Executive Summary

The Lao People’s Democratic Republic is a landlocked country with a population of 6.4 million, where the majority of the workforce is engaged in agriculture. As a result of rapid economic growth, poverty reduction has been impressive. The country was classified by the World Bank in 2011 as a lower-middle-income country, with a gross national income (GNI) of US$ 1010 per capita. Between 1980 and 2010, life expectancy at birth increased by 18 years, from 49 to 67. The proportion of the population living below the national poverty line fell from 45% in 1992 to 27.6% in 2008.

However, inequalities in income distribution have become prominent. Poverty remains high, particularly in remote and highland areas where access by road or river is difficult, and rural areas continue to have poor access to sanitation and electricity. Despite data limitations, it is evident that infectious diseases still account for a significant proportion of disability-adjusted life years lost (DALYs). Both communicable and noncommunicable diseases are major causes of mortality and morbidity; the prevalence of tuberculosis, malaria and dengue, although there has been some significant success with malaria control over the last decade. The high rate of traffic accidents are of particular concern. Millennium Development Goals (MDGs) 4, 5 and 6 are on track to be achieved by 2015.

Net official development assistance to the Lao People’s Democratic Republic was 17% of GNI in 1990 and had decreased to 6.2% in 2010, challenging the country’s historical reliance on ODA. Fiscal space is favourable and the national budget deficit has declined. Government revenue (excluding grants) has increased from 12.2% of GDP in 2006 to 14.4% in 2010. While this is not high compared with international peers, it does give more room for government investment in health.

Chapter 2 describes the organization and governance of the health system of the Lao People’s Democratic Republic. The health-care delivery system is a government-owned system with three administrative levels: central (Ministry of Health, or MOH), provincial (17 provincial health
offices) and district level (district health offices in all districts). The Ministry of Finance is the account holder of the projects, while the Ministry of Home Affairs allocates the quota of health workers. Requests have been increasing for the MOH to have more decision-making space in relation to human resources for health, and more positions for the health workforce.

Health sector development is implemented according to two types of national health plan formulated by the MOH: the medium-term five-year health sector development plan (HSDP) and the annual operational plan. In alignment with the 2006 Vientiane Declaration on Aid Effectiveness, a Sector-Wide Coordination (SWC) mechanism for health furnishes a platform for the MOH, in partnership with all stakeholders. Decentralization has been implemented but there is a need to streamline this process and to improve management capacity, including budgeting and planning at the central and provincial levels. A policy aimed at improving the quality of private health services through accreditation and licensing has yet to be fully implemented. The emerging private-sector providers are currently only loosely regulated by the Government, and dual practice is common among public sector doctors.

Though the health information system (HIS) continues to improve, challenges remain in relation to further improvement of the routine information system, the move from a paper-based to a computerized system, and roll-out of the vital and civil registration system. The private sector is not covered by the national HIS. The use of health information for planning is still weak. The capacity for health technology assessment to guide cost-effective investments in health is limited.

Chapter 3 explains the health financing system. The public health sector has transitioned from a centralized system under which the Government provided free services, to a system of charging the users of government health services, followed by the slow reintroduction of user fee exemption for some target populations, such as the poor. Out-of-pocket payments are high and are increasing. Publicly financed free services are soon to be implemented for all antenatal care, delivery services and postnatal care, as well as free health services (including inpatient treatment) for children under age five, to be financed by pooled government and donor funding.

There are four health financing schemes: [1] Social Security Organization (SSO) for salaried private employees; [2] State Authority for Social Security (SASS) for civil servants; [3] Community-Based Health Insurance (CBHI)
for non-poor workers in the informal sector; and (4) a Health Equity Fund (HEF) for the poor. Population coverage by these four main prepayment schemes is limited to around 19.6% of the population (excluding coverage of fee exemption schemes, police and military personnel). Both SSO and CBHI have low coverage of their targeted populations. Donor-financed HEF covered around 40.7% of the poor in 2012. Besides competition from private health services and services obtained in neighbouring countries, the quality of the government health services is also seen as a barrier to expanding the coverage of these health insurance schemes and improving compliance with them.

Given the increased fiscal space and favourable economic prospects, the Government is looking to improve population coverage by health financing schemes, as outlined in the Health Financing Strategy 2011–2015. Recently, the Government has initiated a decentralized system, including further strengthening of district-level management, planning and budgeting.

Chapter 4 profiles the physical and human resources of the health system. Health services at the secondary and tertiary levels in the Lao People’s Democratic Republic are provided through 4 central general hospitals and 3 specialist hospitals in the capital city, in addition to 4 regional and 12 provincial hospitals. Meanwhile, there are approximately 130 district hospitals, 860 health centres, and around 5239 village drug kits for provision of primary health care. The number of hospital beds per 1000 population is low in the country, at just 0.8. Pressure from capital investment is high in private hospitals, due to a combination of factors from the donor side, a loosely regulated private health sector and increased demand for private health services. Health education institutions include the University of Health Sciences in Vientiane, and seven provincial colleges/schools. There is a large primary health care network of health workers with qualifications at a range of levels, including large numbers of village health workers and volunteers.

The human resources for health situation has remained largely unchanged in the last two decades until very recently. Due to limited post allocations by the Ministry of Home Affairs, there are a large number of qualified health graduates waiting for a sanctioned post, and retention of qualified health workers in rural areas is challenging. A number of recent initiatives are aimed at improving the situation, including: recent increased quotas within the health workforce; improving standards of
professional health training and educational institutes; enforcing the implementation of the Ministry of Health (MOH) regulation No. 103 supporting mandatory employment of all new graduates to work for three years in rural areas; providing adequate financial and non-financial incentives to retain health staff in rural and remote areas; and improving the information system.

Chapter 5 describes the system for provision of health services. There is poor access to and acceptance of the quality of services provided by public primary health care (PHC), probably due to the high level of out-of-pocket payments required, and the inadequate quality of public health facilities. The PHC system lacks a gate-keeping function; there is no effective referral system in place. Services at the PHC level have a lower rate of utilization as patients tend to go directly to a hospital for curative services, as evidenced by the relatively crowded outpatient department services in provincial and central hospitals. Inpatient services at hospitals also have relatively low utilization rates, as reflected in bed occupancy rates and length of stay data.

The public health surveillance system is gradually developing and becoming operational, in the context of renewed political commitment in response to the H5N1 (avian influenza) outbreak in 2007. Further strengthening of the health management information system, and bringing the private health sector into compliance with the national requirements, is high on the agenda. Routine coverage of the Expanded Programme on Immunization is still low. Pharmaceutical care is more developed than other programmes. The rehabilitation, long-term care and mental health-care systems are in their infancy.

Chapter 6 provides an overview of the principal health reforms in the Lao People’s Democratic Republic. Within a short timeframe and in a very challenging environment, the Government has undertaken some major health sector reforms, guided by the socioeconomic changes in the country, with a view to providing better health services for all people in the country. There is convergence towards a specific health sector reform plan. Major efforts can be categorized within four policy frameworks: governance and leadership; health financing; service delivery; and human resources for health. The MOH has made significant progress in terms of health policy formulation and decentralization of health services to the provincial, district and health centre levels since the 1990s. The primary health care policy of 2000 sets service delivery at the PHC level
as a priority area. Various laws provide a framework for better regulation and implementation of health programmes. However, the institutional capacity for regulation, enforcement, and translation of policy into effective implementation is still limited. The Government’s four health financing schemes are being merged into one National Health Insurance Scheme for efficient management and larger risk-pooling (GOLPDR, 2012). The Government has committed to achieving 50% coverage with the health financing scheme by 2015, and has introduced a national policy on free maternal and child health services in 2012. However, these targets are unlikely to be met due to weaknesses in PHC services and managerial capacities of the implementing agency, as well as low public expenditure on health, geographical, language and cultural barriers to accessing care, and the limited range and quality of services at PHC facilities in rural areas.

Recent reforms have supported progress in service delivery: drug kits, outreach services for the poor, and a voucher programme for improved maternal, neonatal and child health have improved accessibility; many health-care facilities have been renovated and upgraded; there is ongoing reassessment and consolidation of the required number of health facilities at each level; and there is accelerated implementation of the minimum requirements for strengthening the quality of district-level services. However, infrastructure, equipment and staffing at health centres and district hospitals all need to be improved to strengthen curative, preventive and health promotion services. Further efforts are also needed to improve health-care access for the poor, especially in some hard-to-reach areas. The MOH has launched the comprehensive National Strategy for Human Resources for Health 2010–2020, in response to the shortage and uneven distribution of skilled health workers across the country. The MOH is working on reintroducing the training programme for medical assistants and in-service PHC training modules, providing an incentive package for staff to work in rural areas, and negotiating for an adequate number of sanctioned posts for rural health workers. There is also a move to provide training and incentives to village health volunteers to become qualified village health workers.

The Health Sector Reform Strategy was finalized and endorsed by the National Assembly in December 2012 and most recently a Prime Minister Decree creating a National Commission to implement the health sector reform strategy. The main reform contents are in line with six health systems building blocks addressing the bottlenecks in a) service provision
at primary health care, b) health workforce, c) financing, d) health information systems, and e) governance, management and coordination.

A sign of strong political commitment for reforming the health system was shown in the fiscal year of 2013–2014 health budget allocation increase to 9% of general government expenditure. Also sanctioned posts have been significantly increased to around 4000 posts in fiscal year 2013–2014. A few challenges such as absorptive capacities and ability to translate these policy intentions into effective program implementation and expected outcomes have to be resolved through capacity building and continuous commitment/leadership to the health sector and the universal health coverage agenda.

Chapter 7 offers an assessment of the health system. There is strong political commitment to the development of the health system, and there have been some major achievements in terms of health-related strategies and policies in the Lao People’s Democratic Republic. The results, however, have been mixed. While there are strong efforts to increase public spending on health and move towards the expansion of insurance-based risk-pooling and prepayment health-financing schemes, out-of-pocket payments by households are still high. The National Assembly has approved an increase in government spending on health from 3% to 9% to support acceleration towards the Millennium Development Goals. Health sector reform has been approved and implementation is in progress since the Prime Ministerial Decree of December 2013 establishing the creation of a national health sector reform committee. Quality of care and health-care provider responsiveness has yet to improve substantially, however. There is ineffective coordination and management, particularly at the district and sub-district levels.

In conclusion, with government effectiveness in mind, the critical review of health systems in this report provides a number of insights. Despite strong government commitments to health, as reflected by a number of policy statements, decrees, national strategies and plans, and a comprehensive health reform strategy, it is evident that there are gaps between policy intentions and effective implementation. Political commitments have not yet been translated into increased health spending. Government health expenditure stagnated at 5.9% of the general government budget in 2008–2010 and is inadequate to make a significant difference, while the number of sanctioned posts was stagnant. The level of total health expenditure—US$ 46 per capita in
2010—is inadequate to purchase a decent service package to achieve the health-related MDGs. The Government has consistently invested more of the budget in education than in health. However, there are signs that this is improving with the increased quota of 4000 health worker posts and 2013–2014 budget increase.

Prepayment health financing schemes targeting different groups of the population have been initiated but only covered 19.6% of the population as of 2012, with a high level of reliance on regressive out-of-pocket (OOP) payments, discouraging the poor from accessing care when needed. The Government needs to spend more on health and significantly strengthen PHC if it is to implement the Health Financing Strategy 2011–2015 successfully. There has been a decade-long stagnation in the number of health workers: the current level of 0.6 health workers per 1000 population is inadequate to reach a desired level of service coverage. Also, the uneven distribution of the health workforce in favour of cities exacerbates the problem of shortages in rural areas. Surprisingly the incidence of catastrophic health-care expenditure was found to be low and declining, and the incidence of health impoverishment has also declined. The low incidence of catastrophic health expenditure can be misleading, since poor households may decide not to seek care when ill, but this lack of care can result in welfare losses, such as mortality or disability. As a result of insufficient investment in the public health infrastructure and workforce, the health service utilization rates are also low, indicating that patients are forgoing health services, which may result in increased levels of preventable mortality and disabilities. This assessment of the health system’s performance reflects large urban–rural and rich–poor gaps of service coverage and health status.

Government strategies and policies are often not fully implemented, implying that serious reflection is needed on the following:

- Strategies, policies and related plans should be well-defined, realistic and doable.
- Capacity and commitment are needed to translate research findings into evidence-based policy, and to translate policy into programme implementation.
- Implementation plans must be fully aligned with relevant policies and strategies.

Progress will need to be monitored and corrective actions taken promptly as the health sector reforms evolve. Improved government
accountability, including financial accountability, will also help towards achieving the goals of the health sector reform. A few successful efforts should be applauded, such as the MDG progress monitoring in 2008, which the Government and development partners worked seriously on.

The context of the health system in the Lao People’s Democratic Republic has evolved in a number of ways: (a) favourable economic performance supported greater fiscal capacity for the Government to spend more on the health of the population; (b) a portion of the government revenue generated from the NT2 Hydroelectric Project is to be spent on health and education; (c) the lower-middle-income status of the country may lead to a reduction in the amount of official development assistance for health and domestic funding should gradually replace donor resources; and (d) income distribution gaps have widened as the country become richer, creating an urgent need for redistribution through improvement of health and education programming in favour of the poor.

While there is a need to make the case for investment in health, the issue of how any additional government funding should best be allocated also needs to be addressed. Simply increasing the size of the health workforce might not resolve the key bottlenecks, given the current low health-care utilization rates, unless this is coupled with a reduced level of out-of-pocket payments and some modifications of the capitation rate system to reflect the actual cost of service provision, so that providers have a greater incentive to be responsive to patient needs, as well as investment in improved competency. Given this context, the Government will need to invest more funding in both the demand side and the supply side of the health-care system. The strategic hub should be at the district level, including health centres and district hospitals, as these are services that the poor and rural residents can better access. These recommendations are in line with the current policy and directions, but significant improvements are needed in the capacity to implement these changes.