# Health Equity Fund initiative in Lao PDR and it contribution to the social protection and moving toward universal coverage

# Definition of HEF

- "is a form of social health protection target at those who are unable to pay the cost of health service at public facilities or health insurance premium of any kind. (HEF regulation, MOH Lao PDR)

- *Health Equity Fund is a demand-side financing mechanism to promote access to priority public health services for the poor in an environment where user fees are charged.* (Source: Por I et al, 2008)

- Cambodia-HEFS is a health financing strategy for Health Services for the poor (Report of HEF Forum-2009 PP)

- Vietnam (Health Care Fund for the Poor/HCFP)

# Why HEF is need for Lao PDR?

- Low coverage Health Insurance (75 % of the population in the informal sector, with very limited associative networks and 30 % of population belonging to minority groups)
- High private health expenditures (67% of Total Health Expenditures is from Out-of-pocket)
- Around 30 % of the population below poverty line and 66 per cent under 2 PPPUS$ per day
- Bias of public financing towards richest quintiles, central/prov level , Lao Loum (Government spent only 1/5 of THE on district health facilities and Health centers)
- Lack of effective mechanism to protect the poor from unaffordable health care costs, catastrophic health expenditures high (>14% of annual household consumption)

# Main purposes of HEF

1. To contribute to poverty reduction by protecting the poor from unaffordable routine and catastrophic health expenditures.
2. To reduce out-of-pocket expenditures for health by the poor.
3. To overcome barriers to access (financial and others) and to provide access for the poor to priority public health services.
4. To help integrate poor patients as users into public health system.
5. To increase utilization of public health services by the poor.
6. To help improve the quality of services in the public health care system.
7. To provide a social safety net for the poor and contribute towards the development of a uniform national universal health coverage system.

# Existing HEF in Lao PDR

| Indicator | Nambak District | Vientiane Province | Sepone District |
|---|---|---|---|
| Year HEF began | 2004 | 2005 | 2006 |
| Catchment population | 59,000 | 420,000 | 44,000 (34,000 covered by HEF) |
| Poverty status (NGPES) | Non-poor | Province close to Vientiane Capital with 2 very-poor districts out of 12 | Very-poor |
| % Poor in 2005 | 20% | 9% | 34% |
| Supported facilities | 1 DH + 4 HC | 1 PH + 1 IDH + 17 HC | 1 DH + 4 HC |
| Targeted for common health care benefits | Poor | Destitute | Poor |
| Target for additional benefits | IPD patient/ceiling, poorest villages, lower primary school pupils, remote villages | IPD patients without money, civil servants Caesarean Section in non-urban areas | |
| Pop. pre-identified for HEF | 4.652 | 11,230 | 7,957 |
| % pop. pre-identified | 8% | 3% | 23% |
| Other assistance schemes | CSS and CBHI | CSS, SSO and CBHI | None |

# Planned HEF in Lao PDR

| | HSIP/WB | HSDP/ADB |
|---|---|---|
| Year HEF began | 2008 | 2008 |
| Catchment population | 23,000 | 52,500 |
| Poverty status (NGPES) | Non-poor (1)<br>Poor (2)<br>Very poor (2) | Xiengkhuang province<br>Three poor districts |
| % Poor in 2005 | 10% | 23% |
| Supported facilities | 5 DH + 37 HC | 1 PH + 8DH + 48 HC+586 villages |
| Targeted for common health care benefits | Poor | All those living below the poverty line, which is an average of about 25% |
| Management model | third-party mechanisms using NGOs | Third party payer and Management committee |
| Pop. pre-identified for HEF | | |
| % pop. pre-identified | | |
| Other assistance schemes | CSS,SSO and CBHI | CSS, SSO and CBHI |

# Key components of HEFs

- Targeting and eligibility
- Benefit package
- Coverage and quality of public health services
- Management arrangement
- Payment mechanism and quality improvement
- Sustainability

# Target and eligibility (identify the poor beneficiaries)

- Geographical targeting (a majority of households living below the poverty line are considered to be common group of eligible beneficiaries. Simple and cheap but includes in the target group people who may not be poor).
- Pre-identification (household survey using list of objective criteria. This method is both the most accurate measure and the most expensive, poverty is dynamic ).
- Post-identification (*selection at health facility when disease occurs by interview)* is simple and inexpensive but cannot reliably identify all eligible poor people living within the facility catchment area (only those who chose – by self-selection – to attend facilities).

# two types of error of objective criteria :

- Exclusion error – refers to the mistaken exclusion of households who *are* genuinely poor but for some reason *have not* been included through the pre-identification process (Under-coverage)
- Inclusion error – refers to the mistaken inclusion of households who *are not* genuinely poor but for some reason *have* been included through the pre-identification process. (Leakage)

# Objective criteria

Poverty screening

**Name of Head of Family:** ..... **Khet** .....

**House No:** ..... **Village** .....

**Number of persons in the family (from family book):** .....

| | | | | | | | Score |
|---|---|---|---|---|---|---|---|
| **Children < 15** | **0** | **1** | **2** | **3** | | | |
| Nbre of children | 5 and more | 4 or 3 | 2 or 1 | 0 | | | 2 |
| **House walls** | **1** | **2** | **3** | | | | |
| Made of | Bamboo Leaves Grass | Wood | Bricks Stones Ciment | | | | 1 |
| **House roof** | **1** | **2** | **3** | | | | |
| Made of | Grass | Bamboo Wood | Iron Fibro | | | | 3 |
| **TV** | **0** | **1** | | | | | |
| No/yes | No | Yes | | | | | 0 |
| **VDO/VCD** | **0** | **1** | | | | | |
| No/yes | No | Yes | | | | | 0 |
| **Bicycle** | **0** | **1** | | | | | |
| No/yes | No | Yes | | | | | 1 |
| **Motorbike** | **0** | **2** | | | | | |
| No/yes | No | Yes | | | | | 0 |
| **Tractor** | **0** | **2** | | | | | |
| No/yes | No | Yes | | | | | 0 |
| **Cash Income/year** | **0** | **1** | **2** | **3** | **4** | **5** | |
| in kips | < 500,000 | 500,000 to 1,500,000 | 1,500,001 to 2,500,000 | 2,500,001 to 3,500,000 | 3,500,001 to 4,500,500 | more than 4,500,500 | 1 |
| **Own a shop** | **0** | **1** | | | | | |
| No/yes | No | Yes | | | | | 0 |
| **Plant Cereals** | **0** | **1** | **2** | **3** | **4** | **5** | |
| Kalong | 0 | 1 or 2 | 3 or 4 | 5 or 6 | 7 or 8 | 9 and more | 1 |
| **Chicken/Duck/....** | **0** | **1** | **2** | **3** | **4** | **5** | |
| Nbre of animals | 0 | 1 to 10 | 11 to 20 | 21 to 30 | 31 to 40 | more than 41 | 1 |
| **Pig/Goat/** | **0** | **1** | **2** | **3** | **4** | **5** | |
| Nbre of animals | 0 | 1 to 3 | 4 to 6 | 7 to 9 | 9 to 12 | 13 and more | 1 |
| **Buffalo/catlle/horse** | **0** | **1** | **2** | **3** | | **5** | |
| Nbre of animals | 0 | 1 | 2 | 3 | | 4 and more | 1 |

| **Total** | 12 |
|---|---|

# Benefit package

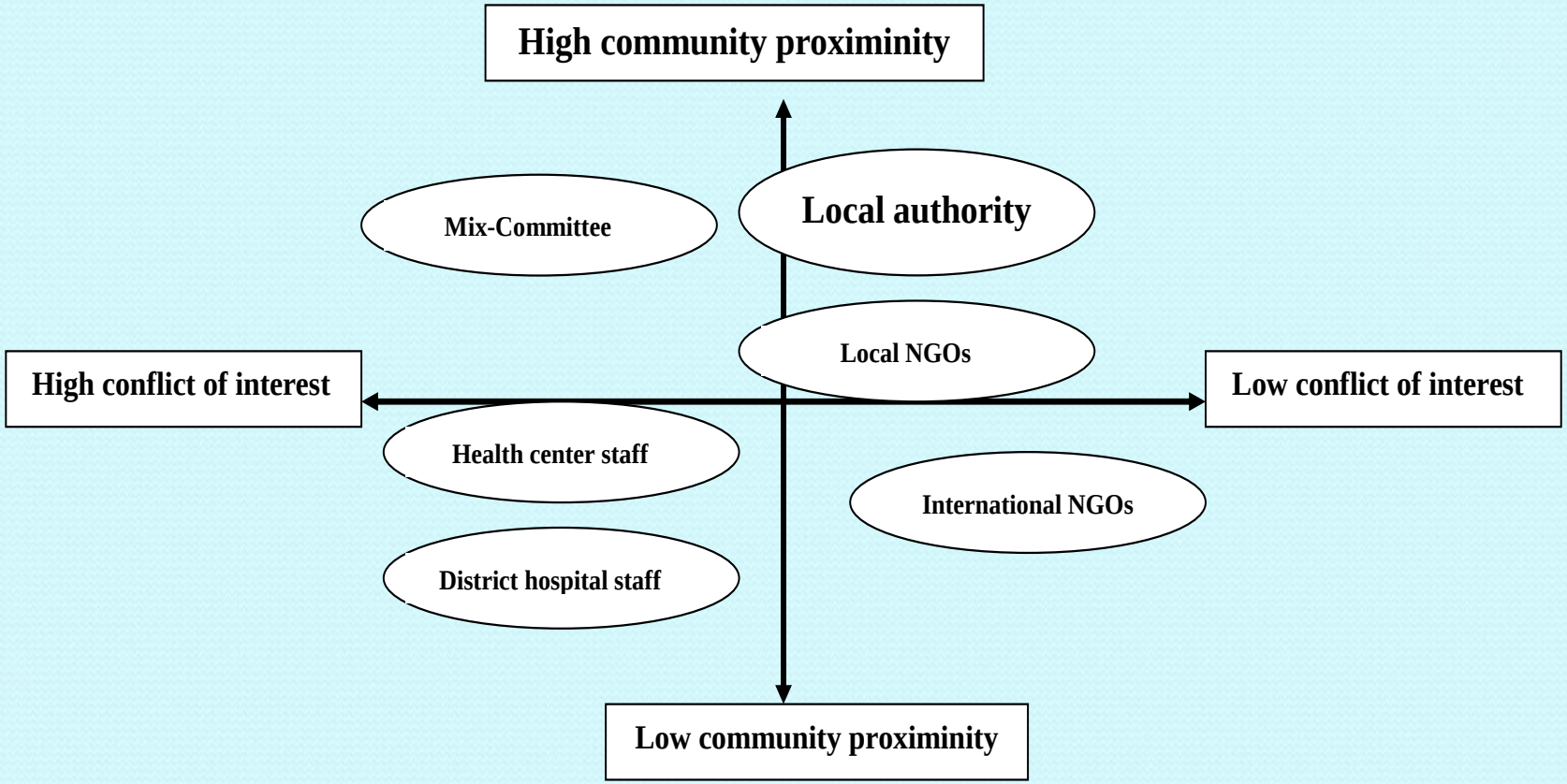
- Cover fees for health care provided through:
  Consultations at health centers, OPD care at the district hospital, IPD admissions at the district hospital
- cover the costs of patient transport from home to facilities and for referral to higher level facilities
- The costs of providing subsistence for the patient and one family carer needed to look after patients admitted for IPD services
- *In Nambak it includes specific round EPI in poor villages and other preventive/promotion services focused to poor villages*

# Coverage and quality of public health services

- HEF-through the public health service only (Health center, District hospital and Provincial hospital)
- Low population catchment and imposes limits on the absolute level of medical skill.
- Improving delivery of health care
  - Broader implementation of HEF procedures
  - Monitoring and assisting the quality improvement process
  - Public-private cooperation

# Management arrangement

**Type of HEF operators Vs Proximinity and Conflict of Interest**



# Management Arrangement (Cont. )

- Management committee (central, provincial and District HEF committee)
- Third party Payer (also Third party manager- high cost, but it seems to be effective)
- HEF management unit (central, provincial and District HEF committee)

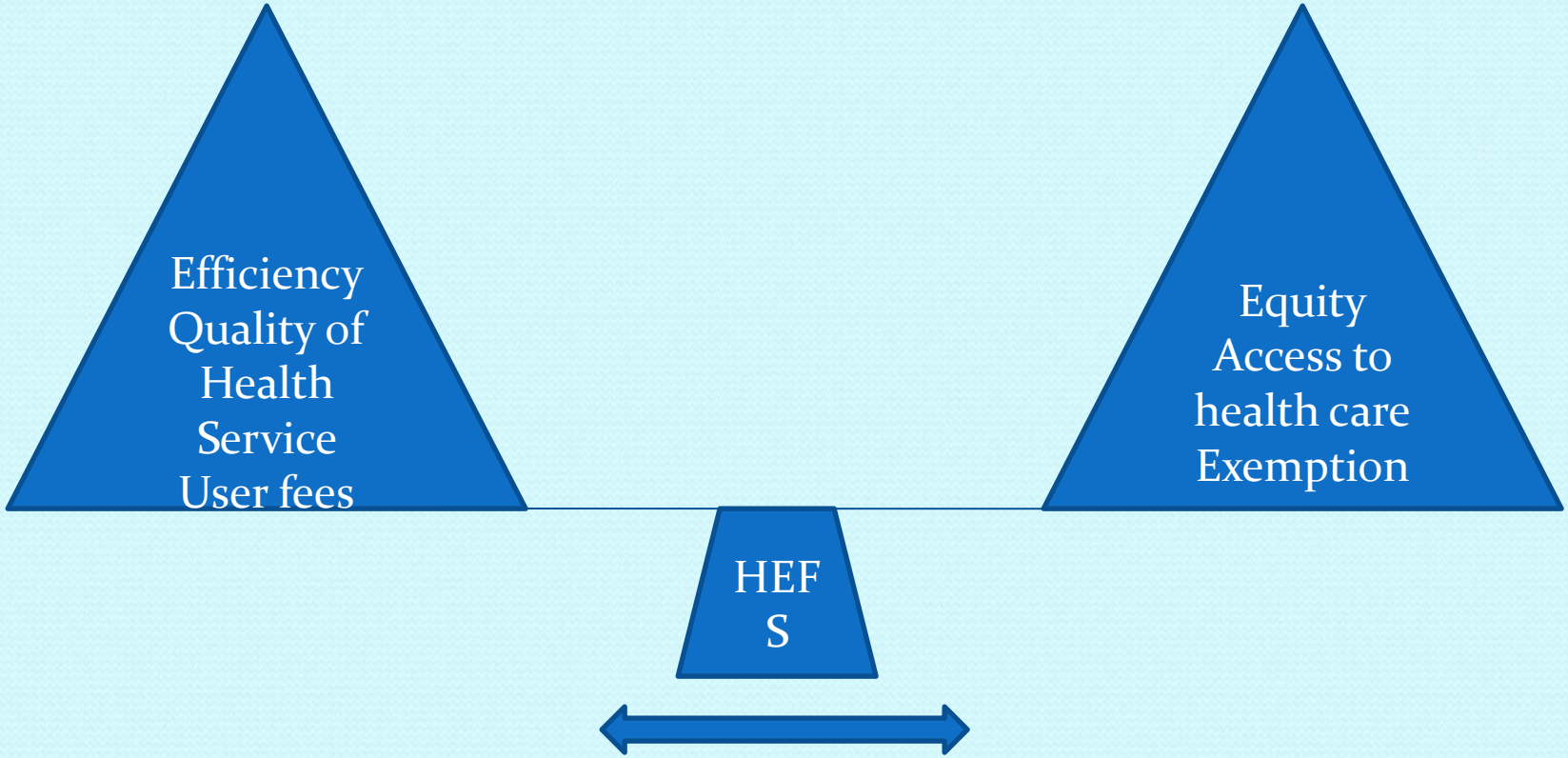
# Payment mechanism

- Reimbursed Fee-for-Service ("pay all bills")
- Reimbursed a fixed amount by type of disease (e.g. OPD, delivery, admission without surgery, medium surgery, major surgery)
- Capitation based (Calculation to be based on the average monthly number of OPD, IPD and obstetric admissions in the previous twelve months, the average user-charges per OPD, IPD and obstetric admission, and the total number of identified HEF beneficiaries in the district )

# Sustainability

- Currently existing and planned HEFs are donor dependent. Consequently, sustainability and accountability are common concerns
- With regard to financial sustainability- mixed funding might be away forward and link with Social Health Insurance (CBHI, SSO, CSS) as a possible way to move towards sustainability.

# The competition of two systems



"….Health Equity Fund can be the most important strategies for health financing , if successfully developed and implemented, because HEFs ideally require certain minimum social and medical skills, a network of community volunteers and an effective independent administration …"

Thank you