International Labour Organization

Review of the Health Insurance Law (amended version) 2018 in Lao People's Democratic Republic

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Acknowledgements

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About this review

This ILO technical note is prepared in the framework of the revision of the Health Insurance Law (amended version 2018).

This note provides general comments and suggestions on the current Health Insurance Law (hereafter referred to as "the Law") to provide some guidance on the development of the new draft Law on Health Insurance. The comments and recommendations included herein are based on the main principles and quantitative and qualitative benchmarks underpinning the ILO at this time, including the:

- Social Security (Minimum Standards) Convention, 1952 (No. 102);
- Medical Care Recommendation, 1944 (No. 69);
- Social Protection Floors Recommendation, 2012 (No. 202); and
- Medical Care and Sickness Benefits Convention (No. 130) and Recommendation (No. 134), 1969.

Where relevant, the comments and recommendations derived from these international labour standards are complemented by additional recommendations drawn from ongoing research, such as the ILO actuarial analysis conducted in 2023 and the ILO's review of the Lao People's Democratic Republic's compliance with Convention No. 102.

This technical note must be read together with the specific comments on the individual provisions of the Law previously provided by the ILO to the Ministry of Health.[1]

The Health Insurance Law will reflect the decisions (to be) made by the Ministry of Health on the funding mechanisms and possible changes to the benefit packages. Because these policy reforms have yet to be defined in detail, this current note does not make reference to them. It can be noted in this regard that international standards provide that the necessary actuarial studies and calculations concerning financial equilibrium should take place, in any event, prior to any changes in benefits, the rate of insurance contributions or the taxes allocated to social protection. Additionally, it is to be noted that related secondary legislation, including decrees and ministerial decisions, will require amendments accordingly.

It is hoped that the comments and recommendations provided in this note, together with previous observations, can serve to guide the completion of this legislative reform.

Disclaimer on translation: The technical note was prepared based on an unofficial English translation of the Health Insurance Law from the original Lao language. While thorough cross-checks were done with the original Lao version, some nuances may have been lost. As such, the interpretation of some provisions should be discussed and confirmed through national consultations with relevant stakeholders in the future.

1 As per an ILO technical note dated 1 June 2023, which includes detailed comments and suggestions on several provisions of the Health Insurance Law.

1. Main comments regarding Part I of the Law on general provisions

1.1. Coverage of legal residents (arts 1, 2, 4, 6, 10, 13, 19, 35–36, 39, 67)

The English translation of the Law includes several references to "Lao citizens" (arts 1, 2, 4, 6, 10, 13, 19, 36, 39, 67), which seems to limit the application of said provisions and the scope of application of the Law to citizens only. However, this seems inconsistent with article 35 of the Law, which states, "The National Health Insurance Fund is the government authorized fund to ensure universal access to basic and essential healthcare services for **the entire population and the health insurance members**" (emphasis added).

ILO comments and suggestions:

Given that the ultimate objective is to achieve universal health coverage,[2] consideration should be given to including a reference to "legal residents" or "persons with permanent residence in the country", and not only Lao citizens. This would be in line with the recognition of the right to healthcare enshrined in the Lao Constitution:

> *The State focuses on improving and expanding public health services to take care and promote the **people's health.***
>
> *The State and society focus on building, improving disease prevention systems, providing healthcare **to all people** with quality, creating conditions to ensure that all people have access to healthcare, especially women and children, poor people and people in remote areas, to ensure the people's good health (art. 25, as amended) (emphasis added)*

This would also be in line with international standards related to social security, notably the Medical Care Recommendation, 1944 (No. 69), Paragraph 12: "The medical care service should cover all members of the community, whether or not they are gainfully occupied." In addition, the principle of equality of treatment is embedded in the Social Security (Minimum Standards) Convention, 1952 (No. 102), which provides that: "Non-national residents shall have the same rights as national residents: Provided that special rules concerning non-nationals and nationals born outside the territory of the Member may be prescribed in respect of benefits or portions of benefits which are payable wholly or mainly out of public funds and in respect of transitional schemes" (Article 68(1)).

Furthermore, ensuring that the Law also covers legal residents would be aligned with the principle enshrined in international instruments, including the principle of non-discrimination recognized in the International Covenant on Economic, Social and Cultural Rights (Art. 2(2)), which was ratified by the Lao People's Democratic Republic in 2007.

2 As specified in section 1.2 of the NHI Strategy 2021–2025: "expand population and service coverage and achieve financial protection for all".

1.2. Objectives (art. 1)

Article 1 of the Law provides:

> *This Law determines the principles, regulations and measures regarding the management, monitoring and control of health insurance activity for systematic, quality, effective and efficient implementation aiming to ensure that **Lao citizen** are covered by health insurance and shall access universally to equitable healthcare services and enable to link with the regional and international cooperation and contribute to the protection and development of the nation.*

ILO comments and suggestions:

- For further clarity, the objectives of the Law could be listed – that is, they should be presented in a format along the lines of: the objectives of the law are as follows: (a), (b), (c) and so on.
- Certain elements regulated by the Law are not necessarily covered in this provision. Concretely, this article could specify that the Law also establishes the types of health insurance, the persons covered by compulsory health insurance, the rights and duties of insured persons and of healthcare institutions, and the dispute settlement procedure.
- See the related comment above concerning the coverage of legal residents.

1.3. Health insurance definition (art. 2)

As per article 2 of the Law: "Health Insurance is a security mean to ensure that all **Lao citizens** have fair access to equitable healthcare services notably the consultation and diagnostic services, medical treatment, physical rehabilitation including health promotion and prevention through the contribution payment to National Health Insurance Fund".

ILO comments and suggestions:

- **The objective of financial protection should be spelled out**: The overarching objective of ensuring universal and equitable access to **quality** healthcare services should be linked with that of securing financial protection and avoid hardship (that is, **affordability**). This will be in line with the vision embedded on the National Health Insurance (NHI) Strategy 2021–2025, which aims to "establish a fully operational, financially sustainable, and integrated Social Health Protection system for all people of Lao People's Democratic Republic, ensuring equitable and affordable access to quality health services and financial protection from catastrophic health expenditure for all to achieve universal health coverage by 2025".

  Considering the high levels of out-of-pocket expenses in the Lao People's Democratic Republic,[3] an explicit recognition of the financial protection component of health insurance seems of particular importance to ensure that individuals and households can access the quality healthcare they need without facing hardship or increasing the risk of falling into poverty.

  It can be further noted that the financial protection dimension of healthcare is recognized in International Social Security Standards, including Convention No. 102 and the Medical Care and Sickness Benefits Convention, 1969 (No. 130), with the latter stipulating, "Where the legislation of a Member requires the beneficiary or his breadwinner to share in the cost of the medical care, the rules concerning such cost sharing shall be so designed as to avoid hardship and not to prejudice the effectiveness of medical and social protection" (Art. 17).

3 In 2022, out-of-pocket expenditure in the Lao People's Democratic Republic corresponded to 28 per cent of current health expenditure (WHO, "Out-of-Pocket (OOPS) as % of Current Health Expenditure (CHE)", Global Health Expenditures Database, accessed 5 December 2024).

- In light of taking a rights-based approach, it is recommended to specify that health insurance is a system to ensure that **all persons** have access to equitable and **quality** healthcare services in accordance with the principles and terms and conditions laid down in this Law and secondary legislation. In this regard, it should be noted that ILO Recommendation No. 69 specifies that "the medical care service should aim at providing the highest possible standard of care, due regard being paid to the importance of the doctor-patient relationship and the professional and personal responsibility of the doctor, while safeguarding both the interests of the beneficiaries and those of the professions participating" (Para. 46).
- Furthermore, given that Chapter 2 of the Law specifies the material scope of the healthcare benefits covered, the second part of the provision could be revised. An alternative could be to replace the broad categories of services by the objectives of the health insurance system (for example, to prevent, diagnose, palliate or cure the diseases, and improve, protect and promote the health of the population).

1.4. Interpretation of terms (art. 3)

Some of the definitions currently included under article 3 of the Law might create ambiguity, for instance, in regard to the coverage offered to various categories of persons and by different schemes.

Overall, the definitions provided should be those considered essential to understanding the provisions of the text in its entirety and facilitate the understanding of the Law both by persons who have to implement it and by those directly concerned by it. Noting that some of the terms defined under article 3 are only used occasionally in the Law (for example, "risk pooling" and "leprosy"), consideration should be given as to whether definitions of such terms are indeed needed or if they could be removed.

Therefore, it is recommended that some of the definitions included in the Law should be carefully revised and re-written by the Ministry's legal experts to ensure that the definitions are sufficiently clear, uniform and harmonized with existing labour, social protection and other relevant national legislation.

Table 1 summarizes some of the potential issues identified among the definitions in the current Law. It proposes alternative language for the consideration of the legal experts responsible for the revision of the Law.

▶ Table 1. ILO comments and suggestions concerning definitions included in the Health Insurance Law

Current definitions in the Health Insurance Law	ILO comments and suggestions
1. Health Insurance Member means a person who pays contribution to health insurance scheme as defined in this law, such as members of the National Social Security, self- employed people, poor people;	Potential issues: ▶ Given that some groups (such as, the poor, pregnant women and so on) are exempted from paying contributions, this definition should be revised. For example, it could specify "or whose contributions are partially or totally subsidized by the Government, under the conditions and modalities established in this Law and secondary legislation". ▶ The examples of members (that is, members of the NSSF, the self-employed and poor people) are not a complete list. Consideration should be given to either including an exhaustive list (that is, a list of the format A), B), C), D) and so on), or to establishing the different types of members under the relevant provisions (that is, the scope of application of the different schemes that are part of the NHI).

Current definitions in the Health Insurance Law	ILO comments and suggestions
	The following alternative definition is presented for the consideration of the legal drafters: **The insured** means a person who pays contributions to the health insurance scheme for themselves or through their employer, as defined in this Law or who is exempted from paying contributions in accordance with the terms and conditions laid down by this Law and secondary legislation;
2. Self-employed Person means a person working for oneself in different sectors such as agriculture, industry, trade and services;	The definition of self-employed is in line with that included in the Social Security Law. Given that the Labour Law (No. 43/NA) does not seem to define this term, it is advisable to revise how the term "self-employed" or "own-account worker" is defined in the labour legislation. It should be noted that typically the labour law defines this term, and all other laws cross-reference that definition without necessarily repeating it. This is to avoid having multiple definitions for the same term across different laws. In comparative practice, this definition typically includes those who work in their own business, professional practice or farm for the purpose of earning a profit and specifies that the work is done independently.
4. Contribution means the money that the government, members of the National Social Security Fund (NSSF), Non NSSF member Lao citizen who pay contribution to the National Health Insurance Fund;	Potential issues: ▶ The term "contribution" only refers to the employees' share (perhaps it is a translation issue, but it seems incomplete that the definition does not include the employers' share, also because employers typically have a legal obligation to deduct the employee's share and pay the total contribution to the relevant fund). ▶ The current definition does not specify the periodicity of contributions. ▶ The reference to "Non-NSSF member Lao citizen who pay contribution to the National Health Insurance Fund" is unclear. Does this refer to persons not subject to mandatory coverage but who register voluntarily?. Alternative definition for the consideration of the legal drafters: Periodic payments (or the monthly amount paid) to the National Health Insurance Fund by the employer on behalf of themselves and their employees, by self-employed persons, or by the Government, as an employer and on behalf of persons eligible for subsidized contributions, towards financing the social health insurance scheme.

Current definitions in the Health Insurance Law	ILO comments and suggestions
8. Poor people means Lao citizen whose name is in the poverty list, as stipulated in the regulation regarding poverty alleviation criteria and development qualification;	To avoid stigmatizing poor and marginalized groups, consideration should be given to replacing the definition of "poor people" (which also has a narrow scope, as this is just one of the groups eligible for subsidized contributions) with the definition of "subsidized beneficiaries" or another term to that effect. This term should accordingly be used throughout the law as a replacement for "poor people". Alternative definition for the consideration of the legal drafters: Subsidized beneficiaries: Lao citizens (and legal residents?) with income below a prescribed threshold and other categories of persons who, due to their vulnerability status or limited contributory capacity, are exempted from the payment of health insurance contributions as specified in this Law and other statutory acts.
11. Essential drug list means the necessary medicines which used in prevention, treatment and healthcare services of the population and are intended to be available at all times and at all level of healthcare facilities;	Consider complementing this definition by specifying that the list of the essential medicines (and medical aids) shall be compiled, adopted and published by the Ministry of Health on the proposal of the National Health Insurance Management Committee. The list of essential medicines will be revised and updated as required to ensure its suitability in ensuring quality medical services. In addition, the legal drafters may wish to specify that the essential drug list applies to both outpatient and inpatient treatments and supplies.
13. Premium rate means the amount of money shall be paid to National Health Insurance scheme as stipulated in the regulation;	This term only appears under article 3(13) in the English version of the Law. Therefore, it is unclear if this definition should indeed be included in the revised version of the Law. Furthermore, the difference between "premium rate" and "contributions" is unclear.

1.5. State policy on health insurance (art. 4)

Article 4 of the Law stipulates:

> *The State shall prioritize and promote Health Insurance by providing appropriately budget, human resources, and tools to implement activities on health insurance and apply the policy regarding the guarantee and exemption of income tax for health insurance.*
>
> *The State shall pay attention to the dissemination on health insurance information through various measures in order to build awareness and encourage* ***Lao citizen*** *to enrol to health insurance scheme aiming to ensure access to healthcare services as stipulated in this law and other related laws;*
>
> *The State shall encourage and mobilize individuals, entities including both domestic and international organizations to provide financial contribution and technical support to the development of health insurance to ensure the growth and sustainability of the scheme.*

ILO comments and suggestions:

An explicit recognition of the role of the State as the final guarantor of the health insurance system could strengthen the provision cited above. Such recognition will be in line with the principle of overall and primary responsibility of the State for the due provision of benefits and the proper administration of institutions and services, which is enshrined in ILO standards related to social security, notably Convention No. 102 (Art. 71(3)),[5] Convention No. 130 (Art. 30), Recommendation No. 69 (Paras 3,[6] 93–102) and the Social Protection Floors Recommendation, 2012 (No. 202) (Para. 3).

In this light, the legal drafters may wish to consider further specifying the role of the State in ensuring the availability of the necessary and adequate resources to finance the health insurance system. For example, the first paragraph of article 4 could be complemented as follows:

> *The State is responsible for respecting, protecting and guaranteeing the progressive and effective materialization of the right to health. To this end, it shall adopt the regulations and policies to ensure the sustainable financing of health services in a sustainable manner and guarantee the flow of resources to meet the health needs of the population in a timely and sufficient manner.*

Furthermore, the Government may wish to specify what the primary objectives of the healthcare policy are – for example: to protect, promote and restore the physical and mental health and well-being of Lao citizens and legal residents and to ensure they can access the health services needed without financial hardship.

Finally, consideration should be given as to whether the provision currently included under article 8 of the Law concerning international cooperation could be merged with this article, as it appears to be more of a policy objective that an enforceable provision.

5 Article 71(3). The Member shall accept general responsibility for the due provision of the benefits provided in compliance with this Convention, and shall take all measures required for this purpose; it shall ensure, where appropriate, that the necessary actuarial studies and calculations concerning financial equilibrium are made periodically and, in any event, prior to any change in benefits, the rate of insurance contributions, or the taxes allocated to covering the contingencies in question.

6 Paragraph 3. The authorities or bodies responsible for the administration of the service should provide medical care for its beneficiaries by securing the services of members of the medical and allied professions and by arranging for hospital and other institutional services.

1.6. Basic principles on health insurance (art. 5)

As noted in the ILO note shared in June 2023, article 5 currently provides for a mix of principles, obligations and objectives. As such, it is recommended to revise this provision to ensure that it contains the foundational principles of the health insurance system in the Lao People's Democratic Republic (see table 2).

▶ Table 2. ILO comments concerning principles listed in the Health Insurance Law

Principles listed in article 5	ILO comments
(1) Be in line with Policy, Direction, Constitution, Laws, Strategies and Social Economic Development plans of the health sector;	This could be moved under article 4 on State Policy.
(2) Ensure the management of health insurance be practiced centrally, equally, fair, transparency, timely and accountable manner;	The legal drafters may wish to consider rewriting this provision so as to put a greater emphasis on the principles instead of the State's objective. For example, the provision could explicitly recognize the principle of overall and general responsibility of the State and specify that the State shall ensure the management of health insurance be practiced centrally, equally, fairly, transparently, and in a timely and accountable manner.
(3) Ensure equitable and universal access to health services for health insurance members;	The objective of ensuring equitable and universal access to healthcare services should not be limited to "health insurance members" but to the whole population (that is, all persons permanently residing in the Lao People's Democratic Republic), who shall effectively enjoy the fundamental right to health throughout the life cycle. This apparent restrictive scope of the principle of universality is of particular relevance as the current definition of "health insurance member" does not include the insured's family members (that is, the spouse and children of the member are only included in the definition of "healthcare beneficiary")
(4) Pay contribution to National Health Insurance;	This falls within the obligations of insured persons, employers and the Government (art. 6)
(5) Ensure fund raising, risk pooling, mutual assistance and sustainability;	The current English version of these provisions seem to place a greater emphasis on the objectives than on the principles of risk pooling, mutual assistance, financial sustainability and quality improvement.
(6) Ensure financial balance and quality improvement of health facilities including physicians, nurses;	
(7) Be in line with international Conventions and treaties that the Lao People's Democratic Republic is bound with;	This could be moved under article 4 on State Policy.

ILO comments and suggestions:

The possible revision of article 5 of the Law could explicitly reference some of the principles found in international social security standards, notably those put forward in ILO Recommendation No. 202, such as universality, solidarity in financing, sustainability and so on (see box 1).

▶ Box 1. Social security principles recognized in the ILO Social Protection Floors Recommendation, 2012 (No. 202)

Paragraph 3. Recognizing the overall and primary responsibility of the State in giving effect to this Recommendation, Members should apply the following principles:

(a) universality of protection, based on social solidarity;

(b) entitlement to benefits prescribed by national law;

(c) adequacy and predictability of benefits;

(d) non-discrimination, gender equality and responsiveness to special needs;

(e) social inclusion, including of persons in the informal economy;

(f) respect for the rights and dignity of people covered by the social security guarantees;

(g) progressive realization, including by setting targets and time frames;

(h) solidarity in financing while seeking to achieve an optimal balance between the responsibilities and interests among those who finance and benefit from social security schemes;

(i) consideration of diversity of methods and approaches, including of financing mechanisms and delivery systems;

(j) transparent, accountable and sound financial management and administration;

(k) financial, fiscal and economic sustainability with due regard to social justice and equity;

(l) coherence with social, economic and employment policies;

(m) coherence across institutions responsible for delivery of social protection;

(n) high-quality public services that enhance the delivery of social security systems;

(o) efficiency and accessibility of complaint and appeal procedures;

(p) regular monitoring of implementation, and periodic evaluation;

(q) full respect for collective bargaining and freedom of association for all workers; and

(r) tripartite participation with representative organizations of employers and workers, as well as consultation with other relevant and representative organizations of persons concerned.

Given that the Lao Government has consistently expressed the objective of attaining universal health coverage, it is recommended that in addition to the principle of universality (see comments in table 2), article 5 of the Law should explicitly recognize the principle of progressive realization. In essence, the principle of progressive realization embodies the commitment of the State to close coverage gaps and provide higher levels of protection to as many people as possible, as soon as possible – albeit in due consideration of the economic and fiscal capacities of the State. This would include increasing access to healthcare services gradually and continuously,

as well as taking the necessary measures to reduce cultural, economic, geographical, administrative and technological barriers that prevent the effective realization of the human right to health.

Other principles recognized in international social security and human rights instruments may be covered in specific articles. These include, for example, the principle of participatory management, the right to appeal and the principles of due process as a means to ensure that every person has a right to a fair and public hearing by an independent and impartial court.

1.7. Rights and obligations of Lao citizen towards Health Insurance (art. 6)

According to article 6 of the Law: "All **Lao citizens** regardless of sex, age, ethnicity, race, religion and social-economic status shall have the right to enrol to health insurance scheme, receive healthcare services and be obligatory for paying contribution to national health insurance scheme."

ILO comments and suggestions:

- See the related comments in section 1.1 concerning the coverage of legal residents.
- To ensure greater clarity, the Government may wish to consider separating the rights and obligations of the persons concerned into separate articles or sub-articles. Furthermore, the rights and obligations of employers, the NSSF and the NHI scheme should be enunciated. For example, employers' obligations include, but are not limited to:

  i. registering their employees with the National Social Security Fund in accordance with the conditions prescribed in the Social Security Law and other statutory acts;

  ii. deducting employees contributions from their wages; and

  iii. paying the contributions to the National Social Security Fund, in the manner prescribed in the Social Security Law and other relevant statutory acts.

  The article could also define the obligations of the NSSF concerning the financing of healthcare benefits and the registration of insured persons and their eligible dependents with the NHI scheme. These obligations include:

  i. collecting social security contributions and transferring the resources to the NHI fund to finance healthcare benefits and services in accordance with the rates, dates and procedures defined in the Health Insurance Law and secondary legislation;

  ii. providing the information of NSSF members to the National Health Insurance Bureau (currently included under article 15 of the Law); and

  iii. notifying the National Health Insurance Bureau of the termination of social security coverage.

  Although the Law defines the rights and duties of the Health Insurance Fund Management Committee at the Central Level (art. 47) and the Provincial Level (art. 49), it is necessary to establish the rights and obligations of the NHI scheme itself. For example, the duties could include (among others):

  i. concluding contracts and paying providers in accordance with the procedure prescribed by laws and other statutory acts;

  ii. monitoring the quality of healthcare services covered by the scheme; and

  iii. issuing health insurance membership cards to each citizen of Laos enrolled with the scheme.

- Concerning the right of all Lao citizens, regardless of sex, age, ethnicity, race, religion, socio-economic, **employment or other status**, to receive healthcare services, this entitlement could be strengthened by specifying that such services shall be **comprehensive, adequate and of high quality**.
- Furthermore, it can be noted that, in line with a rights-based approach, it is a good practice to **recognize the right of insured persons to access clear, appropriate and sufficient information**, including from health/treatment facilities regarding, inter alia, the state of their health, planned medical tests, medical procedures, methods of treatment and their potential risks, the scope of the healthcare services covered, the place of their provision and any conditions related to these services.
- Noting that article 34 of the Law defines the appeal process and that Part V (arts 57–62) establishes the general framework for dispute resolution, consideration could be given to specify under article 6 **every person's right to lodge a complaint and the right to appeal** in accordance with the terms and conditions laid down in the Law and other statutory acts.[7] Such recognition would align with the principles enshrined in ILO social security Conventions and Recommendations, including Convention No. 102 and Recommendation No. 202. More specifically, complaint and appeal mechanisms enable persons covered by a health protection system to lodge complaints regarding a decision of the entity responsible for the delivery of benefits, such as the refusal of medical care or the quality of the care received, so that the appropriate authority can investigate.
- It can also be noted that, as it is, article 6 imposes an obligation on all Lao citizens to pay contributions to the National Health Insurance scheme. However, "poor persons" (article 10 of the Law) and other population groups defined in secondary legislation[8] are exempted from paying contributions to the system. To resolve this apparent inconsistency, the legal drafters may wish to consider specifying that the obligation to contribute towards the financing of the system does not apply to categories of the population that, due to their characteristics, are exempted from this obligation in the Law and secondary legislation.
- Finally, the legal drafters may wish to specify that all **Lao citizens** shall provide the information necessary for their registration within the National Health Insurance scheme and have an obligation to notify the competent authority of any significant change in the circumstances determining their eligibility for enrolment within the different schemes. This includes, but is not limited to, changes in family composition (that is, births and deaths of family members, marriage, divorce and so on), place of residence, and socioeconomic and employment status. Such a provision would be linked with the obligations arising from article 17 (displacement or relocation of health insurance member) and with the reasons for termination of health insurance membership (article 18 of the Law).

7 It can be noted that article 4 of the Law on Healthcare (No. 09/NA), concerning the Rights and Obligations of Citizens in Respect to Healthcare, recognizes "the right of all citizens to … bring a complaint if they find that the healthcare provided is not in conformity with professional techniques or is not equitable".

8 As stated under section 3.6 of the Instruction of the Minister of Health No: 0476/MO on contribution collection, payment mechanisms and calculation of service fees of the National Health Insurance, dated 16 May 2018, collection of contribution is exempted for the following insured persons using the services:

- patients in the list of poor households approved annually by district authorities in accordance with Decree No. 348/Gov, dated 16 November 2017;
- pregnant women;
- children under age 5 in accordance with Decree No. 273/Gov, dated 19 August 2014;
- monks and novices; and
- eligible people with an NSSF membership card.

For persons insured under the Community Based Health Insurance (CBHI) programme who have paid their contribution in advance and are still eligible, contributions must not be collected from them unless their eligibility has expired.

2. Main comments regarding Part II, Chapter 1 of the Law on Schemes, targets of Health Insurance and membership terms

2.1. Health insurance schemes (art. 9)

In the current Law, article 9 list three different schemes: (1) Health insurance scheme for informal sector; (2) Health insurance within Social Security system; and (3) Health insurance scheme within insurance system. However, as raised in the commentary of the Law and in the ILO note shared in June 2023, there seems to be some confusion in the law and in practice on what the schemes are actually called.

In particular, the following observations and recommendations can be drawn from the current Law vis-a-vis national practice:

- The first name above – "Health insurance scheme for informal sector" – only appears twice in the Law (arts 9 and 10).
- The name "Health insurance scheme for informal sector" is not often used, but it is sometimes referred to as the "NHI scheme". However, the term "NHI" is sometimes used to refer to the merged scheme (somehow described in article 35) and sometimes used to make reference to the scheme for "workers in the informal economy" only.
- The name "Health insurance scheme for informal sector" does not reflect the reality of the persons that are currently covered through government subsidies. Since this scheme also covers persons who are not working (children under age 5, pregnant women, poor persons and so on) and who are not part of the informal economy, it is recommended that the name of the scheme be revised, perhaps to the "subsidized health insurance scheme". Given that the informal sector is not a legal category, as informal employment can occur in different forms, it is not recommended to include this term in the Law. Globally, workers in the informal economy can be in wage employment or be self-employed (often as own-account workers) or be contributing family members. In this respect, the ILO Transition from the Informal to the Formal Economy Recommendation, 2015 (No. 204), defines the informal economy as "all economic activities by workers and economic units that are – in law or in practice – not covered or insufficiently covered by formal arrangements" (Para. 2(a)). From this perspective, workers in the informal economy are by definition outside the scope of the law in the sense that the very existence of their activity is unknown. Once this activity becomes known, it should be integrated into the various corresponding legal categories established by the national legal frameworks. Therefore, "legalizing" the concept of an "informal worker" or a "worker in the informal economy" by including it in the National Health Insurance Law is not recommended.

Furthermore, it can be noted that the informal sector is not a homogeneous group, but rather is a broad and diverse category that includes persons engaged in different economic activities with distinctive income levels and patterns. In other words, although many workers in the informal economy do not have sufficient contributory capacity to pay contributions on a regular basis, the current presumption that being in the informal economy equates to lacking the resources to contribute might create incentives for informality, and therefore, this could be revised. The methodology for determining eligibility for subsided contributions should be based on the individual's contributory capacity so as to ensure that vulnerable individuals and households, including workers in the informal economy (provided that they do not have the necessary contributory capacity) are eligible for subsidized contributions.

- The third name above – "Health insurance scheme within insurance system" – is only used in article 9. Upon clarification provided by the National Health Insurance Bureau (NHIB), we understand that the "health insurance scheme within the insurance system" refers to the private insurance sector. However, these are not part of the government-led health insurance and would, therefore, seem to fall outside the scope of the Law. As such, it is recommended that the reference to this scheme (sub-article 3) be removed from article 9.

  Alternatively, should the Government decide to specify the expected role of private health insurance within the context of the NHI, it will be necessary to include additional provisions to the Law. These would include limitations to providing complementary insurance, the impossibility of opting out of the NHI, and so on.

- Article 35 defines and refers to one "NHI Fund", the revenues of which have several sources, but does not identify the schemes as defined under article 9.

In view of the above, the revision of the Law would be an opportunity to bring some clarity on the number and names of the schemes. For example, the legal drafters may wish to consider referring to the overarching system as the "National Health Insurance System" or the "Universal Health Insurance System", which is composed of the two schemes currently listed under article 9(1) and (2). Furthermore, the law could refer to multiple overarching schemes whose revenues are merged into a single fund (that is, National Health Insurance Fund).

2.2. Existing schemes and their personal scope of coverage (arts 10–11, 13)

Health insurance scheme for informal sector (art. 10)

See the comments and suggestions included in section 2.1. above concerning this scheme.

In addition, it is recommended that the wording of the current provision "Health insurance for informal sector is the guarantees to ensure that **Lao citizen** who are not covered by National Social Security Fund" be revised in light of the considerations mentioned above, notably the fact that "informal sector" is not a legal category. As it stands, the English translation of the provision can be interpreted as saying that Lao citizens who are not affiliated with the NSSF (even if there is a legal obligation to be affiliated but a lack of compliance with this an obligation) would be covered by the Health insurance scheme for informal sector (that is, the subsidized scheme). Therefore, it is suggested to replace the term "coverage" by "under the scope" of the social security law to distinguish legal issues from compliance issues.

Concerning the second part of the provision – "The poor shall be exempted from the contribution payment to National Health insurance and medical and non-medical services shall also be provided to the poor as stipulated in articles 20 and 21 of this law" – the Government may wish to consider replacing all references to "the poor" with "low-income persons" or "vulnerable or disadvantaged groups", depending on how eligibility for government subsidies will be assessed. For example, if there is an income test, the Law should say "persons earning below a prescribed threshold". If there will not be a means test, the article should refer to "disadvantaged or vulnerable persons as prescribed at article XYZ". Implementing this recommendation will provide a more

accurate representation of the current groups that benefit from subsidized healthcare. Therefore, the legal drafters may wish to specify that other groups, under the conditions and modalities established in the Law and secondary legislation, are also exempted from paying contributions. This could safeguard the right of specific population groups to subsidized health insurance membership.

Furthermore, consideration should be given to specify that the poor (though, "persons below an income threshold as prescribed by law" or words to that effect would be preferable) are also exempted from paying copayments or fees for services. This is in line with international standards, notably Convention No. 102, which sets the following principle: "The beneficiary or his breadwinner may be required to share in the cost of the medical care the beneficiary receives in respect of a morbid condition; the rules concerning such cost-sharing shall be so designed as to avoid hardship" (Art. 10(2)). This is also in line with article 50 of the Law on Healthcare, which specifies, "When the poor and people with low incomes, who have been certified by the relevant local administrations, consult or receive treatment in different health-care establishments, they do not need to pay directly for the treatment, but all their expenses are directly covered by the health insurance fund in conformity with regulations."

Health insurance within the Social Security system (art. 11)

Article 11 of the Law provides: "Health insurance within the Social Security system is the guarantee for providing health insurance fund to ensure accessibility to healthcare services for the beneficiaries defined in the Social Security Act."

The legal drafters may consider revising the wording of article 11 for further clarity. As it stands, the reference to the health insurance fund needs to be clarified. More concretely, it is unclear if this provision intends to state that the "Health insurance within the Social Security system" is responsible for providing the healthcare benefits and services defined in this Law (and therefore not Social Security Law) to the persons covered by the Social Security Law. Furthermore, article 11 could specify that such benefits are financed through the portion of the contributions paid by workers and employers or by the voluntarily insured to the NSSF, which are transferred from the Lao Social Security Organization to the National Health Insurance Fund.

It is also worth noting that the English translation of article 10 of the Social Security Law provides:

> *Health insurance benefit **is a provision of cash benefit** to ensure that insured persons including their spouse and children, survivor beneficiaries, care taker receive medical care services such as health examination, diagnosis, medical care, rehabilitation, pre- and post-natal services, and medical care for the employment injury or occupational diseases" (emphasis added).*

As such, given that, broadly, the benefit package is defined under article 20 of the Health Insurance Law, it is recommended that the two provisions (article 11 of the Health Insurance Law and article 10 of the Social Security Law) be revised so as to avoid unnecessary duplication and to ensure coherence between the two legislations. The ILO recommendations in regard to the scope and extent of the benefit package stipulated under the Health Insurance Law are included in Section 3 below.

In addition, consideration should be given to specify that persons under the scope of the Social Security Law are not eligible to receive state subsidies under the Health Insurance Law.

Targets of health insurance (art. 13)

As mentioned in the previous ILO technical note, some of the target groups listed under article 13 overlap and could be improved and streamlined to secure better implementation outcomes.

Table 3 summarizes some of the potential issues identified, and provides possible reformulations for the consideration of the legal drafters.

▶ Table 3. ILO comments and suggestions concerning the target groups for health insurance

Target group (current provision)	ILO comments and suggestions
1. Lao citizens who are not Social Security Member	For the reasons mentioned above, instead of defining the target group with reference to membership/affiliation/coverage (or the lack thereof) within the NSSF or social security, it will be preferable to do so by specifying "not within the scope of the Social Security Law". This is because the subsidized scheme aims to cover those who do not fall within the scope of application of the existing contributory scheme (that is, NSSF), but not those who fall within the scope of the law but are not members despite coverage being mandatory. In addition, the legal drafters may wish to invert the order of targets 1 and 3, so that the target population of the contributory scheme (NSSF) appears before that of the subsidized scheme. Alternative wording: 2. Lao citizens* who are not within the scope of the Social Security Law. * See previous comments regarding limiting the scope of application on the grounds of nationality. In light with the principles of equality of treatment and non-discrimination enshrined in international law, the ILO recommends that medical care benefits be extended to non-national residents.
2. Insured member who are not entitled for National Social Security fund	This groups appears to overlap with target group 1, therefore it is recommended to remove it. It is worth noting that, as it is, the English version of this sub-article suggests that insured members of the NSSF who are not entitled to benefits (for example, those who have not met the minimum qualifying period established in the Social Security Law) are a target group. However, none of the provisions of the Health Insurance Law specify how benefits and services would be financed in that case.
3. Beneficiaries of National Social Security Fund;	Given that the Social Security Law does not define the term "beneficiary", but only "healthcare beneficiaries", it is recommended that this sub-article be revised. Furthermore, the legal drafters may wish to consider merging this sub-article with sub-article 4 for further clarity, with the understanding that the dependent spouses and children of the mandatorily insured and the voluntarily insured within the NSSF are legally covered by healthcare benefits.
4. People who buy health insurance including self-employed /informal sector	This sub-article seems to refer to the voluntarily insured as per the Social Security Law; as such, this sub-article and sub-article 3 could be merged and reordered to avoid redundancy and confusion. See the alternative text above and the previous considerations as regards the terms "informal sector" and "informal worker".

Membership registration and health insurance membership card (arts 15–16)

According to article 15 of the Law: "The registration for health insurance membership is the process of recording information of Lao citizen, **members of the National Social Security Fund into Health Insurance Scheme**" (emphasis added).

Article 16 of the Law further provides that:

> *Health Insurance membership card is a document certifying health insurance membership issuing by health insurance and to be used at health facility at different level during the utilization of healthcare services as stipulated in this law.*
>
> *Health insurance membership card composes of membership information such as eligible number, name, surname, date of birth and other necessary information of the member.*
>
> *The concerned health insurance bureau **shall issue health insurance membership card to non-NSSF Lao citizens within 30 days upon receiving accurate and complete registered documents**" (emphasis added).*
>
> *The members of National Social Security shall be referred to NSSF membership or civil servant membership as health insurance membership card.*

The provisions quoted above only specify that the NHIB will issue the membership cards for Lao citizens not registered within the NSSF. Members of the NSSF have access to healthcare benefits regulated by the Health Insurance Law upon presentation of a NSSF membership card or a civil servant card (article 14 of the Law). In this configuration, further clarification is needed regarding the harmonization of the cards' design and an effective process to ensure their cost-effective issuance. In principle, providing every person insured with the National Health Insurance scheme with a membership card (or health insurance certificate in the absence of a physical card) would enable the person concerned to avail themselves of the benefits wherever employed or living, improving portability between locations. Noting that, based on the information available to the ILO, membership cards have yet to be introduced, it is recommended that the abovementioned provisions be revised to facilitate their interpretation and application.

Finally, the legal drafters may wish to consider specifying that the NHI Board or competent authority shall define the procedure to issue, change or replace the health insurance membership card.

3. Main comments regarding Part II, Chapter 2 of the Law on Health Insurance Benefits

3.1. Nature of medical care benefits (art. 20)

Article 20 of the Law defines the medical benefits covered as follows:

> *Medical benefits refer to healthcare services that health insurance members shall receive such as consultation and diagnostic services, medical treatment and physical rehabilitation, promotion and prevention according to the level of healthcare services as stipulated in article 25 of this law.*
>
> *In general condition Health Insurance member shall use OPD consultation at his/her main contracted hospital only. If exceeding its treatment capacity, the patient shall be referred to the next upper level of services.*
>
> *In case of severity and emergency or necessity for hospitalization, Health Insurance member can use the service at any level of health facilities.*
>
> *Due to medical necessity certified by the highest level of services, the member of health insurance, including NSSF member who is authorized to work abroad less than 3 months shall be able to seek care abroad;*[9]
>
> *The payment for health seeking abroad shall be made firstly by health insurance member then the bill and document from the related facility shall be submitted to District National Health Insurance Bureau in his/her respected area for reimbursement within 10 official days in accordance to the rate internally used by category of services specified by the National Health Insurance (NHI).*

As raised previously by the ILO, the provision quoted above can benefit from a revision that addresses the following elements, from the legal and international standards perspectives:

- **Article 20, paragraph 1**: the provision should be as specific and straightforward as possible to facilitate the application of the law. Therefore, it is recommended that the overall benefit package be enunciated instead of referring to some of the benefits covered by the scheme (that is, "such as consultation and diagnostic services, promotion and prevention"). For example, the provision could specify that medical care benefits shall be provided for preventive purposes and in the event the insured (and their eligible dependents) experience ill health, injury or maternity, while listing the benefit package.

9 Given that the Law cannot regulate whether care is provided abroad or not – as the English version of this provision suggests – it is recommended that the current wording be revised so it reads: "… including NSSF members who are authorized to work abroad for less than 3 months, shall be able to **be reimbursed** for care abroad" instead of "shall be able to **seek** care abroad".

It is recommended that the law reflects the provision of benefits aligned with the minimum standard, which is listed under Article 10 of Convention No. 102, which states:

1. The benefit shall include at least--

(a) in case of a morbid condition--

(i) general practitioner care, including domiciliary visiting;

(ii) specialist care at hospitals for in-patients and out-patients, and such specialist care as may be available outside hospitals;

(iii) the essential pharmaceutical supplies as prescribed by medical or other qualified practitioners; and

(iv) hospitalization where necessary; and

(b) in case of pregnancy and confinement and their consequences—

(i) pre-natal, confinement and post-natal care either by medical practitioners or by qualified midwives; and

(ii) hospitalization where necessary.

Regarding the medical care that needs to be provided in the event of ill health resulting from an employment injury or occupational disease, the Law should specify that persons insured through the "Health insurance within the Social Security system" shall be entitled to, at a minimum, the benefits listed under Article 34(2) of Convention No. 102, which specifies that the medical care shall comprise:

(a) general practitioner and specialist in-patient care and out-patient care, including domiciliary visiting;

(b) dental care;

(c) nursing care at home or in hospital or other medical institutions;

(d) maintenance in hospitals, convalescent homes, sanatoria or other medical institutions;

(e) dental, pharmaceutical and other medical or surgical supplies, including prosthetic appliances, kept in repair, and eyeglasses; and

(f) the care furnished by members of such other professions as may at any time be legally recognized as allied to the medical profession, under the supervision of a medical or dental practitioner.

In addition, it is worth noting that the first paragraph of article 20 of the Law only refers to "health insurance members", which, according to the definition provided under article 3(1), includes "a person who pays contributions to health insurance scheme as defined in this law, such as members of the National Social Security, self-employed people, poor people". As such, the legal drafters may wish to specify that medical benefits are also provided to family members (that is, the spouse and children of the insured, who currently fall under the definition of "healthcare beneficiaries") and to those benefiting from State's subsidies.

- **Article 20, paragraph 2:** Given that this paragraph deals with referrals, the legal drafters may wish to move the last part of the previous paragraph here (that is, "Medical benefits shall be provided according to the level of healthcare services stipulated in article 25 of this law and the Law on Healthcare") before explaining that protected persons should seek medical care at contracted hospitals in their area/village, but that this requirement is waived in case of medical emergencies. In cases where a healthcare beneficiary requires services that exceed the healthcare facility's capacity, the contracted health facility shall provide a referral letter to a designated provider or hospital at the next service level above. Referrals shall be based on medical necessity, in accordance with the Law on Healthcare and other relevant statutory acts and implementing regulations.

- **Article 20, paragraphs 4 and 5:** Consideration should be given to having a separate article specifying the conditions for receiving medical care abroad, the procedure to be followed in such cases, and other administrative matters (such as whether there is a ceiling on the medical expenses that are reimbursed by the NHI, and specifying that the rates that the NHIB reimburses in case of medical care received abroad shall be determined in secondary legislation). Furthermore, it is recommended that such a provision differentiates between these two cases:
  - Persons whose medical condition and situation require them to receive medical benefits that are not available/cannot be rendered in the Lao People's Democratic Republic and therefore might be authorized by the competent authority to receive treatment abroad, according to prescribed conditions.
  - Persons who are working abroad for less than three months and remain insured in the Lao People's Democratic Republic and can, therefore, access medical services abroad and be reimbursed under prescribed conditions. This possibility should also be regulated elsewhere in this law, including: when can a person working abroad remain attached to this health insurance scheme, under what conditions and what are the limitations. For example, in terms of reimbursement, are they reimbursed along the same price list even if care is more expensive abroad? Or are their agreements with institutions in different countries?

3.2. Non-medical benefits (art. 21)

As per the English version of article 21 of the Law: "Non-medical benefits refer to the expenditures for food allowance, round trip transportation for the poor and the referral fee for intensive care patient to higher care level facility including the allowance for physician, nurse and driver or the fee for transfer death body to their family as stipulated in the regulation."

As raised previously by the ILO, the provision could be revised for further clarity. In particular, it is unclear whether the word "expenditures" means reimbursement for the expenses incurred for food and roundtrip transportation, or whether such reimbursements are paid in full or are subject to a maximum ceiling as prescribed by the competent authority. Nor is it clear how roundtrip transportation is defined – for instance, does it refer only to medically necessary transportation costs?

In addition, as per the current wording of the provision, only the poor[10] are entitled to reimbursement for transportation; however, secondary legislation and administrative procedures[11] suggest that this entitlement, as well as food expenses, shall be provided to other categories of the population that are covered via the subsidized health insurance scheme (pregnant women, children under age 5 and so on). Therefore, the legal drafters may wish to consider revising this provision to ensure coherence with secondary legislation.

Furthermore, it is worth noting that, in comparative practice, reimbursement for transportation expenses are also covered by health insurance schemes in cases where the medical care needed is not available at local healthcare facilities (that is, when the insured or their dependents need to travel to a different village or district to receive benefits, including care at secondary, tertiary and specialized care at higher-level facilities).

Finally, the reference to a "referral fee" should be revised. If the level of care required by an insured person or healthcare beneficiary is not available at contracted facilities, the person concerned should be able to receive a referral letter without having to pay a referral fee.

10 As raised previously, the ILO recommends revising all references to "the poor" in the Law to avoid stigmatizing persons covered by the NHI system through government subsidies.

11 As per section 4.1.6 of the Minister of Health Instruction No. 0476, "Admitted patients, pregnant women and children under 5 in the list of poor households approved annually by district authorities in accordance with the Decree 348/Gov. dated 16/11/2017, will receive food allowance and transport allowance for round trip home – hospital."

3.3. Healthcare services not covered by the NHI (art. 22)

In the English version of the Law, this provision specifies the healthcare services excluded by the NHI, understood as the medical benefits and expenses not covered in this insurance. For ease of reference the current list of not-covered benefits, as well as the ILO comments in this regard are reproduced in table 4.

▶ Table 4. ILO comments concerning healthcare benefits not covered by the NHI

Healthcare benefits excluded/not covered	ILO comments
(1) Healthcare services that are already covered by the third party or vertical programme such as treatment for Leprosy, HIV/AIDS, Tuberculosis, Malaria and other healthcare services which are under someone responsibility or vertical programme.	The reference to "someone responsibility" is unclear. Does this refer to: ▶ medical services borne by the government (either at local or province level) according to other laws or regulations? ▶ medical benefits and services covered by private insurance (such as, benefits reimbursed by insurance companies in case of road/traffic accidents).
(2) Other services including Aesthetic/ cosmetic services, VIP room services, annual medical check-up and other healthcare services which are personal demand.	In addition to aesthetic/cosmetic services, consider adding "and surgeries". It is worth noting that, in comparative practice, this limitation is waived in cases where the surgeries are deemed necessary (that is, for reconstructive procedures and those needed to recover a person's functional capacities). The reference to VIP room services is uncommon, so these services could be spelled out for a better implementation of the Law. (Does it refer to semi-private and private rooms in case of hospitalization? What other services are considered VIP?) To promote preventive medicine and care, consider removing annual medical check-ups from the list of benefits not covered by the NHI.
(3) Obtaining of healthcare abroad which is not in line with article 20 of this Law.	Given that all the conditions and administrative procedures for receiving medical care abroad are not defined in this Law, it might be necessary to add "and other relevant statutory or administrative acts" or words to that effect.
The exclusion of healthcare services under National health Insurance plan shall be determined periodically by Ministry of Health.	Given that, in practice, only essential drugs are covered, the list of exclusions should be revised so that it is clear that the NHI does not provide non-essential medicines and pharmaceuticals, nor does it reimburse the insured's expenses in purchasing non-essential medicines and pharmaceuticals. For further clarity, consider adding a cross-reference to article 26 (List of healthcare services covered and not covered by health facilities) and article 27 (list and tariff of drugs and medical supplies) of this Law.

In addition, it is worth noting that section 4.25 of the Minister of Health Instruction No. 0476 stipulates that "the NHI won't be responsible for service charge in case of accidents resulted from drinking or consuming alcohol, injuries from theft, robbery, and other cases under penal codes which were not judged yet must be the responsibility of the patient". To ensure that protected persons are not deprived of the social security benefits they would otherwise be entitled to, international standards, including Convention No. 102, establish limitative grounds under which social security benefits can be suspended. As such, benefits can be suspended in the cases permitted under Article 69 of the Convention, which specifies:

> *A benefit to which a person protected would otherwise be entitled in compliance with any of Parts II to X of this Convention may be suspended to such extent as may be prescribed-*
>
> *(a) as long as the person concerned is absent from the territory of the Member;*
>
> *(b) as long as the person concerned is maintained at public expense, or at the expense of a social security institution or service, subject to any portion of the benefit in excess of the value of such maintenance being granted to the dependants of the beneficiary;*
>
> *(c) as long as the person concerned is in receipt of another social security cash benefit, other than a family benefit, and during any period in respect of which he is indemnified for the contingency by a third party, subject to the part of the benefit which is suspended not exceeding the other benefit or the indemnity by a third party;*
>
> *(d) where the person concerned has made a fraudulent claim;*
>
> *(e) where the contingency has been caused by a criminal offence committed by the person concerned;*
>
> *(f) where the contingency has been caused by the wilful misconduct of the person concerned;*
>
> *(g) in appropriate cases, where the person concerned neglects to make use of the medical or rehabilitation services placed at his disposal or fails to comply with rules prescribed for verifying the occurrence or continuance of the contingency or for the conduct of beneficiaries*

Based on the above, it is recommended that medical care be provided for "any morbid condition, whatever its cause" and that neither the national legislation nor the administrative acts contain limitations in this respect (for example, in case of self-harm, intoxication by alcohol or drugs, environmental poisoning, terrorist attack and so on).

4. Main comments regarding Part II, Chapter 3 of the Law on Quality assurance and contracting for healthcare services

4.1. Quality assurance (art. 23)

The current provision should be revised to strengthen the role of the NHIB in ensuring and setting the conditions that health facilities must meet to ensure the quality of the services provided by the Law. This includes revising the reference to "collaborate with related parties" and specifying that providing quality healthcare benefits and services requires that these are comprehensive, accessible, suitable, and delivered safely and on time.

4.2. List of services covered by the NHI Fund (art. 26)

Consider specifying that the list of health services covered and not covered **by the NHI Fund** shall be established, revised and updated periodically in specific regulations.

It is worth noting that, in comparative practice, the lists of healthcare benefits are typically established by the competent authority on the proposal of the relevant Health Insurance Committee(s) and in consultation with the relevant stakeholders (such as government agencies, health insurance experts, representatives of insured persons and healthcare beneficiaries, employers, and contracted medical care facilities).

In addition, the legal drafters may wish to consider including a separate article setting the criteria that shall be considered for drawing up the list of health services covered by the NHI and deciding on the inclusion of benefits or services therein. Such criteria could include, for example, the proven medical efficacy of the health service, its adequacy and cost-effectiveness, and the necessity of the health service in society (for example, responsiveness to the country's disease burden and epidemiological profile, compatibility with national health policy and so on). The competent authority shall establish the detailed contents of the criteria and the procedure for revising the lists in secondary legislation or administrative acts.

4.3. List and tariff of services (art. 28)

The second paragraph of article 28 provides: "The tariff of services is the fee that health facility charged for healthcare services **such as consultation and diagnostic services, medical therapeutic and physical rehabilitation including health promotion and prevention**" (emphasis added).

As raised previously by the ILO, to avoid risks of inconsistency within the law, it is recommended to add a cross-reference to the healthcare benefits covered by the NHI (that is, "as defined under articles 20, 21, 26 and 27") instead of repeating some of those benefits and services in this article.

In addition, the legal drafters may wish to consider specifying that contracted healthcare facilities must respect the tariffs and prices set by the competent authority (or words to that effect), either under this article or under the provision that establishes the rights and obligations of healthcare facilities.

4.4. Privacy and confidentiality of data on HI members (art. 31)

Article 31 of the Law deals with confidentiality and privacy of personal information. It provides:

The data collected on utilization of services of insured members shall be kept in privacy and confidence manner such as diseases, specific mark. ...

The National Health Insurance Bureau and healthcare facilities including authorized staff from NHIB at different level shall keep data collected in privacy and confidence in order to prevent unauthorized access to those data.

ILO comments and suggestions:

In line with the principles contained within international social security standards, and notably Recommendation No. 202, Governments should establish a legal framework to secure and protect private individuals' information contained in their social security systems (Para. 23). As such, the right to privacy in relation to personal data should not be limited to data collected on utilization of services only, **instead it shall apply to all personal data**[12] gathered by the National Health Insurance scheme and the institutions entrusted with the implementation of the Law and the delivery of benefits, including contracted health facilities and their staff.

From a practical perspective, it would be advisable that the following elements be included in the legal framework:

- Personal data collected, stored and used should be accurate, complete and kept up to date as necessary for the purposes for which it is used.
- The personal data collected should be limited to data that is relevant to the purpose for which it is compiled (and therefore not excessive) and not stored longer than is necessary.
- The information provided is kept confidential and restricted to the purposes for which it was compiled, and the State is responsible for ensuring data protection and confidentiality.
- Individuals are entitled to know where their information is stored, what it contains and for what purposes, as well as being entitled to correct or remove personal information as the case may be.
- Individuals must give permission for personal data to be used for purposes other than the purposes for which it was captured.

In light of the above, the legal drafters may consider specifying that all persons, legal entities and organizations that participate in the application of the Law, its control or supervision that have access to insured persons' and healthcare beneficiaries' personal data shall maintain confidentiality and protect the right to privacy of the persons concerned. Furthermore, consideration should be given to specifying in the Law that the NHI scheme, health facilities and other institutions entrusted with the implementation of the Law have the right to collect information, including personal data, in so far as such information is necessary for the performance of the functions assigned to the National Health Insurance scheme or relevant body by the Law and other statutory acts.

4.5. Appeal process (art. 34)

The legal drafters may wish to consider moving this provision to Part V on Dispute Resolution so that all matters related to the right of protected persons (health insurance members and their eligible dependents) and other stakeholders (such as healthcare facilities) to access complaint and appeal mechanisms are provided under the same section.

12 Personal data refers to any information or set(s) of information that can, either by itself or together with other relevant data, be used to identify an individual (known as the "data subject"), directly or indirectly, via an identifier (such as an identification number) or via one or more factors specific to the person's physical, physiological, genetic, mental, economic, cultural or social identity. Personal data can be held in both electronic and physical form (Regulation No. 2016/679 of the European Parliament and of the Council of 27 April 2016, art. 4(1))

5. Main comments regarding Part III, Chapter 1 on the National Health Insurance Fund

5.1. National Health Insurance Fund (art. 35)

Article 35 of the Law provides: "The National Health Insurance Fund is the government authorized fund to ensure universal access to **basic and essential healthcare services for the entire population** and the health insurance members" (emphasis added).

As mentioned before, there is a potential legal inconsistency between the current wording of article 35, which refers to "the entire population", and the other provisions defining the scope of application of the Law and the different schemes, which seem to restrict coverage to Lao citizens.

Furthermore, there is a partial redundancy in defining the objective of ensuring universal access to both: (i) the entire population; and (ii) the health insurance members – as these two categories are not mutually exclusive (that is, health insurance members are part of the total population).

In addition, it is worth noting that the Law does not define "basic and essential healthcare services".

5.2. Sources of income of the NHI Fund (arts 36–40)

As raised previously by the ILO, the legal drafters may wish to revise the provisions that set out the sources of income of the NHI Fund, in particular, to address the following:

- **Article 36(1):** Specify that the contribution from the Government are for the purpose of subsidizing contributions for those categories of the population covered through public funds (poor persons, pregnant women, and so on) and to finance administrative expenses.
- **Article 36(2):** Include an explicit mention of the employer's contributions to the NSSF. The recognition of the employer's obligations regarding financing and contribution collection is currently absent from the Law in various articles (such as arts 3(4), 6, 36 and 38).
- **Article 37:** This provision could bring additional clarity regarding the "annual contribution plan approved by the National Assembly" – for example, by presenting the criteria that shall be considered when defining the amount of the financial resources allocated,[13] the purposes for such contributions and so on. In addition, it is recommended to specify that the procedure for determining the Government's contribution to the NHI Fund shall be laid down in a statutory act. It can also be noted that the current version of the Law does not stipulate whether a reserve fund shall be established, which would be crucial to ensuring the financial sustainability of the schemes. As such, it is unclear what would happen if, due to reasons

13 Examples of such criteria include: the country's demographic profile; the epidemiological profile of the population covered by the subsidized scheme; the scheme's expenditure in the previous year; and the projected cost of the scheme as projected by actuarial valuations.

unforeseen when the annual contribution plan was approved, the expenditure increases, and the fund budget is not in a position to fulfil all obligations determined by the Law (perhaps the current rules allow the payment of additional allocations from the Government/National Budget to the NHI Fund?).

- **Article 38:** The article could be revised to differentiate more clearly between the contribution paid by members of the NSSF that is transferred to the NHI and the copayments/service fees paid directly at healthcare facilities when receiving medical care. In this regard, it is recommended that a separate provision lay down the overarching rules concerning copayments (for example, under Part II, Chapter II, which defines the benefits financed by the NHI Fund). From the perspective of international social security standards, the following considerations regarding cost-sharing of medical care are necessary:
  - Financing must be based on the principles of solidarity and broad risk pooling, recognizing that health is a public good. As such, out-of-pocket payments should not be a primary source for financing healthcare systems.
  - Convention No. 102 accepts that healthcare beneficiaries may be required to share in the cost of the medical care they receive, however only in respect of a morbid condition (ill health). This is not permitted in case of pregnancy, confinement and its consequences, which should be provided free of charge.
  - Recommendation No. 202 provides that persons in need of healthcare should not face hardship and an increased risk of poverty due to the financial consequences of accessing essential healthcare, and urges States to consider free prenatal and postnatal medical care for the most vulnerable (Para. 8).
  - As regards out-of-pocket spending due to ill health, Convention No. 102 requires that measures be in place to ensure this cost-sharing does not lead to financial hardship. Examples of such measures include exempting persons with chronic conditions and multiple pathologies from paying copayments or ensuring that persons of small means can access the benefit package guaranteed by the Convention (see comments in section 3.1 concerning article 20) without being required to pay user fees.
- **Article 39:** This provision makes reference to "pay during care seeking at the health facility". As noted above, co-payments at the point of service are not a pre-payment mechanism and do not allow risk pooling (as only sick people would pay), which does not constitute a social health protection mechanism. As such, the legal drafters may wish to differentiate between co-payments and periodical contributions ("premiums" in the private insurance sector), a pre-payment mechanism that allows for risk sharing.
- **Article 40:** Consider including a reference to fees, fines and penalties collected within the scope of National Health Insurance or words to that effect. In addition, assuming that there is (or would be) a legal obligation to build a reserve fund (see previous comment under article 37), which would seem to be the case given the reference to "income from investments" currently included under article 42 of the Law, the legal drafters may wish to include an explicit reference to "profits generated from investments and the management of the reserve fund" as one of the legitimate sources of revenue listed in article 40.

5.3. Adjustment of National Health Insurance contributions (art. 41)

Article 41 of the Law provides: "The adjustment of the National Health Insurance contribution is the review of the contribution rate periodically based on the social economic growth and the finding of healthcare services costing in order to ensure the progress and sustainability of the National Health Insurance Scheme."

Although article 41 provides for the adjustment of contributions based on the social economic growth and the findings of healthcare services costing exercises, this provision could more clearly specify that prior to any changes to contributions or benefits, actuarial valuations need to take place. Furthermore, no other provisions in the Law mention that actuarial valuations should be undertaken. International social security standards establish that the State has the responsibility to ensure that the necessary actuarial studies and calculations

concerning financial equilibrium are made periodically and, in any event, prior to any change in benefits, the rate of insurance contributions or the taxes allocated to covering the contingencies in question (Convention No. 102, Art. 71(3)).

As such, the legal drafters should specify the need for periodic actuarial assessments to be made, especially prior to any change in benefits, the rate of insurance contributions or the taxes allocated to covering the medical care. It would also be good practice for the law to establish the maximum period that can elapse between such examinations. In comparative practice, health insurance schemes are generally required to undertake actuarial valuations at least once every two or three years.

5.4. Health Insurance Fund Management Committee at the central level (arts 46, 48, 50)

The Law provides for the participation of representatives of workers and employers in the Health Insurance Fund Management Committee at the various levels (central, provincial and district level); however, there is no representation of persons who are not within the scope of the NSSF and that are instead covered by NHI through government subsidies, despite these persons accounting for the majority of the insured population. As such, the Government may wish to consider including representatives of the persons protected by the health insurance scheme (such as, workers in the informal economy, civil societies, patient associations and so on) when establishing membership of the committees at the different levels. This is in line with Recommendation No. 202, which says that States should apply the principle of "tripartite participation with representative organizations of employers and workers, as well as consultation with other relevant and representative organizations of persons concerned" (Para. 3(r)). The centrality of the principle of participatory management in the administration of social security systems, in general, and the medical care branch, in particular, has long been recognized in ILO social security standards. Notably, Recommendation No. 69 provides a comprehensive framework regarding the meaningful participation of protected persons for the proper functioning of medical care systems (see box 2).

▶ Box 2. ILO Medical Care Recommendation, 1944 (No. 69): Selected provisions concerning the principle of democratic and transparent governance of the medical care branch.

Unity of health services and democratic control

92. All medical care and general health services should be centrally supervised and should be administered by health areas as defined in Paragraph 24, and the beneficiaries of the medical care service, as well as the medical and allied professions concerned, should have a voice in the administration of the service.

Unification of central administration

93. A central authority, representative of the community, should be responsible for formulating the health policy or policies and for supervising all medical care and general health services, subject to consultation of, and collaboration with, the medical and allied professions on all professional matters, and to consultation of the beneficiaries on matters of policy and administration affecting the medical care service.

94. Where the medical care service covers the whole or the majority of the population and a central government agency supervises or administers all medical care and general health services, beneficiaries may appropriately be deemed to be represented by the head of the agency.

95. The central government agency should keep in touch with the beneficiaries through advisory bodies comprising representatives of organizations of the different sections of the population, such as trade unions, employers' associations, chambers of commerce, farmers' associations, women's associations and child protection societies.

96. Where the medical care service covers only a section of the population, and a central government agency supervises all medical care and general health services, representatives of the insured persons should participate in the supervision, preferably through advisory committees, as regards all matters of policy affecting the medical care service.

97. The central government agency should consult the representatives of the medical and allied professions, preferably through advisory committees, on all questions relating to the working conditions of the members of the professions participating, and on all other matters primarily of a professional nature, more particularly on the preparation of laws and regulations concerning the nature, extent and provision of the care furnished under the service.

98. Where the medical care service covers the whole or the majority of the population and a representative body supervises or administers all medical care and general health services, beneficiaries should be represented on such body, either directly or indirectly.

99. In this event, the medical and allied professions should be represented on the representative body, preferably in numbers equal to those of the beneficiaries or the government as the case may be; the professional members should be elected by the profession concerned, or nominated by their representatives and appointed by the central government.

100. Where the medical care service covers the whole or the majority of the population and a corporate body of experts established by legislation or by charter supervises or administers all medical care and general health services, such body may appropriately consist of an equal number of members of the medical and allied professions and of qualified laymen.

101. The professional members of the expert body should be appointed by the central government from among candidates nominated by the representatives of the medical and allied professions.

102. The representative executive body or the expert body supervising or administering medical care and general health services should be responsible to the government for its general policy.

103. In the case of a federal State, the central authority referred to in the preceding Paragraphs may be either a federal or a state authority.

Such representation would be particularly important to strengthen public support, build trust and ensure a sense of ownership of the system, as it would facilitate considering the population's priorities and needs in decision-making and policy formulation.

5.5. Rights and duties of the Health Insurance Fund Management Committee at the central level (art. 47)

For further clarity, the legal drafters may wish to consider the following:

- **Under numeral 7**, specify if, in addition to studying and considering health service contracts, the committee can actually conclude contracts with healthcare facilities.
- **Under numeral 8**, specify if the reference to "propose the adjustment of National Health Insurance Fund contribution rates to the Ministry of Health" also includes the government contributions. Also, it is unclear if the responsibility for preparing and submitting the data/report/draft budget of the NHI Fund to the General Assembly for approval of the "annual contribution plan" (art. 37) lies with this Committee or with the Ministry of Health.

In addition, consideration could be given to specifying either directly in the Law or in subsidiary legislation the responsibilities of the committees at the central, provincial and district levels, within the scope of their competence, as regards:

- Exercising control over the quality of individual healthcare services paid for with the NHI resources;
- Monitoring the NHI's performance, including in terms of population coverage, scope of services covered, financial protection and overall equity of the system;
- Monitoring and analysing the financial situation of the scheme and the use of NHI Fund resources, and proposing policy adjustments to ensure the overall sustainability of the scheme.

6. Main comments regarding Part IV on prohibitions and Part VII on measures against violators

6.1. Prohibitions (arts 54–56)

Articles 54 to 56 of the Law establish general prohibitions, prohibitions for health insurance staff and concerned public officials and health insurance members; however, none of these provisions specify the applicable sanctions. Given that Part VII of the Law provides for a general framework of sanctions, the legal drafters may wish to consider adding "as defined in articles 71 to 77 of this Law and other subsidiary legislation".

6.2. Sanctions (arts 72–77)

Articles 72 to 77 of the Law provide a general overview of the types of sanctions that can be applied for violations of the provisions of the Law. These sanctions include re-education measures (unclear what these would be) and warnings, disciplinary sanctions, penalty measures (fines to be determined in separate regulations), civil measures and criminal measures.

ILO comments and suggestions:

- For sanctions to be operational, it would be necessary to establish a clear schedule of sanctions proportional to the severity of the offences. Such a schedule can be provided for directly in the Law or regulated in secondary legislation, noting that the latter approach is more practical in case penalties are established as flat rate amounts that will need to be adjusted to account for inflation. If a regime of sanctions is regulated under another law or decree, the Law should make reference to the relevant legal instrument.
- While the regime of sanctions should include pedagogical measures to be applied in case of minor offences, as defined in the national legislation, it is essential to ensure that the legal framework also provides for disciplinary sanctions and penalties that are dissuasive and effectively deter non-compliance with the obligations established in the Law. As such, it is recommended that a scale of sanctions be designed for different categories of offences (for example, minor, serious, severe) that takes into consideration the prejudice caused by the violation, the previous behaviour of the offender (for instance, negligence and intent, failure to comply with previous warnings), and other circumstances that may aggravate or mitigate the level of the infringement (for example, the number of persons affected by the offence).
- Furthermore, defining a comprehensive schedule of sanctions reduces discretionary power and, as such, favours due process and procedural fairness.

7. Main comments regarding Part V on dispute resolutions

7.1. Complaint and appeal mechanisms (arts 34, 57–62)

The Law provides the general framework for complaint and appeal mechanisms under article 34 (appeal process) and Part VI, articles 57 to 62, concerning dispute resolution.

ILO comments and recommendations

As raised previously by the ILO, the current provisions of the Law relating to mediation/compromise and the available mechanisms for dispute settlement would benefit from further defining certain elements, such as specifying the concrete situations in which the parties can avail themselves of the different mechanisms in place, as well as the general processes for each mechanism.

According to international social security standards, national laws should provide for effective and accessible complaint and appeal procedures. Such procedures should be impartial, transparent, simple, rapid, accessible, inexpensive and free of charge to the applicant.[14] In this regard, the legal drafters may wish to take into account the following considerations to ensure that the available mechanisms are defined in a sufficiently clear and unambiguous manner so as to facilitate better access to effective complaint and appeals mechanisms:

- Further clarification would be needed in regard to the procedure for settlement through the administrative channel (art. 59 of the Law). In particular clarification of the level of the Health Insurance Management Authority (district, provincial, central level) at which the person concerned needs to request the settlement of the dispute.
- In addition, it is necessary to clarify the difference between what would be considered a "dispute related to health insurance" and a "dispute related to healthcare services". Likewise, it is important to understand the reasons for establishing an additional ten days for resolving the latter type of disputes, particularly given the fact that disagreements concerning medical care (especially if the need for such care is urgent) might necessitate a more rapid response.
- Clarification is needed concerning the types of disputes that can be brought to the Economic Dispute Resolution Authority (art. 60) – specifically, whether this only applies when the parties concerned have already sought mediation but failed to reach an agreement – as well as whether there are administrative formalities that need to be followed to access this mechanism. For example, the provisions could be formulated in a way that stipulates whether this is a required step before being able to take the dispute to the court system (art. 61); whether the claimant can choose between the two mechanisms; or whether the persons concerned can apply article 60 in some instances but directly apply article 61 in others.

14 Recommendation No. 202, Paras 3(o) and 7.

Administrative procedures that are complex, inaccessible, ineffective or inefficient can constitute an obstacle for people accessing healthcare benefits and services, and consequently reduced their willingness to contribute towards the financing of such benefits and services. In this regard, the Law could be strengthened by including provisions that provide for facilitated access to complaint and appeal mechanisms, especially mechanism that seek to address the needs of vulnerable parts of the population.

Examples and related good practices:

In Mexico, national law incorporates a citizen services mechanism that considers various mediums to facilitate the lodging of complaints, including by mail, drop boxes, email, telephone, fax, in person and on the internet.[15] In addition, national law provides that beneficiaries and their families have a right to receive timely attention to their requests, including complaints and suggestions.[16] Particular consideration can also be given to the difficulties certain groups of workers may have in accessing complaint and appeal mechanisms specifically, but also in relation to understanding and accessing social protection systems generally. Access therefore also implies making social protection programmes and schemes easy for people to reach, understand and use, irrespective of age, literacy, disability, ethnicity, geographical location or other factors. The national legal framework should provide for this general principle. For example, in South Africa, the Social Assistance Act provides that "the Agency must offer all reasonable assistance to a person, who, due to his or her age, a disability or an inability to read or write, is unable to understand, appreciate or exercise his or her rights, duties or obligations in terms of this Act, in the official language of the Republic which he or she is likely to understand".[17]

15 Ministerial Agreement No. 512 of 4 July 2003, art. 13.
16 Ministerial Agreement No. 512 of 4 July 2003, art. 3(6)(1).
17 Social Assistance Act of South Africa (Law No. 13 of 2004), section 2(3).

Additional comments on the draft new law[18]

Through the provisions under article 6 and article 34, the Committee on Health Insurance Law Revision proposes to reintroduce contribution collection from persons not covered by the NSSF, as a way to increase the National Health Insurance scheme's revenues and address the scheme's financial deficit. While acknowledging the need to secure financial resources for the health insurance scheme, the ILO would like to bring attention to the likely consequences of this proposal:

- **A decrease in population coverage:** The previous experience of the Lao People's Democratic Republic with such an approach, in particular through the Community Based Health Insurance scheme, proves that relying solely on contributory schemes is not conducive to high levels of population coverage. As such, if the proposed amendments were to be implemented, the progress achieved by the Lao Government towards the objective of ensuring universal health coverage could be significantly threatened. International social security standards in general, and Recommendation No. 202 in particular, recognize that a diversity of schemes and mechanisms, including of financing mechanisms and delivery systems (Para. 3(i)) are needed to ensure adequate protection throughout the life cycle. Similarly, Recommendation No. 69 notes: "Medical care should be provided either through a social insurance medical care service with supplementary provision by way of social assistance to meet the requirements of needy persons not yet covered by social insurance, or through a public medical care service" (Para. 5). Comparative practice also shows that countries that have managed to close coverage gaps have done so through an efficient combination of contributory and non-contributory mechanisms, as the latter are required to ensure the protection of persons with limited or no contributory capacity.
- **A limited increase in government revenues:** The cost of collecting contributions and monitoring and enforcing compliance, including through inspection mechanisms, as well as the consequences of adverse selection on healthcare utilization, are likely to considerably reduce the amount of financial resources left available to the scheme.
- While addressing funding deficits is essential to ensure the financial sustainability of the health insurance system, the measures envisaged should not increase the concerned persons' risk of impoverishment and financial hardship. Instead, additional consideration could be given to the policy options outlined in the Ministry of Health's Policy Brief "Options for the Financial Sustainability of the National Health Insurance Scheme" produced in April 2021, which were formulated on the basis of a comprehensive costing exercise, and included ways of increasing government revenues, such as health taxes on tobacco and alcohol. In this regard, Recommendation No. 202 underlines the need to give due consideration to the principle of equity when considering the financial architecture of the system. The dimension of equity needs to be at the forefront of social health protection design and reforms.
- The 2023 ILO Actuarial Analysis Report (forthcoming) provides for the required Government financial allocations and increased contributions to the Lao Social Security Organization to ensure the financial sustainability of the funds.

The ILO stands ready to support the Government of the Lao People's Democratic Republic in revising the proposed amendments to the National Health Insurance Law to ensure their alignment with the principles enshrined in international social security standards.

18 This section is based on the limited information available concerning the proposed amendments to the Health Insurance Law currently being discussed by the Committee entrusted with its revision.

Review of the Health Insurance Law (amended version) 2018 in Lao People's Democratic Republic

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