



Lao People's Democratic Republic: Health Financing Reform and Challenges in Expanding the Current Social Protection Schemes

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Acronyms and Abbreviations

CBHI	Community-based Health Insurance
CSS	Civil Servants Scheme
HEF	Health Equity Funds
LAK	Lao Kips (currency)
MOF (Lao)	Ministry of Health of Lao People's Democratic Republic
RDF	Revolving Drug Fund
SSO	Social Security Organization

This document provides background information for agenda setting and policy formulation. The dual purpose is to review financing of the health sector in the Lao People's Democratic Republic and identify the main challenges in health financing and expanding social protection schemes to achieve universal coverage.

3.1. Background

3.1.1. Socio-economic perspective

The country has a population of 5.9 million² with low density (24 people per square kilometre³). Some 49 multi-ethnic groups make up about 30 per cent of the population. Minority peoples in the Lao People's Democratic Republic are classified into four linguistic groups: Tai-Kadai (44 per cent), Mon-Khmer (33 per cent), Hmong-Mi (16 per cent), and Sino-Tibetan (7 per cent). Many of them live in rural areas (90 per cent), are subsistence farmers (83 per cent) and are poor (46 per cent). Poverty is mainly regional, rural and ethnically related. The majority of the poor are minority groups who live in remote mountainous areas.

The Lao People's Democratic Republic is one of the poorest countries in South-East Asia. However, recently, it has enjoyed a period of macroeconomic stability, underpinned by fiscal and monetary discipline. With the gradual integration of the country with its fast-growing neighbours and an expansion of its mining and hydropower sectors, the country has experienced robust growth.⁴ However, many challenges remain. It is currently ranked at 133rd of 177 countries on the Human Development Index. The country is still financially heavily assisted by external sources when compared to other countries in the South-East Asian subregion. Progress in strengthening fiscal management has been slow and uneven. The fiscal position is still fragile and public debt remains high (75 per cent of GDP).⁵ Though proportionally decreasing, the agricultural sector still predominates, representing 75 per cent of Lao workers and 41 per cent of GDP share.⁶

Significantly, the country is one of the most decentralized countries in the region. Most of the spending in priority sectors is carried out by the provinces which often lack administrative, legal and technical capacity. At the same time, there are no bottom-up mechanisms through which local voices can be expressed.⁷

2 MPI, *Statistical Yearbook 2007, Lao PDR* (Department of Statistics, June 2008).

3 Ibid.

4 World Bank, *IMF and ADB, Lao PDR Public Expenditure Review, Integrated Fiduciary Assessment* (May 2007; hereinafter "World Bank, *Lao PDR Public Expenditure Review*").

5 United Nations Common Country Assessment (June 2006).

6 World Bank, *Lao PDR Economic Monitor* (November 2007).

7 Ibid.

3.1.2. Health outcomes

While the Lao People's Democratic Republic has made good progress in health indicators over the last 30 years, those indicators reveal major differences between socio-economic groups. Health outcomes mainly were improved in the non-priority districts.⁸ Moreover, with current trends, the country will still fail to achieve all the Millennium Development Goals for the health sector, mainly the maternal mortality ratio which has only been reduced from 530 to 405 per 100,000 live births from 2000 to 2005, compared with the related Millennium Development Goal of 185 per 100,000 live births in 2015. Child mortality was reduced from 107 to 98 per 1,000 live births from 2000 to 2005, compared with the related Millennium Development Goal of 55 per 1,000 by 2015. A study undertaken in 2006 by the United Nations Children's Fund found that 39 per cent of children under 5 years of age were underweight (based on weight for age), compared with 40 per cent in 1990. Malnutrition is possibly associated with as much as 58 per cent of child mortality. Surrounded by five countries with higher HIV prevalence, the country faces the difficulty to halt the spread of HIV and AIDS.

3.1.3. Health policy framework

The Sixth National Socio-Economic Development Plan (NSED 2006-2010) identifies health as one of the four priority sectors for development. The "Health Strategy to the Year 2020" is Strategic Programme 12 of the Sixth National Plan, with four basic concepts: (1) full health-care services coverage and equity; (2) development of early integrated health-care services; (3) demand-based health services and (4) self-reliant or financially autonomous health services. It targets the improvement of health management and health financing structures as well as the affordability of services for the poor. Specifically, Strategic Programme 12 includes "the introduction of health insurance and Health Equity Funds (HEF), both of which have a considerable impact on the financing of health services for the poor." In addition, the 2007 Primary Health-Care Policy of the Ministry of Health (MOH (Lao)) directly addresses the Millennium Development Goals and is supported by such policies as those for reproductive health and, soon, regarding nutrition.¹⁰

3.1.4. Health systems organization

The health-care delivery system is essentially a public system, with government-owned and -operated health centres and district and provincial hospitals.¹¹ The Lao public health system is mainly divided under the three arms of (a) health care; (b) prevention, promotion and disease control and (c) health management and administration with traditionally a strong vertical structure. The public health network is graphically represented in figure 3.1.

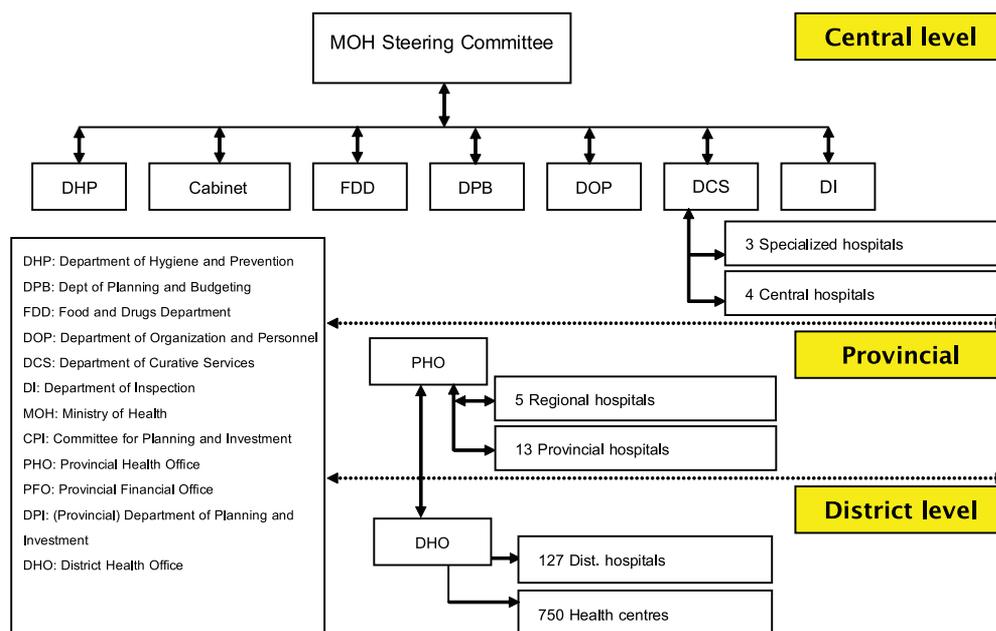
8 AGEG, *Health Sector Development Program*, Final Report ADB TA 4608-LAO (February 2007; hereinafter "AGEG, *Health Sector Development Program*").

9 Ibid.

10 B. Schwartz, "Health care financing background in Lao PDR", PPTA HSDP project, 2006 (hereinafter "Schwartz, Health care financing background in Lao PDR").

11 A. Ron, "CBHI Lao PDR: Review of CBHI pilot scheme, MOH (LAO) – WHO", May 2006 (hereinafter "Ron, CBHI Lao PDR: Review of CBHI pilot scheme, MOH (LAO) – WHO").

Figure 3.1. Organizational chart of the Lao public health system



Source: Ministry of Health, "Resources for Health: Analysis of the situation in the Lao PDR" (June 2007).

With the MOH (Lao) at the apex, there are 4 central hospitals, 6 special centres, 17 provincial and regional hospitals, 141 district hospitals, 740 health centres, and around 5,000 village drug dispensaries. There are around 5,000 hospital beds in the country.¹² Each health centre covers about 7,000 people, but many centres serve less than 1,000. The health network covers 93 per cent of population at an average walk of 90 minutes to a health facility.¹³ There are, however, major differences between urban/rural and rich/poor villages as shown in the Lao Expenditure and Consumption Survey 2002/2003: 108 minutes for rural residents to 19 minutes for urban ones; 3 hours to reach a health facility in the highlands compared to an average of 48 minutes in the lowland areas. One quarter of the poor live in villages with a medical practitioner against one half of the non-poor. Those figures represent the correlation between poverty and geographic location or ethnicity.

As to health personnel, there are about 18,000 public sector health workers of which 70 per cent are MOH (Lao) staff and 30 per cent are from the ministries of National Security and National Defence. Low salaries and low levels of basic training inhibit health system efficiency.¹⁴ Staffing is urban-biased; there is often low motivation, conflict of interests and a lack of training and career development opportunities. Only 63 per cent of the medical staff work at health facilities.

The private sector for health is expanding, mainly in urban areas with over 2,000 private pharmacies, about 500 private clinics and 600 traditional medicine practitioners.¹⁵ Currently, the first private hospitals are about to start operating. The regulatory framework is more or less in place. Implementation and enforcement face typical challenges including conflicts of interest, as most of the senior public health personnel are directly or indirectly involved in private health practice after official working hours.

12 Lao Department of Organization and Personnel, Ministry of Health, *Human Resources for Health: Analysis of the Situation in the Lao PDR* (June 2007).

13 ILO Laos, *Consultative Study — Social Protection for All: The Way Ahead*, LAO/01/M91/LUX – Development of Social Security Phase II 2002-2007 (2007; hereinafter "ILO Laos, *Social Protection Study 2007*").

14 WHO Laos, "Health care financing in Lao PDR; WHO's perspective," a PowerPoint presentation by A. Antunes.

15 ILO Laos, *Social Protection Study 2007*, supra.

In addition, mass organizations, especially the Lao Women's Union and the Lao Red Cross, are involved in specific health activities, especially in promotion and prevention at the grass-roots level. There are 45 international non-governmental organizations working in the health sector. There is fragmentation among health programmes supported by donors and lack of coordination among them. However, some progress in coordination between the MOH (Lao) and donors is underway in line with the Paris Declaration and the Vientiane Declaration on aid effectiveness.

3.1.5. Health services utilization

Government services are underused, and a significant share of out-patient health care is privately delivered.¹⁶ Purchase of drugs in official or unofficial pharmacies is the first health-seeking behaviour. Public facilities, especially district and health centres, are poorly utilized, with only 0.2 curative contacts per capita per year, as reported at the National Health Conference in August 2007. Coverage for preventive health services is also low. As detailed in subsequent sections, the ability to pay is a major barrier to utilization.

There is a bias towards the richer quintiles. Wealthier people use substantially more public health facilities, including health centres, than the poor.¹⁷ Surveys showed that the highest quintile has more than twice the rate of hospital admissions than the lowest quintile, despite higher and more severe sickness levels of the poor. The inequity is most acute in rural areas, where households in the highest quintile have an in-patient admission rate of 42.4 per 1,000 population, compared with 15.9 for households in the lowest.¹⁸

Table 3.1. Annual hospital admissions per 1,000 population, by per capita consumption quintile and urban/rural residence, in percentages

Consumption Quintile	Urban	Rural	Total
Highest	38.1	42.4	40.4
Next Highest	25.5	38.2	34.4
Middle	49.8	27.4	32.3
Next Lowest	22.7	22.8	22.8
Lowest	24.5	15.9	17.0
Total	33.0	26.7	28.3

Source: World Bank, IMF and ADB, *Lao PDR Public Expenditure Review, Integrated Fiduciary Assessment* (May 2007), June 2006 draft version.

The quality of health care, traditional perceptions and language barriers influence health-seeking behaviours and demand for health services, particularly among minority groups.¹⁹ Additional social barriers exist for isolated ethnic groups. They use services less and are less educated about health matters, such as HIV prevention. They generally prefer to consult health staff who speak their language and understand their views.²⁰

3.1.6. Gender and health

As expressed in the Millennium Development Goals, gender issues are critical in health care, with women bearing the responsibility of family health care and reproductive health. Reviews of gender situations in the Lao People's Democratic Republic demonstrate such links and emphasize that maternal mortality ratios are strikingly high,

¹⁶ World Bank, *Lao PDR Public Expenditure Review*, supra.

¹⁷ Ibid.

¹⁸ Schwartz, "Health care financing background in Lao PDR", supra.

¹⁹ Gender Resource Information and Development Center (GRID) World Bank, *Lao PDR gender profile*, 2005 (hereinafter "GRID, *Lao PDR gender profile*").

²⁰ AGE, *Health Sector Development Program*, supra.

with large rural-urban disparities. Nationwide, 86 per cent of deliveries occur at home where 9 out of 10 maternal deaths occur. Access to emergency obstetric care is a major problem in rural areas; where such care is provided, the very high costs of transport and operations often make them unaffordable.²¹ Coverage of key maternal and child health interventions remains low, and the immunization rate is worsening.²² Important differences exist between Lao Tai women and women of other ethnic groups in terms of place of delivery, for cultural and economic reasons. Often, age at first marriage and level of education influence health outcomes.²³

3.2. Financing of the Health Sector

3.2.1. Overview of health financing

The Lao health system can be characterized as:

- ☑ Under-funded (low per capita health-care spending, low Government funding).
- ☑ Inequitable (overly dependent on direct household expenditure for curative care).
- ☑ Weak in social protection (low coverage of the population).
- ☑ Inefficient and with low productivity.

Capital investments have been overemphasized in the past. There seem to have been improvements but capital and recurrent expenditure are still managed separately, leading to inefficiencies. Weak synergies exist between Government, donor and beneficiary resources.

The Lao Government is undertaking health-financing reform with an array of pilot initiatives such as health insurance, HEF, performance subsidies, staff incentives, budget support with health indicators, improved management systems and auditing and monitoring.

Total health expenditure²⁴ is still low and depends heavily on household out-of-pocket payments. Public spending on health is low, currently estimated to be less than 1 per cent of GDP per annum and mainly supports capital investment, salaries and administration of the Government health system, and disease control. Budgets for health-care facilities are inadequate to cover even the costs of basic utilities such as electricity. The major part of such expenditure is supported by external funds.

Beside the low rate of public expenditure, another feature of Lao health financing is decentralization. Currently, 75 per cent of the domestic health budget is provided by provinces and districts.²⁵ Provinces are key actors in both financing and delivery of health services, but are not accountable to the central administration. Per capita governmental health spending varies considerably across provinces and districts. Coverage of key primary health services also varies widely among provinces, reflecting their autonomy.²⁶ Government budget decentralization leaves the MOH (Lao) with little power to enforce public health policies.

21 Ibid.

22 World Bank, *Lao PDR Public Expenditure Review*, supra.

23 GRID, *Lao PDR gender profile*, supra.

24 Total health expenditure is government health expenditure plus household out-of-pocket spending on health care, where government health expenditure includes both domestically financed government health expenditure (i.e., recurrent and capital health expenditure financed mostly out of tax revenue) and foreign-financed government health expenditure (i.e., health expenditure financed by foreign donors and international NGOs, all of which is classified as capital expenditure). Schwartz, "Health care financing background in Lao PDR", supra.

25 Ministry of Health, Department of Finance and Planning, *Health Development Plan 2006-2007* (2007).

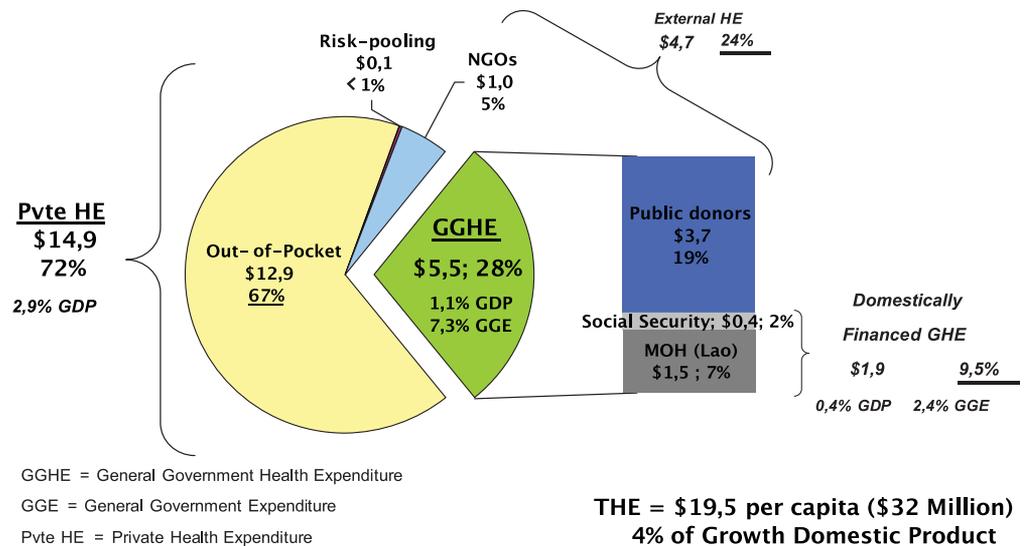
26 World Bank, *Lao PDR Public Expenditure Review*, supra.

Public health spending is inefficient and inequitable. Gaps are emerging between the poor and non-poor and between the Lao-Thai and the other ethnic groups. Indeed, more favourable outcomes are found in urban areas and among the better-off segments of the population. There is overspending on capital investment (the country has more hospital beds per 1,000 people than any other in the South-East subregion), but its health facilities remain significantly underused. The country's public health sector wages are among the lowest in the world, and salary increases are among the lowest across sectors. Statistically, public spending does not correlate with such factors as income, poverty or health needs. Effective mechanisms to protect the poor from unaffordable health-care costs are lacking, especially for the poor who do not live in the 47 priority districts.

3.2.2. Public health expenditure

Figure 3.2 shows total health expenditure in 2005, which is at a low level compared with other Asian countries, of USD 19 per capita or Int. \$83 of purchasing power parity, being 4 per cent of GDP. General governmental health expenditure is also low at USD 5.5 per capita, including donor and loan funds, which represents 7 per cent of the total Government budget. Only USD 1.9 per capita of that amount comes from domestic sources (9.5 per cent of total health expenditure), indicating high dependence on donors for public health. Public donor funding, at USD 3.7 per capita, financed two thirds of the general Government health expenditure. Private health expenditure is comparatively high at USD 13.9, more than 90 per cent of it being out-of-pocket expenditure (USD 12.9). Pooling of resources is still low, being less than 1 per cent of total health expenditure.

Figure 3.2. Total health expenditure, 2005



Source: Extracts from WHO, "Estimates for country NHA data, Lao PDR Database" (2007), accessed from <<http://www.who.int/nha/country/lao/en/>>, adjusted with MOH (Lao), "Official Figures Gazette".

Analysis of public health financing by function and resource costs shows that in the past five years, hygiene and prevention accounted for around 45 per cent of public health expenditure, while curative services represented around 25 per cent and management around 30 per cent. Capital costs represented almost 38 per cent and

personnel costs were only 12 per cent of total costs,²⁷ resulting in a major effect on the quality of services and productivity. At the same time, 75 per cent of domestically financed Government expenditures were spent on salaries. Meanwhile, disease control is mainly financed by donors and grants or loans. Investment, training, management and administration costs are also mainly financed by donors and grants or loans. Hospitals, as well as curative activities at health centres, depend largely on user charges for recurrent costs except for modest salaries (table 3.2). A WHO survey in 2004²⁸ showed that provincial and district hospitals receive between 48 and 83 per cent of their recurrent budgets from user fees.

Table 3.2. Health centre and hospital curative financing

HC & Hosp curative financing	Govt	Donors	Patients	Total	%
Salaries	2.409.755	552.619	341.057	3.303.431	38%
Admin & maintenance	213.655	108.424	815.447	1.282.971	15%
Drugs	105.079	326.908	3.744.120	4.030.662	47%
Total 2004/05 estimates	2.728.489	987.951	4.900.625	8.617.065	100%
%	32%	11%	57%	100%	

Source: Department of Budget and Planning, Ministry of Health, "NGPES Program Costing Report for Health Sector" (May 2005).

The analysis on beneficiaries shows that, overall, the richest quintile captures 27 per cent of public subsidies for health services, compared with 13 per cent for the poorest. Public subsidies to central hospitals are heavily biased in favour of the richest quintile.²⁹

3.2.3. Public mechanisms and risk pooling

The Lao health system mainly operates on a fee-for-service basis, while health insurance schemes operate on the capitation payment to medical providers.

3.2.3.1. Institutional framework and out-of-pocket payment

From 1975 until the late 1990s, the Government funded health care for the entire population. Services were officially provided free of charge to patients in public health facilities. However, budgetary constraints increasingly limited the care that the Government could fund. Salaries of health workers were low, shortages of essential drugs and medical supplies became increasingly frequent, and infrastructure deteriorated. It was not feasible to increase Government funding from general tax revenues to improve the situation. Thus, rather than letting the public health system collapse, the Government officially introduced user fees in 1996, through the Decree 52, for specific services. The Decree 230 in 1997 expanded the Revolving Drug Funds (RDF). In parallel, under a National Drug Policy, the Government allowed private pharmacies to develop, in order to improve the availability of drugs. As a result, over 2,000 private pharmacies are currently operating.

RDF resulted in a start of user fees for services in governmental health-care institutions, with fees levied for patient registration and for ancillary services, but not for consultations with professional health workers. RDF are being implemented in 86 per cent of Government health facilities and over 1,000 villages. The fees to patients for drugs were set at cost plus 25 per cent in order to ensure re-supply, associated drug

27 Lao Ministry of Finance, *State Budget Implementation of 2002-2003 and State Budget Plan for 2003-2004* (La Gazette, 2004); Government of Lao PDR, *National Growth and Poverty Eradication Strategy* (2004; hereinafter "Lao Govt, *National Growth and Poverty Eradication Strategy*").

28 WHO, *Hospitals' Costing Survey in Lao PDR* (September 2004).

29 World Bank, *Lao PDR Public Expenditure Review*, supra.

administration and transport costs and consolidate the capital. Diverted from its initial role after the Asian financial crisis of the late 1990s and the decreased public health financing for curative health care, RDF, as the only non-earmarked revenue at the facility level, was inevitably set to finance recurrent costs of the facilities. As a result, RDF have quickly become the major source of funding at curative health-care facilities.³⁰

Despite the adequate RDF starting strategy at the beginning of the 1990s and success in ensuring drug availability and financial management in health facilities, the limitations and negative effects on provider behaviour have also been apparent. RDF were seen as a source of revenue for the hospitals and generated a situation in which providers over-prescribed and easily responded to patients' requests for unnecessary drugs. Drug procurement by the public providers is not adequately regulated and controlled while the mark up on the costs is also not adequately controlled. In practice, drugs are often charged at cost plus 40 per cent. Uncontrolled and unregulated purchasing of drugs at very different prices exacerbates the problems. As a result, expenditure on drugs may reach over 80 per cent of the total expenditure on patient care in health-care facilities, excluding salaries paid by the Central Government. It should be noted that the difficult implementation of effective quality control is more acute in the private market, resulting in development of counterfeit and substandard drugs.

Service charges are another type of user fee progressively implemented in association with RDF. Limited in scope under the Decree 52/PM, the Article 381 of the *Curative Law* in 2005 was extended and generalized to all levels of health-care facilities for a wide scope of examinations and consultations. In addition, the Ministry of Finance Decree 1646 details all acceptable pricings for service fees for all sectors including health services, translating an attempt to centralize the pricing of public services. However, in reality, this centralization contradicts local socio-economic disparities and community involvement.

Various problems associated with the current user fees have become apparent. User fees, despite their intended function in sustaining health services, are deleterious in the development of public health systems. They may lead to problems related with inequity, financial barriers, patients delaying seeking care until illness is severe, unpredictability, incomplete treatment, and negative provider behaviour including incentives for over-prescription, catastrophic health expenditure, escalation of hospitalization costs due to cost recovery, introduction of more sophisticated technology and the epidemiological transition (more expensive pathology than the previously dominant infectious diseases).

Further, relatively high charges for treatment and poor quality of service, often driven by irrational prescription of both drugs and diagnostic tests, contribute to under-utilization of health facilities. People tend to mistrust public health services and to rely on such alternatives as traditional medicine or self-prescribed medication. At the same time, the cost of treatment is a major barrier to access to care. A 2004 household health survey showed that among the poorest quintile, 34 per cent of households sold possessions and 29 per cent borrowed from relatives to pay for hospital care, compared respectively to 5 per cent and 7 per cent in the highest quintile.³¹

30 Hospitals receive between 48 and 83 per cent of recurrent budgets from user fees. Ibid.

31 B. Schwartz and V. Viravong, "Health care financing in Lao PDR: Sub-sector analysis", Health Sector Development Program, LAO TA 4608, 1 May 2006 (hereinafter "Schwartz, Health care financing in Lao PDR: Sub-sector analysis").

3.2.3.2. Exemptions and waivers

According to policy (PM Decree No. 52 of 1995), the poor³² and several other groups (i.e., civil servants and their families, monks and students in government schools) are supposed to be exempt from having to pay user fees at government health facilities of the Lao People's Democratic Republic. In practice, however, there appear to be few exemptions provided in many facilities. In Oudomxay Province, for example, less than 1 per cent of the people who received services from the provincial hospital or one of the district hospitals reported that no fees were paid.³³ A 2003 study by the MOH (Lao) and WHO indicated that exemptions at district hospitals ranged from 0.3 per cent to 11.9 per cent of total fee revenues. Luang Prabang Hospital reported a value of exempted services at 14 per cent of total user fees (8 per cent for poor patients), while Sayaboury Hospital reported 5 per cent exemption (1 per cent for the poor).³⁴ In most cases, it is left up to individual health facilities to decide whether or not to grant a fee exemption, and it is reported that there is wide variation among health facilities in this practice.

3.2.3.3. Social protection³⁵ mechanisms

The Government has recognized the importance of issues associated with health financing, including equity, and started implementing social protection schemes. There are social insurance programmes for those in the formal sector, the Civil Servants' Scheme (CSS), and in the formal private sector, the Social Security Organization (SSO). In the informal sector, Community-based Health Insurance (CBHI) is progressively being expanded. HEF are being piloted to mitigate the often-catastrophic impact of illness in a family and compensate the health-care facilities for services provided to the lowest income patients who would otherwise be exempt from user fees.

The risk-pooling approaches provide an alternative and a sustainable model of health financing appropriate for the country. Social health insurance distributes the burden of health-care financing more evenly across the population and encourages an increase in utilization.³⁶ However, health insurance is still in its infancy in the country and to date has had little impact on improving the affordability of health-care services, particularly for the poor. It is not likely to be a substantial source of funding for the health-care needs of the poor in the near future. For a majority of the rural population living in the informal sector (80 per cent), it will still take a long time before health insurance is a widely available option and an accepted method to pay for health-care services.³⁷

Below, the major social protection schemes available in the Lao People's Democratic Republic are briefly summarized. Figure 3.3 presents the proportionate shares of population coverage by the different types of social protection.

32 Lao Govt, *National Growth and Poverty Eradication Strategy*, supra. Prime Minister Instruction Nb10 on Poverty Reduction: "Poverty is the lack of ability to fulfil basic human needs, such as: not having enough food [i.e. less than 2,100 calories per day per capita], lack of adequate clothing, not having permanent housing, not capable of meeting expenses for health care, not capable of meeting educational expenses for one's self and other family members, and lack of access to transport routes".

33 Schwartz, "Health care financing in Lao PDR: Sub-sector analysis", supra.

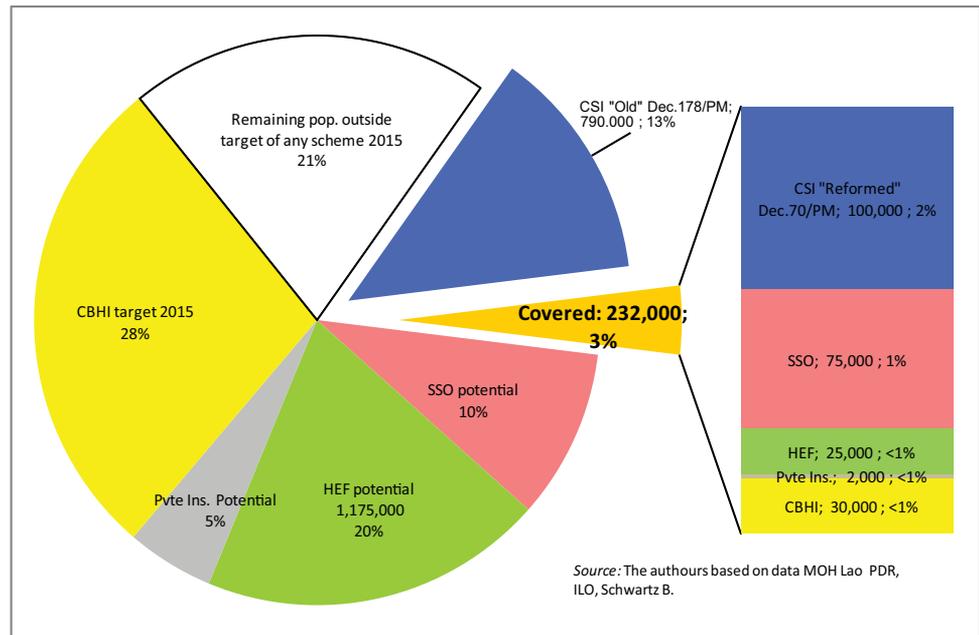
34 Luang Prabang and Sayaboury Provincial Hospitals, *Annual Reports (2004-2005)*.

35 "Social Protection is defined by the ILO as the set of public measures that a society provides for its members to protect them against economic and social distress that would be caused by the absence or a substantial reduction in income from work as a result of various contingencies (sickness, maternity, employment injury, unemployment, invalidity, old age, and death of the breadwinner): the provision of health care; and, the provision of benefits for families with children". ILO Laos, *Social Protection Study 2007*, supra, citing ILO, *World Labour Report (1998)*.

36 Ministry of Health and WHO, "Strengthening and Capacity Development in Health Care Financing in Lao PDR", a concept programme proposal presented for funding to Ministry of Foreign Affairs of Luxemburg, 2007 (hereinafter, "Ministry of Health, Strengthening and Capacity Development in Health Care Financing in Lao PDR").

37 Schwartz, "Health care financing background in Lao PDR", supra.

Figure 3.3. Social protection coverage in Lao PDR: Estimates of 2007



Source: Compilation of data from the Lao Ministry of Health, ILO and B. Schwartz and V. Viravong, "Health care financing in Lao PDR: Sub-sector analysis", Health Sector Development Program (LAO TA 4608), 1 May 2006.

Social Security Organization

A first step in the development of social safety nets in the Lao People's Democratic Republic was made through the Social Security Decree (207) promulgated in 2001 and administered by the Social Security Office (SSO). This Decree includes health care among the benefits in a broad social security scheme, covering salaried employees in the private sector. The scheme is mandatory. After several years in which the Decree covered workers in enterprises with over 100 workers, and then over 10 workers, the *Labour Law* has been amended to require employers to provide social security for all workers, even enterprises with 1 or more worker. However, compliance is still low, as enforcement of registration requires implementation of the changes in the *Labour Law*. At present, several high salary companies, including banks having their own social security and health insurance schemes, still do not register their workers with the SSO.

The SSO started operating in Vientiane Municipality and has expanded to Vientiane Province and Savannakhet and Khammouan Provinces. The total number of persons covered at the end of 2006 was around 65,000 within 260 companies (10 to 15 per cent of targeted companies), including insured workers and dependent spouses and children below 18 years. The scheme is financed by employees and employers with employees contributing 4.5 per cent and employers 5 per cent of the covered employee's wage, with an income ceiling of LAK 1,500,000 (USD 1 = LAK 8,500, 2008).³⁸ The health-care component is set at 2.2 per cent. Health-care benefits include ambulatory and in-patient care (with exclusion of traffic accident injuries and cosmetic care), without co-payment or limits on the number of contacts or services provided. The public providers of health care are paid according to the capitation method, which means a fixed amount of LAK 65,000 per insured person, regardless of actual

38 ILO Laos, *Social Protection Study 2007*, supra.

use. Recent developments include a refinement of the capitation payment to reflect the risk of populations affiliated with the contract hospitals.

With a rather healthy young working population, the utilization rate of SSO members is usually higher than for people without insurance but lower than for people with voluntary insurance or for civil servants. Hospitals thus can usually keep a positive financial balance. However, the slow growth of coverage has been a serious issue associated with other problems, including difficulties enforcing regulation and registration of all company workers, low quality of services, adjustment of benefit packages and service delivery to the target group, use of capitation and influence of hospitals on the SSO board, among others.

Civil Servants Scheme

Under the Decrees 178/PM and 70/PM/2006, the Ministry of Labour and Social Welfare has also started a reform of the compulsory civil servants health-care benefits scheme (CSS), beginning with Vientiane Municipality and Vientiane Province. The benefits include retirement pensions, survivors' benefits, employment injury, sickness benefits and maternity benefits. The State Authority Social Security, an autonomous agency established under the Decree 70/PM/2006, currently allocates a capitation payment to a specific health-care provider for each person covered (civil servants, their spouse and children) to provide the same health-care benefits as the population covered by the SSO. The new contribution rates for all social security benefits for civil servants include a 4 per cent contribution for health care, with 2 per cent paid by the Government as employer and 2 per cent by the worker. Currently, over 65,000 persons are covered by that social health insurance scheme. Members must go to district hospitals as the first level of diagnosis with referrals made according to medical needs and proximity, in line with national health services delivery procedures.

More than 180,000 civil servants, military and police were covered for medical care through a very small reimbursement of costs under the decree 178/PM (average reimbursement of 20 per cent of actual costs paid). Some medical coverage was also provided for their dependents, numbering about 680,000 and bringing total coverage to about 860,000 persons. The national implementation of the decree 70/PM 2006 which introduced the capitation-based social health insurance fund began in 2008. Civil servants were to increase their contribution rates from 6 per cent (leading to a capitation of LAK 40,000) to 8 per cent (expected capitation at LAK 65,000) to cover the improved social security benefit package, including social health insurance and survivors benefit.

With higher utilization rates for health staff, lower capitation rates (currently at LAK 40,000 per year, but to be increased to LAK 60,000 in 2008, equivalent to LAK 60,000 to 65,000 for CBHI-SSO), more services covered (transport costs for referrals) and a potential conflict of interest (because those prescribing are civil servants), inequitable cross-subsidies might arise. If the income from capitation does not cover the operation costs plus an expected margin, the hospitals might be less keen in reversing the situation as they would also benefit from the system. As a result, the people paying directly through out-of-pocket payments and the HEF could end up subsidizing the treatments for CSS members. Increases in government salaries should automatically increase the capitation. Further, the low capitation level leads to losses for contracted hospitals, low quality of services and moral hazard from supply and demand sides. There also exists some dissatisfaction among insured civil servants regarding mandatory referral.

Community-based Health Insurance

In 2000, the MOH (Lao) established a Health Insurance Unit, in the Department of Budget and Planning, and requested technical assistance from WHO to develop health

insurance for the informal working and non-salaried populations. With funding from the United Nations Human Security Fund, four pilot schemes were launched from 2001 (Sissatanak, 2001; Nambak, 2003; Champassak, 2004; Hatxaiphong, 2005) followed by others in KeoOudom/Viengkham and Phonhong in 2005 with the support of a Lao — Luxembourg project. The expansion phase of the project with a new grant from the United Nations Human Security Fund plans 15 new schemes in more than 5 provinces and more with support of other major health projects. Five new schemes were starting to operate at the beginning of 2008 (Saysettha, Champhone, Pakse, Luang Prabang and Oudomxay).

Community-based Health Insurance (CBHI) operates under a governmental regulatory framework and national policy, through a national programme according to MOH (Lao) guidelines and regulations to ensure compliance to standards related to the major characteristics as well as management of the schemes.

CBHI follows a set of design principles, with the following components:

- Contributions should be affordable for the majority of people of the target area.
- All family members are covered, with family defined as all the individuals listed in the Lao People's Democratic Republic family book.
- Benefits include ambulatory and in-patient care, with a referral mechanism to hospital care.
- Provider payment is by capitation, paid directly to the contracted hospitals, with no co-payments or other form of cost-sharing by the patient at the time of use.
- A management committee is responsible for day-to-day operation of the scheme.
- Overall policy is determined by the MOH (Lao) Health Insurance Committee.
- To the greatest extent possible, the benefits and conditions should follow those of the SSO health insurance, thereby avoiding the providers favouring insured persons in the different schemes.

Coverage was about 3,500 families or 25,000 persons in 2007 before the expansion to the five new schemes (30,000 with the expansion). Nearly 10 per cent of the target population has been enrolled at sites where CBHI schemes operate. However, only about 40 per cent of such households pay their monthly premium on time. Transaction costs are consequently high and capitation paid to providers fluctuates from month to month.

Still, CBHI has improved utilization of facilities³⁹ and avoided some catastrophic health expenditure. It should be noted that premiums are not based on actuarial calculations, but on the ability to pay for the majority of the population. The amount of contribution currently is not expected to cover all operating costs of the provider — and should not remove the financing obligation of the Government.

Current issues include general comprehension among the population, difficulties with contribution collection, quality of care, behaviour of insured members and health providers (such as over-prescription of drugs and provision of unnecessary diagnostic tests to members, and health worker reluctance to provide more services without additional compensation), adverse selection, moral hazard, high membership dropout rates, late membership payments and the tendency to cover the higher socio-economic

39 Utilization of health care, from 1.2 to 4.2 out-patient department contacts per insured per year (general population, 0.29); from 0.04 to 0.05 in-patient department case per insured per year (general population, 0.036). Information from Lao Ministry of Health, CBHI Unit, September 2006.

40 Swiss Red Cross, *Nambak Health District: Year 2004-2005 and 4-year evaluation* (October 2005); IHPP and NIPH, *Socio-economic profile and Satisfaction of Insured and un-insured group in Lao P.D.R., supported by WHO and ILO* (31 October 2007).

profiles of the population.⁴⁰ Most contracted hospitals currently do not make any surplus with the CBHI and therefore perceive it as a loss compared to revenues from out-of-pocket payments. That leads to dissatisfaction as CBHI was expected to generate a surplus superior to those of the RDF and fees that could allow for staff incentives.

Health Equity Funds

Health Equity Funds (HEF) are a form of social health protection targeted at those who are unable to pay the cost of health services at public facilities or health insurance premiums of any kind. HEF are another important aspect of the social protection system, designed to cater for the needs of the poorest households and communities. The aims of HEF are to provide access to public health services for the poor, to meet medical costs at public hospitals and health centres and to prevent poor or near-poor households from further impoverishment. The main purposes of the HEF can be described as follows:⁴¹

- Contributing to poverty reduction by protecting the poor from unaffordable routine and catastrophic health expenditures.
- Reducing out-of-pocket expenditures for health by the poor.
- Overcoming barriers to access (financial and others) and to provide access for the poor to priority public health services.
- Helping to integrate poor patients as users into the public health system.
- Increasing utilization of public health services by the poor.
- Helping to improve the quality of service in the public health-care system.
- Providing a means of expressing the voice of the poor as health service users.
- Providing a social safety net for the poor and contributing towards the development of a uniform, national, universal health-coverage system.

There are three HEF schemes currently being pilot-tested in the Lao People's Democratic Republic. Swiss Red Cross operated a health equity fund in Nambak District, Luang-Prabang Province from 2004 until 2005 when they transferred responsibility for the fund to Lao Red Cross. Lao Red Cross is continuing to support the operation of the fund. In Vientiane Province, Belgian Technical Cooperation is supporting HEF in two districts, and Luxembourg Development is supporting them in nine districts. The MOH (Lao) is currently planning to expand HEF. In 2008, MOH (Lao) began to pilot HEF schemes in up to five districts in the southern provinces of Laos with funding from the MOH(Lao)-World Bank Health Sector Improvement Project and in three northern provinces under the Health Sector Development Project with funding from the Asian Development Bank.

The Lao legislative confirms the principle of user charges for health services, guarantees the entitlement of all citizens to receive the health care they need, and provides for free health care for poor patients unable to pay for services. In particular, Article 50 of the *Law on Health Care* provided for the introduction of "public welfare health-insurance funds" (or HEF) for poor people who do not qualify for social health insurance (CSS and SSO), cannot meet the costs of insurance premium payments (private or CBHI), and are unable to afford needed health care. For such people, according to the Law, "all of their expenses are directly covered by their public welfare health insurance fund". Article 50 also provides that funding for HEF schemes may come from multiple sources, including the Government, individuals, the community, national and international organizations and foreign donors.

Each of the current HEF schemes pre-identifies the poorest people in the district and provides them health cards to obtain free services. Benefits include medical

41 P. Annear, "Health Equity Funds in the Lao PDR Vol. 1: Guidelines for implementation and management", a draft for HSIP/Ministry of Health, March 2007.

services, drugs, supplies, laboratory tests, transport, food and soap. Free treatment is provided from health centres to provincial hospitals. Poor patients, who require hospital admission and are not pre-identified, can still be qualified for HEF based on a hospital-based interview and decision by the hospital administration. HEF administration bodies vary from a local association to a unit of the provincial or district health office. They show that HEF can be a cost-effective measure to target the poor. The cost of the pre-identification ranged between USD 1 and USD 3 per annum per pre-identified beneficiary. Reimbursement to health provider is on a fee-for-service basis except for caesarean section on a flat fixed-fee basis in Vientiane Province. HEF currently represents a low proportion of the revenues of facilities⁴² and therefore is mainly neutral in terms of being a motivating factor. However, there still remain various challenges, such as unsecured funding, management and targeting, promotion/marketing, quality of services, still limited scale and separation from other social protection schemes.

Private for-profit commercial insurance

Private insurance is still at a low level with few private companies in the country. That situation might change soon, as, with the prospect of private hospitals, a private insurance company is starting to operate in Vientiane. Some wealthier Lao families in addition to local insurance also hold Thai insurance, usually health insurance.⁴³

3.2.4. Public finance management

MOH (Lao) plays a relatively limited role in the budget planning process. The Ministry of Finance is responsible for the overall fiscal framework and for sector allocations from the recurrent budget. The Committee for Planning and Investment and donors are key players in the allocation of the capital budget. The current donor support is best illustrated by the three separate project units within MOH (Lao) supporting different donor-funded programmes: the World Bank, the Asian Development Bank, and the Global Fund to Fight AIDS, Tuberculosis and Malaria. At the same time, with the decentralization, there is an indecisive role between MOH (Lao) and the provinces.

In terms of planning and budgeting, a lack of coordination clearly exists between national and subnational health plans. In recent years, there have been good efforts to introduce medium- to long-term financial planning in the health sector. Within the reforms in overall public finance, the first health-sector Medium-Term Expenditure Framework has been finalized with the assistance of the Asian Development Bank and the Ministry of Finance. At the provincial level, planning is more difficult. As a result of decentralization, some planning and budgeting responsibilities have been devolved to provincial health offices and district health offices. However, the transfer of responsibilities has not been accompanied by clear guidelines from MOH (Lao) about how to plan and budget at the local level. There is no mechanism for ensuring that provinces reflect national priorities in their budget plans. There is little flexibility for local governments in preparing their recurrent costs health sector budgets. A disconnection also exists between resource allocation and health outcomes at all levels. The disconnection and the absence of a pro-poor focus in budget management and planning have resulted in an inequitable and inefficient health system.

The official budget is formulated only for general Government funding (approximately 10 per cent of total health expenditure) while other substantial items like user fees and the drug revolving fund are not covered and no coherent and integrated plans exist for those sources at all levels. In addition, most donor-funded projects and programmes are not included in the recurrent budget. Budget execution rates are high for salaries, but especially low for capital expenditures. At the provincial level, budget

42 Between 8 and 28 per cent of total revenues from beneficiaries.

43 ILO Laos, *Social Protection Study 2007*, supra.

execution is more problematic. Cash frequently is unavailable owing to incorrect revenue projections and/or problems in transferring revenue from surplus to deficit provinces.

The mechanism of ensuring the accountability for implementation of activities according to the budget has not been developed effectively. Accountability for expenditure below the provincial-level is problematic owing to deficient accounting and reporting systems as well as a lack of capacity to conduct effective monitoring and control functions. Internal auditing functions are almost non-existent at all levels of the health sector.

There is limited technical capacity in all of the financial management subsystems including weak authority and capacity of treasury offices at each level, ineffective implementation of public procurement, weaknesses in the accounting and reporting system, and deficiencies in public financial accountability and transparency.⁴⁴ There is an acute shortage of staff with adequate training and experience in accounting or finance throughout the public sector; some agency staff have little or no formal training. The shortage of trained personnel is particularly acute at provincial and district levels. Decentralization has happened at a faster pace than capacity development and provinces lack human resources, various financial management skills as well information infrastructure and incentive mechanisms. The limited technical capacity in financial management is hampering the extension of the social health protection mechanisms introduced to bring additional funds into the public health-care system through prepayment and to increase utilization.

Aware of such deficiencies, the Government with the support of donors is developing different manuals and guidelines to facilitate and improve the existing planning, financial management and budgeting practices. They are mainly at pilot stages and often lack comprehensiveness. MOH (Lao) is engaged in development of the first Medium-Term Expenditure Framework in the health sector. Efforts to improve current planning and budgeting at provincial and district levels are being conducted with support of many donor programmes (among them, Asian Development Bank, World Bank, Governance and Public Administration Reform Program and World Health Organization); including a comprehensive approach in Vientiane Province with Luxembourg support. An MOH (Lao)-World Health Organization pilot project has also started to establish hospital financial management information systems; pilots were started at four hospitals. At the facility level, there is a progressive introduction of an accounting system to deal with problems of integration and of multiple reporting per source (by donor/programme/project).

3.3. Challenge in Health Financing

3.3.1. General challenges

The three main challenges may be summarized as follows:

- 1) **To ensure adequate public funding for public health.** Public funding for health needs to be increased in a stable way with a focus on performance of services, on the poor and on ensuring support for basic routine recurrent costs for the functioning of the public health apparatus.
- 2) **To ensure efficiency.** Efficiency needs to be increased through improving staff performance, efficiency of donor funding in support of performance improvement, and limiting conflicts of interest between health personnel and the private sector. Financing strategies must complement the major challenge of capacity-building to provide adequate technical quality of care and services.

⁴⁴ Ministry of Health, "Strengthening and Capacity Development in Health Care Financing in Lao PDR", supra.

Integrated management of the recurrent and capital expenditures is also a key challenge for improved efficiency.

- 3) **To ensure affordability and equity.** Affordability and equity need to be improved through subsidizing priority services with a pro-poor concern, promoting prepayment and risk-pooling mechanisms, limiting perverse effects of user fees and developing adequate safety nets for the poor through demand-side financing. An adequate balance between public and private provision must be found together with partnership and synergies to ensure that public health can at least provide adequate quality services to the non-rich population.

The National Socio-Economic Development Plan for health foresees a significant gap in financing recurrent spending. Public health expenditure to meet its challenges exceeds its available resources considerably. Estimates suggest that the funding gap for staff and salary increases alone would be approximately USD 14 million by 2010, even assuming that the promised levels of external funding are delivered. An additional gap will exist for non-wage recurrent spending. Filling this gap will require increased donor funding. In addition, user fees are likely to play an increasingly important role in financing Government health services but may make such services unaffordable to the poor.⁴⁵

Health insurance alone cannot pool enough resources and replace total Government investment and expenditure in health. That in part is due to the economic constraints of the actual target populations for the existing risk-pooling and social safety net instruments, and their slow growth makes it unlikely that they will be able to support the health sector needs sufficiently in either the short-or medium-term.⁴⁶ Equity will need to be maintained not only through the financing of services for the share of the population that cannot afford health care, but also through the sufficient financing of an adequate and effective regulatory framework. The health-care financing envelope will have to be supported by governmental revenues and taxes, domestically and externally financed, at a fair and sufficient level.

In the transition period before collecting expected revenue increases from major investment programmes, such as Nam Theun 2, the Government and donors will have to find bridging funds to change the vicious cycle of poor quality, under-utilization and under-funding, low cost recovery and low pooling.

3.3.2. Challenges in advancing towards universal coverage

There is an important difference between universal coverage in terms of access (i.e., health network) and in terms of financing (i.e., social protection). Under universal social protection coverage with society risk-pooling, all households share the financing of the health-care costs.⁴⁷

The main challenges facing the health sector are related to financing and coverage extension:

- A total of 75 per cent of the population in the informal sector, with very limited associative networks and 30 per cent of the population belonging to ethnic minority groups.
- Around 30 per cent of the population below the poverty line and 66 per cent living at under Int. \$ 2 purchasing power parity per day.

45 World Bank, *Lao PDR Public Expenditure Review*, supra.

46 Ministry of Health, "Strengthening and Capacity Development in Health Care Financing in Lao PDR", supra.

47 G. Carrin and C. James, "Social health insurance: Key factors affecting the transition towards universal coverage", *International Social Security Review* (2005), vol. 58, no. 1.

- Major constraints to provide a quality public health service package at the front-line level.

The key challenges towards universal social protection coverage are:

- Acknowledging the need for a long-term effort (progressive coverage, continuity) and need for a mix of social protection schemes.
- Focusing on expanding coverage when a reliable package and financing are reached.
- Assuring similarity among schemes in terms of benefit packages, administrative body, management and reporting to enable linkages and mergers.

Most of the following challenges are obviously interlinked; linkages are indicated in parentheses.

Coverage

- (All) Improve awareness and understanding by the population and the providers.
- (All) Ensure a feeling of local ownership by the community, which is created mainly by having a locally known and trusted management structure.
- (All) Strengthen the political will at all levels — national, provincial and district.
- (All) Develop responsiveness and demand-side approaches.
- (All) Do not put all energy into health insurance but also focus in parallel on the current out-of-pocket mechanisms and ways to limit their drawbacks.
- (SSO) Ensure compliance in the compulsory scheme by enforcing regulations.
- (SSO/CSS) Extend coverage to new provinces.
- (SSO, CBHI, CSS) Strengthen promotion/marketing.
- (HEF) Provide clear policy orientation and agree on a set of policy framework regulations.
- (HEF) Develop reliable cost-effective identification/targeting.

Providers

- (All) Ensure adequate, effective and perceived quality of services.
- (All) Respect prices and refrain from pursuit of unofficial payments.
- (All) Ensure responsiveness and collaboration.

Benefit package

- (All) Develop an adequate benefit package to meet the people's needs, the epidemiologic transition, occurrence and burden of diseases (chronic diseases, vehicle accidents).
- (SSO) Ensure an adapted package to companies (specialized services, proximity, opening hours).
- (HEF) Cover more than health services: transportation and food.

Management

- (All) Reach transparency in management, accountability and adequate management procedures.
- (All) Develop planning and management skills at all levels.
- (All) Establish a national committee to set the level of capitations with representatives of the providers, beneficiaries and Government.
- (CBHI) Ensure cost-effective collection of premiums (including periodicity, collectors' status and synergies).
- (CBHI) Enforce and professionalize management capacity at the district level.
- (HEF) Choose implementing agents who provide the best mix to ensure neutral third-party management, social proactive proximity-service, low administrative costs and reliable accountable management.
- (HEF) Do not underestimate the social-proactive dimension with a focus on minority groups.

Financing

- (All) Ensure understanding of the provider payment mechanism that is not volume-based and shifts the burden of cost control to the provider.
- (CSS) Ensure a sufficient level of capitation to cover health costs and avoid deficits for health providers.
- (CSS, CBHI) Collect a sufficient level of premiums to cover costs and ensure providers' commitment.
- (CBHI) Take appropriate measures to limit adverse selection and moral hazard (e.g., over-utilization).
- (HEF) Ensure sustained long-term funding (15 years).
- (HEF) Tackle cost-effectiveness issues to develop the most satisfying approach.
- (HEF) Develop adequate provider payment mechanisms (cost containment, capitation/reimbursed fee) to limit administrative costs and explosion of health-care costs on fee-for-service reimbursement.

Equity

- (HEF) Accurately pre-identify the poorest households, reassess their poverty status on a regular basis and develop a harmonized methodology to avoid inequity across districts and across sectors.
- (HEF) Develop and maintain a pro-poor focus and avoid perverse cross-subsidization.
- (HEF) Ensure control for non-stigmatization and non-discrimination.
- (CSS/SSO) Ensure that dependents are covered by all health-care financing mechanisms.

3.4. Strategic Options and Recommendations

3.4.1. Health-care financing in general

The main recommendations are summarized as follows:

Increase public funding, mainly from domestic sources

- Increase domestic public resource allocation for health, mainly for decent salary and working conditions for health workers in the public sector.
- Consider specific taxation for health funding (e.g., cigarettes, alcohol).

Improve efficiency, mainly from donors' support

- Develop general budget support and/or sectoral budget support for health, to co-finance and ensure basic recurrent costs in a continuous manner (bridging period up to 2015).
- Subsidize the services for the poor, for priority drug and medical items, maternity costs and priority cash transfers.
- Develop provincial performance-based subsidy schemes for salary supplements and funding of operational costs for curative facilities.
- Work in line with donors' alignment.
- Rationalize/prioritize key issues and especially look urgently at recurrent costs.
- Strengthen the enforcement of regulatory frameworks and financial management.

Improve affordability and equity

- Focus on effective health-care delivery service in remote poor areas with ethnic minorities.
- Promote and extend health insurance and prepayment schemes.
- Develop direct subsidization through the establishment of public assistance funds.

- Ensure that Nam Theun 2 revenues finance health-care services for the poor.
- Pilot-test modified out-of-pocket mechanisms with less harmful consequences on affordability, catastrophic expenditure and rational prescription.

In more detailed form, the recommendations specify the following:

Increase resource allocation for health

- Increase the public resource allocation for health from domestic sources, mainly for decent salary and working conditions for health workers in the public sector:
 - Increase the share of public health expenditure.
 - Consider specific taxation for health funding when the tax base permits (e.g., cigarettes, alcohol).
 - Ensure that Nam Theun 2 revenues and funding within the framework of the National Growth and Poverty Eradication Strategy and National Socio-Economic Development Plan are used to finance health-care for the poor, and not simply investments. That requires a different channel than the public investment programmes of the Committee of Planning and Investment.
 - Invest in strengthening regulatory frameworks to channel donors and national resources.

Improve technical efficiency

- Link investment decisions to recurrent costs, in order to limit new construction and health-care technologies and contain recurrent costs.
- Improve the efficiency of donor support:
 - Keep a balance between capital and recurrent costs funding through integrated management.
 - Use the Government system, though general budget support and/or sectoral budget support to health, to co-finance and ensure the coverage of basic recurrent costs in a continuous, transparent manner during the bridging decade period.
 - Subsidize during the bridging period, the services for the poor, priority drug and medical items, maternity costs and priority cash transfers.
 - Develop provincial performance-based subsidy schemes for salary supplements and operational costs funding for curative facilities.
 - Fund well-targeted curative medical and nurse technical assistance in provincial and interdistrict facilities.
 - Work aligned with donors' by reinforcing health sector strengthening approaches, limiting project management units, developing joint donors' approaches and minimizing funding instruments to limit transaction costs.
- Rationalize and prioritize key issues. Look urgently at recurrent costs, in particular in human resources:
 - Introduce pricing policies for drugs and medical supplies.
 - Introduce monetary and non-monetary incentive packages based on performance.
 - Introduce measures to assure funding of utility payment by public providers.
 - Increase monitoring of performance.
 - Limit the perverse, indirect incentives for meetings and training, limiting availability of staff for service delivery.
- Align budget planning and monitoring with the key functions of the public health sector (stewardship, public health, delivery of preventive and clinical health services).

Improve efficiency in resource allocation

- Encourage the growth of the regulated private sector to shift much of the burden for services being provided by the public sector to those with the

highest ability to pay, especially for costly curative care, and thereby increase the capacity of the public health system to better serve those most in need.

- Ensure adequate non-wage basic recurrent costs subsidies at the front-line curative facility level.
- Develop more transparent, need-based formulas for budget allocation at both central and provincial levels.⁴⁸

Improve payment mechanisms and affordability

- Promote and extend health insurance and prepayment schemes and develop long-term information, marketing and promotional strategies adapted to beneficiaries.
- Develop direct subsidization through the establishment of public assistance funds with Government and donor contributions via well-targeted safety nets for the poor and especially HEF schemes.
- Pilot-test modified out-of-pocket mechanisms with less harmful consequences on affordability, catastrophic expenditure and rational prescription, such as:
 - Fixed flat fees for admissions at district hospitals (with surgery, without surgery) eventually coupled with subsidization of priority drugs or consumable items.
 - Ceiling amount for admissions at rural district hospitals not covered by insurance to limit catastrophic expenditure, possibly subsidized by HEF.
 - Subsidized maternity flat fee packages (antenatal care, delivery, transport, caesarean, maternity gift as a basic kit to promote baby care and attract deliveries in health facilities).
 - Agreed fixed fees for transportation to hospitals with private transporters in collaboration with district authorities.
 - Enforcement of maximum selling price of drugs and renewable items controlled by Provincial Health Offices.
- Improve and enforce regulation of user fees and revolving drug funds:
 - No incentive for irrational prescription of drugs and diagnostics.
 - Improve accountability of health facilities.
 - Control of procurement practices on drugs and diagnostics.
 - Include the private sector in control.
- Choose which level of curative care benefit package (technology level) is affordable for public health financing under insurance schemes, as tertiary care is on the increase.

Improve management

- Strengthen regulatory frameworks and especially more effective regulation of the private sector via positive incentives instead of unimplemented regulation control.
- Improve evidence for health-care financing policymaking.
- Partly re-centralize budgeting for the health sector for recurrent costs by:
 - Establishing minimum per capita allocations for salaries and non-wage recurrent costs together with formula-based allocations.
 - Introducing earmarked grants to fund targeted recurrent expenditure (e.g., allowances for staff in remote areas, yearly recurrent budgets for front-line facilities).
- Improve the health finance management system and budget recording system to ensure transparent execution and permit reliable analyses of health expenditure in line with public expenditure management:
 - At the MOH (Lao) level: develop national health accounts, improve the charting of accounts to better track donors' subsidies and the distribution

48 World Bank, *Lao PDR Public Expenditure Review*, supra.

- between capital and recurrent costs.
- At the facility level: computerize accounting and drug management at provincial and central hospital levels.
- Harmonize and align Government and donor programmes with high-priority areas in the health sector.

Improve equity in access

- To ensure access to essential health services by the poor and their protection from catastrophic health expenditure, target them through demand-side financing by ensuring sufficient resources, developing appropriate targeting mechanisms and selecting cost-effective, performance-based methods to pay health-care providers.
- Implement financing mechanisms based on gender issues (e.g., maternity package, specific package for female labour force in companies).
- Ensure that Nam Theun 2 revenues finance health care for the poor.

3.4.2. Current social health protection schemes

3.4.2.1. Recommendations for current schemes

- Act in parallel upon technical and perceived improvement in quality of services and upon awareness through appropriate promotion/marketing.
- Develop and propose an attractive benefit package of services as a mix between public health concerns, financial concerns and beneficiaries' request in a demand-side approach.
- Maintain capitation payment for health insurance schemes.
- Ensure that capitation at least matches with providers' costs for recovery in order to warrant responsiveness and commitment of providers by increasing and/or subsidizing contributions.
- Consider the introduction of a moderate co-payment per visit to reduce moral hazard as well as financial risk for hospitals.
- Professionalize the management of social protection schemes and ensure proper accountability.

In addition, the following questions need to be examined for all schemes:

- What provider's costs should the scheme expect to cover? (Full costs, all recurrent costs, non-wage recurrent costs, value of user fees, basic subsidized package, or only a basic package with increased public subsidies in drug and administration costs of facilities).
- Should the protection schemes also reimburse services provided by private providers?

3.4.2.2. Specific recommendations for current schemes

CSS

- ⇒ Increase capitation to the same level as SSO by salary increase and/or higher proportion of health benefits in the contributions; as planned under the decree 70/PM, LAK 40,000 was only used for the pilot, because of the current contribution rate of 6 per cent of basic salary.
- ⇒ Develop computerization at the scheme level with possible integration with SSO, CSS and HEF.

SSO

- ⇒ Extend the coverage to all enterprises with no minimum employee requirement (amend Decree 207).
- ⇒ Extend the geographic coverage towards provinces.
- ⇒ Use a combination of (a) positive rewarding through marketing/promotion techniques, accreditation/certifications, (b) improved services in quality,

proximity, rapidity and (c) political pressure to increase the enrolment and compliance of employers.

- ⇒ Test compulsory systems, in between CBHI-SSO, in Luang Prabang and Vang Viang for the tourism sector (guesthouses, hotels, tourism shops and restaurants) with a compulsory enforcement by the provincial and district governors.

CBHI

- ⇒ Reinforce more efficient promotion, registration and collection of the premium, considering the use of social marketing mechanisms, mass media, trusted persons in the community such as monks, savings and loan groups, microcredit associations and utility agencies, such as electricity and water.⁴⁹
- ⇒ Strengthen primary health care and the referral system. In urban areas, the first level of care should be provided in community clinic facilities, with adapted opening hours and specific appointments with provincial hospital specialists in the relevant areas on a scheduled basis.
- ⇒ Develop computerization at the scheme level with possible integration with SSO, CSS and HEF.
- ⇒ Create competition to reach targets and reward systems (on memberships, timely payments, management committee meetings and correct use of capitation by hospitals).
- ⇒ Review the feasibility of covering motor vehicle accident injuries and funeral grants.
- ⇒ Consider amendments of the guidelines and regulations, based on experiences and opportunities for new and improved management mechanisms, to include, for example, small reserve funds, penalties on late payment, inappropriate prescribing and demand for additional payment by provider.
- ⇒ Question the efficiency of the district-based management and the hospital model (one hospital in each district) for effective scaling-up.
- ⇒ Develop alternatives to monthly premium payments, so that monthly capitation money is more regular and predictable.
- ⇒ Link up with agencies that implement microcredit schemes or have other microfinancing initiatives and/or target villages where such activities are conducted.
- ⇒ Increase the amount of capitation by CBHI schemes through economies of scale attained by having administration and accounting at health facilities done by fewer persons for all schemes in areas where they are concurrently operational.
- ⇒ Provider payment;
 - Maintain the capitation system,
 - Test the possibilities of differential capitation payment, or
 - Improve the quality of care by providers by use of performance related pay. For example, pay 50 per cent of capitation unconditionally and have 50 per cent conditionally. That would ideally be done at hospitals where other schemes are operational, so that respective capitations can be merged.
- ⇒ Possibly field-test:
 - Village-based subsidized CBHI coupled with HEF with strong community links.
 - Subsidized CBHI on a digressive basis to ensure sufficient incentives for

49 A. Ron, "CBHI Lao PDR: Review of CBHI pilot scheme Project MOH (LAO)" (WHO, April 2007).

providers.

- The requirement of villages to have a certain proportion of households to enrol before joining the scheme.
- Mandatory CBHI/SSO schemes.
- Systems for in-kind payment for premiums in rural areas where cash flow is limited.

HEF

- ⇒ Draw on lessons from experiences in tested HEF in-country and in the region.
- ⇒ Ensure that governmental lists of the poor and HEF pre-identification are similar or at least comparable. In case of a reliable, comprehensive Government database that is verified by samples using ethnicity as one of the key indicators, rely on Government lists. Otherwise, ensure that HEF pre-identification is agreed and owned by the provincial and district administrations.
- ⇒ Promote synergies and joint package of services for the poor for health and education sectors.
- ⇒ Give the responsibility for managing the funds to a third-party body for a nationwide programme.
- ⇒ Set up HEF schemes to serve an entire province or region rather than individual districts in order to benefit from economies of scale in administration, training, equipment and marketing.
- ⇒ Reimburse providers on a fixed-fee basis or test on a capitation basis for lower levels to simplify the administrative cost of reimbursement and provide the right incentives for good quality care.
- ⇒ Provide services at the village level (drug kits, transport, health promotion services), on capitation basis as proposed by the Health Sector Development Project.
- ⇒ Purchase CBHI premiums at a discount rate proportional to the utilization rate and review each year or use part of the premium to facilitate accessibility by shouldering the influential — but as yet undetermined — opportunity costs.
- ⇒ Use joint administration with existing risk-pooling schemes.

3.4.3. Towards universal coverage

3.4.3.1. Options for the future

The study by ILO Laos, *Consultative Study — Social Protection for All: The Way Ahead*, LAO/01/M91/LUX — Development of Social Security Phase II 2002-2007 (2007) identifies the main policy choices in the extension of social protection to all.

- The extension of the social insurance schemes in the formal sector is a clear policy which does not appear questionable. It will require an extension towards all workers in all government and private organizations in all provinces.

The key policy options to reach universal social protection coverage relate to the non-formal sector. Two main options arise;

- The expansion of the existing framework by extending the CBHI model for the non-poor and the use of HEF for the poor, and
- A universal scheme mainly through taxation.

In the long run, there should be an evaluation or analysis of discussion of whether the expansion of the existing social protection schemes would be the best or most efficient way to reach universal coverage. The extension of the current framework could bear disadvantages. For example, extension of the current framework could result in an extremely complex system, even if they were merged into one.

A universal tax-based system has a number of advantages, not the least of which

is administrative efficiency. However, its fiscal and political feasibility could be a challenge. The use of designated or dedicated taxes to provide funding for health care, the so-called 'sin taxes', could generate a part of the required funds. Taxes on tobacco, alcohol and gambling, as well as lotteries, have been used successfully by several countries.

In terms of social assistance programmes, the Lao People's Democratic Republic also faces the choices between universal programmes aimed at all the members of a particular group (for example, all older persons, all children, all pregnant women and newborn babies) or targeted programmes (for example, the poor). Proxy measures for poverty may be geographical, or based on ethnicity, type of housing, household size, or livelihood.

3.4.3.2. Recommendations towards universal coverage

The recognition that social protection is primarily a cross-sectoral issue is a key prerequisite for the development of universal coverage. Such recognition has to be embedded into the national socio-economic development plan.

The recent ILO consultative study on "Social Protection in Lao PDR 2007" estimated that a package of basic social protection would cost about USD 95 million per year. Within such a package, the universal health insurance component would cost USD 30 million and maternity programmes including cash transfers and a maternity package would cost an extra USD 9 million (see table 3.3.).

Table 3.3. Estimate of a basic social protection package

BASIC SOCIAL PROTECTION PACKAGE Program	Estimated beneficiaries	Benefit	Annual cost
Health Care			
Universal Health Insurance	Total population		\$30,432,500 (0.94% GDP)
Social Insurance and Social Assistance			
Age Pension Programs			
Universal age pension to over 65	210,000	185	\$38,850,000 (1.2% GDP)
Child Programs			
Cash payment twice annually to poorest rural	60,000	80	\$4,400,000
School Food Programs			
School food program - poorest regions	100,000	40	\$4,400,000
Maternity Programs			
Cash transfer on birth of any child	125,000	40	\$5,500,000
Cash transfer to ethnic minority women — any child	55,000	20	\$1,210,000
Maternity package	40,000	50	\$2,200,000
People with Disability Programs			
Set of initiatives	5,000	100	\$500,000
Labour Market Programs			
Set of initiatives	100,000	50	\$5,000,000
Disaster Relief Programs			
Cash transfer to disaster victims	10,000	100	\$1,000,000
Sub-total			\$63,940,000
TOTAL			\$94,372,500

Source: ILO Laos, *Consultative Study — Social Protection for All: The Way Ahead*, LAO/01/M91/LUX - Development of Social Security Phase II 2002-2007 (2007).

Social Protection Road Map

- ⇒ The Social Protection Road Map should:⁵⁰
 - Be coherent with the objectives of the National Growth and Poverty Eradication Strategy and the National Socio-Economic Development Plan, in line with the MOH (Lao) and Ministry of Labour and Social Welfare, master plans, and integrated into the existing Sectoral Working Groups for Health.
 - Be fiscally responsible.
 - Capitalize on activities of development partners and create synergies where possible.
- ⇒ The long-term strategy to reach universal coverage would require at least the following:⁵¹
 - Extension of SSO to all provinces, all enterprises (now only enterprises with over ten workers).
 - Merging of the civil servants scheme with SSO to lead to a compulsory scheme for all salaried workers.
 - Linking microfinance institutions and CBHI to cover the self-employed and people in informal sectors especially for health, maternity and death.
 - Enrolment of the self-employed formal and informal labour sectors in the SSO.
 - Merging at the provincial level as coverage within districts of each scheme reaches a high percentage (at least 60 per cent); to allow for broader pooling, savings in local administration and some redistribution of funds between the salaried and informal economies.
 - Establishing an autonomous national health insurance scheme for rural populations.
 - Government funding for the essential benefit package for all and State subsidies for the poor.
 - Developing additional revenue opportunities via earmarked 'sin taxes' or lotteries.
 - Ensuring appropriate legislation for the above stages and to reach universal coverage.
- ⇒ Develop strong leadership by the Government, especially at MOH (Lao) and the Ministry of Labour and Social Welfare, with a continued dialogue and collaboration between the main stakeholders. Continued efforts to enable as much similarity as possible between SSO, CSS and CBHI schemes are essential.
- ⇒ Develop an action plan with clear objectives towards universal coverage, with a timetable for leading to the appropriate legislation and merging of systems.
- ⇒ Consider the establishment of a mechanism to steer the development of the social protection road map, possibly a multi-actor steering committee and a working group that can progress and monitor activities.

Inter-schemes and inter-sectoral mechanisms to accelerate extension of coverage

- ⇒ Develop joint activities among the four protection schemes to solve similar problems.
- ⇒ Progressively use joint administration and reporting systems between protection schemes.
- ⇒ Progressively join capitations upstream and pay providers by a single payment mechanism.

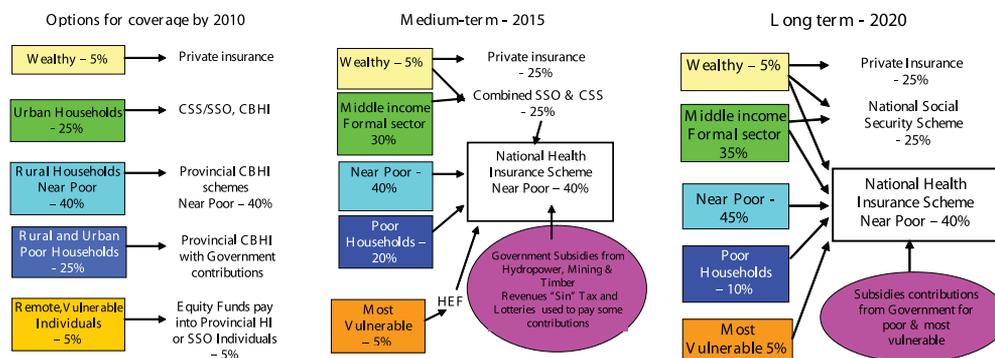
50 ILO Laos, *Social Protection Study 2007*, supra.

51 Ibid.

Possible Phasing

The graphs below show a possible phasing towards universal social protection developed by the Ministry of Labour and Social Welfare and ILO for a workshop on the Social Protection Road Map in 2007.

Figure 3.4. Possible phasing towards universal social protection



Source: ILO Laos "Development of Social Health Insurance in Laos PDR", a PowerPoint presentation Fiona Howell and Prasong Vongkhamchan, Ministry of Labour and Social Welfare and the ILO (2007).

3.5. References

General Documents on Lao People's Democratic Republic (Lao PDR)

- ASEAN Secretariat (2006). *ASEAN Statistical Pocket Book 2006*, accessed from <<http://www.aseansec.org/19188.htm>>.
- Government of Lao PDR (2004). *National Growth and Poverty Eradication Strategy*.
- Government of Lao PDR (2006). *Medical law*.
- Government of Lao PDR (2006). *Sixth National Socio-Economic Development Plan 2006-2010*.
- Government of Lao PDR (2006). *Vientiane Declaration on Aid Effectiveness*, 29 November.
- Gender Resource Information and Development Center, World Bank (2005). *Lao PDR gender profile*, November.
- MPI (2008). *Statistical Yearbook 2007, Lao PDR*, Department of Statistics, June.
- United Nations (2006). *United Nations Common Country Assessment*, June.
- World Bank (2007). *Lao PDR Economic Monitor*, November.
- World Bank, IMF and ADB (2007). *Lao PDR Public Expenditure Review, Integrated Fiduciary Assessment*, May.

General Documents related to health financing in Lao PDR

- AGEG (2007). *Health Sector Development Program*, Final Report ADB TA 4608-LAO.
- Annear, P. (2007). "Health Equity Funds in the Lao PDR Vol. 1: Guidelines for implementation and management", a draft for HSIP/Ministry of Health, March.
- Bousquet, C. (2005). "Le Secteur de la Santé en RDP Lao: Etat des lieux et perspectives" (CERDI).
- Derche, C. et al. (2005). "Measuring public hospitals costs and activities in Lao PDR".
- Ergo, A. (2000). *Implementation of Health Insurance in Lao PDR: Master Plan* (WHO September).
- Government of Lao PDR (2005). *Prime Minister Decree 381 on Technical Revenues*, 23 December.
- Government of Lao PDR (2006). *Ministry of Finance Decree 1646 on implementation of Decree 381/PM*, 26 July.
- Hohmann, J., S. Vorasarn and K. Manivong (2005). "The promising role of the formal sector towards health for all".
- IHPP and NIPH (2007). *Socio-economic profile and satisfaction of insured and uninsured group in Lao P.D.R., supported by WHO and ILO*, 31 October.
- Hennicot, J.C. (2007). Lao PDR Report to the Government on the Actuarial Valuation of the Social Security Fund (ILO, Bangkok).
- Holm, Karolin (2004). *Social Protection for the Informal Economy in Lao PDR* (ILOSSP).
- ILO Laos (2007). "Development of Social Health Insurance in Laos PDR", a Power Point presentation Fiona Howell and Prasong Vongkhamchan, Ministry of Labour and Social Welfare and ILO.
- ILO Laos (2007) *Consultative Study — Social Protection for All: The Way Ahead*, LAO/01/M91/LUX — Development of Social Security Phase II 2002-2007.
- ILOSSP (2005). "Achieving Universal Healthcare Coverage in Lao PDR", Mission Report, Viroj Tangcharoensathien and Walaorn Patcharanarumol, 23 February.
- ILOSSP (2005). *Developing the Roadmap for Health Insurance in Lao PDR: Report on Health Insurance* (Soutsaka Institute of Management and Technology, October).
- Jacobs, B. (2007). "Community-based health insurance at Lao PDR: Suggestion for the way forward", Discussion Paper, WHO Laos, December.
- JICA (2002). *Lao Health Master Plan Study, Final Report*, Vol.1-4, November.
- Jurgensen, N. (2005). *Social Health Insurance in Lao PDR* (WHO, May).
- Knowles, James C. (2006). "Public Expenditure in the Lao PDR Health Sector: Background Paper for 2006 PER", Report prepared for the Governance, Finance and Trade Division Mekong Department, ADB, RSC-C51839 (LAO): Public Expenditure Review.
- Lankers, C. (2005). *Health Care Financing, Provider Payment Mechanism and Costing Studies*, Report for BTC Project Lao Social Health Insurance, February.

- Ministry of Finance (2004). *State Budget Implementation of 2002-2003 and State Budget Plan for 2003-2004* (La Gazette).
- Ministry of Health (1996). *General Policy on Cost-Recovery of Medical Services and Revolving Drug Funds*.
- Ministry of Health (1997). *National Guideline on Revolving Drug Funds*.
- Ministry of Health (2005). *Regulations CBHI, 2nd Edition, Min Decree 723*, April.
- Ministry of Health (2005). *NGPES Program Costing Report*, 16 May.
- Ministry of Health (2005). *Consultation on Health Financing: recommendations*, Powerpoint presentation, Vientiane, 28-29 October.
- Ministry of Health (2005). "Ministry of Health view point on Beneficiaries Payment in Lao PDR", Powerpoint presentation by Dr. Khamphet Manivong, 28 October.
- Ministry of Health (2007). "Health Care Financing: Formulation process on user fees and exemption policy", Powerpoint Presentation by Dr. Bounfeng Phoummalaysith, February.
- Ministry of Health (2007). *Health Development Plan 2006-2007*.
- Ministry of Health (2007) *Human Resources for Health: Analysis of the Situation in the Lao PDR* June.
- Ministry of Health (2007). *Resources for Health: Analysis of the situation in the Lao PDR*, June.
- Ministry of Health and WHO (2007). "Strengthening and Capacity Development in Health Care Financing in Lao PDR", a concept programme proposal presented for funding to the Ministry of Foreign Affairs of Luxemburg.
- Ministry of Social Welfare and ILO (2007). *Civil Service Scheme Health Insurance Situational Analysis*, June.
- Murakami, H. et al. (2001). "Revolving Drug Funds at the front-line health facilities in Vientiane, Lao PDR", *Health Policy and Planning*, vol. 16, No. 1, pp. 98-106.
- NIOPH and WHO (2003). *Lao Health Survey*.
- Paphassarang, C. et al. (2002). "Equity, privatization and cost recovery in urban health care: the case of Lao PDR, Health Policy and Planning", vol. 17, suppl. 1, pp. 72-84.
- Ron, A. (2004). "CBHI Lao PDR: Review of CBHI pilot scheme Project Ministry of Health — WHO", August.
- Ron, A. (2006). "CBHI Lao PDR: Review of CBHI pilot scheme", Ministry of Health- WHO, May.
- Ron, A. (2006). *Study on linkages between statutory social security schemes and community based social protection mechanisms to extend coverage: Case study on Lao PDR*, ILO/ISSA/AIM, September.
- Ron, A. (2007). *CBHI Lao PDR: Review of CBHI pilot scheme* (WHO, April).
- Schwartz, B. (1999). "Lao PDR Public and Private Health Expenditures PPTA Primary Health Care Project", ADB Loan TA-N0 3058-LAO, 23 May.

- Schwartz, B. (1999). "Beneficiary Financing of Health Services in Lao PDR PPTA Primary Health Care Project", ADB Loan TA-N0 3058-LAO, 23 May.
- Schwartz, B. (2005). "Hospital Financing Study: Strategies to Finance Expenditures Incurred by People Using Hospitals", Primary Health Care Expansion Project, ADB Loan 1749-LAO (SF).
- Schwartz, B. (2006). "Health care financing background in Lao PDR", PPTA HSDP project.
- Schwartz, B. and V. Viravong (2006). "Health care financing in Lao PDR: Sub-sector analysis", Health Sector Development Program, LAO TA 4608, 1 May.
- Social Security Organization (2007). *Ministry of Labour and Social Welfare-Social Security Organization: Annual report 2005 and 2006*.
- Tangcharoensathien, Viroj (2005). *Lao PDR Community Based Health Insurance Final Report* (ILOSSP, August).
- Thomé, Jean-Marc (2006). "Health Financing Support in Vientiane Province", Lao/015 Project, 3rd Interim report.
- Patcharanarumol, W. (2006). "Health Care Financing for the Poor in Lao PDR", Powerpoint presentation for PhD thesis in London School of Public Health.
- WHO (2004). *World Health Survey Lao PDR*.
- WHO (2004). *Hospitals' Costing Survey in Lao PDR*, September.
- WHO (2004). *Macro-Economics and Health: Achievements through September 2004*, Lao PDR.
- WHO (2005). *Country Health Information Profiles 2005: Lao PDR*, pp. 129-141.
- WHO Laos (2005). "Health Financing Indicators in Lao PDR", Powerpoint presentation by Dr. Dean Shuey, 28 October.
- Yamabana, H. (2005). "New approaches to extending social security coverage", ISSA.

Technical reports on Health Financing in Lao PDR

- Knowles, James C. (2002). "Design for a Hospital Cost Recovery Study in Oudomxay Province", TA No. 3478 LAO-Capacity Building for Primary Health Care, Vientiane, Lao PDR, June.
- Luang Prabang and Sayabouri Provincial Hospitals (2004-2005). *Annual Report*.
- Lux-Development S.A. (2003). "Health in Vientiane Province, Phase III", Lao/015 Project.
- Schwartz, B. (2005). "Hospital Financing Study: Strategies to Finance Expenditures Incurred by People Using Hospitals." Primary Health Care Expansion Project, ADB Loan 1749-LAO(SF), Ministry of Health, Vientiane.
- Swiss Red Cross (2002). *Nambak Health District: Year 2001-02 and 1-year evaluation*, October.
- Swiss Red Cross (2003). *Nambak Health District: Year 2002-03 and 2-year evaluation*, October.
- Swiss Red Cross (2004). *Nambak Health District: Year 2003-04 and 3-year evaluation*, October.

Swiss Red Cross (2005). *Nambak Health District: Year 2004-05 and 4-year evaluation*, October.

Thome, Jean-Marc (2005). *Health Financing Support in Vientiane Province*, 1st Interim report, Lao/015 project, February.

Thomé, Jean-Marc (2005). *Health Financing Support in Vientiane Province*, 2nd Interim report, Lao/015 project, August.

Thomé, Jean-Marc (2006). *Health Financing Support in Vientiane Province*, 4th Interim report, Lao/015 project, November.

WHO (2006). *Health in Vientiane Province, Mid-Term Review*, Project Lao/015 December.

Some Major Documents on Health Financing in General

Carrin, G. and C. James (2005). "Social health insurance: Key factors affecting the transition towards universal coverage", *International Social Security Review*, vol. 58, no. 1.

Gottret, P. and G. Schieber (2006). *Health Financing Revisited: a Practitioner's Guide* (Washington, D.C., World Bank).

ILO (2007). *Social Health Protection: An ILO strategy towards universal access to health care, draft for consultation*, March.

WHO (2000). *World Health Report 2000 – Health Systems: Improving Performance* (Geneva, WHO).

WHO (2005). *Achieving Universal Health Coverage: Developing the Health Financing System*, Technical Briefs for Policy-Makers, WHO/EIP/HSF/OB/05.01, Number 1.

WHO (2006). *Strategy on health care financing for countries of the Western Pacific and South-East Asia Regions (2006-2010)* (Geneva, WHO).

WHO WPRO (2006). *Health Financing: A Basic Guide* (Manila, WHO WPRO).