Provincial Health Department of Vientiane Province

Supported by the Luxemburg's & Belgian Co-operations

Social Protection Schemes

As part of Health System Strategies To Improve Access to Care

A Case Study in Vientiane Province, Lao PDR

Pre-ASSA Meeting , Louang Prabang – April 24, 2008

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Contents

I. Context – Health Financing

- **Under-funded** (low per capita health care spending, low government funding)
- **Inequitable** (overly dependent on direct household expenditure for curative care)
- **Affordability is a major issue** for a majority of people, mainly in rural areas, mainly ethnic groups
- **Developing social protection schemes but with still low coverage** (75% of population in informal sector)
- **Low productivity**
- Weak synergies between government, donors and beneficiaries resources

II. Case Study in Vientiane Province

2.1. Context

- Vientiane Province: ~420.000 people, more well-off
- Health Reform and Support: 2 major health projects
- Approach:

  Health Systems Strengthening (bottom-up and top-down)

  ➡Network – Infrastructure & equipment

  ➡Capacity Building

  ➡Systems

  ➡Financing

  ➡(Demand side – behaviour change)
- Social Protection: 1st Province with all 4 schemes

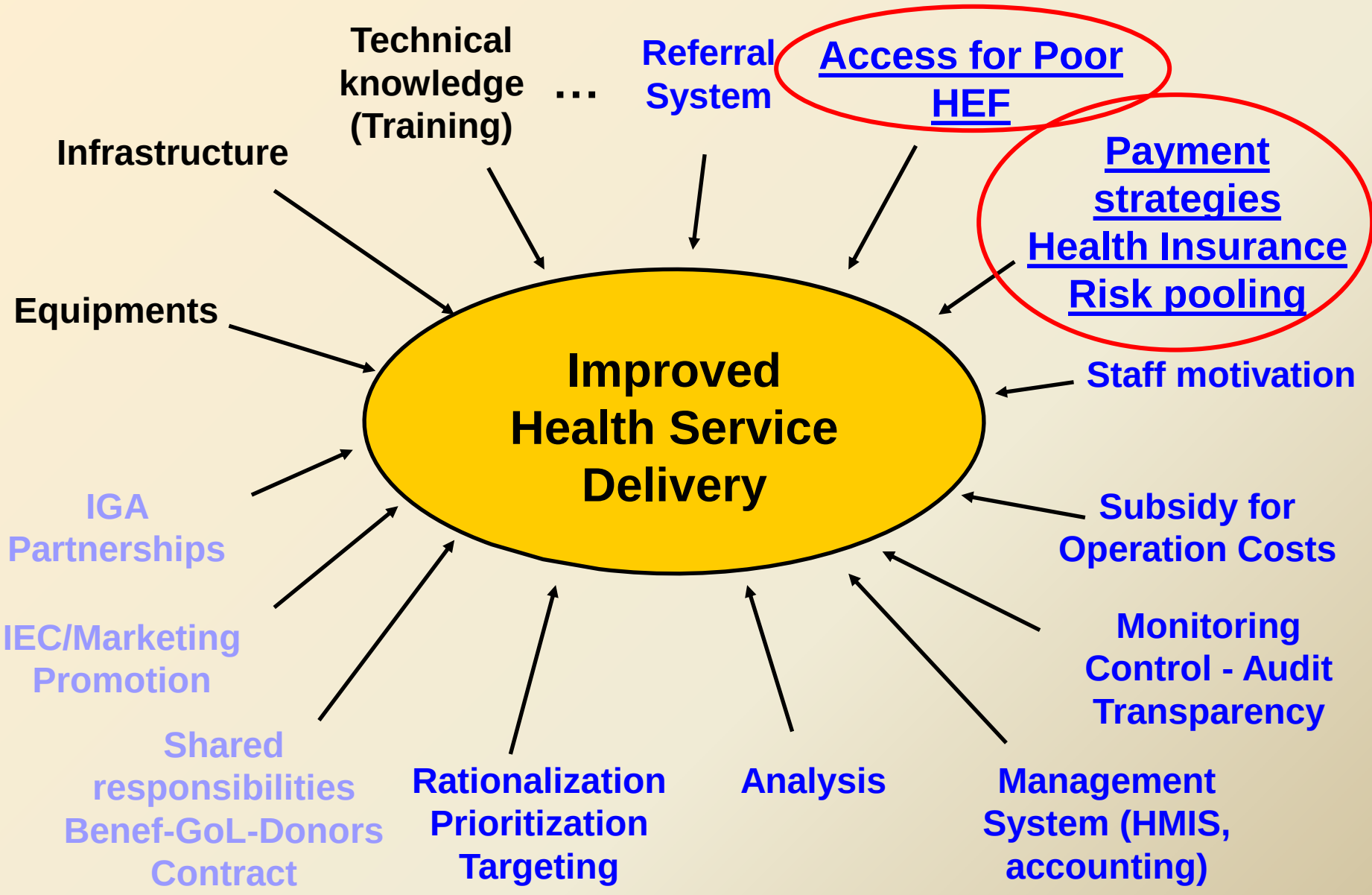

VIENTIANE PROVINCE, LAO PDR
Luang Phabang Province
Xieng Khouang Province
Sayaboury Province
THAILAND
Kasy
Vangvieng
Saysomboune Special Regon
Hom
Met
Hinheub
Feuang
Longsan
Keo Oudom
Phonhong
Vieng kham
Thoulakhom
Vientiane
Subdistrict Koukadou
Ban Mai Pakthom
Xanakham
Province boundry
District boundry
Mekong
District
District Hospitals

2.2 Health Financing Strategies

Objectives

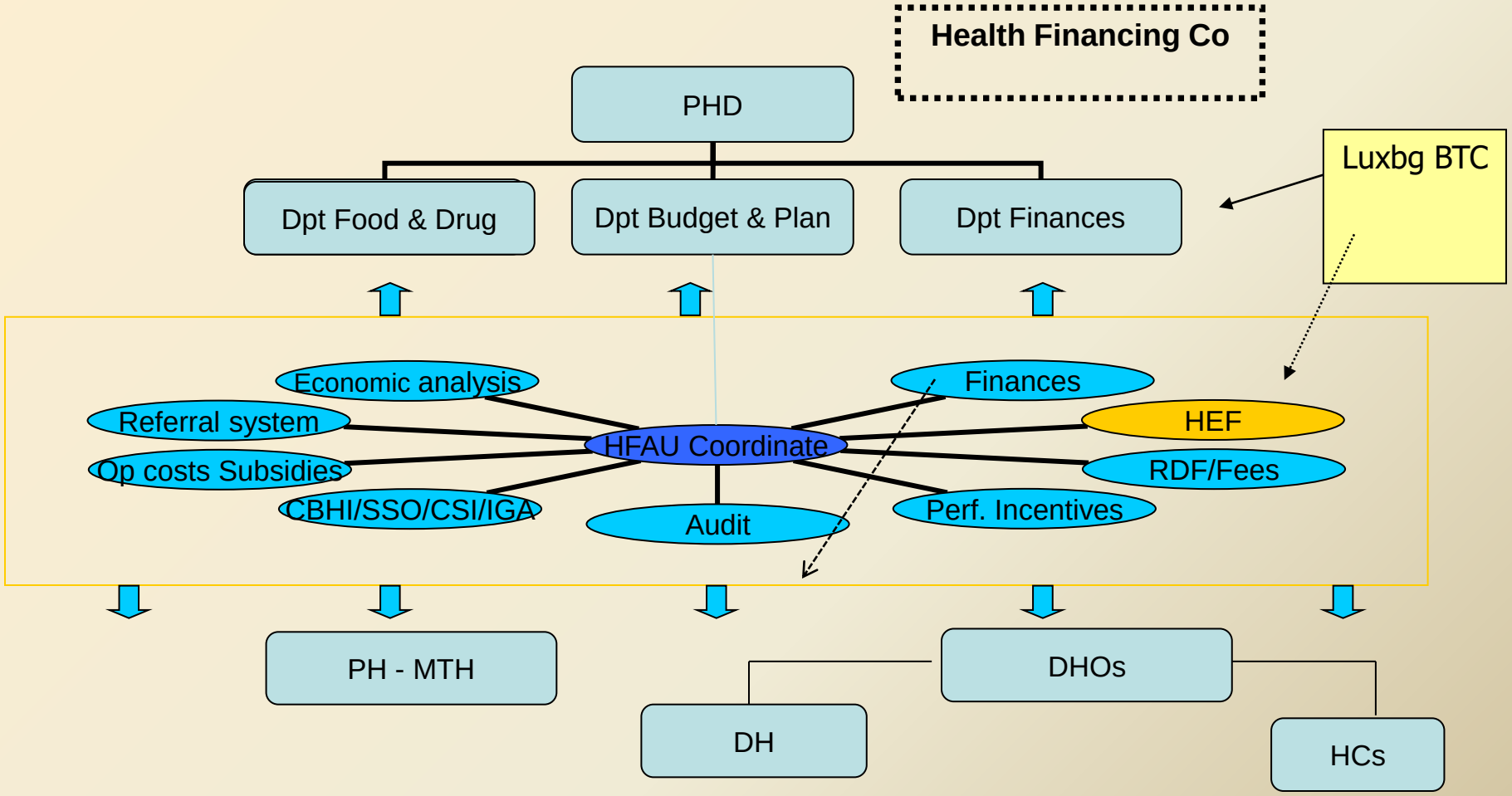
1. **Contribute to improved service delivery**
   - **Improving coverage (quantity of curative and preventive)**
   - **Improving quality of service delivery**
2. **Improve financial accessibility and equity by:**
   - **Developing pre-payment and risk pooling**
   - **Limiting the perverse effect of out-of-pocket payments**
   - **Developing safety nets for the poor**
3. **Improve performance and efficiency**
   - **Ensuring sufficient stable and regular revenue over time**
   - **Avoiding fragmentation and verticalization**
   - **Adequately motivating providers to improve health outcomes and responsiveness**
4. **Work with concern for financial & technical sustainability**

2.2 Health Financing Policy- Components

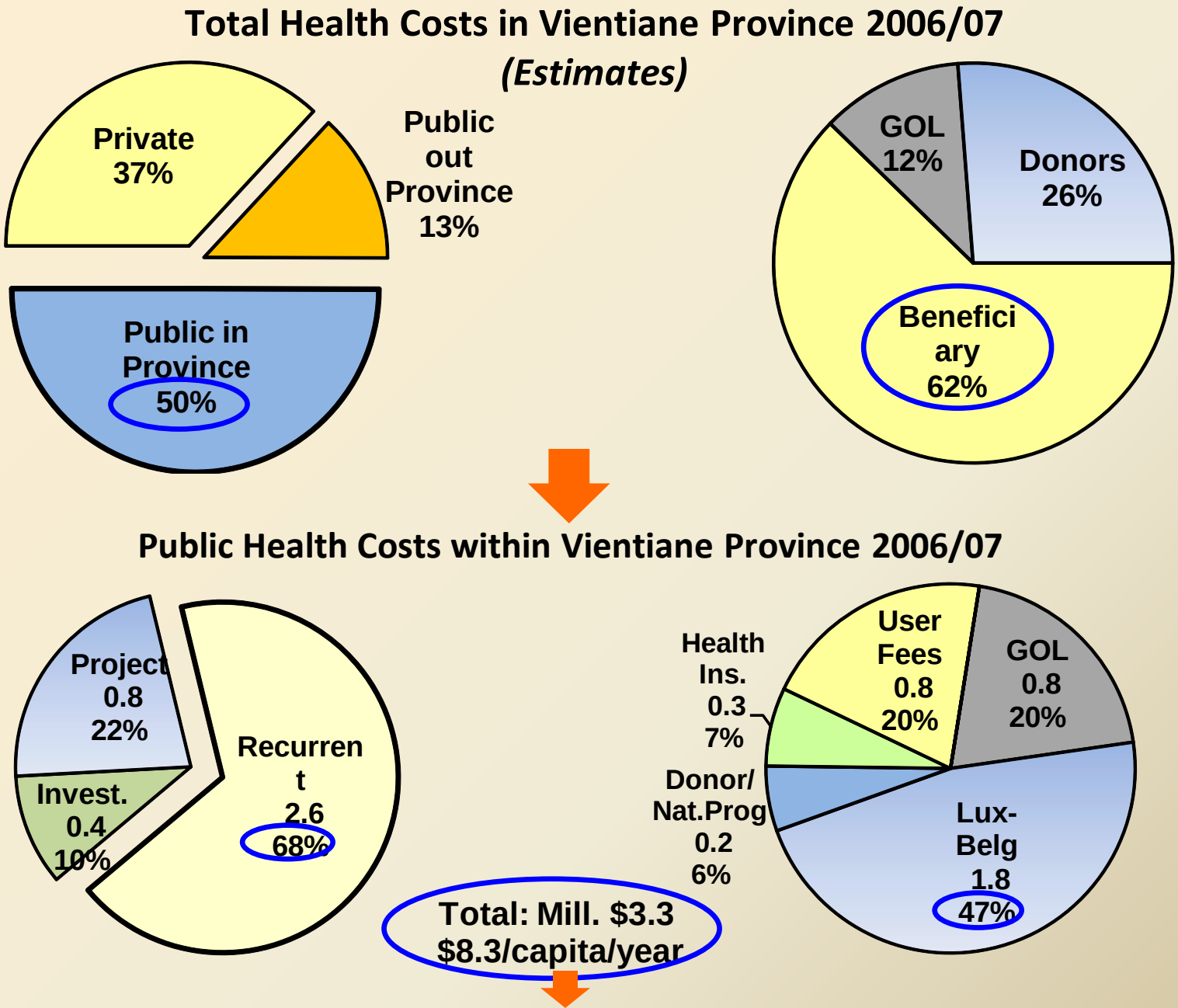


2.2. Health Financing Policy: Organization

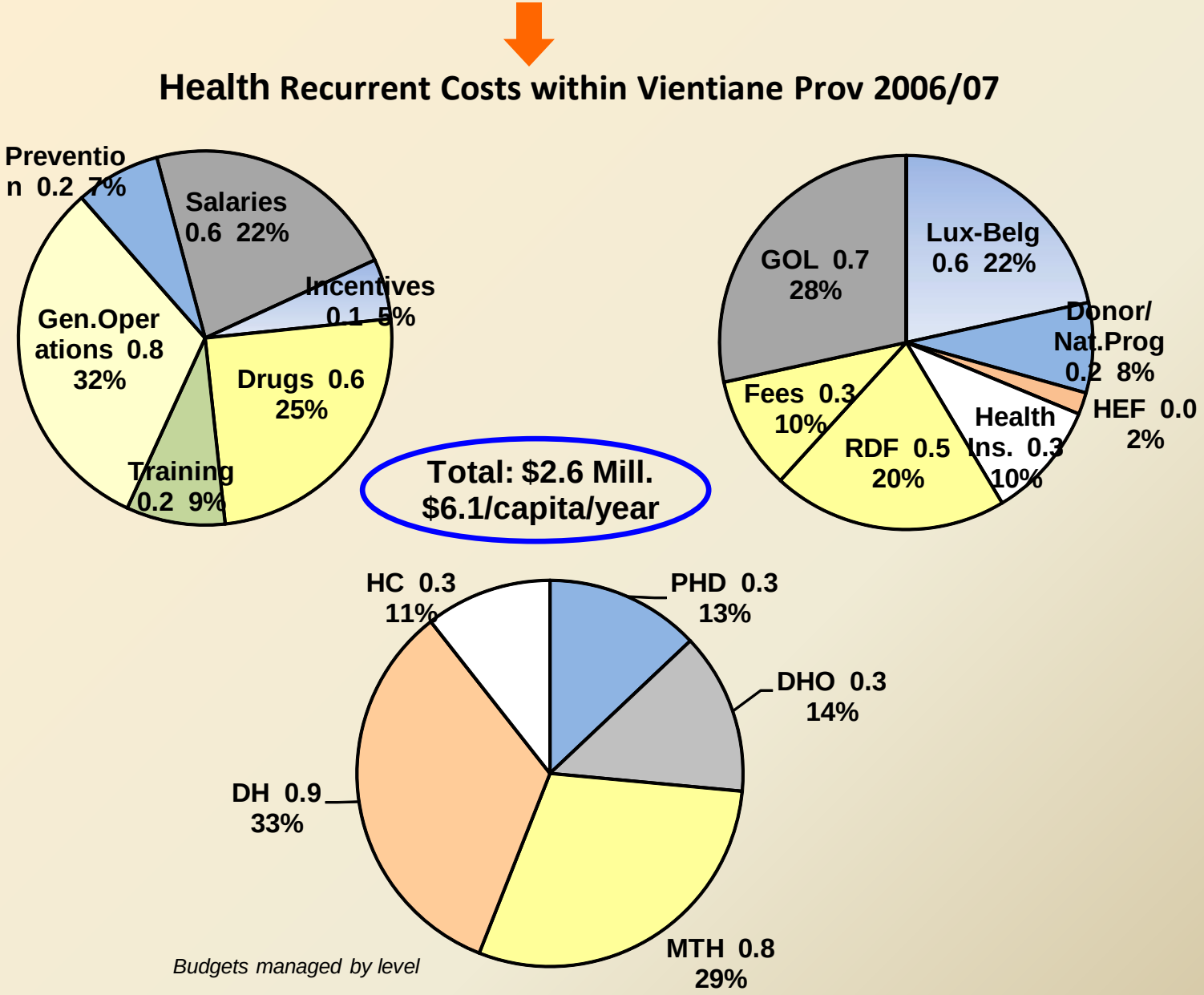
- Provincial Health Financing Audit Unit (HFAU)
  - Working groups ➔ Ad-hoc unit ➔ Formal



2.3.Picture: Health Financing in Vientiane Pr.



2.3.Picture: Health Financing in Vientiane Pr.



2.4 Social Protection Schemes

	SSO	CSI	CBHI	HEF
Target	Private sector	Civil Servants	Non-salaried Informal	Very Poor C/S, Catastrophic
Beneficiaries	Empl, Spouse, Child<18	CS, Spouse, Child<18, Pens	Household	Household Pre-Ident.(Card) Post-Ident. (Hospital)
Type	Mandatory	Mandatory	Voluntary	(Voluntary)
Financing	Employee-Employer	Civil Servant-Government	Members (vary w/ size ~60.000k/p/y)	Donors (Luxbg - Belg)
Benefits	OPD-IPD Excl. road acc.	OPD-IPD Transport	OPD-IPD Excl. road acc.	OPD-IPD (IPD only in Post-Ident.) (all C/S non-urban area) Food-Transport
Management	SSO	MOLSW	CBHI PH-PHD CBHI District	PHD HEF Unit
Payment to provider	Capitation 65.000k/p/y	Capitation 40.000k/p/y	Capitation ~90% premium	Fee-For-Service Flat fee C/S

2.5. Results

A. General Health Financing Strategies

A General Health Financing Strategies

	Strategy	Results 2005/07
1	**HFAU** (Health Financing & Audit Unit)	1st Provincial HFAU: Flexible, alignment of 2 donors
2	**HFMIS** (Health Financing & Management Information System)	•Basic comprehensive accounting in all facilities consolidated at PHD •MOH Health Information System
3	**Subsidies Incentives**	•Performance subsidies based on quantity & quality of services •Responsibility incentives to managers subsidized by projects •Staff incentives ($10-$30) based on attendance/quality •Progressive decrease in subsidy co-financing ~20% (20% Fee, 5% RDF)

A General Health Financing Strategies

	Strategy	Results 2005/07
4	**Subsidies Op. Costs**	•**Mainly at delivery facilities: PH ($5.600/m digressive), DH ($1.700/m) HC ($50-$200/m)**
5	**Audit & Monitoring**	•**Quarterly audit in all facilities on finances, drugs, HEF, Referrals, HIS, general quality of service**
6	**Referral System**	•**Policy design and procedures** •**Agreement on price for private and public transports from DH to PH**
7	**User Fees (RDF-Fees)**	•**Standard Provincial RDF management** •**No loans to staff and bad debts** •**Rules for use of income from fees** •**Regular audit & monitoring** •**Policy on drug procurement and maximum selling price**

TOTAL PACKAGE: $0.7/Cap/Year

Problems with current Revolving Drug Funds + Service Fees

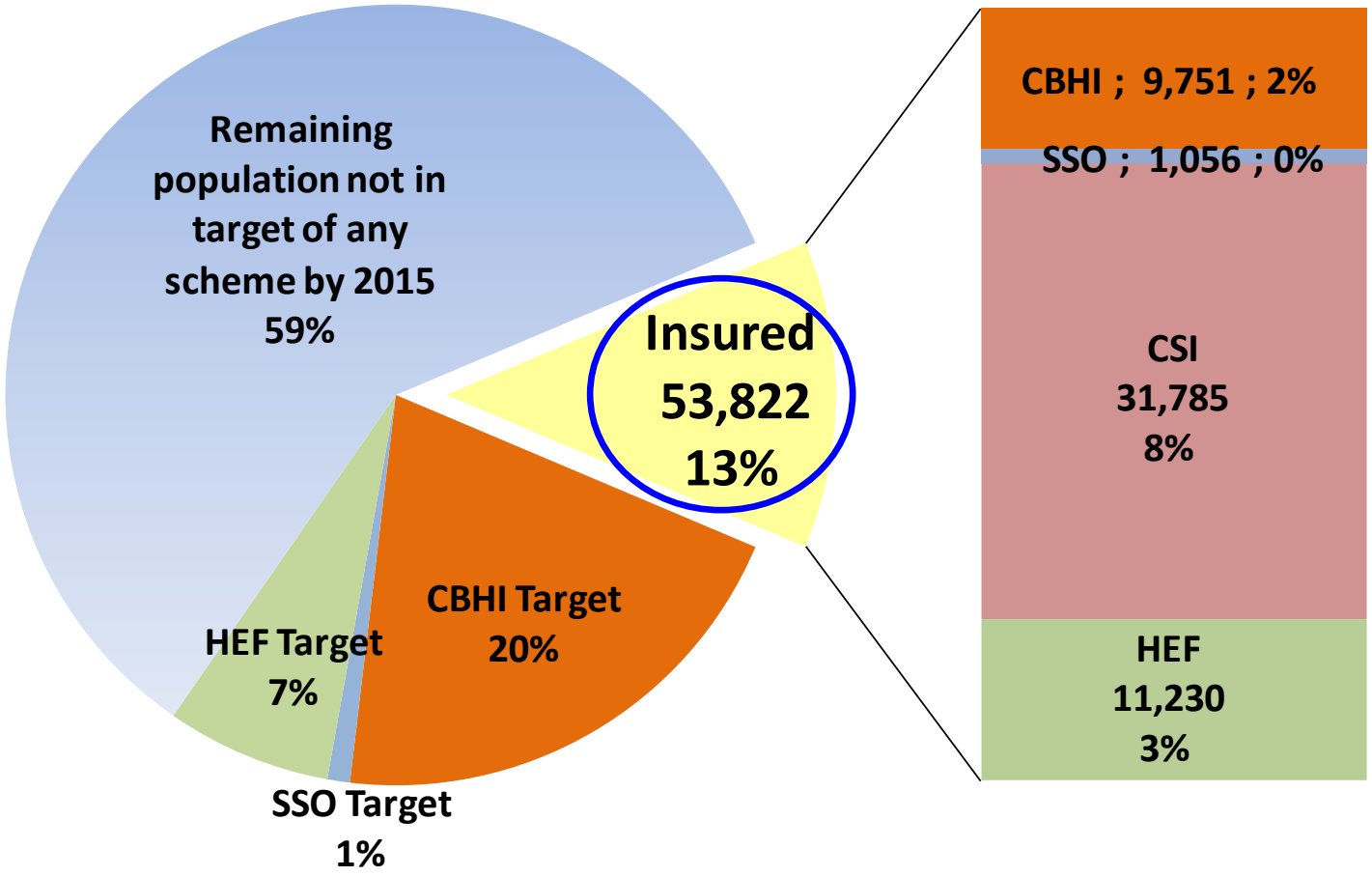
- **<u>Demand-side</u>: inequity, financial barrier/catastrophic health expenditure, delayed seeking care, incomplete treatment, non predictability, not user friendly**
- **<u>Provider-side</u>: incentives for over-prescription, cost inflation, promotion of sophisticated technology, non-optimal drug procurement, price variation**

- ***<u>Perverse effects</u>*: low government funding => reliance on RDF/Fees => business approach to 'sell' the most 'profitable' services**

2.5. Results

B. Social Protection Schemes

Social Protection Vientiane Province 2007



Highest coverage in the country
Potential in medium-term ~40%

Selected Households Characteristics Vientiane Province 2007		Uninsured	CBHI	CSI	SSO	Total
Education	No schooling or Not completed primary school	25%	16%	0%	0%	15%
Work	Non-paid work or temporary work	34%	22%	5%	0%	23%
Socio-Economic status	Household size	4.9	5.0	4.9	4.1	4.8
	Annual income per household	$489	$634	$430	$699	$511
	Annual expenditure per household	$1,592	$2,031	$1,860	$1,357	$1,684
	Asset index	-0.2	0.9	0.7	1.7	0.2
Comparison of profile 1 (higher) to 4 (lower)		4	2	3	1	

Source: IHPP/NIPH Laos (2007) Socio-economic profile and satisfaction of insured and un-insured people in Lao P.D.R. with contracted health care providers

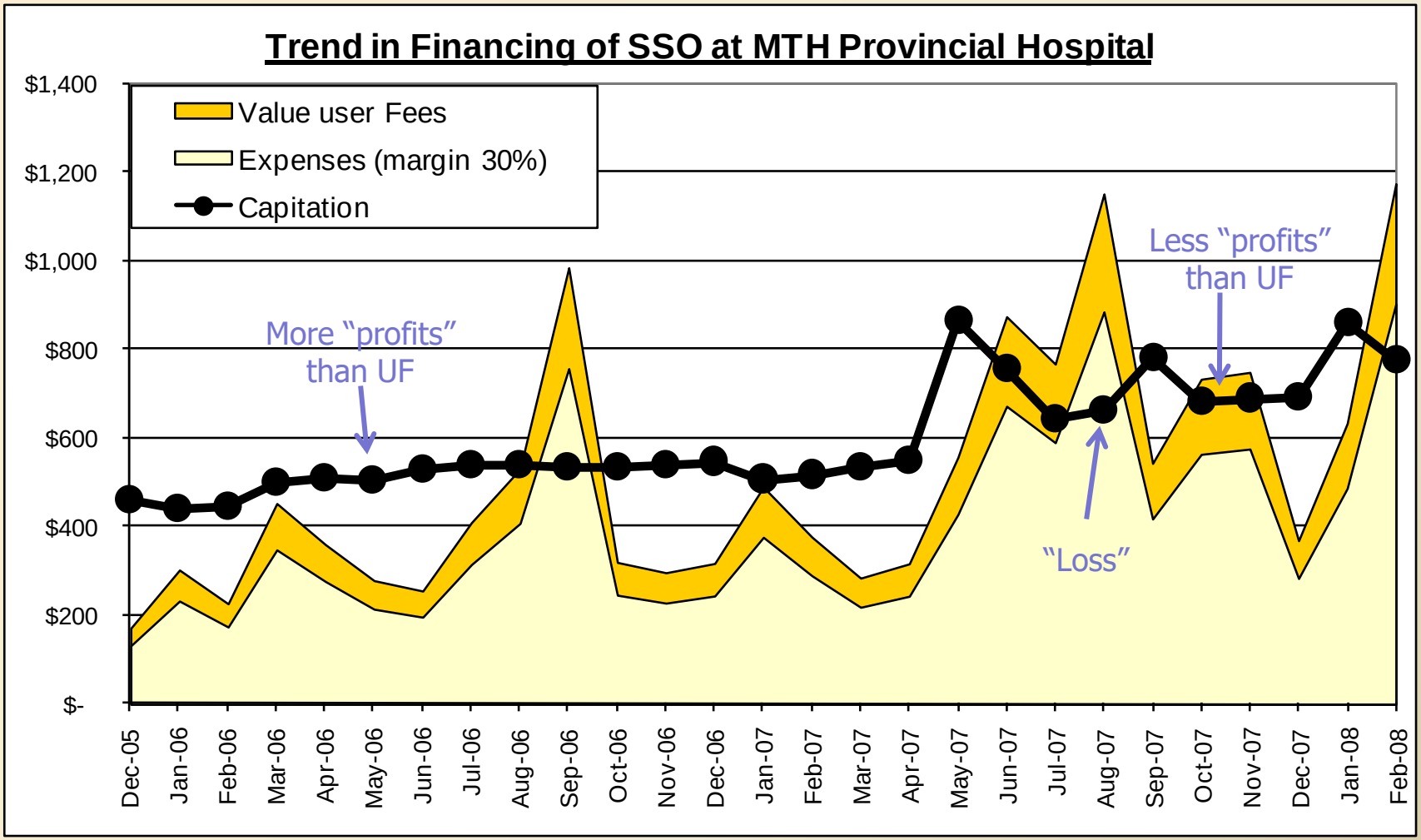
SSO family members are more well-off ... Uninsured households are the poorest

(1) Social Security Organization (SSO)

SSO Coverage		2005/06	2006/07	2007/08
MTH Provincial Hospital	Insured number	305	329	362
	Spouses	244	265	301
	Children <18 years	377	408	480
	Total	**926**	**1,002**	**1,143**
Vang Viang Hospital	Insured number			530
	Spouses			289
	Children <18 years			536
	Total			**1,355**
Province	**Total**	**926**	**1,002**	**2,498**
	% population	**0.2%**	**0.2%**	**0.6%**

Low - Stable

(1) Social Security Organization (SSO)



"Profitable" for provider .. But less than before

(2) Civil Servants Insurance (CSI)

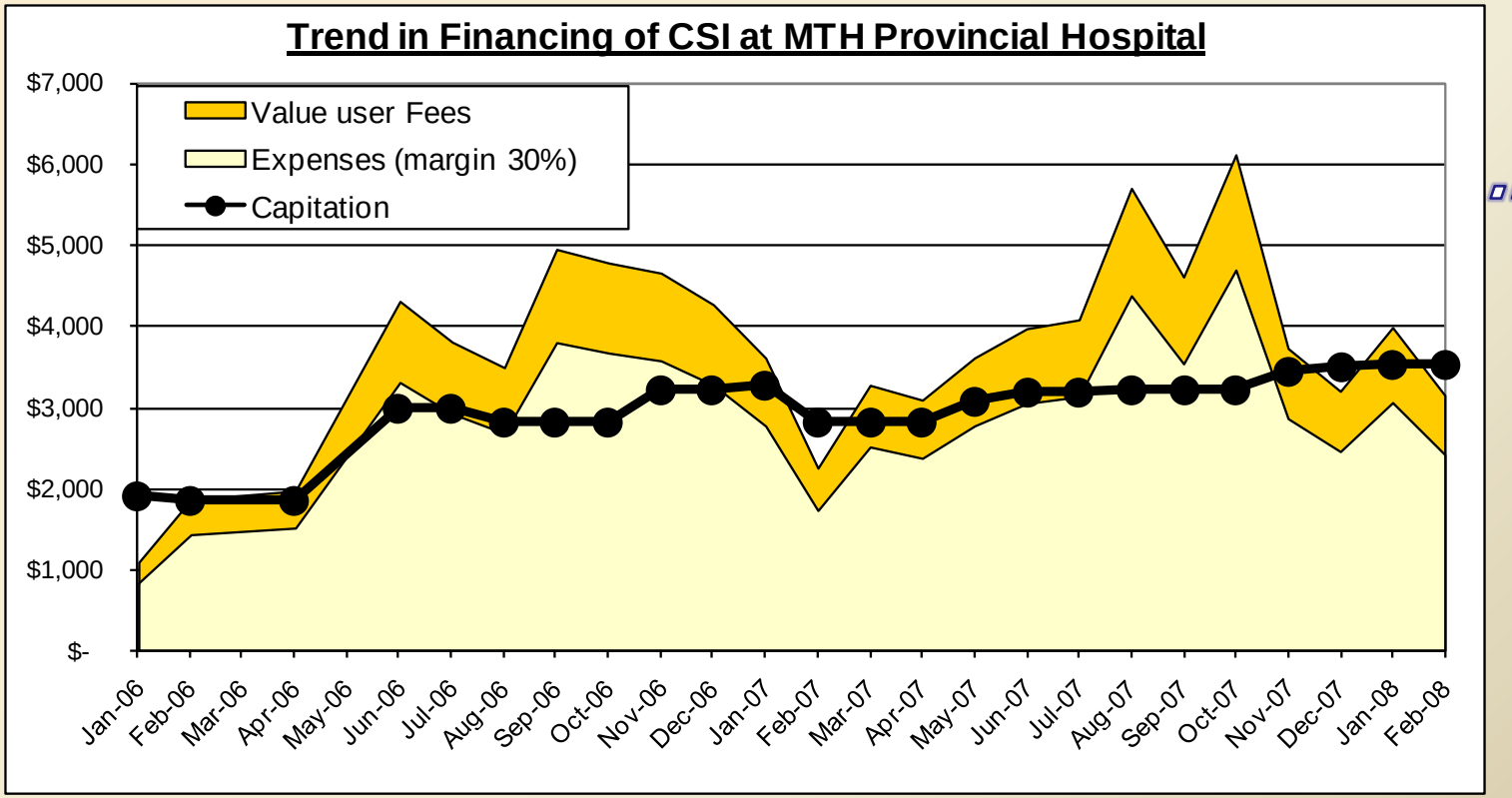
CSI	2005/06	2006/07	2007/08
Beneficiaries	25,507	31,410	31,785
Coverage	*80%*	100%	100%
% Population	7%	8%	8%

Full Coverage

(2) Civil Servants Insurance (CSI)

CSI FINANCIAL SUMMARY PROVINCE	2005/06*	2006/07
Total Capitation for the period	$ 95,965	$ 133,688
Total Price of Services	$ 60,217	$ 127,316
Total Cost of Services (if margin 30%)	$ 46,321	$ 97,936
Margin compared to Price	**59%**	**5%**
Net margin	**107%**	**37%**

** Based on 7 months excl. transport costs*



Funding is still acceptable Province-wide...

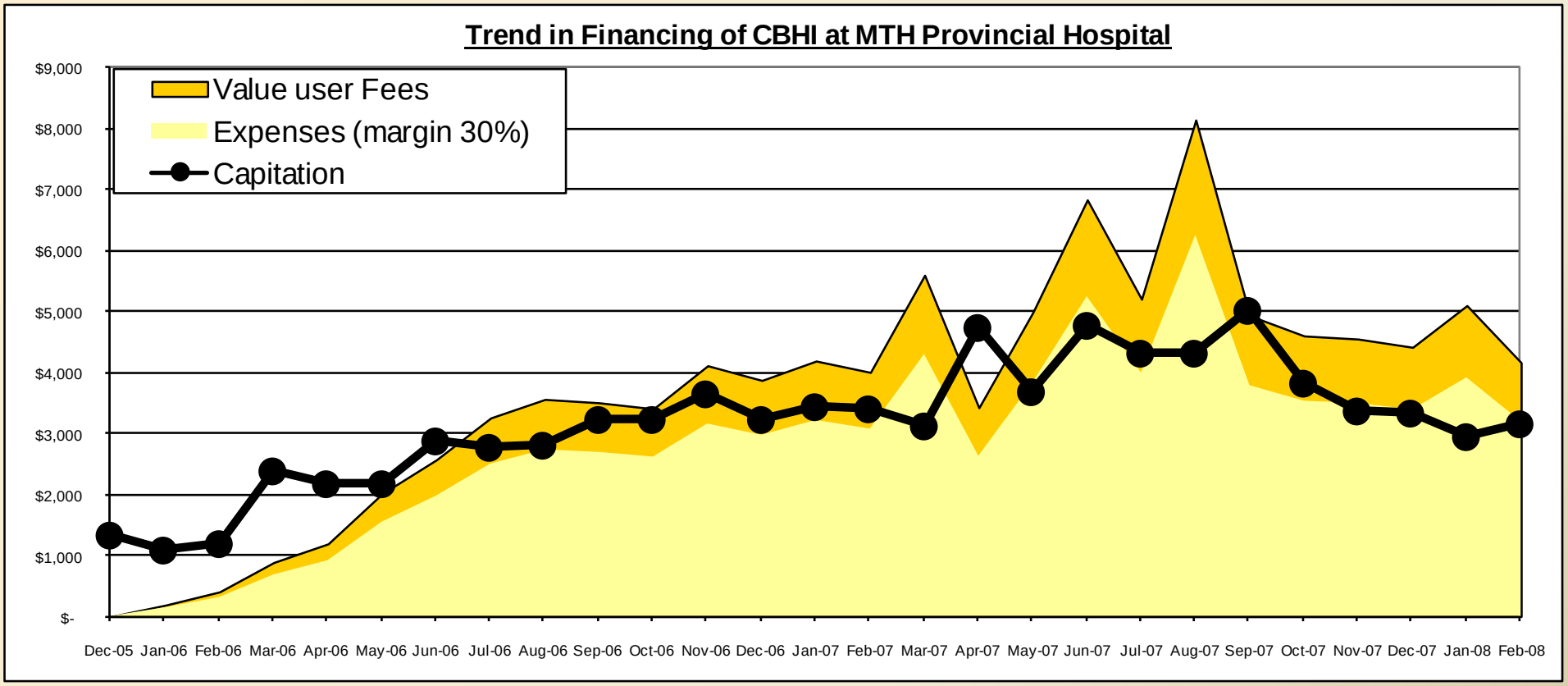
... But with losses or at least loss of "profits" at PH

(3) Community Based Health Insurance (CBHI)

CBHI Coverage in all 3 districts (average)	2005/06	2006/07	2007/08
Total CBHI families	1,697	2,024	1,943
Total persons covered	8,317	10,182	**9,850**
% families covered	15%	23%	23%
% population covered	19%	23%	**23%**
Families did not pay	385	782	797
Families paid all year	N/A	42	58
% families did not pay	28%	41%	**41%**
Number families left	42	61	**73**
Number new families	186	102	51

Major CBHI scheme in the country
Good coverage ... but deteriorating situation

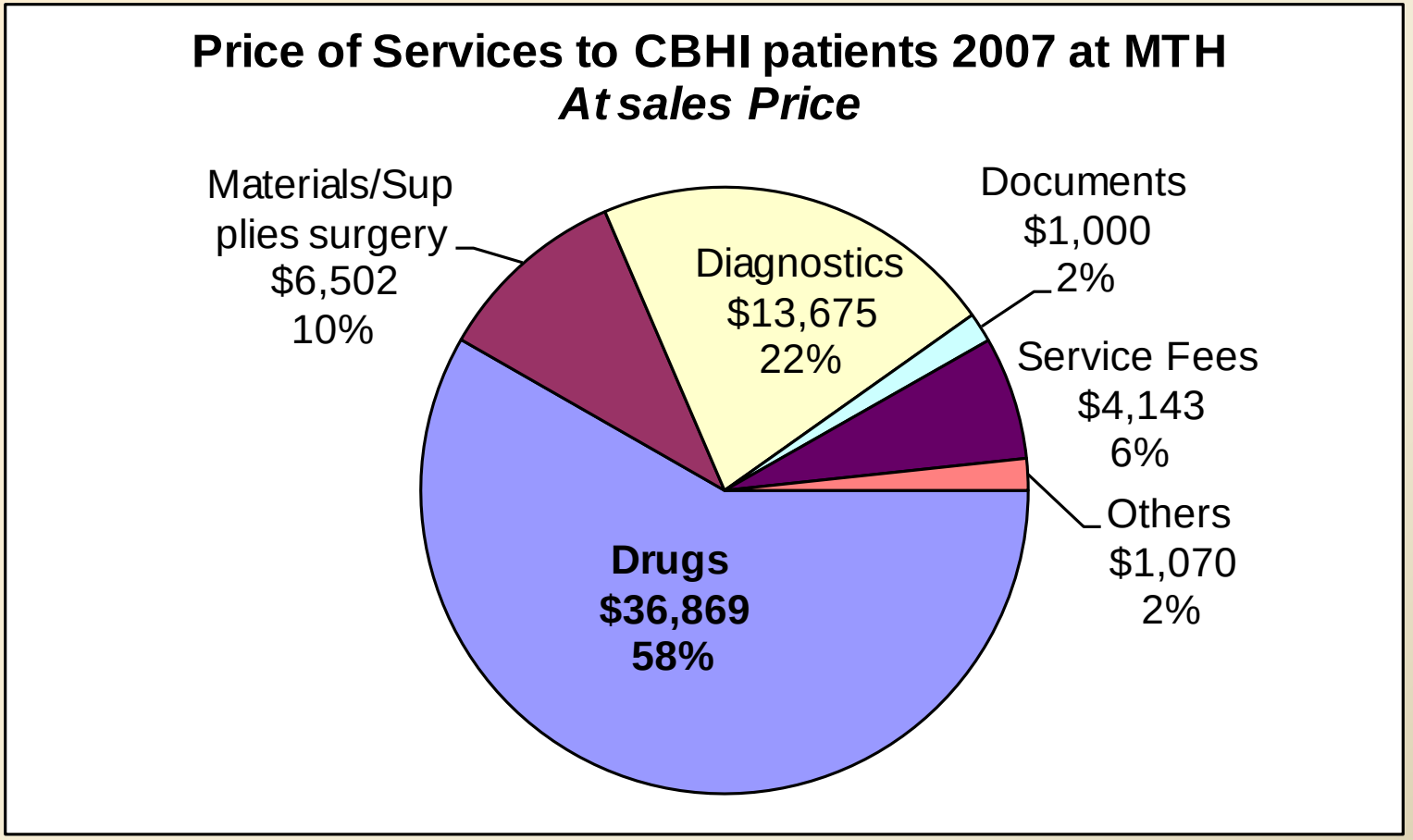
(3) Community Based Health Insurance (CBHI)



From Sept 07, split in Management between Phonhong and MTH

Poorly motivating for provider and … worsening

(3) Community Based Health Insurance (CBHI)

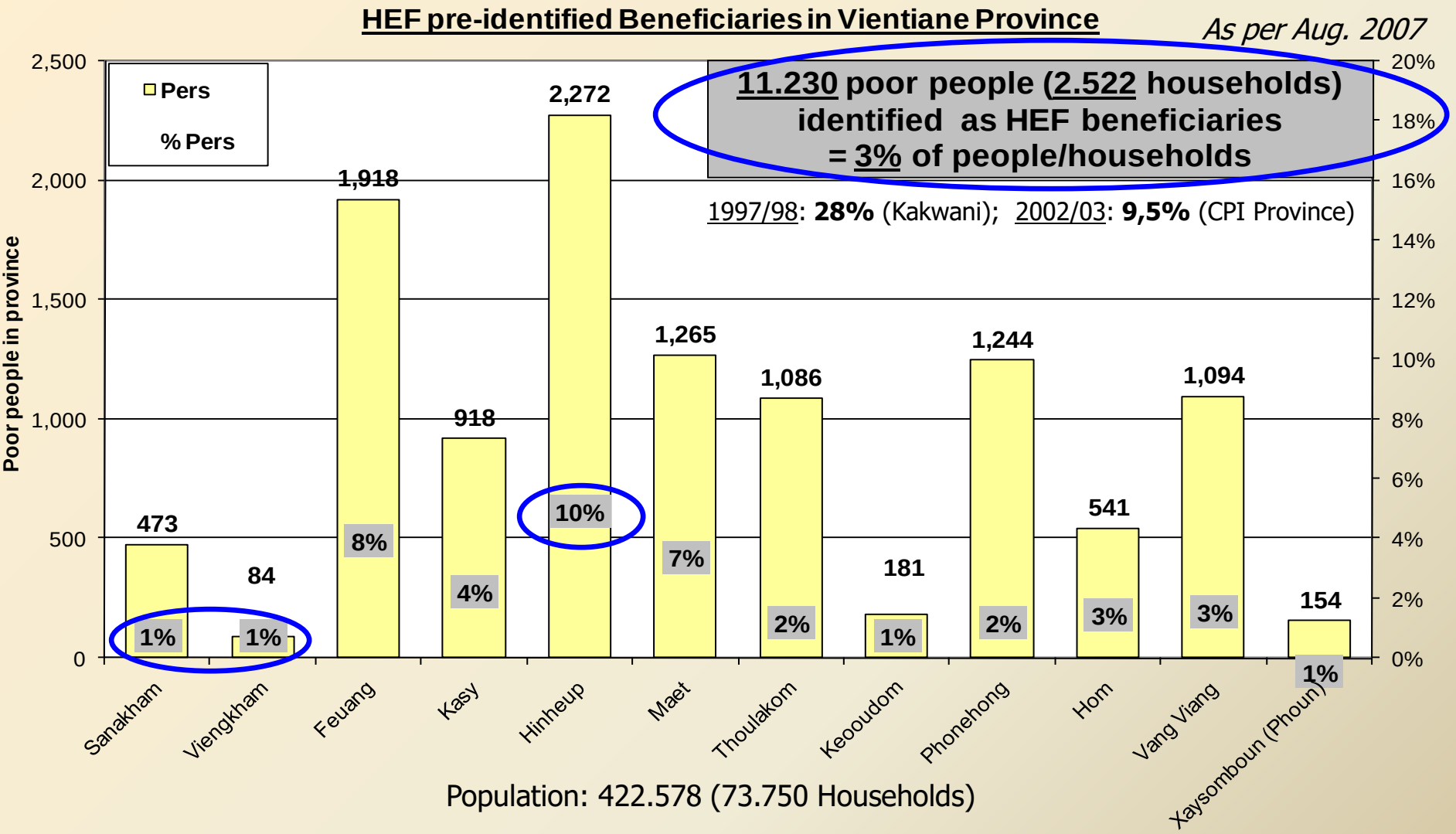


The major share of the capitation is to finance drugs & supplies … even at Provincial Hospital

(4) Health Equity Funds for Poor

Results 2005/07
▪1st Province-Wide HEF ▪Fully functional in the whole province ▪Policy on HEF ▪Managed by PHD HEF Unit with project control and External Audit ▪Ownership of the Provincial HEF Unit ▪Co-Funding by Luxemburg & Belgium Coop. ▪Integrated into routine audit ▪Monitoring, Analysis, Reporting

(4) Health Equity Funds for the Poor



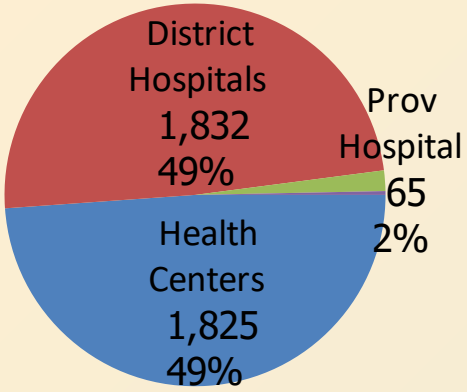
Low proportion of pre-identified poor in HEF

(4) HEF: Free Caesarean Policy

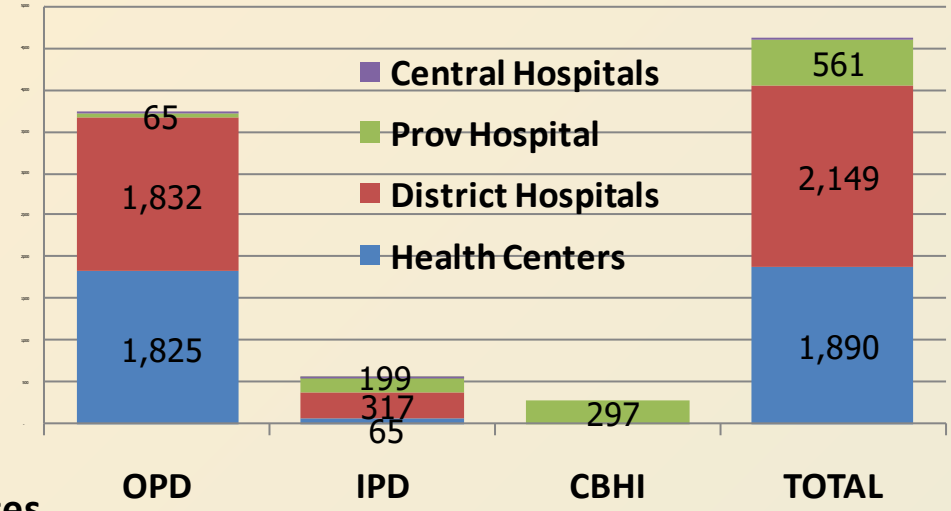
- Rule:
  - Free for patients from remote districts (paid by HEF)
  - Patients from urban districts pay by themselves except for HEF members. Hospital can also decide on post-exemption for near poor.
- Fixed fee reimbursement to Hospitals by HEF:
  - Caesarean: 1.300.000 kips ($140)

(4) HEF Utilization

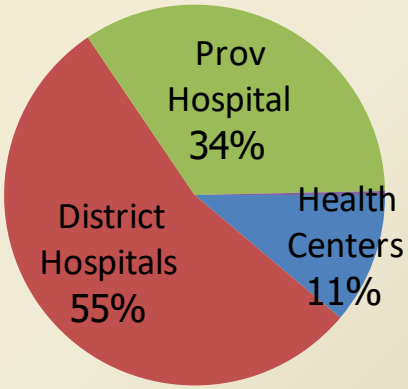
OPD cases by provider



Total OPD : 3.734 Cases



IPD cases by provider

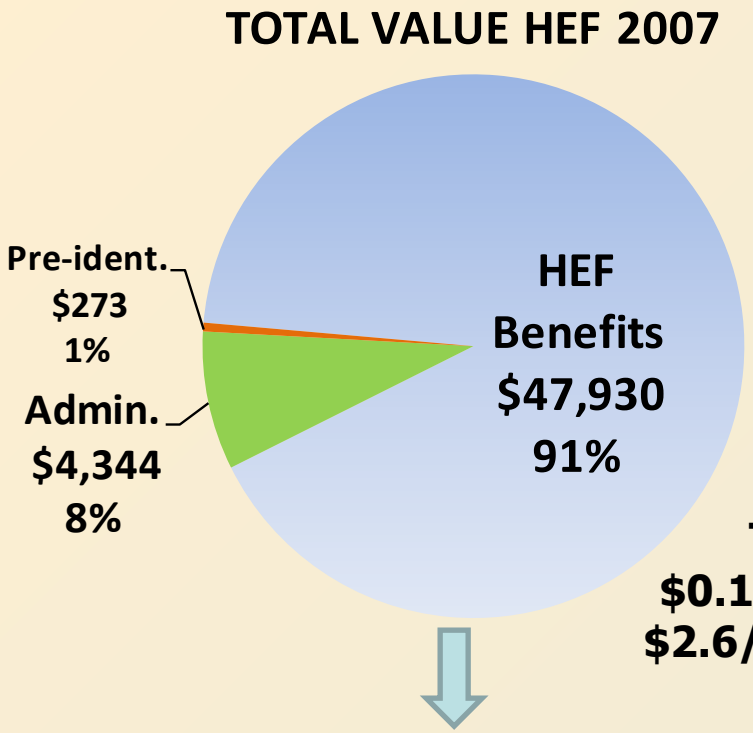


Total IPD : 583 Cases

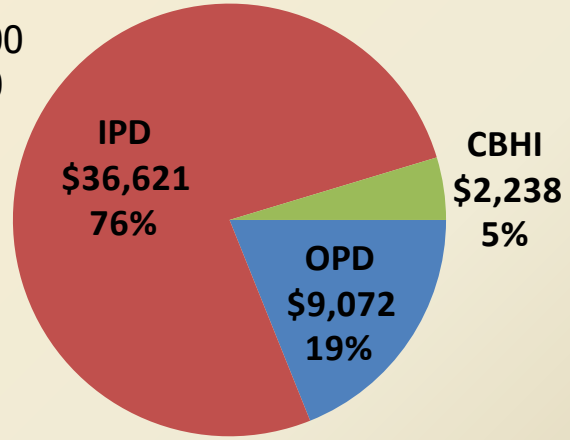
HEF Pre-identified cases 2007	OPD	IPD
Total	**3,635**	**445**
% pre-identified	**97%**	**76%**
HEB utilization rate	**0.32**	**0.040**
Non-HEF utilization	**0.42**	**0.047**

HEF has not removed all barriers to access for poor

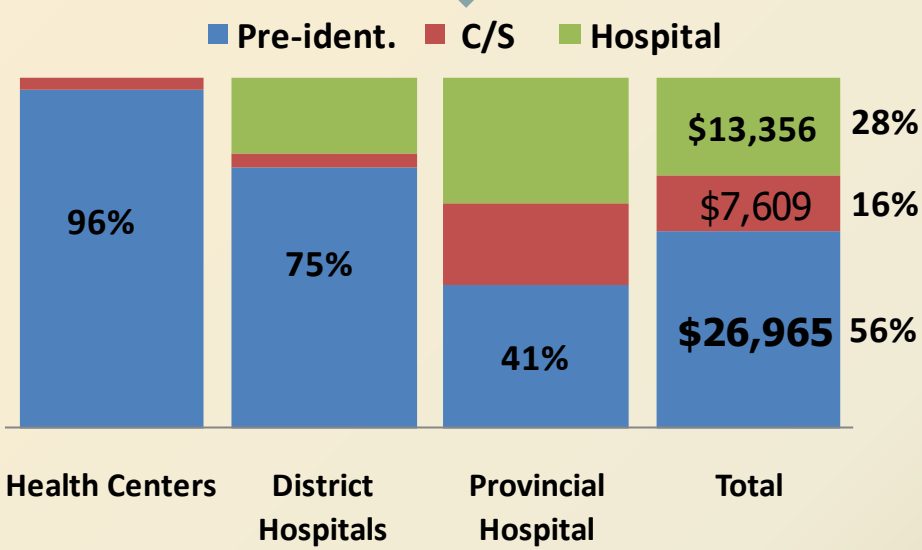
(4) HEF Finances

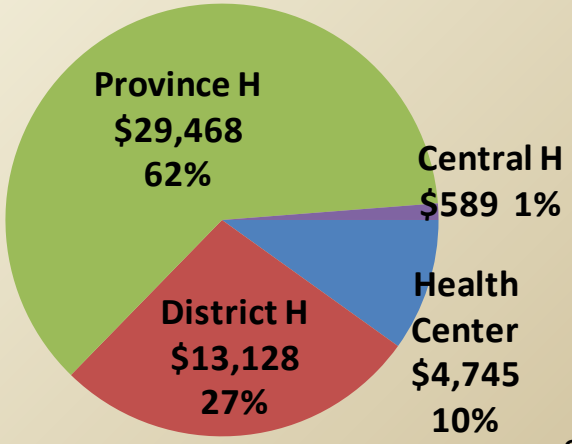


25% IPD (141p) >$100
6% IPD (34p) >$200



Total: $52,546
$0.12/cap; $11.4/case
$2.6/mber+$2.1 post-id

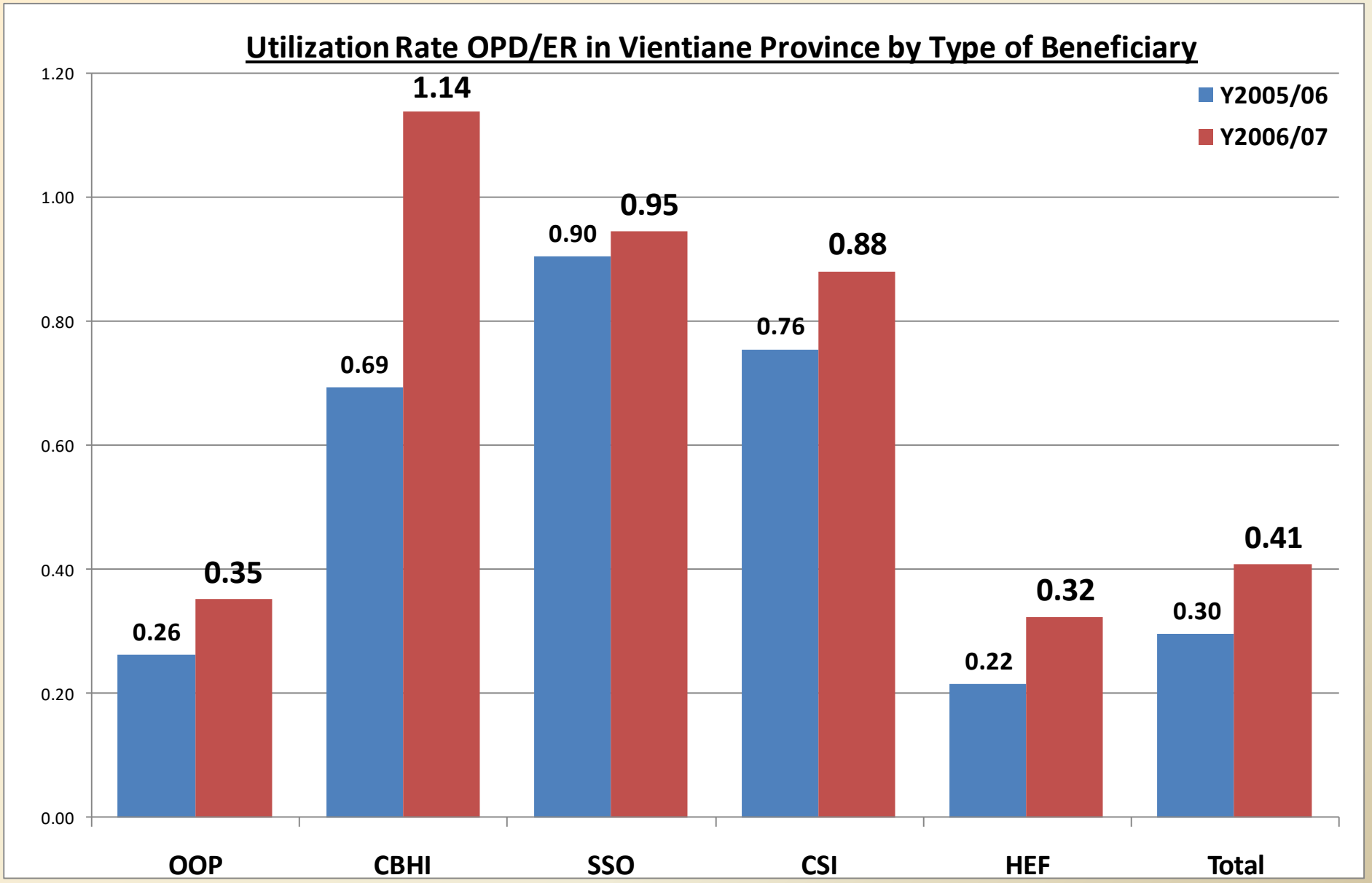


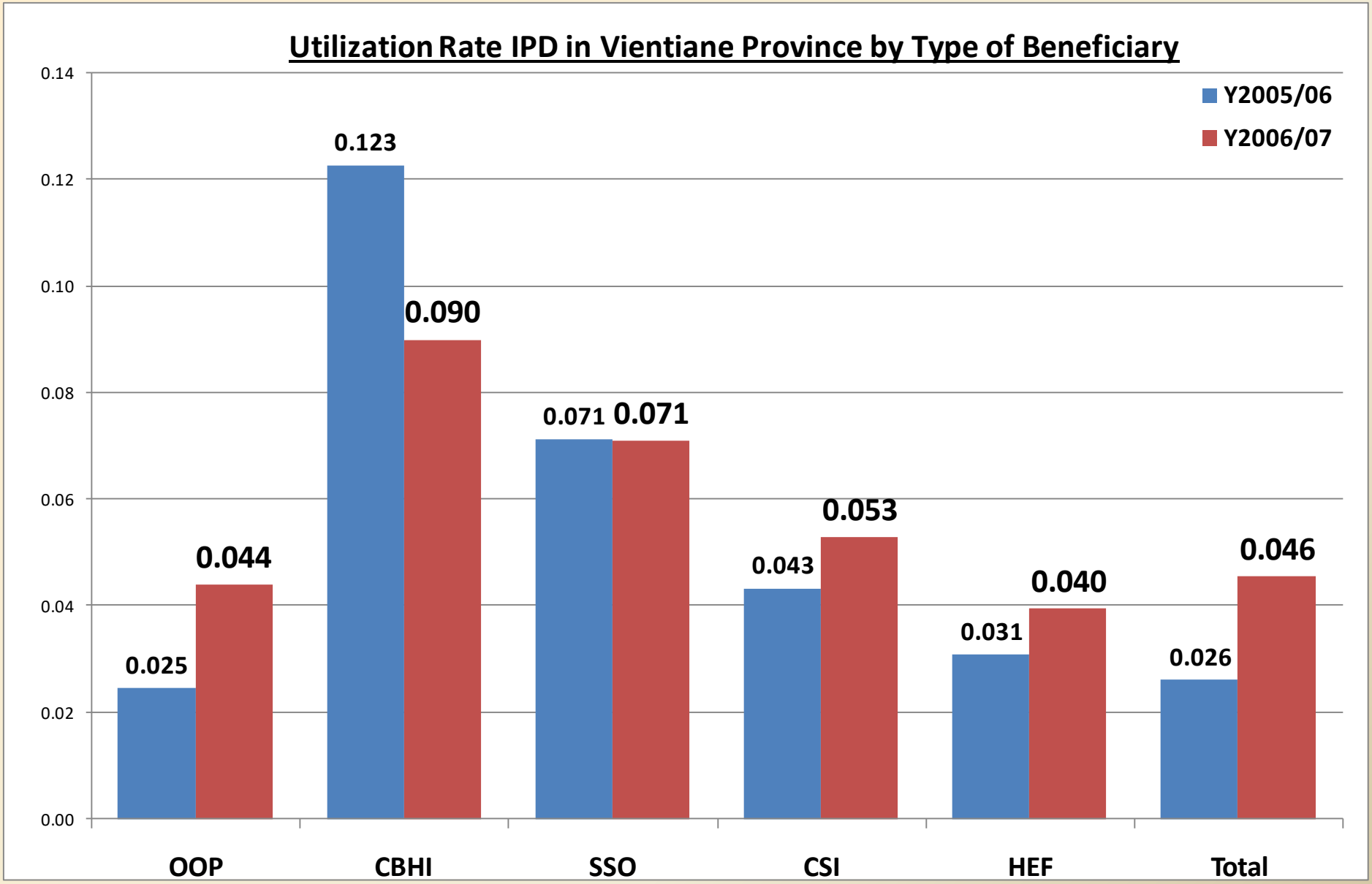


(4) HEF Finances

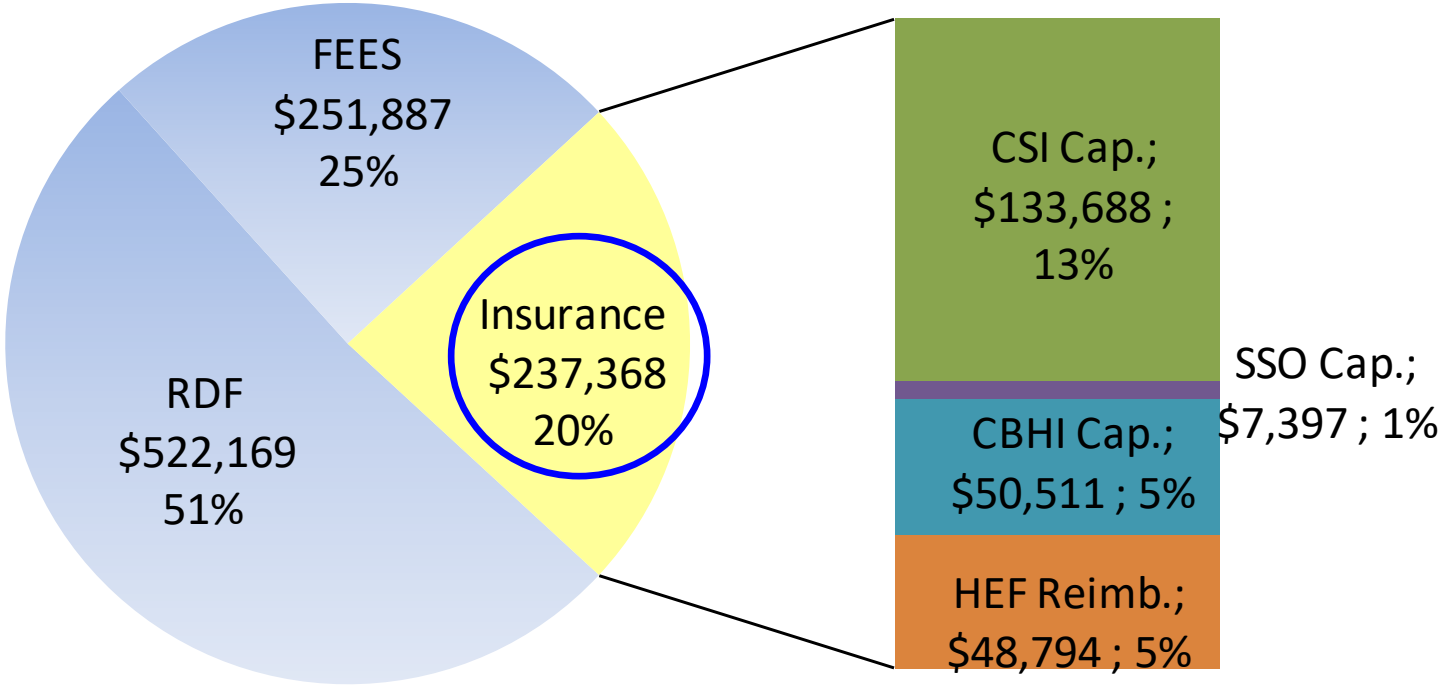
HEF average benefits	OPD	IPD
Health Centers	$2.1	$14
District Hospitals	$2.5	$27
Provincial Hospital	$8.8	$134

High expenditures averted in 2007	Cases					Value
	HC	DH	PH	Total	% IPD	
> 500.000 kips ($55)	1	32	154	187	32%	$29,948
> 1.000.000 kips ($110)	1	22	118	141	24%	$26,391
> 2.000.000 kips ($220)		1	33	34	6%	$10,655


Utilization Rate OPD/ER in Vientiane Province by Type of Beneficiary
1.20
1.00
0.80
0.60
0.40
0.20
0.00
Y2005/06
Y2006/07
0.26
0.35
0.69
1.14
0.90
0.95
0.76
0.88
0.22
0.32
0.30
0.41
OOP
CBHI
SSO
CSI
HEF
Total

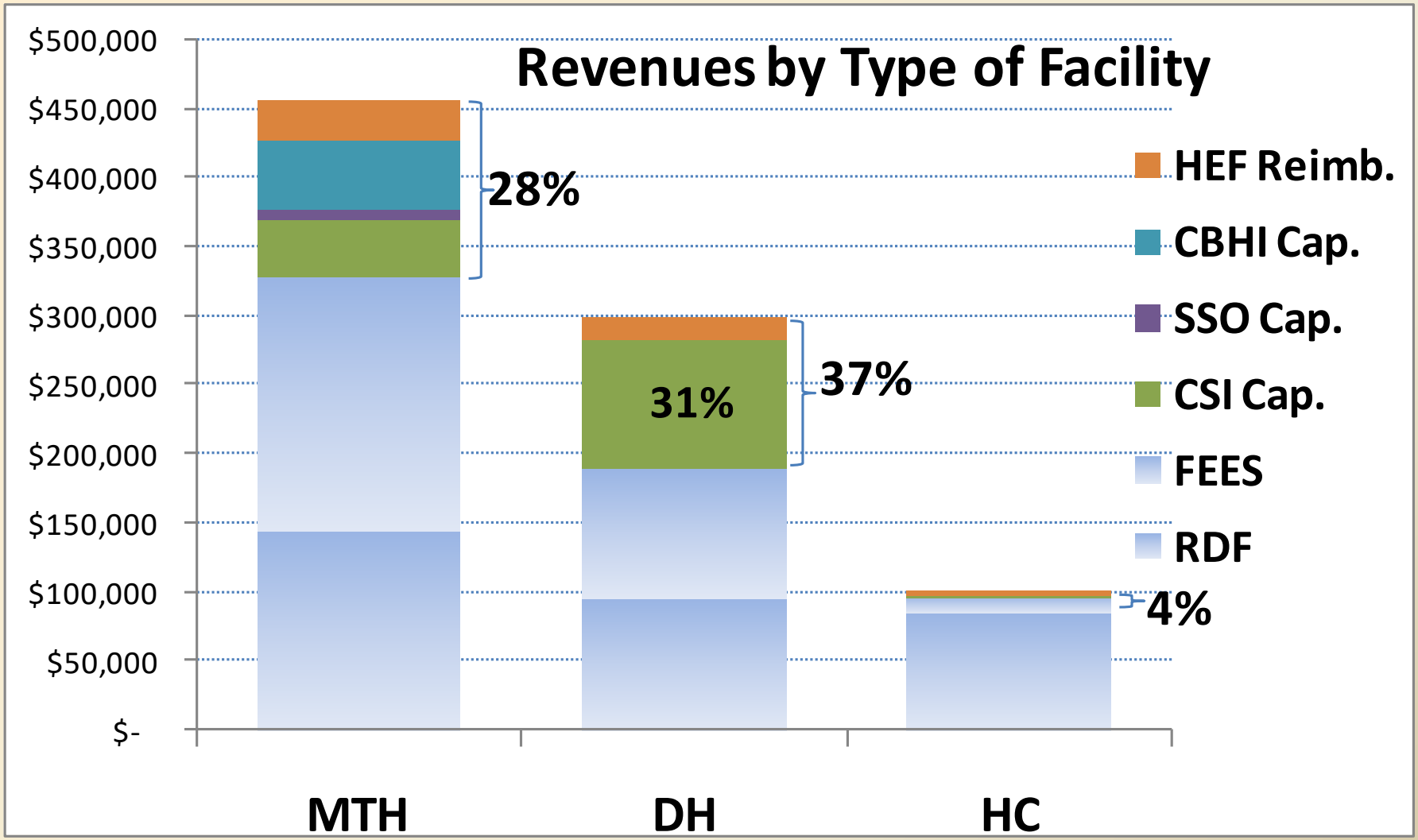

Utilization Rate IPD in Vientiane Province by Type of Beneficiary
0.14
0.12
0.10
0.08
0.06
0.04
0.02
0.00
Y2005/06
Y2006/07
0.025
0.044
0.123
0.090
0.071
0.071
0.043
0.053
0.031
0.040
0.026
0.046
OOP
CBHI
SSO
CSI
HEF
Total

Facility Revenues by Type of Beneficiary 2006/07

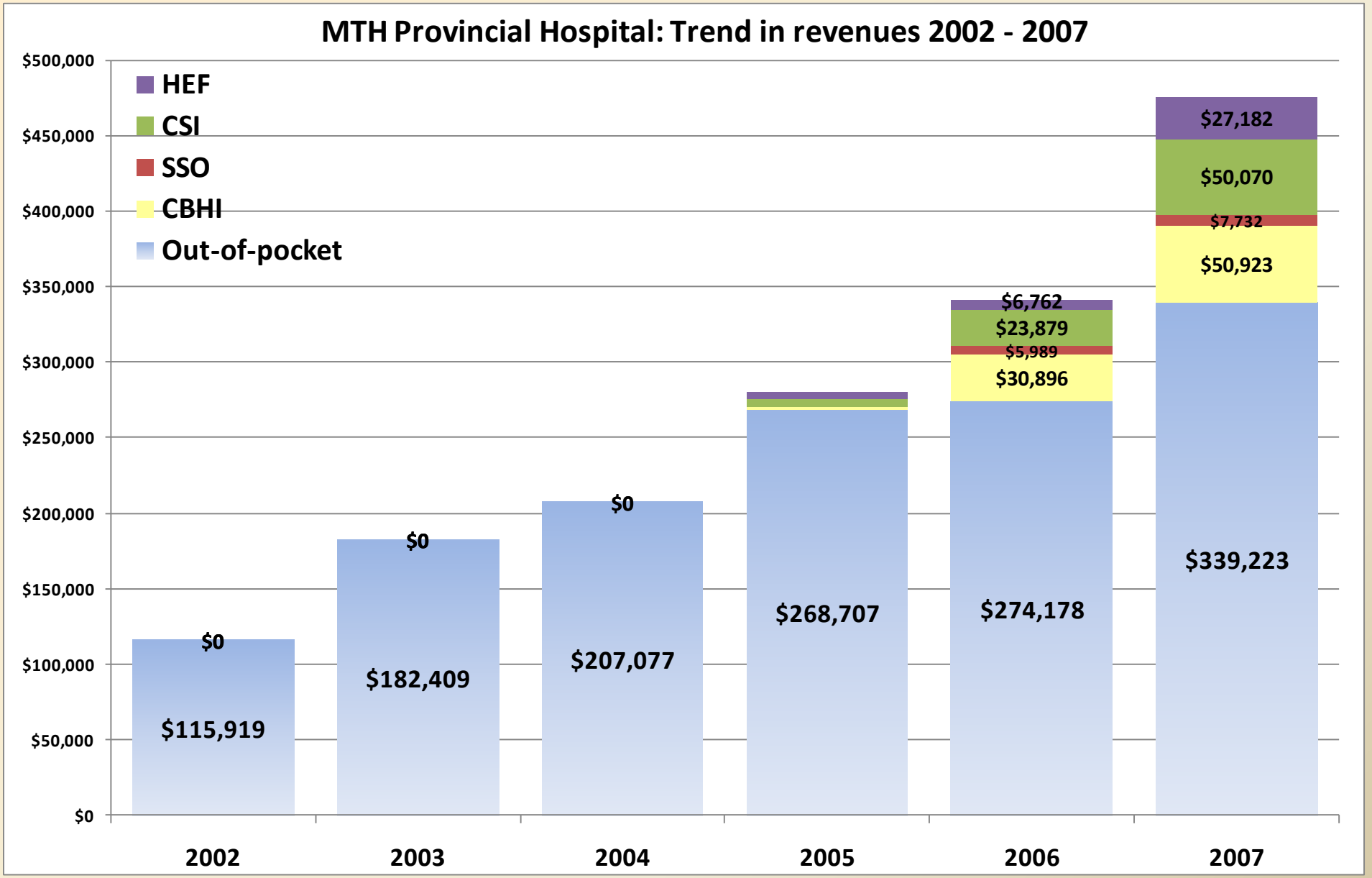


Total Revenues: $1,014,446 ($2.4/capita)

Social Protection schemes become a significant income for providers but...



... Especially for Provincial Hosp. & CSI at District Hosp.



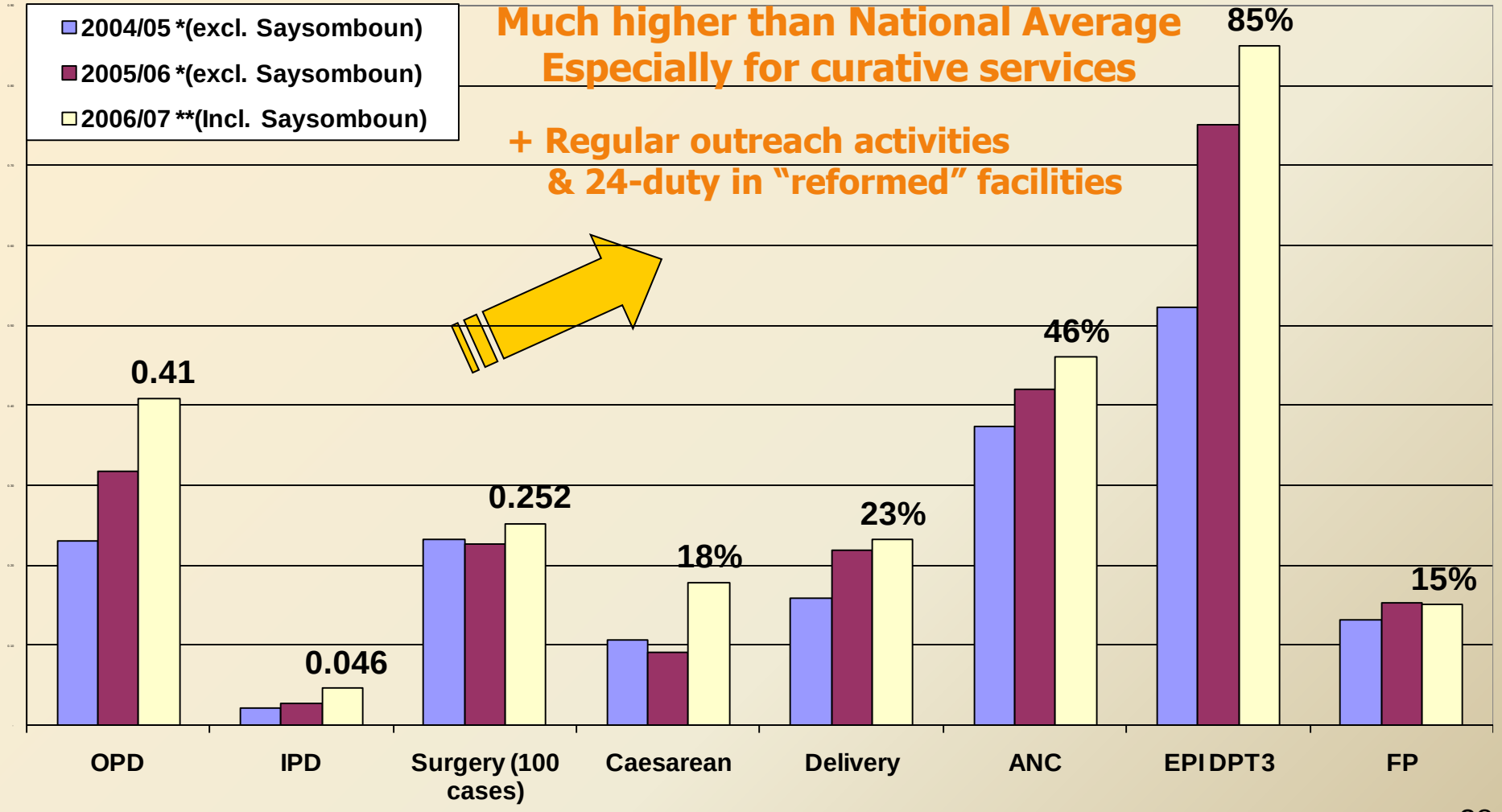
... Fast progression at Provincial Hosp.

2.5. Results

C. Utilization/Coverage of Public Health Services in Vientiane Province

➡2.5. Results: Utilization/Coverage of Public Health Services in Vientiane Province

Reported Health outputs/coverage in Vientiane Province 2005-07



Source: HIS PHD Vientiane Province

2.6. Issues in the Implementation of Social Protection Schemes

Social Security Organization (SSO)

	STRENGTHS	PROBLEMS	OPTIONS
System	•Capitation system •Cover spouse, children <18 •Regular contracts		
Implementation	•Willingness of members •Regular sufficient income •Lesson's learned meetings •Few companies, few providers	•Non respect of rules by members (choice of provider)	•Control of reimbursement for emergency patients •Control of the Rational Use Drugs

Civil Servants Insurance (CSI)

	STRENGTHS	PROBLEMS	OPTIONS
System	•Government Policy •Possibility to treat anywhere in case of emergency	•Unclear responsibilities central, province, districts •Financial imbalance (High benefits + transport for relatively low capitation)	•Clear responsibility for transfer/emergency •Higher capitation rate
Implementation	•100% CS included	•Chronic diseases •Increased transfers DH-PH • Over-utilization of CS in administration and hospitals •Reluctance to go first to DH •Insufficient links, admin, reporting central/prov/district •Late payment from Central •Inadequate % DH-PH (70-30%) •Reports bypass PHD responsible •No control of CSI card	•Rules for transfers •Control of RUD •Admin, Reporting system through PHD •Review % DH-PH •Control of CSI card

Community-Based Health Insurance (CBHI)

	STRENGTHS	PROBLEMS	OPTIONS
System	•Government Policy •Detailed system	•Mainly monthly payment •Require 1st contact at DH when split PH-DH= drop-out ↗	•6-12m payment with discount + presents •Pilot village mandatory CBHI+HEF (subsidized first?)
Implementation	•Quality of care at PH •Support from donors •Main scheme in the country •Adequate utilization	•Adverse selection (chronic disease, plan surgery) •High % of late payment •High treatment costs •No regular promotion •Late transfer of money by collector •Financial imbalance? Premium to pay basic benefits OK But also pay quiet high OPD cost, motivate collectors, provide incentives to providers?	•CBHI in indicators of performance subsidy •CBHI counter besides reception in hospital •Reward best villages (best % paid premium, progress) •Link CBHI-HEF-SSO-CSI administration •Professional collectors (Civil Servants, VHV, better paid) •Continued promotion (in villages with low enrollment, when special events, in hospitals)

See Jacobs B (2007) CBHI at Lao PDR: Suggestion for the way forward, WHO Laos

Health Equity Funds (HEF)

	STRENGTHS	PROBLEMS	OPTIONS
System	•Province-wide HEF •Co-financing 2 donors	•Risk of cost inflation •Pre-identification criteria's •Managed within health system (no 3rd party, weak link with beneficiaries)	•Add Transport from Village to HC in benefits •Payment by capitation for Village-HC-DH •Fixed fees at PH (DH A) •Coherence HEF list & general list of Distr/Prov
Implementation	•PHD-PH-Donors •Support from 2 donors •Integrated quarterly audit including HEF •Cost-effective Prov. HEF management	•Rather passive •Not relieve barrier of transport, language, culture •Only 3% pre-identified (very poor) due partly to uncertainty of funding •Costly & time-consuming pre-identification	•Sub-contract demand-side grassroots organizat for feedback, promotion, control, survey, etc •HEF in indicators of performance subsidy •Pre-identification with HC family files

2.7. Conclusions

- The package of health financing strategies has developed progressively for 2 years and still requires technical support.
- Impact on accountability and policy is clear
- It certainly has contributed to better service delivery at facility level although it remain difficult to assess to what proportion
- But impact on cost-effectiveness and sustainability needs time

III. Lessons' Learned

- General health systems
  - Package of strategies
  - Communication/collaboration of stakeholders
  - Continuity and proximity
  - Ensure sufficient funding for basic routine operations
  - Act jointly on the providers (People, Systems, Infrastructure) and beneficiaries (two-side IEC)

III. Lessons' Learned

- General Social Protection Schemes
  - Long-term effort
  - Capitation system is a definite advantage
  - Requires having the providers "on board"
  - Requires improvement in quality of services (Don't expect too much that social protection scheme leverage will improve quality by itself)
  - Requires working in parallel on limiting the perverse effects of Fee-For-Service (RDF-Fees)

Thank you !

Documentation & References

- PHD Health Financing Unit ToR and Performance contract
- Health Financing Expert: Progress reports, Thomé JM (5 reports)
- Health Financing Workshops presentations (>30 Power-Point presentations)
- Health Financing Committee agreements and decisions
- HEF in Vientiane Province: Guidelines
- HEF database of beneficiaries (updated August 2007)
- HEF database of benefits provided in 2005, 2006, 2007 & analysis
- RDF and Service Fees database with all prices per facility
- Performance contracts with district hospitals and health centers
- Monitoring table with performance staff incentives per facility 2005, 2006, 2007
- Audit monitoring forms & results
- CBHI/SSO/CSI/loans to patients monitoring tables
- Economic analysis forms

Available on request: ***hef_vte@yahoo.com, jmthome@laopdr.com***