Social Protection in Action: Building social protection floors for all

Country Brief: Lao People's Democratic Republic

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Extending Social Health Protection in Lao People's Democratic Republic: Accelerating progress towards Universal Health Coverage

1. Introduction

In less than a decade, the Lao People's Democratic Republic has made remarkable progress towards Universal Health Coverage (UHC) by expanding social health protection to a large proportion of its population. To date, more than 90 per cent population coverage has been achieved. The rapid expansion of social health protection in the country is the result of a strong political commitment to achieving UHC and its financing modalities. The Lao Health Sector Reform Strategy for the period 2013–2025 was introduced in 2013 to set out a roadmap to achieve UHC by 2025, with a consequent increase in domestic spending on health (WHO 2017). In its Eighth Health Sector Development Plan (Lao People's Democratic Republic Ministry of Health 2016), the Government of Lao People's Democratic Republic outlined its aim to achieve UHC by 2025 and set the target of achieving 80 per cent population coverage by 2020. The Plan also sought to address cultural, financial and geographical access barriers encountered by vulnerable groups in accessing health care to promote a more equitable health system (WHO 2017). Subsequently, in 2017, the Ministry of Health (MOH) and the National Health Insurance Bureau (NHIB) introduced the National Health Insurance (NHI) Strategy 2017–2020 (Lao People's Democratic Republic Ministry of Health 2017) to provide a clear vision and logical framework for the development of a unified National Health Insurance scheme. Finally, the Law on Health Insurance was promulgated in 2018, which became the first law on social health protection in the country, creating a legal framework for NHI. On this basis, the health protection system, which previously comprised various schemes, is currently being streamlined into a single NHI scheme.

2. Context

The very first pre-paid pooled fund in the Lao People's Democratic Republic was introduced in 1995 to cover government employees and their dependents through the State Authority for Social Security (SASS) scheme. In 2001, social health protection coverage was extended to private employees and their dependents via the establishment of the Social Security Organization

(SSO) scheme. Both schemes were managed through the National Social Security Fund (NSSF) under the Ministry of Labour and Social Welfare (MLSW). In 2002, social health protection was further extended to informal economy workers through the voluntary and contributory Community-Based Health Insurance (CBHI) scheme. In 2004, the fully subsidized Health Equity Fund (HEF) was established under the management of the MOH to provide coverage to the poor and vulnerable. However, population coverage of the CBHI remained limited, with low enrolment rates, mostly due to the voluntary nature of the scheme and a lack of subsidies. Targeting errors of the HEF also posed challenges to the extension of social health protection to the poor and vulnerable. Consequently, only 10.8 per cent of the population was covered by a social health protection scheme in 2008 (Phetpasak, unpublished).

In 2010, a policy of Free Maternal Neonatal and Child Health (FMNCH) services was implemented, which contributed greatly to improving health services utilisation. However, informal payments and out-of-pocket (OOP) payments remained very high, which limited financial protection for intended beneficiaries of the policy (ILO 2019). In recognition of the difficulties inherent in extending coverage to informal economy workers through voluntary health insurance, in 2012, the aforementioned NHI fund was created under Decree 470/PM. The Decree not only provided the foundation for integrating all MOH and MLSW schemes into a single NHI scheme, but also introduced the provision of a 50 per cent subsidy for contributions from workers in informal employment.

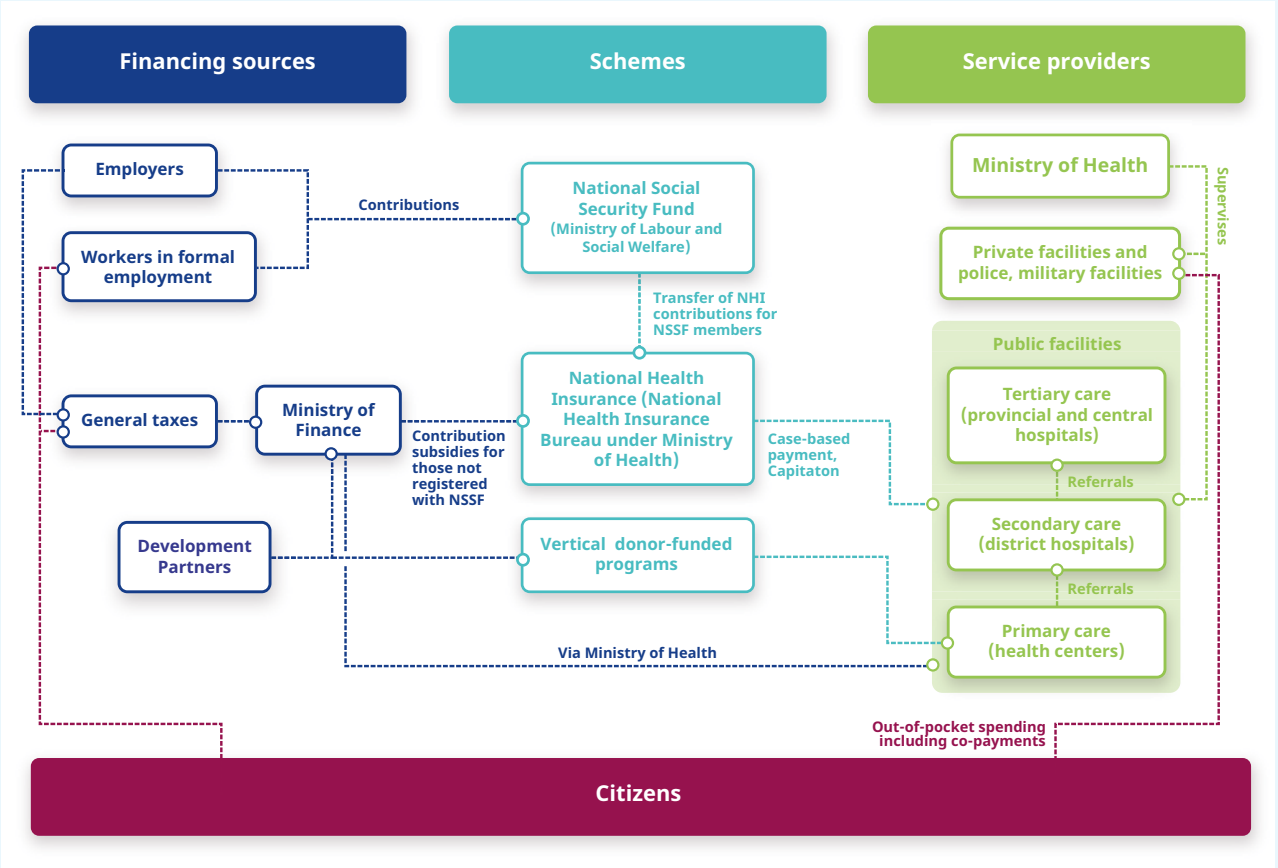
The implementation of the integrated NHI scheme, merged with the pre-existing schemes under the MOH (CBHI, HEF and FMNCH) was set in motion in 2016 and rapidly rolled out to all provinces in 2017. At the time of writing, the only region not included in the NHI scheme is the Capital of Vientiane, where protection for workers in informal employment is provided through CBHI and FMNCH (ILO 2019). To further extend coverage, in 2017, along with the merger of the MOH schemes, the Government decided to adopt a tax-based financing model, which replaced contributions from informal economy workers with full public subsidies directly transferred to the NHI Fund. These public subsidies led to rapid coverage expansion nationwide, bringing the coverage rate up to 80 per cent in 2018 – two years earlier than the target set by the MOH in the NHI strategy (ILO 2019). As part of the second step of the merging, which aimed to integrate NSSF schemes into the NHI Scheme, a pilot merger in Sekong and Vientiane provinces was initiated in October 2018. The nation-wide roll-out of the newly consolidated scheme was implemented in July 2019, covering all provinces except Vientiane Capital. The police scheme is also intended to be integrated into the NHI scheme, while the army scheme will maintain separate arrangements.

3. Design of the social health protection system

- Financing

The NHI is now a predominantly tax-financed health insurance scheme, with contributions from formally employed workers constituting a small share of the total revenues of the scheme. Health benefit contributions to the NSSF amount to 4 per cent of insurable salary, equally split between employers and employees. The NSSF transfers 1.25 per cent of the total social security contributions collected to the NHIB. In addition to taxes and member contributions, the scheme is intended to be financed by other sources of funding, such as grants, the tobacco control fund and other related funds (Law on Health Insurance of 2018, article 40). With the exception of Vientiane Capital, all sources of funding are now pooled into the NHI fund, which is used for to pay providers. Figure 1 below illustrates the financing flows of the NHI in Lao People's Democratic Republic.

▶ **Figure 1. Overview of main financial flows of the social health protection system in Lao People's Democratic Republic**



Source: Authors.

In 2017, government health expenditure accounted for 35.1 per cent of total current health expenditure in Lao People's Democratic Republic, while international sources (including aid and grants) accounted for 16.7 per cent. In the same year, OOP payments remained a dominant source of health financing, representing 46.2 per cent of total current health expenditure (WHO n.d.).

- Governance

The implementation of the NHI scheme is based on Decree 470/PM, [1] which was issued to provide the legal basis for the creation of a single NHI fund. The Law on Health Insurance was enacted in 2019, and further defines the principles, rules and measures regarding the management of national health insurance activity. The objective of the Law is to guarantee the scheme's effective and efficient implementation, *"aiming to ensure that Lao citizens are covered by health insurance and shall access universally to equitable health care services"*. [2] In addition, the Law on Social Security was amended in 2018 to define social security principles and rules, protecting the rights and interests of social security fund members and their families. Since then, the Lao People's Democratic Republic has introduced additional strategic documents to guide and support the achievement of UHC.

[1] Decree 470/PM on National Health Insurance Fund of 2012, available at: file:///C:/Users/admin/AppData/Local/Temp/433970.pdf
[2] Law on Health Insurance of 2018, article 1.

The NHI fund is implemented under the leadership of the MOH. It is managed by the National Health Insurance Management Committee (NHI Management Committee) and its Secretariat, the National Health Insurance Bureau (NHIB). The NHI Management Committee is comprised of Management Committees at central, provincial and district levels wherein the NHIB at each respective level serves as its secretariat. The NHIB at the central level is a department of the MOH, in charge of all NHI management functions. According to the National Health Insurance Strategy 2017–2020, the NHIB is tasked with fulfilling nine main operational functions to provide effective coverage: stewardship, revenue collection and pooling, financial management, interface with the public, administration, strategic purchasing, technical support, verification and monitoring and evaluation (Lao People's Democratic Republic Ministry of Health 2017). Provincial and district offices are set up nationwide for the daily implementation of the scheme.

- Legal coverage and eligibility

The NHI scheme is inclusive, in that "all Lao citizens regardless of sex, age, ethnicity, race, religion and social-economic status shall have the right to enrol in a health insurance scheme", as stipulated in the Law on Health Insurance. NHI enrolment for workers in formal employment – both public and private – is compulsory via NSSF membership. However, there are no registration mechanisms in place for the rest of the population, including for the self-employed and informal economy workers, who gain access to NHI services by showing an ID card at public health facilities. Enrolment to the NSSF is family-based, with the same health benefits entitlements extended to the contributing member's spouse and children.

- Benefits

All NHI members are entitled to a relatively comprehensive benefits package covering most health services in the public sector and at each level of care. The package is regulated by the Law on Health Insurance, using a combination of both negative and positive definitions. Through the negative definition, the package excludes aesthetic/cosmetic services, VIP room services (private), services used at private or overseas facilities and health services which are based on personal demands. It also excludes health services already covered by a third party or other vertical programmes (for example, those that provide treatment for leprosy, HIV/AIDS, tuberculosis or malaria). Using a positive definition, the Law on Health Insurance also provides the legal foundation for the consequent introduction of under-law regulations on a list of essential drugs and medical supplies, as well as price caps on services covered by NHI.

While the harmonization of benefits is a priority, there are still some differences in the benefits provided to members who register through the NSSF or directly to the NHI. Table 1 compares the differences between NHI and NSSF benefit exclusions. As noted, the NHI benefit package for the general population is broader, as it covers many NSSF exemptions such as heart surgery, dialysis, thalassemia treatment and chemotherapy.

▶ Table 1. NHI and NSSF Benefit Package exclusions

NHI exclusions	NSSF exclusions
1. Services requested by patients: VIP rooms, additional services, repair surgery, cosmetic surgery, artificial teeth, sterilization, glasses and contact lenses; 2. Services used in private facilities or overseas health care facilities; 3. Health care services covered by vertical programmes; 4. Health care services covered by other personal liabilities (for example, injuries caused by traffic accidents will be covered by the party responsible for the accident or by accident insurance, and injuries caused by dog bites will be covered by the dog owner); 5. Transportation costs to and from health care facilities.	1. Health care services covered by government vertical programmes (for example, TB, HIV, malaria and leprosy); 2. Heart surgery; 3. Dialysis (not more than 5 sessions); 4. Thalassemia; 5. Chemotherapy; 6. Glasses or intraocular lenses (except for work injuries or occupational diseases); 7. Dental prosthesis, except for work injuries; 8. All medicines related to the treatment of HIV/AIDs; 9. Annual health check-ups; 10. Sex reassignment surgery, artificial breeding, sterilization and plastic surgery.

Sources: Adapted from MOH NHI implementation guideline, No. 0263/NHIB; 2016 Social Security Law implementation guideline, No. 2751/MoLSW, dated 24 July 2015.

Co-payments apply at the point of service, except for those identified as poor by village/district authorities, pregnant women, children under five and monks, all of whom are fully exempt from co-payments. Although the Law on Health Insurance stipulates that the unsured must comply with the co-payment policies, this provision has not yet been enforced.

- Provision of benefits and services

NHI members can access treatment at all public health facilities in all provinces where NHI is rolled out. Public health services in the Lao People's Democratic Republic are delivered through a network of health centres, and district, provincial, central and specialized hospitals. In addition, the military and police sectors also provide health care services for their own employees and their families, as well as parts of the local community. Today, an increasing number of private clinics and hospitals are becoming a prevalent part of the health service delivery network (WHO 2018). Within the NHI network, there are currently three levels of health care services:

(i) Primary health care services (health centres);
(ii) Secondary health care services (district/community hospitals);
(iii) High level health care services (provincial and regional hospitals).

There is a referral system in place, but it is not very effective (World Bank 2017) due to the lack of a gate-keeping function at primary health care facilities (Akkhavong et al. 2014). In cases where provincial hospitals cannot treat a patient, they will send them to a central hospital. In such cases, third party payment does not apply, meaning that the patient will have to make a claim after treatment for reimbursement from the NHI Office. At the time of writing, only one private hospital (Xaymangkorn hospital) in Udomxay is contracted with NHIB and part of the NHI network.

The NHI scheme uses a mix of payment mechanisms. Capitation is the payment method for outpatient services, while the case-based method is used for inpatient services (World Bank 2017). The case-based method is used to pay for the free provision of maternity care services and inpatient care for children under five, which is free-of-charge for patients, whereas capitation is used to pay for outpatient care (World Bank 2017). Payment mechanisms at different levels of care are summarized in Table 2 below.

Table 2. NHI provider payment mechanism

Patient co-payment	Health centre	District hospital	Provincial hospital	Regional hospital
Outpatient	Capitation	Capitation	Capitation	Capitation
Admission		Case-based payment	Case-based payment	Case-based payment

Source: Author based on information provided by NHIB.

Presently, there is an emerging purchaser-provider split, whereby the NHI Fund is the purchaser and contracted NHI facilities are service providers. Both are placed under the leadership of the MOH. A third-party payment mechanism applies for all NHI members. As noted above, the only exception is at central hospital level, where referred patients need to pay first and submit a claim to the NHI Office to be reimbursed.

When seeking care, direct co-payments apply to NHI members, with the exception of members who registered through the NSSF and members of poor households identified by their village heads, as well as pregnant women, children under 5 and monks. The co-payment amount varies depending on the level of care, as follows:

- Health centres (outpatient and inpatient): 5,000 Lao Kip (LAK) (approximately US$0.55) per visit or admission
- District hospitals (outpatient): LAK10,000 (US$1.10) per visit
- Central hospitals (outpatient): LAK20,000 (US$2.20) per visit
- Provincial and regional hospitals (outpatient): LAK15,000 (US$1.60) per visit.

"High-cost surgery and treatment" requires much higher co-payments from non-NSSF members, while a specific schedule of provider payments applies for NSSF members seeking high-cost treatment, as summarized in the table below.

Table 3. Co-payments for high-cost cases and risk adjusted capitation for chronic diseases for NSSF members

Co-payments for high-cost surgery or treatment for hospitals or members	Risk adjusted capitation for chronic disease of LAK10,000 per member per year
1. Brain surgery: LAK1,500,000 per surgery; 2. Orthopedic surgery with steel implants: 50 per cent of total cost; 3. CT scan, MRI or mammogram: 50 per cent of total cost; 4. Road accidents (in case of hospitalization): not more than LAK1,000,000 per admission; 5. Transportation cost for serious cases: 50 per cent of total cost/time based on the actual receipts; 6. Chemotherapy not exceeding 6 sessions per year: members pay 50 per cent of total cost but this should not exceed LAK5,000,000 per session; 7. Haemodialysis not exceeding 5 sessions or renal cleaning fee for patients not over LAK4,000,000.	o Cardiovascular; o High blood pressure; o Diabetes; o Hyperthyroidism; o Hepatitis; o Renal failure; o Gout.

Source: Author based on information included in a 2018 MoU between LSSO and NHI.

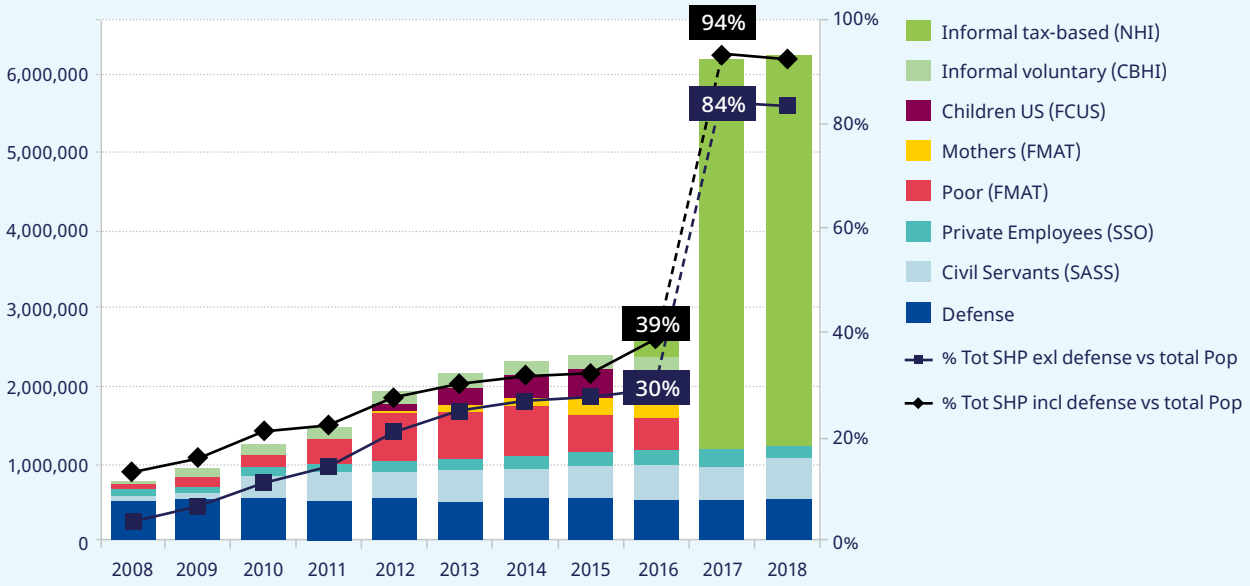
▶ 4. Results

- Coverage

Owing to the introduction of public subsidies to finance the participation of poor households and workers in the informal economy in the NHI scheme, social health protection coverage in the Lao People's Democratic Republic has increased remarkably, reaching 94.3 per cent of the population in 2020 (National Health Insurance Bureau 2020). The coverage rate has been maintained at this level since then.

In 2018, the NHI covered 75 per cent of the population through tax subsidies, while SASS, SSO and the scheme for police and military forces covered 7 per cent, 3 per cent and 8 per cent of the population, respectively. As previously noted, the unified NHI scheme has not been implemented in Vientiane Capital yet. The CBHI (the MOH's voluntary scheme for workers in the informal economy) and Free Maternal and Child Health (FMCH) programmes still exist in Vientiane Capital, covering around 2 per cent of the total population in 2019.

▶ Figure 2. Social health protection coverage in Lao People's Democratic Republic, 2008-2018



Note: FCU5, FMAT, HEF, CBHI except VTC merged into NHI

Source: Adapted from Phetpasak (unpublished).

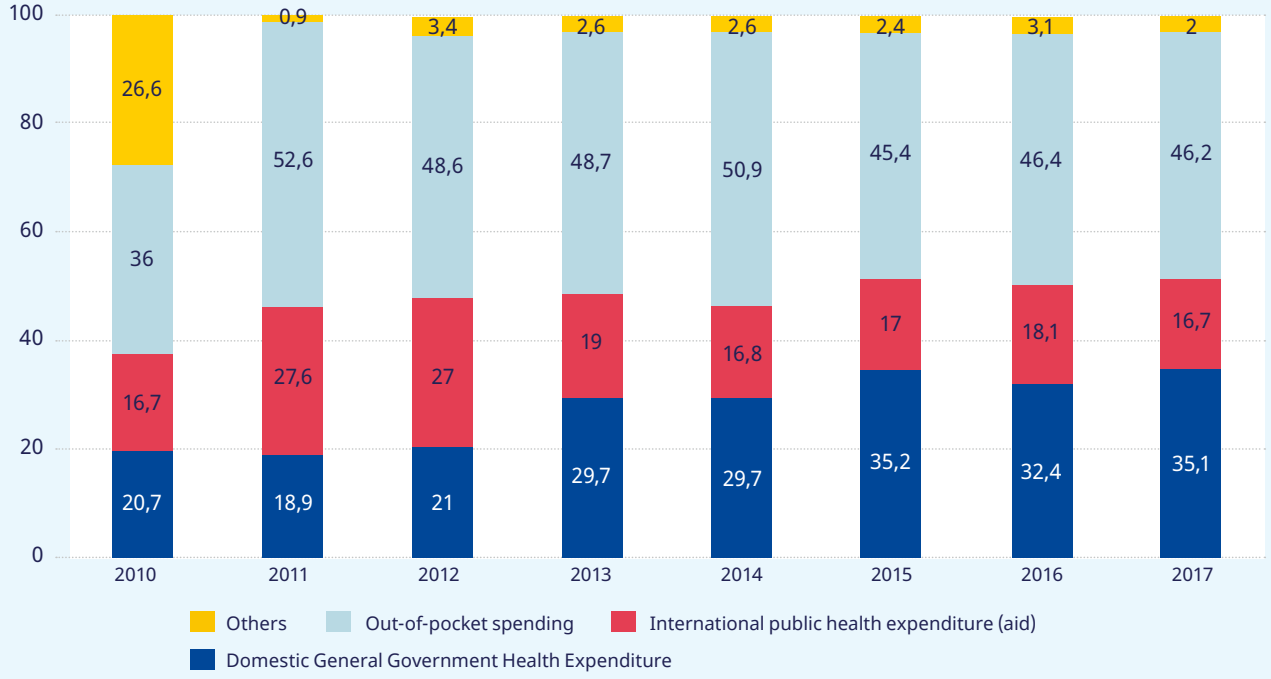
This high level of coverage has been achieved in just one year, from 2016 to 2017, during which time the population coverage expanded exponentially from 31 per cent to 91 per cent. The remarkable coverage expansion in the country has been facilitated by increased budget allocation to subsidize enrolment of informal workers and the poor and vulnerable into social health protection schemes. However, challenges remain in maintaining this coverage rate. Inadequate and erratic budget allocation by the Ministry of Finance has been observed recently, posing a major threat to the financial sustainability of the NHI and transferring financial risk to health facilities. This may have significant implications for the continuation of contribution subsidization and level of protection provided to workers in the informal economy, as well as the poor and the vulnerable.

- Adequacy of benefits/financial protection

Despite the comprehensive benefits package and the low co-payment amount, the financial

protection capacity of the NHI remains limited, as reflected in the high rate of OOP payments in the country. Albeit on a downward trend, OOP expenditure as a proportion of total health expenditure is very high, at 46.2 per cent in 2017 (WHO n.d.). Informal direct payments remain significant at facility level, which limits financial protection for the NHI beneficiaries (ILO 2019).

▶ Figure 3. Health expenditure structure in Lao People's Democratic Republic (as % of total health expenditure), 2010 2017



Source: Adapted from WHO Global Health Expenditure Database.

- Responsiveness to population needs

  o Availability and Accessibility

Even though the NHI benefits package is relatively generous in design, the provision of benefits is hindered by a lack of supply-side readiness (World Bank 2017). This is manifested in a lack of basic amenities and equipment, limited diagnostic capability and the absence of basic medicines at health centres and district hospitals, which include primary and secondary facilities (WHO 2018).

In 2017, the number of doctors and nurses, and midwives per 10,000 inhabitants in Lao People's Democratic Republic was 3.7 and 12.6, respectively. In the same year, health service coverage index (SDG 3.8.1) reached 51 units (WHO n.d.), in which the indicator of service capacity and access was relatively low, at 35 units (WHO 2019b).

Although the country's network of health care facilities covers 93 per cent of the population within a 90-minute walking distance (Akkhavong et al. 2014), there remain financial and physical barriers to accessing health care for NHI members, especially among the poor and the vulnerable, and ethnic minority groups living in rural and remote areas. Significant inequalities in health care utilization and health outcomes persist across socioeconomic quintiles, ethnic groups and geographic locations (ILO 2019; Nagpal et al. 2019). For example, it has been

found that "distance to the nearest health care facility" and "ethnicity" are the most significant predictors of the immunization rate in the country (Mobasser et al. 2016).

- Acceptability and Quality

In general, quality of care remains a challenge with regard to health care delivery at public facilities, especially at primary and secondary levels (health care centres and district hospitals). The shortage of qualified health workers in primary and secondary health facilities, which is caused by a shortage and mal-distribution of health workers, contributes to worsening the quality of care at these two levels (World Bank 2017).

However, in terms of maternal care services, skilled birth attendance increased significantly, from 37.5 per cent in 2011 to 64.4 per cent in 2017 (Lao Statistics Bureau 2018), with an overall increase in utilization of maternal services of over the last 10 years. This has translated into significant improvements in health outcomes. Specifically, the maternal mortality ratio, measured as the number of deaths per 100,000 live births, plunged from 272 in 2011 to 185 in 2017 (WHO n.d.). In addition, the under-five mortality ratio decreased from 58.9 to 47.3 per 1,000 live births between 2013 and 2018 (WHO n.d.). Despite these positive trends, in general, utilization of health care services in the Lao People's Democratic Republic remains relatively low. Specifically, utilization rates among NHI members for outpatient and inpatient care are only 53.9 per cent and 5.6 per cent, respectively (ILO 2019). Health care utilization among NSSF members is much higher than that of NHI members. According to the NSSF, utilization rates among NSSF members in 2017 were estimated at 97 per cent for outpatient care, 20 per cent for emergency care and 7 per cent for inpatient care.

▶ 5. Way forward

Despite the impressive pace of advancement towards UHC in the Lao People's Democratic Republic, challenges remain. The MOH is developing a new NHI strategy for the period 2021–2026, in which enhancing financial sustainability and decreasing OOP payments are among the top priorities to maintain the coverage rate achieved so far and provide better financial protection. Addressing the budget deficit requires a thorough fiscal space analysis and fiscal restructuring, which will require concerted government efforts and a strong political commitment. To enhance population coverage, the NHI Bureau plans to roll out the NHI scheme in Vientiane Capital and is considering various design options (within the constraints of the limited budget available). Capacity strengthening, particularly at provincial and district levels, and the modernization of the administration of the NHI scheme are also among top priorities. Among the administrative reforms needed, the MOH is considering the development of a fully functional Management Information System, operational nationwide and providing real time information, as an essential tool to strengthen the efficiency of administration and responsiveness to members' needs.

▶ 6. Main lessons learned

- Voluntary contributory health insurance is neither an efficient nor a sustainable option for covering informal economy workers in low-and middle-income countries, especially in the context of widespread poverty and limited understanding of insurance.
- Substantial government funding is essential to fully or partially subsidize enrolment into social health protection schemes for workers in informal employment, as well as the poor and the vulnerable, providing almost "automatic" solutions to address population coverage gaps.
- To sustain the current policies and financing arrangements, it is essential to define domestic resources, taking into account the contributory capacities of different population groups., and the variety of means available to create fiscal space. Such methods may include (individually or in combination) effective enforcement of tax and contribution obligations, reprioritizing expenditure, or a broader and sufficiently progressive revenue base.

- A comprehensive benefit package with minimal co-payments is not sufficient to provide sound financial protection. Health care services must be accessible and of sufficient quality, with strict control over unofficial payments at the point of service. Without supply-side readiness, increasing NHI enrolment is not sufficient to guarantee effective and equitable access. Strengthening health care supply, especially at primary level, tackling the shortage and mal-distribution of qualified medical workers, and addressing social, economic and financial barriers to accessing health care are necessary, alongside a comprehensive NHI policy.
- Integrating multiple schemes to increase risk and financial pooling for better redistribution is achievable through strong political will and good inter-ministerial collaboration, with a common vision for universal social health protection.

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