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TB CARE II

MEETING REPORT

Exploring the Promise of Improving Access and Delivery of TB Services Through Insurance-based Financing Reforms

Bangkok, Thailand
September 18-20th, 2014

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This product was produced under the overall direction of USAID TB CARE II Project Director, Dr. Refiloe Matji. The lead author was Alisha Smith-Arthur. Technical inputs were provided by Neeraj Kak, Diana Weil, Nobuyuki Nishikiori, William Wells, Tamar Gabunia, Stacy Kancijanic, Hala AlMossawi, and Varduhi Ghazaryan.

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Introduction

The Global Strategy and Targets for Tuberculosis (TB) Prevention, Care and Control after 2015 (the End Strategy) was endorsed by the World Health Assembly in its 67th session in May 2014 through resolution WHA67.1. The strategy outlines a framework of TB control in the coming 20 years with ambitious targets. While calling for further expansion and consolidation of quality TB services, the strategy emphasizes a need for bold national policies, including those for universal health coverage (UHC) and social protection, to ensure equitable access to quality TB care and the sustainability of TB control efforts.

The global drive for UHC provides important opportunities for strengthening TB control by emphasizing the need for more sustainable and effective funding models and the promotion of policies designed to improve universal access to high quality diagnosis, care and treatment. In many countries, efforts to achieve UHC have taken the form of newly designed or expanded national and/or social health insurance programs. Currently, there are significant questions around how best to organize, manage, and effectively monitor delivery of TB services in insurance-based systems in order to facilitate increased access, high quality (especially when engaging additional providers), and coverage for all necessary services.

Many countries in Asia and the Pacific have made important advances in rolling out wide-scale national health insurance programs and, in other countries, similar financing reforms are underway. The current moment provides a critical opportunity to review the current status of these reforms and to monitor progress in incorporating TB services in the context of insurance-based financing reforms. A knowledge of recurrent challenges, key organizational frameworks, successful practices, and principles for policy is needed to assist countries which are considering embarking on insurance-based reform. Careful and sound planning by both health financing authorities and National TB Control Programs is necessary to weigh the pros and cons of different financing models, in order to establish and strengthen TB care financing mechanisms in the context of achieving universal health coverage as well as implementation of the End TB Strategy.

Meeting Objectives

This document summarizes issues and discussion points emerging from a consultative workshop held in September 2014 in Bangkok, Thailand (for agenda, see Annex A). The workshop was planned and organized by the USAID TB CARE II Project, in coordination with the World Health Organization's Global TB Programme and Regional Offices for the Western Pacific and South-East Asia. The focus of the workshop was to provide a forum for information sharing and review of current systems for ensuring access to, and provision of, essential TB services and core public health functions in the context of UHC financing reforms in Asian countries. Participation targeted countries in South and South East Asia that have in place or are planning or considering implementation of public health insurance as part of UHC reforms, and also are among the high burden TB countries. As such, the meeting included a mix of countries with differing models of public health insurance and at different stages in terms of designing and implementing financing reforms to achieve UHC objectives. The workshop was designed to build on several consultations that have occurred recently, including the USAID/PATH/World Bank Public Private Mix (PPM) meeting which took place in Washington, DC in May 2014[1] and the WHO/ Global Fund Joint PPM Workshop in Delhi in June 2014.[2] These prior meetings highlighted the role of health insurance in achieving UHC and End TB Strategy objectives, and drew attention to the need for further analysis and dialogue around the potential for introducing TB services via health insurance programs, including the models for service delivery, mechanisms for coordination, joint planning and management between NTP and insurance programs, and coverage of TB services. The impetus for the workshop stemmed as well from a series of case studies undertaken by TB CARE II to examine the situation of TB services delivery in several countries with different models of health insurance.[3] These case studies led to an initial attempt to analyze the coordination of TB service delivery within insurance-based systems and highlighted the need for further discussion and information gathering.

1 http://www.who.int/tb/careproviders/ppm_tb_dcmeeting_report.pdf

2 http://www.who.int/tb/careproviders/ppm/WHOGF_workshop_Delhi.pdf

3 http://tbcare2.org/content/tb-care-ii-synthesis-report-inclusion-tb-national-insurance-programs

The workshop was to be a foundation for countries to discuss these issues directly and to strengthen linkages between National TB Programs and other policymakers introducing UHC reforms. After the identification of major and recurring issues in the introduction of health insurance, these issues were outlined in an analytical framework which can guide planners going forward and inform WHO's guidance to attain the End TB Strategy objectives around national policies for UHC and social protection, to ensure equitable access to quality TB care and the sustainability of TB control efforts.

Background and Overview

Universal Health Coverage (UHC), defined by the World Health Organization as "access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access,"[4] has increasingly been adopted as a health systems goal in low and middle income countries. The UHC policies enacted in lower and middle income countries in recent years have generally been designed around the principles of equity of access to health services, provision of quality care, and financial risk pooling. Efforts to reduce the financial burden associated with poor health and to reduce the reliance on direct payments from patients for health services and commodities have led countries to explore the development of prepayment and risk pooling mechanisms, and increasingly countries have moved towards adoption of National Health Insurance (NHI) models as a means to support sustainable financing for UHC. Several objectives of UHC-based financing reforms, including insurance, can support advancement towards TB targets and are synergistic with the new global TB strategy. These include mobilizing more financing for health, increasing access especially by the poor and others previously facing extreme barriers to health services including for TB, and improving technical and allocative efficiencies.

In settings where high rates of TB justify strong national programs with clearly defined clinical and public health functions, the impact of the introduction of a national health insurance program has been unclear. The different NHI programs that are currently in place or in development in high burden TB countries include a varying degree of integration of TB services. As TB is a critical public health threat in many countries, inclusion of services for TB diagnosis, treatment, and follow-up care within NHI programs has the potential to play an important role in extending care to TB patients not currently reached. This will reduce patient costs and involve more health providers who could be engaged to provide services according to a routine standard of care. At the same time, TB is a highly infectious airborne disease and TB control should be considered a public good. So the activities, roles, and functions of National TB Programs, including the legacy of established policies and existing service delivery systems, should not be jeopardized by the introduction of health insurance. Indeed, in terms of achieving priority national TB control targets, it is important for countries to examine what gaps exist in the design of insurance programs to understand whether an insurance-based financing model provides the best promise of achieving UHC. Under some conditions, retaining and expanding critical components of public financing for TB may be the most effective means of ensuring widespread and high quality coverage.

Critical Questions and Outcomes

The Bangkok workshop occurred at an exciting moment. Policy makers around the world are engaging in a lively discussion around how we can define and capture the promise of UHC (and related insurance-based reforms), and are also moving towards a better understanding of the complexities and challenges of these policies. The workshop aimed to help countries clarify and explore their plans in regards to how health insurance programs could optimally function in the context of their national TB epidemic and TB policy targets. The promise of national health insurance, as a component of UHC reform, is often cited as including the following:

- Promoting better access to health services for a wider range of the population
- Increasing the availability of health services by purchasing care from a wider number of providers and improving regulation of the private sector
- Protecting households from impoverishment due to high out-of pocket spending

4 World Health Organization "Health Financing for Universal Coverage," http://www.who.int/health_financing/universal_coverage_definition/en/index.html; 2012; accessed June 15, 2012

The workshop raised critical questions about how each of these potential benefits may or may not be achieved in relation to delivery of TB services. It also discussed the conditions and processes which need to be put in place in order to make health insurance programs supportive of TB control targets. As national health insurance programs display a wide heterogeneity in their structure and formats, and are designed to accomplish different objectives depending on national policy, the workshop participants each came to the discussion with unique perspectives and differing country experiences. Although a wide variety of models exist (see Box 1), similar themes and recurring issues which emerge regarding the optimal delivery of TB services in the context of health insurance allow room for sharing of practices and discussion of key principles for successful planning and organization.

Through expert presentations, meeting participants discussed the implications of the introduction of insurance-based financing in the context of the End TB Strategy, as well as in the context of trends in financing and the TB situation in Asia, and through the lens of ensuring TB services are provided according to the International Standards of TB Care. Presentations highlighted the experience of countries with advanced health insurance programs such as the Philippines, Thailand and to an extent Indonesia, and the components of other planned social or national health insurance reforms in the region.

There are important design principles that apply to all health insurance systems, on a general level.[5] In addition, there are considerations that are specific to TB. An emerging framework for analyzing TB and insurance contains the following components:

1. TB and UHC policy objectives (ensuring that TB objectives are included in UHC)
2. Administration and organization (coordination between the NTP and the insurance authority, including a mechanism for routine engagement)
3. Service delivery (defining benefits package and ensuring that all patient needs are covered)
4. Access (reviewing the continuum of care including referrals, and educating patients around access)
5. Engaging providers (licensing and role of professional associations; reimbursement and incentives)
6. Ensuring quality of care (monitoring patient outcomes; patient centered care)

Each of these components is discussed in more detail in the following sections.

Box 1. Overview of the Current State of Health Insurance in Workshop-participating Countries

CAMBODIA: While there is no widespread national health insurance program, various health protection schemes exist, including Health Equity Funds (an NGO-supported social protection scheme which reaches 58 of 82 districts) and a limited community-based health insurance program.

CHINA: Health insurance provided through the New Rural Cooperative Medical Scheme, Urban Employee Basic Medical Insurance and Urban Resident Basic Medical Insurance; over 95% population coverage.

INDONESIA: BPJS/ Jaminan Kesehatan Nasional (JKN) national health insurance program introduced in 2014; includes strong regulatory and accreditation component, geared at increasing involvement of private sector. Aiming for universal coverage by 2019.

LAO PDR: In the absence of a national health insurance program, TB services remain financed through MOH line item budget.

MALAYSIA: TB services remain financed through MOH line item budget; reforms are under consideration

PHILIPPINES: National health insurance provided through PhilHealth, covering around 80% of the population. Includes a TB DOTS benefit package and incorporates certification/ accreditation process.

THAILAND: Insurance benefits are provided under the Civil Servant Medical Benefit Scheme, Social Security Scheme for formal sector employees, and the Universal Coverage Scheme, collectively reaching nearly 100% of the population.

VIETNAM: An existing social health insurance program reaches 68% of the population; TB services are excluded and provided through the national program, though reforms are underway.

5 For example, see the "Health Insurance Handbook: How to Make It Work" World Bank Working Paper #219, https://openknowledge.worldbank.org/handle/10986/5913

1. TB and UHC Policy Objectives

TB services have had a privileged position in many health systems, with earmarked financing and free services, at least in the public sector. Insurance reforms bring the promise of increased access and equity in health services generally, but they may result in less attention being paid to TB. However, this attention is still needed, given the burden of TB, and its infectious nature and public health importance. A policy discussion is needed to ensure mutual understanding on this issue.

An important principle highlighted during the workshop was the necessity of defining the essential public health functions of a national TB program. This should be maintained in the context of introducing a strong health insurance authority with responsibility for organizing and monitoring service utilization. There is a need to discuss and fund the operation of the NTP's policy and supervision functions, and its oversight and support for supply and TB commodity management. The division of responsibilities for TB and multidrug-resistant TB (MDR-TB) diagnostic and clinical services between the national program and insurance program also needs to be carefully planned. All necessary TB diagnostic, treatment, and care services should be available free of charge according to national standards. Thus, any gaps between what is covered by the insurance program and the national standards for TB care need to be monitored and covered by the national program. This underlines the responsibility of the NTP both to continue to lead in developing standards, supervising implementation, and monitoring outcomes, and to be able to provide any services not covered by insurance networks.

2. Administration and Organization

There is a need to ensure coordinated planning between the health insurance authority and NTP, plus other policy makers and financing authorities. This coordination is critical to facilitate a phased introduction of TB insurance benefits, especially if this correlates with a reduction in funding or responsibilities for delivery of clinical services by the NTP. The timing for introducing TB-related insurance benefits should ensure that the existing level of access to TB services is maintained (i.e., through direct provision of free services from the public sector) if and when responsibility for financing service delivery shifts to the insurance authority, to avoid a situation where access to free TB services is weakened before the insurance-based service is available. This is particularly important for TB, since insurance schemes may initially show greater enrollment by higher-income populations (such as government or other salaried employees), thus potentially missing the low income populations that have the highest burdens of TB.

The introduction of health insurance alongside the national program has the potential to create a two-tiered service delivery system, with overlapping delivery networks between the insurance provider and the NTP. This can fragment funding streams, reduce the risk pool, and create confusion among patients and clients about where they should seek TB services. Coordination efforts should anticipate and help reduce this potential challenge. Critical NTP functions including the definition of policies and guidelines, supervision, and research and surveys should be facilitated by coordination of data collection and flow between NTP and the insurance authority. The two entities can play complementary roles in data collection, but coordinating this requires significant discussion.

3. Service Delivery

The package of insurance benefits for TB must be carefully defined in coordination with the NTP to ensure that all internationally recommended TB prevention, care, and treatment interventions are available and accessible.

Health insurance programs traditionally do not include a strong preventive or health promotion function, so they may struggle with the competing goals of finding patients early (which costs money in the short term) and minimizing service delivery costs. Defining the correct balance between the work of the national TB program and the mandate of the insurance program—as described above—becomes essential to ensure a continued emphasis on prevention and early detection.

In the long run, national health insurance programs may aim to include coverage for all TB and MDR TB curative services. However, during the initial introduction of insurance benefits, insurance funds may be limited and TB benefits may need to be more narrowly defined, e.g., to include only inpatient services or only drug-sensitive (DS) TB DOTS services. Such a situation raises several concerns. First, it excludes MDR TB, pediatric services, or services for other complicated cases, which would remain the purview of the national program, and the national program would have to ensure full funding to minimize out-of-pocket costs for these patients. Second, a patient who

cannot utilize the insurance program to cover all aspects of care will need to use different providers for different services. This may result in delays or potential for loss to follow-up. If the health insurance is unable to cover all necessary services, close coordination with the national program is critical to ensure that patients adequately move between service sites without experiencing gaps in care. This will require the establishment of a strong referral and follow-up system.

Given the gap between estimated MDR TB cases and the number able to access services within the current infrastructure, there is a need for countries to examine their systems for scaling up access to MDR TB diagnosis, treatment and support services. The possibility of expanding coverage for MDR TB benefits provides a potential means of increasing financing for these services and increasing the number of providers engaged in delivering MDR TB benefits. However, since many providers lack the necessary training in MDR-TB treatment, in many insurance systems, MDR TB treatment is still most often offered at limited sites directly supported by the NTP. Efforts to define a benefits package for MDR TB should also include models for expanding decentralized service provision (i.e., in tandem with efforts to introduce community programmatic management of MDR TB) and to increase the role that health insurance can play especially in supporting referrals, ambulatory treatment phases, and patient adherence. Insurance programs should be encouraged to develop mechanisms for partnering with other TB providers, i.e. at the community level, to support a continuum of patient care.

4. Access

As of yet, there is insufficient evidence on whether health insurance benefits increase or decrease access to services for TB diagnosis, treatment and care. Anecdotal evidence from the workshop provided a range of circumstances through which insurance might or might not benefit a patient. Success depended on access to an accredited provider (i.e., how many providers the client went to before finding one with appropriate licensing), knowledge and understanding of how to navigate the insurance system and utilize benefits (i.e., whether the client presents themselves as an insurance customer or has met all the requirements for reimbursements or subsidies), and whether the service needed matches an insurance benefit (e.g., outpatient vs. inpatient care; DS TB vs. MDR TB).

UHC aims to both improve access to services and eliminate financial hardship in paying for those services. However, UHC programs do not generally consider indirect costs, which can be addressed instead by social protection programs. A common gap in insurance programs reviewed was around the integration or coordination with social support benefits including transportation, nutrition, and other support services. With a few exceptions (e.g., the social protection programs in Cambodia), community-based care and support services are excluded from health insurance benefits. A high proportion of TB patient costs occur before the patient is diagnosed in a formal health care setting, so the impact of insurance on reducing patient costs may be limited unless efforts are made to engage and reimburse community-based providers and/or incorporate other direct patient benefits to cover indirect treatment costs.

5. Engaging Providers

The country experiences covered by the workshop participants stressed the complexity of developing a highly functional, transparent, and effective purchasing and reimbursement mechanism for TB providers. Although health insurance programs have much potential to increase the involvement of additional health providers to diagnose, refer, and/or treat TB cases, retaining providers and ensuring their continued involvement in the insurance system relies on the ability to easily and quickly provide reimbursements. Among the potential payment models discussed, including case-based payments, capitation, fee-for-service, and others, the advantages and disadvantages were highlighted, depending on the type of service or service site and the additional administrative or organizational requirements associated with monitoring and managing the payments.

The workshop identified the need for additional evidence on how to effectively match payments to performance or incorporate targets for service delivery outcomes into insurance schemes. Many insurance schemes provide funding simply tied to the delivery of a clearly defined package of services rather than to a treatment outcome, such as completion or cure. However, more advanced insurance financing schemes offer the potential to introduce payments linked to patient outcomes or to public health interventions. In this case, insurance-based financing can often be far more flexible than government line budgets, and thus more amenable to the introduction of these performance-based financing measures.

Payment mechanisms that are linked to structured accreditation and licensing/certification systems can allow both the insurance authority and the NTP to maintain oversight of the skills and capacities of providers, and mandate service standards; these act as a “lever” for ensuring in-network providers deliver services according to TB standards. This direction is being pursued with great vigor in Indonesia, though much of the necessary work is only just beginning. In practice, the management of the licensing/certification and accreditation process can be challenging, due to the large amount of administration and follow-up required. Different organizations can be considered to take on this task: medical societies have the ability to reach their members, but may lack the necessary regulatory mandate and often the organizational capacity; while the capacity of the NTP may be challenged if the country’s administration is decentralized.

6. Ensuring Quality of Care

The level of quality of services in an insurance-based system is ultimately the most critical barometer of the effectiveness of the program—patients should be receiving care which is timely, appropriate, and effective. To date, few measures have been made to comparatively demonstrate the quality of TB care in an insurance-based system, and to provide an understanding of how the various mechanisms may work to assure quality. The workshop highlighted strengths and weaknesses of several interrelated quality mechanisms, including payments schemes, monitoring systems, and accreditation.

Payment schemes, as discussed above, provide a powerful tool to restrict or direct the delivery of services. For example, quality under insurance systems can be improved via non-reimbursement of unapproved drugs or tests, and by linking payments to other indicators such as re-admission rates. Any payment scheme will introduce perverse incentives, so it is important to implement quality measures that can monitor for these effects so that remedial action can be taken quickly. At the same time, each quality measure requires more paperwork and monitoring, so there will always be pressure to minimize such initiatives. In the developed world, these quality measures are based on data analysis rather than inspectors; the same will be necessary for many private sector initiatives in certain low income settings, due to the overwhelming number of private providers.

Monitoring service provision is a well-documented challenge. On the positive side, under an insurance system, a healthcare worker needs to provide data in order to get paid. When insurance-based financing is used at the primary healthcare level, however, capitation is typical. To get this funding, a provider must report the number of people under his or her care, but not the individual health conditions (such as TB) that are being treated. Thus, it will be difficult to get the necessary TB data from a recording system that is designed with only the insurance system in mind. Even at higher levels of the health system, which may have fee-for-service instead of capitation, the billing records may record only “infectious disease” rather than TB, and would typically not include data on outcomes.

The efficiency of insurance is based on averaging the cost per patient, rather than itemizing everything. The challenge facing the TB program is to formalize the essentials of TB standards of care (such as the International Standards for TB Care (ISTC)) into a simple list of actions that trigger insurance payments.

This level of quality monitoring is typically the purview of a national TB program. The mandate of an insurance system will extend beyond TB to include wider health services, so it will have less flexibility and less reason to focus on a specific disease area than a vertical program such as the NTP. Thus, there will likely be a continued need, after the introduction of an insurance scheme, for the NTP to monitor quality. In Japan, which has a highly developed system, this role was carried out by the public health centers, which did TB clinical audits to maintain quality. This quality control effort will need to maintain the standards already achieved in the public sector – and ensure they are not diluted by the more broad-based insurance program – but also monitor private sector engagement around TB. In many cases, a country may be starting with a much lower level engagement of private providers by the NTP. In this situation, any minimal information that can be obtained by the insurance system (e.g., number of TB diagnoses only) is a bonus and improvement over the status quo.

In summary, quality of care can be addressed under insurance systems via the financing carrot and the regulatory stick. The financing carrot can achieve some things, but, for TB many of the details will not be available. The insurance system will have pressure to make

payments dependent on the fewest conditions necessary to assure quality, in the interest of feasibility and efficiency. Regulatory approaches (see previous section) may offer supportive means to ensure quality is not compromised. The two mechanisms are, of course, related, since regulations can use the availability of the financing (i.e., the ability for a provider to receive insurance payments) as their regulatory stick.

Conclusions and Recommendations Moving Forward

Increased spending is needed to end TB, but donor contributions are expected to stagnate or decrease. Fortunately, countries are developing plans to transition to domestic financing for health and taking on UHC objectives. As part of this process, the TB community should facilitate consideration of health financing reforms that do not endanger TB services. The decision to include insurance-based reforms should be carefully made with due consideration of the country context including feasibility and appropriateness.

Participants of the workshop agreed that insurance represented an opportunity to engage more private sector (and previously unengaged public sector) providers in delivering high quality TB services – indeed, in countries with a large, unregulated private sector, insurance may be the main opportunity to align providers with guidelines and to minimize out-of-pocket expenses. But the introduction of health insurance also brings a potential risk of reducing the financing and capability of the existing public sector TB program to monitor, deliver, and oversee TB services. Any country proposing to introduce health insurance for TB services must carefully evaluate whether insurance will provide a more efficient and effective means of financing TB services, without sacrificing patient access or quality of care. In some cases this decision may be out of the hands of the TB program: national moves towards insurance-based financing for health services can create a powerful momentum. The path towards inclusion of TB services should be made with the close contribution of the national TB program. Many participants stressed that the introduction of insurance is usually deeply political, and is such a large undertaking that it requires a lot of "learning by doing"; TB services need to be part of this learning process.

The workshop demonstrated that there is a great need and interest in providing further practical guidance on how countries can approach planning for the design and roll out of health insurance in the context of maintaining support for critical disease programs such as TB. Several countries expressed the need for further knowledge of how the process had been managed in countries with existing programs (i.e., Philippines, Thailand, and, increasingly, Indonesia). For countries in South and Southeast Asia on the brink of health financing reforms, understanding the implications and requirements of different approaches is critical to ensuring proper planning is conducted, so that introduction of an insurance program results in optimal outcomes in terms of improved access to services, reduction in out-of-pocket costs, and ultimately, high quality care and improved treatment outcomes.

Beyond Asia, the workshop highlighted many critical issues that will be relevant for other regions where momentum for insurance-based reforms is growing, especially in countries in Sub-Saharan Africa with high burdens of TB. At a minimum, the outcome of the workshop justifies the need to support continued consultations between National TB Program managers and health financing and other policy makers or agencies involved in the design and planning of health insurance programs to promote more effective coordination and planning. Going forward, stronger and more concrete guidance on how countries can approach development of financing and/or insurance-based reforms in the context of their national TB and UHC objectives is required. This should be supported by the development of further evidence on the impact of health insurance on TB outcomes and the economic wellbeing of beneficiaries.

Annex A: Agenda

Time	Topic	Presenter/Facilitator
THURSDAY, SEPTEMBER 18, 2014		
9:00-9:30	Participant registration	
9:30-10:00	Introduction and welcome	Dr. Refiloe Matji
10:00-10:45	Panel I. TB and Universal Health Coverage	Dr. Refiloe Matji
	I. Pursuing TB-sensitive Universal Health Coverage policy as part of the post-2015 Global TB Strategy	Diana Weil
	II. The burden of TB patient costs and related access and adherence barriers	Knut Lonnroth
	III. Regional perspectives on health financing reforms	Ke Xu
10:45-11:00	Coffee Break (panel resumes after coffee break)	
11:00-12:30	Panel I. TB and Universal Health Coverage (resumes)	
	IV. Key practices and models for meeting financing needs for TB	David Collins
	V. Findings from TB CARE II health insurance case studies	Alisha Smith-Arthur
12:30-13:30	Lunch	
13:30-15:00	Panel II. Overview of regional models of insurance-based financing and TB service delivery	Nobuyuki Nishikiori
	I. Philippines	Dr. Celine Garfin
	II. Vietnam	Dr. Le Van Hoi
15:00-15:30	Coffee Break	
15:30-17:00	Panel III. Defining a benefits package for TB services	
	I. Overview of TB service provision requirements, WHO guidance	Dr. Mukta Sharma
	II. Considerations for extending TB benefit packages	Dr. Mao Tan Eang
17:00	Wrap-up and house keeping	
FRIDAY, SEPTEMBER 19, 2014		
9:00	Introduction and welcome for the day	
9:15-10:30	Group Work Session 1	
10:30-10:45	Coffee break	
10:45-11:30	Group Work Session 1 Presentations	
11:30-13:00	Panel IV: Planning and administering TB services effectively in an insurance-based system	Dr. Celine Garfin
	I. Planning and policy making for UHC-experience of Cambodia	Dr. Lo Veasnakiry
	II. Challenges and considerations for planning health insurance	Dr. Asmah Razali
	III. Increasing enrollment and ensuring utilization	Dr. Xuilei Zhang
13:00-14:00	Lunch	
14:00-15:30	Panel V. Engaging more providers effectively through insurance-based financing	William Wells
	I. Accreditation and engaging more care providers in Indonesia	Dr. Setiawan Laksono
	II. Approaches for working with the private sector to ensure access to and quality of TB services	Dr. Tamar Gabunia
	III. Models and approaches to incentivize providers to provide high quality TB care	Peter Cowley
15:30-15:45	Coffee Break	
15:45-17:00	Group Work Session 2	
17:00	Conclude for the day	
SATURDAY, SEPTEMBER 20, 2014		
9:00	Convene	
9:15-10:45	Group Work Session 2 Presentations	
10:45-1:00	Coffee Break	
11:00-2:00	Summary Panel	Dr. Refiloe Matji
12:00	Closing and thanks	
12:00-3:00	Lunch	

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