Institutional arrangements for UHC in Cambodia and Laos
Peter Annear and Shakil Ahmed

Second Roundtable Discussion:
Supporting health system reforms to achieve universal health coverage

Melbourne 23-24 May 2013
## Geographic context

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Cambodia</th>
<th>Lao PDR</th>
<th>Australia (Victoria)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Land Area (sq. km)</td>
<td>176,520</td>
<td>230,800</td>
<td>227,416</td>
</tr>
<tr>
<td>Total Population (million)</td>
<td>14.1</td>
<td>6.2</td>
<td>5.6</td>
</tr>
<tr>
<td>Rural vs. Urban Population (% of total)</td>
<td>80 / 20</td>
<td>67 / 33</td>
<td>11 / 89</td>
</tr>
<tr>
<td>GDP per capita (US$)</td>
<td>795</td>
<td>1,158</td>
<td>49,000</td>
</tr>
<tr>
<td>Health Expenditure per capita (US$)</td>
<td>45</td>
<td>46</td>
<td>5,517</td>
</tr>
<tr>
<td>Population below national poverty line (% of total pop.)</td>
<td>30.1</td>
<td>27.6</td>
<td>12.8</td>
</tr>
<tr>
<td>Employment in formal sector (% of total pop.)</td>
<td>17</td>
<td>14</td>
<td>49</td>
</tr>
</tbody>
</table>
The demographic context

Conceptual view of coverage for different population segments

- **Higher income**
  - 5%: Wealthy: private coverage
  - 10%: Urban formal sector: SHI (civil servants, private employees)
  - 50%: Urban and rural near-poor: Public health care, user fees and CBHI
  - 35%: Rural and urban poor: Fee exemptions, HEF and other subsidies

- **Lower income**

15% of the pop.

85% of the pop

35% below the poverty line
The analytical framework

Stewardship

- Resource Collection and related tasks
  - Institutional design
  - Organisational practice

- Pooling and related tasks
  - Institutional design
  - Organisational practice

- Purchasing/provision and related tasks
  - Institutional design
  - Organisational practice

Health financing functions
- Level of funding
- Level of population coverage
- Level of equity in financing
- Degree of financial risk protection
- Level of pooling
- Level of administrative efficiency
- Equity in BP delivery
- Efficiency in BP delivery
- Cost-effectiveness & equity in BP definition

Health financing performance indicators

Health financing objectives

Universal coverage
- Sufficient and sustainable resource generation
- Financial accessibility
- Optimal use of resources

Improved and equitable health outcomes
Current arrangements:

- fragmentation of the health financing schemes and
- a slow pace of implementation

Population coverage, benefit packages and provider payment mechanisms differ

These constraints:

- complicate the stewardship function of the government
- produce inefficiencies in implementation
- prevent a rapid increase in population coverage

Both countries are moving to establish national social health protection or national health insurance agencies
### Social health protection schemes

<table>
<thead>
<tr>
<th>Population</th>
<th>Cambodia</th>
<th>Laos</th>
</tr>
</thead>
<tbody>
<tr>
<td>Civil Servants</td>
<td>NCSSF (proposed)</td>
<td>SASS</td>
</tr>
<tr>
<td>Private sector</td>
<td>NSSF (proposed)</td>
<td>SSO</td>
</tr>
<tr>
<td>National programs</td>
<td>Vaccination</td>
<td>Vaccination</td>
</tr>
<tr>
<td></td>
<td>TB, Malaria, AIDS</td>
<td>TB, Malaria, AIDS</td>
</tr>
<tr>
<td></td>
<td>MCH incentives</td>
<td>Free MCH (proposed)</td>
</tr>
<tr>
<td>Informal sector</td>
<td>CBHI</td>
<td>CBHI</td>
</tr>
<tr>
<td>The poor</td>
<td>User-fee exemptions</td>
<td>Health Equity Funds</td>
</tr>
<tr>
<td></td>
<td>Health Equity Funds</td>
<td>Free MCH (proposed)</td>
</tr>
<tr>
<td></td>
<td>Gov’t subsidies</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vouchers/MCH</td>
<td></td>
</tr>
</tbody>
</table>
Informal sector and the poor

The key questions:

Targeted coverage vs. universal coverage?

Type of targeting mechanism in place?

Using voluntary insurance?

Tax funding vs. social health insurance?
Creating a National Health Insurance Agency for the national population

Institutional design
A single National Health Insurance Agency / and Decree Report to the Minister for Health
Compulsory membership for the formal sector
Subsidies for the informal sector and the poor

Organisational practice
Integration of four schemes
Department status within the MOH
Risk pooling across income groups is undecided
NHIA secretariat limited to analysis and planning
Financial mechanisms are not yet established
Creating a National Social Health Protection Fund
for the poor and the informal sector

Institutional design
- Health Financing Charter now being prepared
- Autonomous status within the Government system (PAE, SOA)
- Third-party status and an independent Board
- With transparency and accountability

Organizational practice
- Extensive HEF coverage created the foundation for the NSHPF
- Semi-autonomous structure within the MOH
- Mechanism for enrolling the informal sector not decided
- Cross-subsidisation of the poor by direct targeting
- Budget leakage is common
Lessons learned

**Institutional design**
- Requires explicit legislation
- Third-party status is necessary
- Stewardship is critical
- With transparency and accountability

**Organizational practice**
- Coverage of the poor provides a foundation for broader coverage
- Purchaser-provider split is essential to prevent conflict of interest
- Specific mechanisms are required for enrolling the informal sector
- Cross-subsidisation of the poor is unavoidable
- Budget leakage is common
Lessons learned

Collection of funds
  Taxation, insurance, user fees and donor funding
  Donor and government funds pooled
  Compliance is a major challenge

Fund and risk pooling
  A common national risk pool or separate schemes?
  Cross-subsidization from the formal sector is not certain
  Compulsory membership for the informal sector is difficult
  ‘Risk-equalisation’ function is required to protect the poor

Purchasing
  Third-party purchaser for services provided by government
  Standard package of services from government facilities
  Capitation provider payment method
  Quality of service delivery is assessed and monitored
A national health insurance system must be underwritten by government health expenditure (taxation, resources revenues, donor support)

The capacity for operating a national health insurance agency does not exist and must be developed as part of the process

Voluntary insurance schemes are not effective at the national level

Arrangements for compulsory membership for the informal sector need to be clearly defined

The poor and the informal sector require subsidies
HEALTH POLICY AND HEALTH FINANCE KNOWLEDGE HUB

THE NOSSAL INSTITUTE FOR GLOBAL HEALTH