Break



16.00-17.00	<b>Review of Social Health Insurance Schemes in the Region</b> (Moderator: Dr Indrani Gupta, Reader, Institute of Economic Growth, New Delhi, India) (Continued) ➤ Discussions Community-based Health Financing
<b>Day 2: Friday, 14 March 2003</b>	
09.00-09.30	<b>Main points of yesterday's discussions</b> (Mr Sunil Nandraj, NPO-WR-India)
09.30-10.15	<b>Development of outline and content of Working Paper for "Technical Discussions on Social Health Insurance" for the Regional Committee</b> (Moderator: Prof Ascobat Gani, Faculty of Public Health, Jakarta, Indonesia) ➤ Draft Agenda ➤ Draft Annotated Agenda
10.15-10.45	Tea Break
10.45-12.30	<b>Development of outline and content of Working Paper for "Technical Discussions on Social Health Insurance" for the Regional Committee</b> (Continued) (Moderator: Prof Ascobat Gani, Faculty of Public Health, Jakarta, Indonesia) ➤ Draft Agenda ➤ Draft Annotated Agenda
12.30-14.00	Lunch Break
14.00-15.00	<b>Objectives and Method of Organizing "Regional Consultation on Social Health Insurance, in June 2003"</b> (Moderator: Dr Viroj Thangcharoensathien, Director, International Health Policy Programme, MoPH, Thailand)
15.00-15.30	Tea Break

15.30-17.00	<b>Future collaborative work</b> (Moderator: Prof Hasbullah Thabrany, Director, Centre of Health Economics, Jakarta, Indonesia) ➤ Plenary Debate
<b>Day 3: Saturday, 15 March 2003</b>	
09.00-09.30	<b>Main points of yesterday's discussions</b> (Dr Stephanus Indradjaya, NPO, WR Indonesia)
09.30-10.30	<b>Policy Options for promotion and expansion of SHI schemes in the Region</b> (Moderator: Dr Widyastuti Wibisana, Director, JPKM, MoH, Indonesia) ➤ General discussion
10.30-10.45	Tea Break
10.45-12.15	<b>Policy Options for promotion and expansion of SHI schemes in the Region</b> (Moderator: Dr Widyastuti Wibisana, Director, JPKM, MoH, Indonesia) ➤ General discussion
12.15-12.30	<b>Closing Session</b>

## Annex 2

### LIST OF PARTICIPANTS

#### India

Dr Indrani Gupta  
Reader, Institute of Economic Growth  
Health Policy Research Centre  
University Enclave  
New Delhi

Ms Urvashi Sadhwani  
Addl. Economic Advisor  
Directorate General of Health Services  
Ministry of Health and Family Welfare  
Nirman Bhawan  
New Delhi

Ms Sujatha Rao  
Joint Secretary  
Department of Family Welfare  
Ministry of Health and Family Welfare  
Nirman Bhawan  
New Delhi

#### Indonesia

Prof Ascobat Gani  
Faculty of Public Health  
University of Indonesia  
Jakarta

Prof Hasbullah Thabrany  
Director, Center of Health Economics, UoI  
Jakarta

Dr Widyastuti Wibisana  
Director of Managed Prepaid Care  
Directorate General of Public Health  
Ministry of Health  
Jakarta

#### Thailand

Dr Viroj Thangcharoensathien  
Director, International Health Policy Program  
Ministry of Public Health  
Tivanond Road, Nonthaburi

Dr Piya Hanvoravongchai  
Health Economist  
International Health Policy Programme  
Health Systems Research Institute  
Dr Siripen Supakankunti  
Director  
Center for Health Economics  
WHO Collaboration  
Faculty of Economics  
Chulalongkorn University  
Bangkok 10330

#### WHO Country Offices

Mr Sunil Nandraj  
National Professional Officer (EIP)  
Office of WHO Representative to India  
New Delhi, India  
India

Dr Stephanus Indradjaya  
National Professional Officer (Program)  
WHO Country Office  
Jakarta, Indonesia

#### WHO HQ

Ms Neelam Sekhri  
WHO/HQ

#### WHO SEARO

Ms Poonam K. Singh  
Deputy Regional Director/Director  
Programme Management

Dr Than Sein  
Director, Department of Evidence  
and Information for Policy

Dr P. T. Jayawickramarajah  
Coordinator  
Strengthening Health Systems Delivery

Dr K. C. S. Dalpatadu  
Short Term Professional  
Evidence for Health Policy

Dr Abdullah Waheed  
Short Term Professional  
Research Policy & Cooperation

Mr Javed Chowdhary  
Short Term Professional  
Evidence for Health Policy

### Annex 3

#### WORKING PAPERS

- (1) Health Care Financing Options WHO South-East Asia Region: A Policy Brief (Dr Than Sein, Director, EIP, WHO-SEARO, January, 2003)
- (2) Social Health Insurance in WHO South-East Asia: A Policy Brief (Dr Than Sein, Director, EIP, WHO-SEARO, January, 2003)
- (3) Social Health Insurance in Indonesia: Current Status and the Plan for a national health insurance (Hasbullah Thabrany et al, Center of Health Economic Studies, University of Indonesia, Jakarta, March 2003)
- (4) Health Financing Technical Brief. Community-Based Health Insurance Schemes in Developing Countries : Facts, Problems and Perspectives (Dr G. Carrin - Department of Health Financing and Stewardship, HFS/EIP, WHO-Geneva, January 2003)
- (5) Achieving universal coverage of health care through public financing – A concept paper of the International Workshop on Health Care Reform: The Missing Jigsaws?, Phuket, Thailand, 26-28 February, 2003 (David M. Dror, Senior Health Insurance Specialist., Social Protection Sector, ILO, Geneva)
- (6) Private-Public Participation in the Health Sector in the Asia and Pacific Region of Third Forum Asia Pacific Health Economics Network (APHEN), Manila Philippines, 20-22 February, 2003 (Dr Kai Hong Phua, Health Services Research Unit, Deptt. of Community, Occupational & Family Medicine, National University of Singapore)
- (7) Structure of the Indian Health Care Market: Implications for Health Insurance Sector; Dr Anil Gumber, Senior Economists, National Council of Applied Economic Research, New Delhi, India (WHO Regional Health Forum Volume 4, Numbers 1 & 2, 2000, p26-34)
- (8) Better Health Systems for India's Poor, David Peters et al, the World Bank, 2002 (Chapter 8 Financing Health)
- (9) Health Insurance Systems in Thailand, Health Insurance Office, Thailand, 2002 (Chapter 2 – Overview of Health Insurance Systems by Dr Viroj et al)

- (10) Health Insurance in India, Prognosis and Prospectus (Randall PE, Moneer A & Indrini Gupta in Economic and Political Weekly, January 2000, 207-217)
- (11) Private Health Insurance and Health Costs: Results from a Delhi Study (Indrani Gupta, Economic and Political Weekly, No. 27, July 2002)
- (12) Social Health Insurance, A guidebook for Planning (Charles Normand and Axel Weber, WHO/ILO, 1994)
- (13) Developing health insurance in transitional Asia (Tim Ensor, Social Science & Medicine 48 (1999) 871-879)
- (14) Study Abstract on Social health insurance in western Europe, March 2003 (Richard Saltman et al (eds)) (<http://www.who.dk/observatory>)
- (15) Health insurance for the Informal Sector: Problems and Prospects (Dr Anil Gumber, Working Paper 90, Indian Council for Research on International Economic Relations, New Delhi, India, November 2002)

