LAOS HEALTH SYSTEM REVIEW

HEALTH SYSTEMS IN TRANSITION

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Contents

1. Introduction of Laos
2. Organization and Governance
3. Financing
4. Physical and Human Resources
5. Provision of Services
6. Principles of Health Reforms
7. Assessment of Health System
8. Conclusion

1. Introduction

- Lao PDR is a land-locked country with 6.8 million population (2013)
- Consistent growth, with GNI increasing from US$200 in 1990 to US$1010 in 2010. Accorded lower-middle-income status (World Bank, 2011)
- Main livelihood : Agriculture (80%)
- 49 ethnic groups → challenge to deliver healthcare and education
- Widening income gap; Health disparities between rural highlands and urban lowlands
- 27.6% of population living below the national poverty line: Goal 2015 <10%

Source: World Bank, 2011,2013

1. Introduction

- Significant improvement in health outcomes over past 30 years, with life expectancy increasing by 18 years, some reduction in the high maternal mortality ratio (MMR), and a reduction in child mortality.
- Areas for improvement include: Low routine vaccine coverage, MMR still high and under nutrition in children.

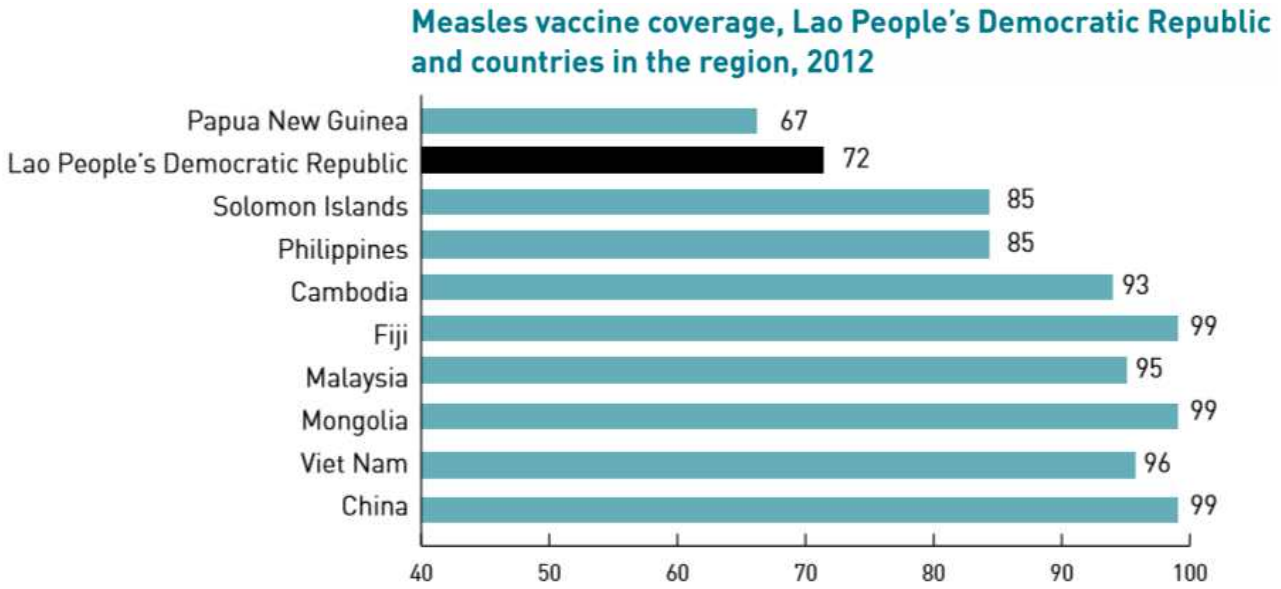
Key health outcome indicators, 1980–2010

Indicator	1980	1990	1995	2000	2005	2010
Life expectancy at birth, total (years)	48.8	54.3	58.2	61.4	64.5	67.1
Life expectancy at birth, female (years)	50.0	55.6	59.5	62.7	65.7	68.5
Life expectancy at birth, male (years)	47.6	53.1	57.0	60.2	63.3	65.7
Mortality rate, adult, female (per 1000 female adults)	NA	NA	NA	226.0	194.0	166.9
Mortality rate, adult, male (per 1000 male adults)	NA	NA	NA	268.2	233.5	207.2

NA: not available.
Source: World Bank, 2013.

1. Introduction

- Both Communicable and non-communicable diseases major causes of morbidity and mortality
- Successful Malaria control
  - decreased incidence: 7.7 to 3.1 per 1000



Source: WHO, 2012a.

1. Introduction

MDG progress: baseline, 2005 and current status against the 2015 targets

MDG 4, 5 indicators	Baseline	Census 2005[a]	Current status 2011[c]	2015 target
4: Reduce child mortality				
4.1. Under-5 mortality rate (per 1000 live births)	170 (1995)	98	79	70
4.2. Infant mortality rate (per 1000 live births)	104 (1995)	70	68	45
4.3. Proportion of 1-year-old children immunized against measles (%)	41.8 (2000)	40.4	55.3	90.0
5: Improve maternal health				
5.1. Maternal mortality ratio (per 100 000 live births)	530 (2000)	405	357	260
5.2. Proportion of births attended by skilled birth personnel	14 (1994)	21.1[b]	42.0	50.0
5.3. Contraceptive prevalence rate			49.8	55.0
5.4 Antenatal care coverage rate - at least 1 visit - at least 4 visits	 - -	 - 28.5[b]	 54.2 36.9	 60.0[b] 40.0

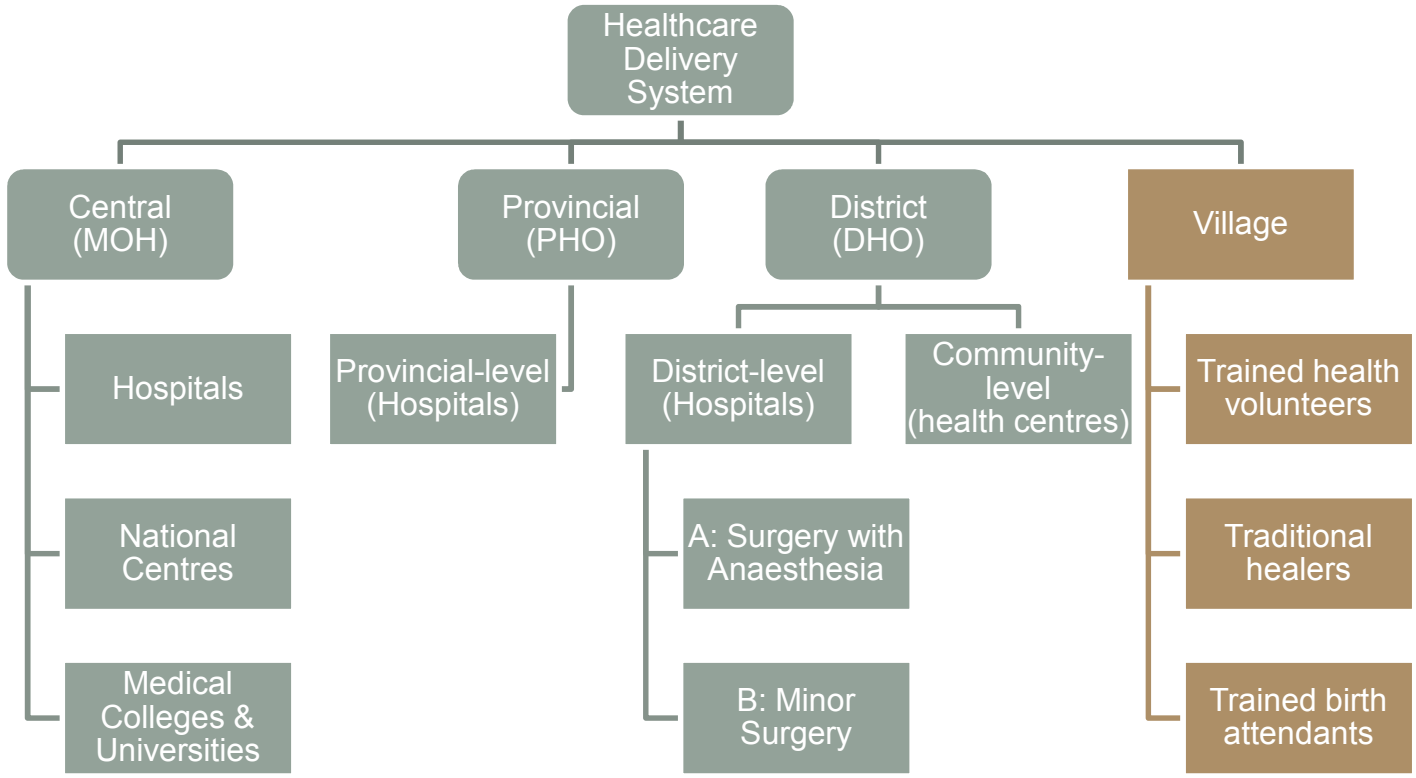
Sources:
a National Statistics Centre, 2005.
b MNCH Strategy 2009–2015.
c MOH & Lao Statistics Bureau, 2012.

2. Organization & Governance

- MOH is the national health authority, responsible for governance and overall guidance of the health sector. **Structure reform: from 7-10 departments.**
- National Health Plan formulated by MOH:
  - Short term (1 year): Annual Plan
  - Medium term (5 years): Health Sector Development Plan
  - Long term (to 2020): Master plan to 2020
- MOH committed to improve Health Information System (HIS): on-going web based routine HMIS reporting; multiple sector initiatives and pilot on civil and vital registration.
- Depending on other sectors:
  - MOF: account holder
  - MHA: quota

2. Organization & Governance

- Predominantly public health-care delivery system, with the recently emerged private sector. Dual Practice existed.



Source: MOH (2012)

Problem: Preference towards Central and Provincial hospitals → Overconsumption and underutilization

3. Financing

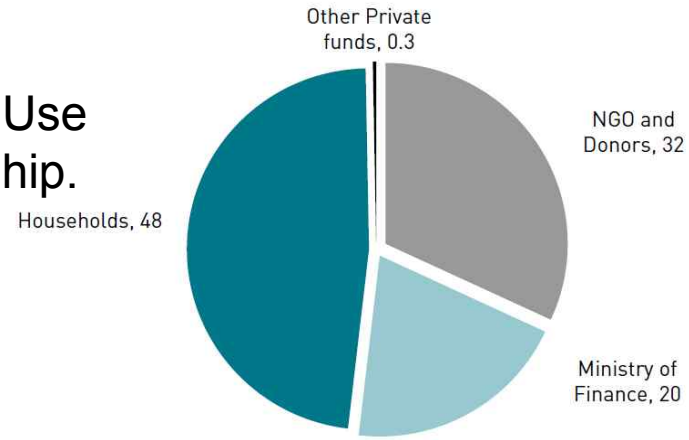
- Transitioned from a government provision of free services to a government fee-for-service system, then a re-introduction of selected free services e.g. healthcare for the poor, free MCH services are now in the pipeline.
- However, exemptions from user fees for the poor is weakly enforced.

- The 4 health insurance schemes cover 19.6% of the population in 2012. Need to address barriers to enable target coverage to be met.

- Uninsured frequently resort to self-medication or traditional medicine due to high prices and perceived poor quality of public health services. Use of health services often results in financial hardship.

- Health sector is financed by 3 main sources; Households, NGOs and Donors, and MOF

Sources of health funds (national health accounts), 2009–2010



Source: MOH (2012)
Note: the very recent data on health insurance schemes cover 27% of the population.

3. Financing

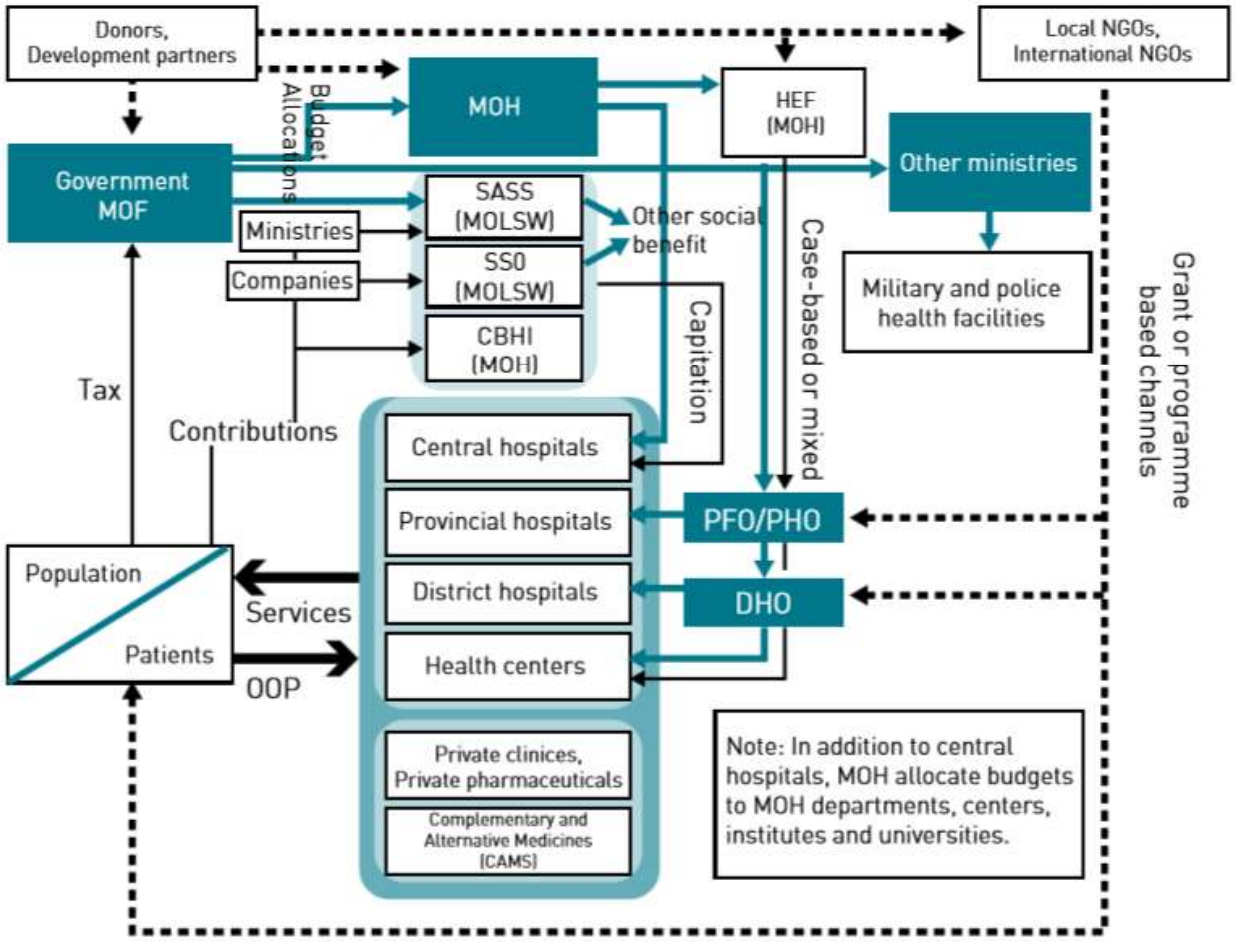
Overview of the four government health insurance schemes, 2011

	SASS	SSO	CBHI	HEF
Responsible body	Ministry of Labour and Social Welfare (MOLSW)	MOLSW	Ministry of Health (MOH)	MOH
Launch	2006 (revised schemes)	2002	2002	2004
Type	Mandatory		Voluntary	Public welfare scheme
Legal status	Prime Ministerial decree		Ministerial regulation	Ministerial regulation (but project-based)
Target population	Civil servants and dependents	Salaried employees in the private sector and dependents	Non-poor self-employed/ informal-sector workers and dependents	Individuals in households identified as living below the poverty line
Source of finance	Employee 8% of payroll, employer 8.5% (note: 2% from each is earmarked for health; the remainder is for other purposes)	Employer 5% of payroll, employee 4.5% of payroll, (note: 2.2% of payroll combined is earmarked for health)	Household payment for premium (flat amount by family size, and urban or rural residence)a	Donor and government
Benefit package	Cover outpatient and inpatient services			Outpatient and inpatient + travel and food subsidies
Payment method	Capitation (₭85 000 per registered member per annum) Cost-sharing for high cost Risk-adjusted capitation for 6 conditions		Capitation (₭45 000 per registered member per annum)	Capitation, fixed feeb and fee for service
Estimated number of target population	399 672c	386 988	3.21 million	1.6 million
Target population covered	315 741	104 487	150 870	192 000
Target pop covered, %	79% 89.1% 2012	27% 33% 2012	4.7% 3.8% 2012	12% 40.7% 2012
Total insured population	763 000 (13.7% of total population) 19.6% 2012			
Total uninsured population	4 827 000 (86.3% of total population) 80.4% 2012			

Source: MOH & WHO, 2013.

3. Financing

Flow of funds to health-care providers through various channels



Source: MOH & WHO, 2013.

3. Financing

- 6.1% government expenditure on health in 2011
- THE was 2.8% of GDP in 2011; low in comparison to other low-income countries
- OOP (39.7% of THE); half (48.3%) used to pay for medication
- Informal payments are often offered to gain access to public hospitals and to receive better quality payments. However, this results in inequity for the poor cannot afford such payments.

The profile of out-of-pocket (OOP) payments by income quintiles, 2005

Income quintile	% paid out-of-pocket				
	Inpatient services	Outpatient services	Traditional medicines	Medicines	Others
1st (poorest)	5.0	19.8	10.5	61.5	3.2
2nd	7.9	12.0	12.7	63.1	4.4
3rd	8.8	10.6	13.3	65.1	2.2
4th	9.0	18.0	9.6	58.8	4.6
5th (richest)	32.0	7.8	10.0	42.9	7.3
Total	25.2	9.8	10.1	48.3	6.3

Source: WHO, 2006.

3. Financing

- Net official development assistance (ODA) was 17% of GNI in 1990 and had decreased to 6.2% in 2010, challenging the country's historical reliance on ODA.
- The Lao Government has developed a Health Financing Strategy for 2011-2015 to improve its health financing. It has also strengthened district-level management and planning, giving more freedom at the district-level for their own activities.
- The Health Care Financing Strategy aims to achieve universal coverage. However, government financial support is required to improve health services and subsidize health insurance for the poor, in order for the vision to be achieved.

4.Physical and Human Resources

- Beds per 1000 persons have decreased from 1.8 beds per 1000 in 1996 to 0.8 beds per 1000 in 2010, as supply has not kept pace with population growth. Most beds are for acute care, with no psychiatric or long term care institutions. The elderly and chronic ill are cared for at home.

- Service utilization is low, with an average stay of 2 days.

Health facility profiles, 2010–2011

Level of care	Type of health facilities	Quantity	No. of beds	Range of number of beds per facility
Tertiary	Central and specialist hospitals	7	1588	60–450
Secondary	Provincial/regional hospitals	16	2138	40–250
Primary	District hospitals	130	1859	10–20
	Health centres	860	2281	1–2
	Drug kits	5239	–	NA

Source: MOH, 2012b.

4.Physical and Human Resources

- Number of health workers remained unchanged between 1988 to 2009
  - The ratio of qualified HCPs (0.69/1000) below recommendation of 2.5/1000
- Gap between rural and urban areas. Retention in rural areas to be addressed.
- Low numbers are supplemented by the informal sector i.e. village health workers
- Various initiatives to improve current situation:
  - Increasing quotas
  - Enforcement of MOH regulation: mandatory employment in rural areas
  - Financial and non-financial incentives to retain HCWs in rural areas

Human resources for health, 2006–2012

Indicators	2006	2007	2008	2009	2010	2011	2012
Total medical doctors	1318	1341	1375	1410	1448	1511	1588
· % in private	NA	NA	NA	NA	NA	NA	NA
New medical graduates	82	65	100	171	202	160	236
· % graduated from private medical schools	None	None	None	None	None	None	None
Total nurse personnel	4845	4942	4797	4873	4962	5017	5435
· % in private	NA	NA	NA	NA	NA	NA	NA
New nurse graduates	627	541	535	629	622	518	881
· % graduated from private nursing schools	None	None	None	None	None	None	None
Doctors per 1000 population: total	0.23	0.23	0.23	0.23	0.23	0.24	0.24
· Doctors per 1000 population: capital city	0.75	NA	0.74	0.74	0.75	0.84	0.77
· Doctors per 1000 population: outside capital city	0.07	NA	0.07	0.07	0.07	0.06	0.07
Nurses per 1000 population: total	0.84	0.84	0.8	0.8	0.79	0.78	0.82
· Nurses per 1000 population: capital city	1.22	NA	1.22	1.13	1.13	1.37	1.50
· Nurses per 1000 population: outside capital city	0.73	NA	0.67	0.69	0.69	0.62	0.61
Midwives per 1000 population: total	0.03	0.04	0.06	0.08	0.09	0.1	0.09
· Midwives per 1000 population: capital city	0.07	NA	0.09	0.16	0.16	0.22	0.11
· Midwives per 1000 population: outside capital city	0.02	NA	0.06	0.06	0.07	0.07	0.08

Source: Department of Personnel (DOP)/MOH, March 2011; NHSR 2010–2011
Note: NA = not available.

Note: Qualified HCPs definition: Health Care Providers including medical doctors, nurses and midwives with high- and mid-level professional qualifications)

5. Provision of Services

- Provision through a network of health centres and district, provincial and central hospitals
- Poor access and acceptance of public primary healthcare (PHC)
  - High OOP
  - Inadequate quality of facilities
- Weak gate-keeping and referral system
- Crowded outpatient services, but underutilized inpatient services
- Service Delivery at PHC set as a priority area

5. Provision of Services

- Effort is placed in developing a public health surveillance system and strengthening of the HMIS
- Private health sector should comply with the national diseases surveillance system
- EPI, rehabilitation, long-term care and mental health-care systems require more development
- Plans to further promote and integrate traditional health care into mainstream health care services

6. Principles of Health Reforms

Government has endeavoured to provide better health services, and has made significant progress in a short time and challenging environment

Governance and Leadership

- PHC policy (2000)
- National Strategy for HRH (2010-2020)

Health Financing

- Plans to merge 4 health financing schemes into 1 national Health Insurance Scheme - improved management and larger risk-pooling
- Aims to achieve 50% coverage by 2020
- Introduced national policy for Free MCH in 2012
- Barriers: Low public health expenditure, geography, high OOP, limited services in rural areas, poor quality of care

6. Principles of Health Reforms

Service Delivery

- Drug kits, mobile/outreach services for the poor
- Renovation and upgrading of facilities
- Barriers: Infrastructure, medical equipment and staffing needs improvements

Human Resources for Health (HRH)

- Shortage and uneven distribution of skilled workers
- National strategy for HRH 2010-2020
- Incentive package to work in rural areas
- Negotiate for adequate health workers quota
- Upgrade village health workers to qualified health workers after 6-months of training

7. Assessment of the Health System

- Strong political commitment to develop the Health System has reaped benefits. There is support for achieving MDGs and UHC, with an approved increase in government spending on health
- Current challenges include:
  - High OOP
  - Low quality of care and health-care provider responsiveness
  - Inequity in the distribution of resources
- Despite the good policies and strategies, they are often not fully implemented. Hence serious reflection is required:
  - Plans should be well-defined and realistic
  - Capacity and commitment are required for translation of research to policy and into implementation
  - Full alignment of the implementation plan and the policy

8. Conclusions

- Laos has achieved impressive health gains such as life expectancy improvements, and MDGs 4 and 6 that are on track to be achieved by 2015.
- Challenges remain however; the widening income inequality, low coverage of health financing schemes (19.6%), high OOP, inadequate quality of services, insufficient workers and disproportionate distribution of the workers hinder advancement
- Net ODA in 1990 had decreased from 17% to 6.2% in 2010, challenging the country's historical reliance on ODA.
- Investments have to be made to improve the infrastructure, workforce and enforcement of policies, so that the large urban-rural and rich-poor gaps can be minimized.
- There might be a lack of management capacity or feasible planning as policies and strategies are often not fully implemented.

8. Conclusions

- It is important to note that inter-linkages among the constraints must be considered. Multi-pronged approaches such as lower OOP payments, greater incentives for providers to be responsive to the health needs of the consumers, and increasing the health care workforce might be potential solutions.
- Increasing financial investment and HR will not improve service utilization much if the performance and quality of services, dual practice, informal payments, regulation of private sector and other barriers to access are ignored.

- Thus, the government has to invest in both the demand and supply side of the health care system to improve the health of their people.