# Protecting the Poor: Options for Financing PHC in Lao PDR

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# PHC Criteria

1. Physical access: needs to be realistic
2. Quality of care: HRD, supplies
3. Acceptable care: gender, ethnic minorities
4. Affordable care: market segmentation
5. Efficient services: adequate utilization
6. Sustainable: program approach
7. Community participation
8. Substantial benefits compared to costs

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# Conditions for fast PHC Development

1. Strong political will and Leadership
2. Human resource development
3. Female Education
4. Other social an d governance factors
5. Some low income countries did well

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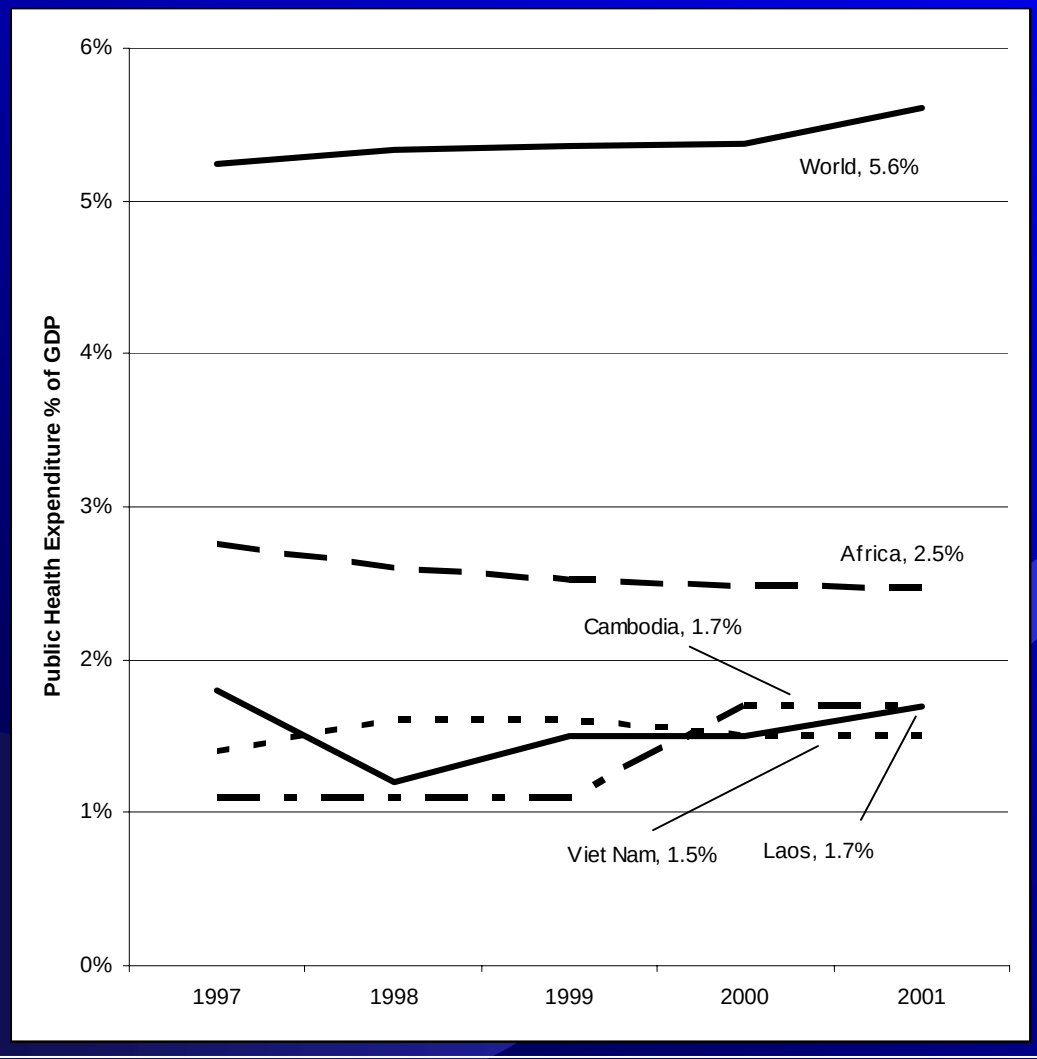
# Public Sector Health Expenditure

From World Bank HNP Database March 2005




**-Very low public health sector spending % GDP**
**-Additional funding required with focus**

1. Evidence of effectiveness
2. Capacity for absorption
3. Coordination
4. Improve health of vulnerable groups
5. Beneficial and of interest to all parties

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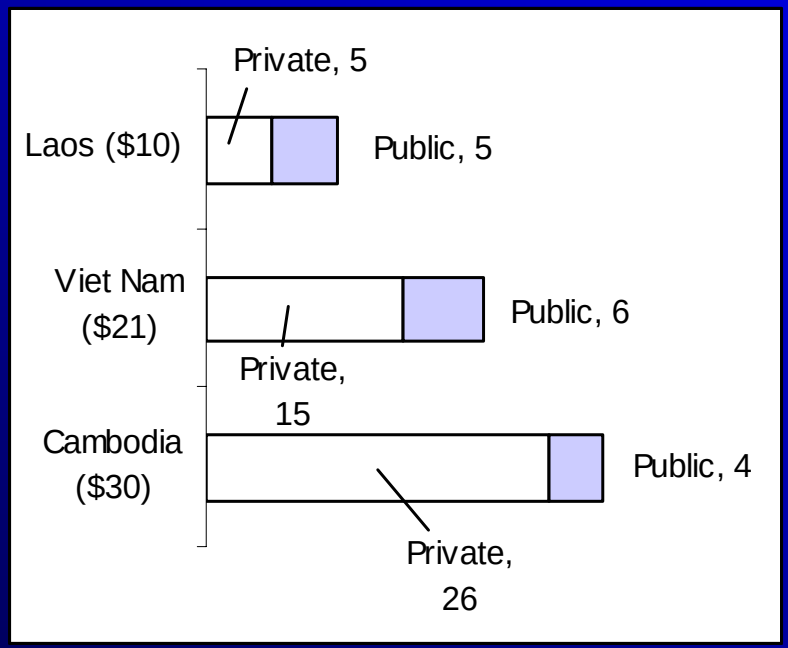
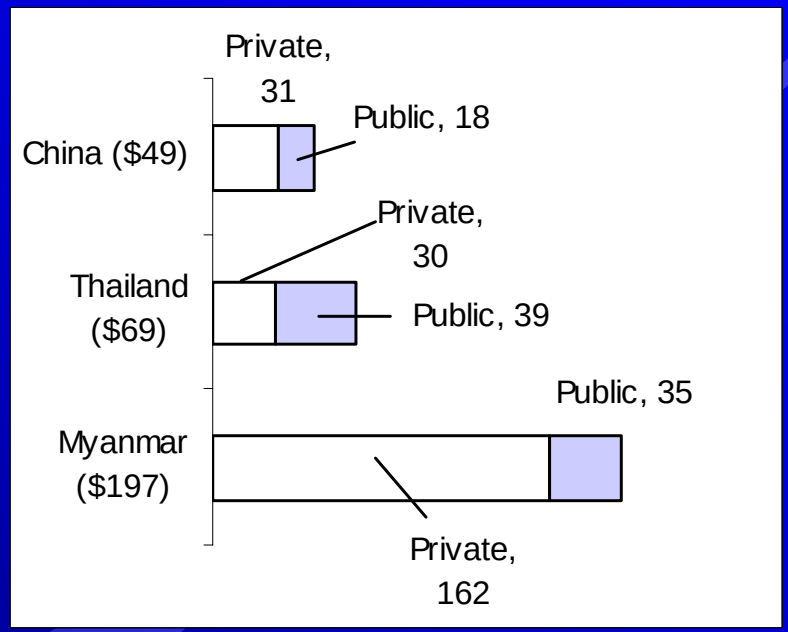
# Source of Health Sector Expenditure




From World Health Report (2004) for 2001 ($ per capita)

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# Allocative Efficiency

- Who benefits from public spending
- Curative versus preventive spending
- Development versus recurrent cost spending
- HRD imbalances
- Dead wood and maldistribution of staff
- Mismatch of resources: staff but no supplies

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# Outcome of PHC Spending: Coverage

## Health Services Coverage for 3 Mekong Countries (2004)

| | Cambodia | Lao PDR | Viet Nam |
|---|---|---|---|
| Access to Essential Drugs (%) | 50 | 80 | 85 |
| Measles vaccination coverage of children 12-24 months (%) | 55 | 42 | 96 |
| Modern Contraceptive Prevalence Rate | 18 | 29 | 56 |

Source: UN, 2002-2004

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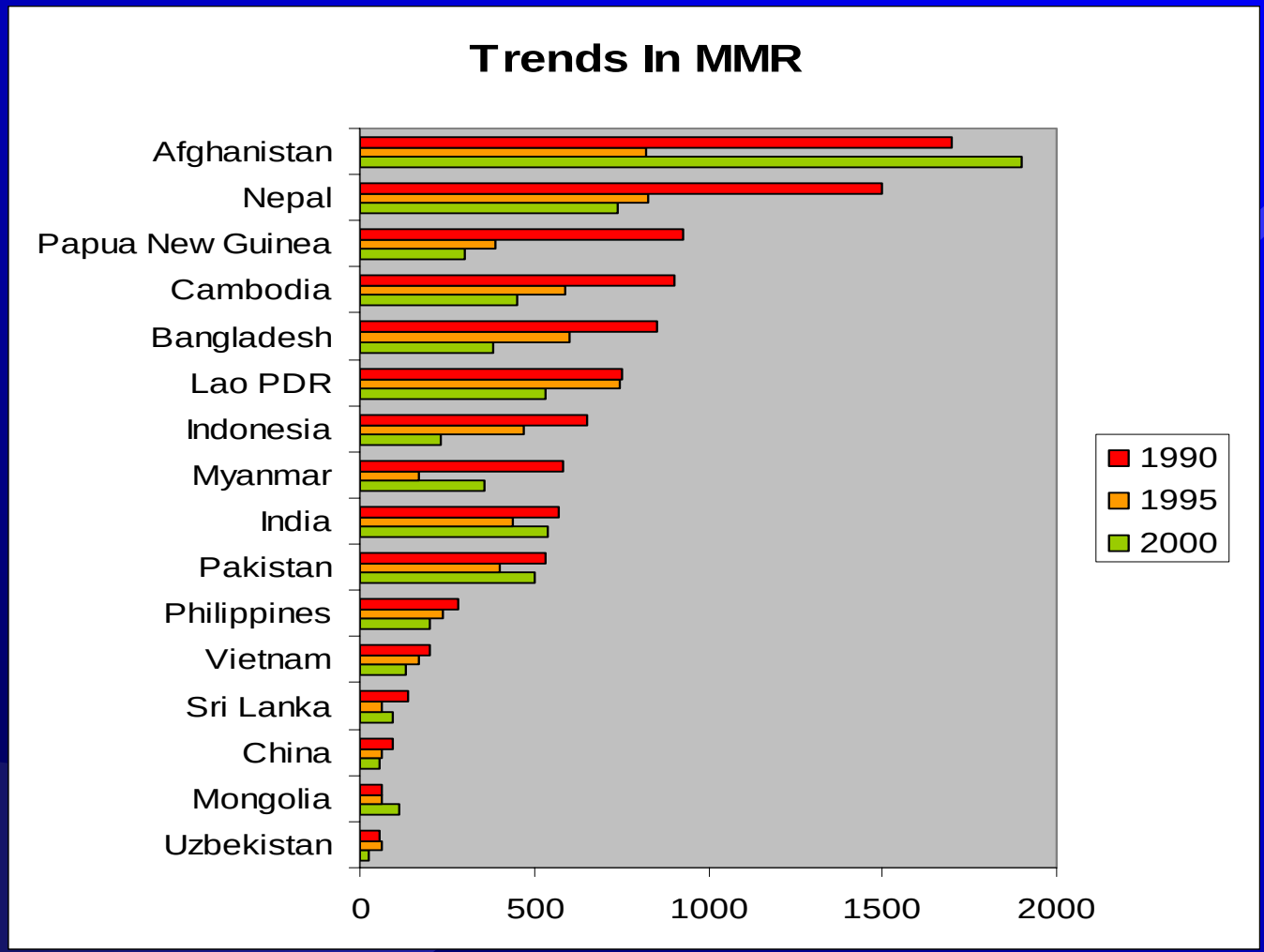
# Outcome of Spending on PHC: Impact



# Private vs. Public Health Care: Who Should Pay?

- Public Sector should pay for health care that the Private Sector:
  - Simply will not provide (public goods)
  - Will not provide in sufficient quantity (mixed private/public)
  - Will not provide to those who cannot afford to pay (equity)

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# Role of Donors

- Health as a basic human right: health care for the poor, including recurrent cost
- Health as an international public good
- Failure to fund public health care in developing countries only delays eventually paying for it later
- Equitable, Effective, and Efficient Aid

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# Current Situation in Lao PDR

- Non-poor capture more benefits
- Poor have access to substandard PHC
- Poor can’t afford cost recovery
- Cycle of poor quality, underutilization and underfunding/low cost recovery

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# Sources of Patient Funds*

## The poor rely more on gifts, loans, and selling household possessions to pay hospital costs

| | Wealth Quintile | | | | |
|---|---|---|---|---|---|
| **Source of Funds** | **Poorest** | **2nd** | **Middle** | **4th** | **Richest** |
| Own household funds | 67.9 | 76.9 | 82.3 | 83.7 | 90.4 |
| Gift from relatives or friends | 16.7 | 7.7 | 6.9 | 13.8 | 1.8 |
| Borrowed from relatives or friends | 22.9 | 6.2 | 8.1 | 8.0 | 7.2 |
| Borrowed from lender | 2.1 | - | - | - | 1.9 |
| Sold household possession | 18.9 | 16.4 | 9.8 | 6.3 | 3.7 |
| Village mutual fund | 2.1 | 1.5 | 4.1 | 2.4 | 2.7 |
| Promised to pay bill later | 1.0 | 4.5 | 3.5 | - | - |
| Other sources | 6.4 | 1.5 | 2.7 | 1.2 | 2.7 |

* This data is preliminary and should not be quoted.

# Hospital Utilization Increases with Ability to Pay*

| Wealth Quintile | Provincial Hospital Data Lao PDR (percent) |
|---|---|
| Poorest | 4.1 |
| 2nd | 5.3 |
| Middle | 6.5 |
| 4th | 6.9 |
| Richest | 12.8 |

* This data is preliminary and should not be quoted.

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# Example: Village Drug Revolving Funds

1. Increases access to basic drugs and curative care in remote villages
2. Increases utilization of basic care in remote villages
3. The poor benefit the most

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# VDRFs Improve Access to Basic Drugs and Services*

| | Baseline | Follow-Up |
|---|---|---|
| Indicators | No VDRF | VDRF |
| Use VDRF for Curative Care (%) | 4.5 | 51.9 |
| Use MOH Approved Providers (%) | 44.7 | 69.3 |
| Availability of Basic Drugs (%) | 11.4 | 84.1 |

* This data is preliminary and should not be quoted.

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# Higher Utilization of VDRFs by the Poor*

| Wealth Quintile | Use VDRF (%) |
|---|---|
| Poorest | **56.8** |
| 2nd | **56.6** |
| Middle | **57.1** |
| 4th | 40.4 |
| Richest | 41.9 |

* This data is preliminary and should not be quoted.

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# Strategy for Financing Hospital Care: Targeting Funds

| Wealth Quintile | Targeted Source of Funds |
|---|---|
| Poorest | Equity Fund |
| 2nd | Patient Loans |
| Middle | Patient Loans |
| 4th | Own funds |
| Richest | Own funds |

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# Conclusions / Recommendations

- Quality and affordability of PHC to be improved to increase utilization, benefits, revenue, returns on investments
- Strong case for patient loans for near-poor, possibly through contracting out
- Strong case for equity funds to subsidize PHC for the very poor with external assistance
- This will help improve coverage and expand social health insurance

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