Institutional strengthening for universal coverage in the Lao PDR: barriers and policy options

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Nossal Institute for Global Health
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SUMMARY

The Lao PDR is committed to achieving a form of universal health coverage by the year 2020. The aim is both to provide a stronger avenue for funding the national health care system and to reduce the burden of out-of-pocket payments, which comprise more than 60 per cent of total health expenditures. The government is now considering the creation of a national health insurance authority formed through the integration of the four different social health protection schemes: compulsory salary deduction schemes for civil servants and for formal-sector employees, government-run community-based health insurance for rural populations and subsidised health equity funds for the poor. This report discusses the key barriers and policy options that the Lao PDR faces in establishing a national health insurance authority (NHIA) for universal coverage.

This research was conducted by the Health Policy and Health Finance Hub of the Nossal Institute for Global Health, the University of Melbourne, Australia. The study team worked closely with the Ministry of Public Health, development partners and international NGOs working in the Lao PDR.

This paper highlights the main institutional reforms, policy options and health financing issues related to the creation of an autonomous NHIA. It will be necessary to provide adequate support from both domestic and external sources for government stewardship of the main health financing functions (collection, pooling and purchasing) in the establishment and operation of the NHIA. Following the adoption of the Decree on the National Health Insurance, the focus of policy development will shift to the complex implementation arrangements for the NHIA, which will require careful planning, the provision of adequate resources and an extended period of institutional development. The best guide to identify how the detailed institutional and health financing arrangements will be made is the official Road Map to a National Social Health Insurance Program (Herrera and Roman 2011).

The results of this study support the proposition that, as a first step, it is necessary to extend the schemes that are designed to protect the poor across the whole country, particularly the health equity funds. This can provide an effective basis for extending broader insurance arrangements in the informal sector. Based on past experience, the opportunity now exists to move ahead.
INTRODUCTION

Universal health care coverage has been identified as a key health policy goal (WHO 2010). Countries can move towards universal coverage by addressing the three main health financing functions: revenue collection, pooling of resources and purchasing of interventions (Evans and Etienne 2010; WHO 2005; Mathauer and Carrin 2011).


Laos is a low-income country in which out-of-pocket spending is more than 60 per cent of the total health expenditure and government health expenditure is constrained. Strengthening existing social health insurance (SHI) and social health protection (SHP) is one of the four objectives of the Laos national health financing strategy (2011-15) (Ministry of Public Health 2010). To date, however, these SHI and other SHP schemes have not greatly reduced out-of-pocket spending (World Bank 2010a).

Achieving universal coverage where out-of-pocket spending is more than 30 per cent of total health expenditure is extremely difficult (WHO 2009). Consequently, shifting to some form of prepayment for health care is essential to achieve universal coverage (Carrin, Mathauer et al 2008) and will require initiatives that could include mandatory (i.e. national or social) health insurance and increased tax funding (McIntyre, Garshong et al 2008). Many different SHI and other SHP initiatives may be useful on the pathway to universal coverage (Carrin, Xu and Evans 2008). To be effective, SHI and SHP systems must specifically target the poor (Gwatkin and Ergo 2010).

The success of any SHI scheme in achieving universal health coverage is closely related to its specific institutional characteristics and its organisational capacities (Mathauer and Carrin 2011; Antunes and Saksena 2009). Universal coverage requires the existence of institutions that allow prepaid funds to be pooled and used to purchase health services (WHO 2005). Institutional design and organisational practice should be related to the key health financing functions of resource collection, pooling and purchasing (Mathauer and Carrin 2011; Mathauer, Cavagnero et al 2010).

Currently, there are four SHP schemes in the Lao PDR (Table 1). The schemes are:

**Social Security Office (SSO) scheme:** This began in 2001 as an autonomous body administered by the Social Security Office under the oversight of the Department of Social Security of the MoLSW. The target population is salaried workers of both state and private enterprises and their dependents (Ron and Jacobs 2009; Bouaphat 2011).

**State Authority for Social Security (SASS) scheme:** The scheme for civil servants began following the revolution in 1975 as the Civil Servant Scheme and was reformed and renamed in 2006. The SASS is an autonomous body administered under the oversight of the Department of Social Security of the MoLSW. The target population is civil servants and their dependents (Ron and Jacobs 2009; Bouaphat 2011).

**Community-based health insurance (CBHI) scheme:** The national CBHI program was established at the end of 2002 and is managed by the Health Insurance Program within the Department of Planning and Finance of the MoPH. CBHI schemes operated in 24 districts in May 2011. The target population is in the self-employed and informal sector, which comprises 80 per cent of the total population (World Bank 2010b).

**Health equity funds:** HEFs were first implemented in a small number of districts by international donor agencies (Swiss Red Cross, Belgian Technical Cooperation and Luxemburg Development) from 2004 and later expanded through the MoPH with assistance from the World Bank and Asian Development Bank. The national program is managed by the Ministry of Health and implemented by donor-funded and/or contracted agencies. HEFs operated in 64 districts as of December 2011. Their purpose is to pay health services fees in public health facilities and other associated health care costs of families living in poverty (World Bank 2010b).

**Problem Statement**

Under current arrangements with four separate SHP schemes, there are constraints related to fragmentation of financing pools, segmentation of the financing systems, slow implementation and perception of quality of service and attractiveness of the schemes.
Institutional strengthening for universal coverage in the Lao PDR: barriers and policy options

by the population (Herrera and Roman 2011). The basic benefit package offered by the different schemes and the population coverage achieved by each vary widely. While the SASS covers 79 per cent of the target population, CBHI schemes together cover only 4.67 per cent of the target population (Bouaphat 2011). Both the prepayment (premium collection) systems and the methods of provider payment differ between schemes. This complicates the stewardship function of the government, produces inefficiencies in implementation and prevents a rapid increase in coverage. To achieve universal coverage, a change in institutional arrangements and improved organisational capacities are needed.

The government is now considering the creation of a national health insurance authority through the integration of the four different social health protection schemes (Office of the Prime Minister 2011). The expectation is that a unified institutional arrangement will lead to universal coverage by 2020 (World Bank 2010b).

To move forward, the MoPH needs to know the main barriers to creating a national health insurance authority and how they can be reduced or overcome. In particular, in the design of the institutional arrangements for universal coverage, the involvement of key financing policy makers and implementers will be required because there will be substantial changes in their roles and duties. Different stakeholders have many different interests and motivations that may require different approaches to incentives (Antunes and Saksena 2009; Brenzel and Naimoli 2009). Collecting and considering their views will help to mitigate resistance and facilitate understanding of the proposed new arrangements. The changes in institutional arrangements need to be clarified, carefully planned and eventually carefully implemented.

### TABLE 1. SUMMARY OF HEALTH CARE FINANCING ARRANGEMENTS IN THE LAO PDR

<table>
<thead>
<tr>
<th></th>
<th>SASS (new Civil Servant Scheme)</th>
<th>SSO</th>
<th>CBHI</th>
<th>HEFs</th>
<th>All schemes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ministerial authority</td>
<td>MoLSW</td>
<td>MoLSW</td>
<td>MoPH</td>
<td>MoPH</td>
<td>MoLSW, MoPH</td>
</tr>
<tr>
<td>Implementation date</td>
<td>2006 (revised scheme)</td>
<td>2002</td>
<td>2002</td>
<td>2004</td>
<td></td>
</tr>
<tr>
<td>Legal tool</td>
<td>PM decree</td>
<td>PM decree</td>
<td>Ministerial regulation (national)</td>
<td>Ministerial regulation but project based</td>
<td></td>
</tr>
<tr>
<td>Target population</td>
<td>Civil servants + dependents</td>
<td>Private sector salaried employees + dependents</td>
<td>Non-poor self-employed + dependents</td>
<td>Individuals in households identified as poor</td>
<td>Total population</td>
</tr>
<tr>
<td>Contribution</td>
<td>Government and employee</td>
<td>Employer and employee</td>
<td>Household</td>
<td>Donors, government</td>
<td></td>
</tr>
<tr>
<td>Estimated number of persons in the target population</td>
<td>About 400,000 (excluding about 590,000 military and police and their dependents)</td>
<td>386,988</td>
<td>About 3 million</td>
<td>About 1.6 million</td>
<td>About 6 million</td>
</tr>
<tr>
<td>Coverage</td>
<td>360,000</td>
<td>119,000</td>
<td>140,000</td>
<td>314,000</td>
<td>933,000</td>
</tr>
<tr>
<td>Coverage as % of targeted population</td>
<td>90%</td>
<td>33%</td>
<td>4.6%</td>
<td>19.6%</td>
<td>15.5%</td>
</tr>
</tbody>
</table>

Source: Bouaphat Phonvisay, MoPH, December 2011
In this research, we gathered and analysed the views of key health financing policy makers and program implementers about the barriers associated with creation of a national health insurance authority and looked at policy options that will assist in advancing towards universal coverage.

The overall aim of the research is to assist the MoPH and donor partners to strengthen the institutional arrangements for a national system of universal health coverage. Our purpose in this paper is to identify the key barriers to policy change and to the strengthening of national institutions for implementation of universal coverage, and to suggest policy options for overcoming these barriers.

METHODOLOGY

This research used qualitative methods of data collection and analysis within a policy analysis approach. Both documentary analysis and qualitative structured key informant interviews were used to collect data on policy barriers and challenges. We analysed the national health financing strategy, investigated key national and donor-partner documentation, conducted a policy maker analysis and analysed key informant data using the framework proposed by Mathauer and Carrin (2011).

Documentary Analysis

We collected and reviewed official documents related to national health policy, health financing strategies, official reports of the health ministries and other health-related departments. The documentary review also analysed information provided in the reports and documents of international agencies and other non-government actors working to support SHP schemes and health financing policy development.

Key Informant Analysis

We conducted 17 key informant interviews with health financing policy makers and other stakeholders at the national level (local and international). The informants were identified during preliminary investigations and invited to take part. They were purposively selected based on their close involvement with and positions in health financing areas. Informants were selected from a range of policy and program areas to provide variation in policy roles and positions.

The key informants interviewed for the research were from:

- Department of Planning and Finance, Ministry of Public Health (4)
- Cabinet of the Ministry of Health (2)
- Ministry of Finance (1)
- Civil Service Management, Office of the Prime Minister (1)
- Social Security Office, Ministry of Labour and Social Welfare (2)
- State Authority for Social Security, Ministry of Labour and Social Welfare (1)
- National Institute of Public Health (1)
- Development partners assisting health financing initiatives (5)

Informants were asked their opinions and experiences concerning the creation of a national health insurance authority and design issues of health financing functions to accelerate universal coverage. Semi-structured interviews in English were conducted in September 2011. An interview guide was prepared to collect data from the informants. Some of the questions were adapted, reflecting the background and roles of the respondents and their organisations. The authors visited the offices of the key informants for the interviews. One informant was not available in country, so data were collected through e-mail. The informants were invited to speak openly and assured of anonymity of their locations. The interviews were focused on institutional arrangement decisions and health financing function issues. Consent for the interview was provided by all informants. Interviews were noted and participant comments were de-identified.

Analytical Framework

The research used the analytical framework proposed by Mathauer and Carrin (2011) in the Bulletin of the World Health Organization (Figure 1). The framework is based on the three health financing functions of revenue collection, fund pooling and the purchase and provision of services. For each function, institutional design and organisational practice are fundamental to achieving the desired outcomes, and procedures are evaluated against nine health financing performance indicators. The ultimate goal is improved equity and health outcomes. Stewardship is the overarching
feature that affects the three key health financing functions, which in turn are dependent on the specific elements of institutional design (policies that prescribe the health financing system) and organisational practice (the way the policies are implemented).
RESULTS

Documentary Analysis

Documents that covered different aspects of the proposed NHIA were obtained from the MoPH and development partners. They included the proposed Decree on the National Health Insurance (Office of the Prime Minister 2011), Draft Health Financing Strategy, 2011-2015 (MoPH 2010); Suggestions for a Road Map towards Merging Social Health Protection Schemes at Lao PDR (Ron and Jacobs 2009) and Road Map to National Social Health Insurance Program (Recommendations) (Herrera and Roman 2011). The WHO Health Financing Strategy for the Asia Pacific Region has been endorsed by the government of the Lao PDR. The draft decree and Draft Health Financing Strategy are both awaiting government approval.

In the draft decree, compulsory membership and risk pooling in health care expenditure are mentioned as two of four basic principles. The government will guarantee the supply of staff and budget contributions for the management, development and extension of the national health insurance scheme throughout the country. The draft decree proposes that the Ministry of Health be considered the central point for coordination between ministries and line agencies. It proposes an executive board, with the minister for health as president acting under the authority of the prime minister, together with representation from other ministries and agencies. A board of directors responsible for
implementing daily tasks according to the NHIA would work under the executive board and comprise one director and a number of deputy directors. Central and local administrative bodies would act as a secretariat to the executive board.

A central plank of the Draft Health Financing Strategy of the Lao PDR is to merge all existing SHP schemes by 2015. Suggestions and recommendations for the merging are made in the two road map documents. Figure 2 presents the road map for the step-by-step establishment of the NHIA proposed by Herrera and Roman to the MoPH. These documents identified a range of critical institutional and health financing issues and challenges and make recommendations for institutional arrangements and design features.

However, these documents do not include an exploration of health financing stakeholders’ perspectives on the proposed NHIA or, importantly, on the potential policy barriers and challenges. Based on the analysis of key informant responses, this paper discusses the proposed institutional arrangements and investigates their effect on the three health financing functions and the goal of universal coverage.

Analysis of Key Informant Interviews

Using the analytical framework developed by Mathauer and Carrin (2011), the key informant interviews were analysed under three main headings:

1. institutional design and organisational changes
2. health financing design issues
3. potential impact on health financing indicators.

Consistently with the analytical framework, key informants generally recognised the role of institutional design and organisational practice in accelerating progress towards universal coverage.

Institutional design and organisational changes

A number of factors related to institutional arrangements may serve as barriers to the creation of the NHIA. Interviews with the key informants revealed the location of the NHIA, its organisational structure (including reporting, capacity development and funding arrangements at the national, provincial and district levels), capacity development and leadership, formation of a central database and information system, and financial management as the key concerns.

Location of the NHIA

Key informants raised three options regarding the location of the NHIA: the Office of the Prime Minister, the Ministry of Public Health and the Ministry of Labour and Social Welfare. All informants, however, favoured the establishment of an independent, autonomous authority regardless of its location, though this may prove to be a challenge, at least in the short term:

Ideally it would be an independent body, but that’s unlikely to be the case. Political support and political realism are the possible options to overcome the barriers (Key informant #5).

If the NHIA is located at a ministry, there is a possibility of capture of the NHIA by the host ministry. This may have a negative impact on the success of the initiation of the NHIA (Key informant #10).

The draft decree suggests that the NHIA will be located at the MoPH. Most informants, however, favoured the Office of the Prime Minster (OPM) as the location of the NHIA to meet the need for political support because it has the ability to strengthen coordination, reduce tensions between ministries and enforce monitoring and evaluation. This would also ensure strong leadership in the implementation of NHIA schemes. At the same time, some key informants had doubts:

The Prime Minister’s office will be unwilling to manage different projects, and the vice prime minister may not have sufficient time to be involved in the process. He has a lot of tasks. Advocacy will be needed to involve the vice prime minister in the process (Key informant #11).

Locating the NHIA at the MoPH was supported with the justification that other ministries do not have experience working with health care providers, and health facilities are regulated by the MoPH. Even so, not all key informants from the MoPH were in favour of this option. One suggestion was that it could initially be at the MoPH, which is currently responsible for the implementation of CBHI and HEF schemes, as a
transitional arrangement, and could be relocated if this did not work well.

Most informants from the development partner agencies wanted the NHIA located either at the OPM or the MoLSW. These informants considered that the MoLSW (which currently administers both the SASS and the SSO offices) had greater human resource capacity in health insurance:

> The merger is a relatively good option, but there are profound differences in capacities and financial resources and reserves between the two ministries (MoPH and MoLSW) (Key informant #8).

Some respondents expressed concern, however, that the MoLSW does not have an interest in coverage of the informal sector. More discussions are needed among the ministries, including the OPM, on the location of the NHIA and the clarification of its role.

**Organisational structure**

The exact organisational structure and reporting arrangements of the NHIA will be affected by its location and ministry structure. An agreed organogram of the NHIA and detailed terms of reference for the executive board, the board of directors and the administrative bodies will be required to complete the general provisions of the draft decree if the NHIA is to function smoothly. One respondent recommended that the NHIA should have three to four departments (a technical unit, a development unit, an administration unit and a policy and planning unit) and emphasised the need to improve and monitor the quality of facility health services. The executive board and board of directors would report directly to the concerned minister and reporting procedures will depend on the line management structure of the ministry chosen to host the NHIA. It will be necessary for the OPM to receive reports from the host ministry.

Drawing together staff and managers from the SASS and SSO as well as CBHI administrators in the MoPH is essential, but difficult. The incomplete use of existing information and technical analysis, however, will undermine design of SHP schemes and the success of the NHIA. Close coordination between different ministries and departments to strengthen policy, technical capacity and SHP scheme implementation requires a team-building approach and effective coordination, according to some informants:

In reality, NHIA would be a mix with staff members coming from both ministries and other relevant departments (Key informant #17).

How we work together will be an important issue as we are coming from different departments. Conflicts of interest and disagreements may hamper the activities of the NHIA (Key informant #13).

**Capacity and leadership**

Political will and strong leadership will be important to bring changes in policy, administration and implementation, and senior civil servants have the opportunity to play a significant leadership role in relation to scheme implementers:

Program managers and health providers are the implementers [of SHP schemes], and they may have different views from the central actors. Facilitation, the critical element of leadership for institutional arrangement, will enable the involvement of different stakeholders (Key informant #13).

Key informants recommended that interdepartmental transfers relocate experienced staff from the SASS and SSO to the new authority, which is possible administratively but may take some time. Critically, the existing departments feel they do not have sufficient experienced professionals for their own work and will be reluctant to relocate staff to the new NHIA; the skilled staff may in any case be reluctant to move because the NHIA is a new arrangement and there is uncertainty about its sustainability. Raising government quotas for employment of new professionals both in existing departments and at the NHIA, together with specific capacity development activities, will be required, as will political negotiation.

The types of professional staff that will be needed for administration of the NHIA, according to key informants, are summarised in Box 1. All the key informants felt that scarcity of technical staff would be a major challenge for the NHIA. Appointing only current or former civil servants will not be adequate because they do not
have the necessary technical expertise:

*Having the right people at the right time and having the right capacity will be crucial for the NHIA (Key informant #4).*

*In Laos there are few professionals with extensive health financing technical skills as well as information technology skills. These may hamper the activities of the NIH authority (Key informant #2).*

Recruiting technical and managerial professionals from the private sector or those with international experience may be necessary, if resources permit. According to the informants, such arrangements need to be long term, because short-term consultancy arrangements do not assist capacity development. However, qualified professionals from the private sector may be less interested in working under a long-term arrangement.

**Central database and information system**

Building information technology infrastructure and providing technical support will be essential for financing and quality improvement decisions. Key informants highlighted the need for improving central monitoring data on providers and members, membership contributions and hospital statistics. Creating a central database will be essential to enable linkages between the various existing SHP schemes.

*Funding for developing IT infrastructure and capacity of the professionals, including analyses and interpretation, are the two prerequisites to develop an integrated information system for the NHIA. There is a need for permanent IT professionals even at the provincial level (Key informant #11).*

**Financial management**

Issues such as independent banking arrangements for the NHIA, decentralised funding, establishing a capable financing team and guidelines for the timely release and use of funds came up when informants were invited to share their views on financial management. While most key informants identified decentralised financial management as important, there were different opinions about implementation arrangements between the different schemes. For example, the SASS and SSO already have centralised arrangements with provincial offices, and CBHI schemes are district-based.

Some key informants recommended the establishment of NHIA provincial branch offices, while others recommended using the existing infrastructure of one of the ministries (MoPH/MoLSW/Ministry of Finance [MoF]). The first group argued that NHIA should have its own provincial and regional infrastructure for management and monitoring. According to the second group, setting up different structures at the different levels would be difficult, expensive and time-consuming. NHIA funds may have to be channelled from the central level to the district level through the provinces, and agreed regulations need to be in place to manage and release funds on time at the different levels.

**Health financing design issues**

The level and equity of funding available, population coverage, the nature of the benefit package and administrative efficiency were the main health financing issues raised by informants. Since there will not be a national budget allocation for the NHIA, it will be necessary to phase in the NHIA over a number of years, beginning with the amalgamation of existing schemes and accepting the current low levels of coverage in the short term.

**Funding and equity**

Guaranteeing the required level of funding, including resources for direct subsidies, and achieving equity in financial contributions are major challenges. Government fiscal resources are constrained, and there

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**Box 1. Types of Professional Staff Needed for the Administration of the NHIA**

Health economists, health care financing specialists, medical doctors, public health management specialists, social workers, health systems specialists, information technology specialists, auditors, M&E specialists, lawyers, financial management specialists, purchasing/contracting specialists, administrators, researchers and SASS/SSO experienced professionals.
is concern that SHP measures may not be sustainable in the long term. Compliance with revenue collection procedures through the formal sector schemes (SASS and SSO) is not complete, CBHI premium collection is low, and concerns were expressed about the sustainability of donor funding for HEF schemes.

Both direct subsidies and mandatory membership for the informal sector are questions being considered in the establishment of an NHIA. Making funds available through the government and donors requires a complex process of planning and reporting that is not yet adequately available through the MoPH, for example:

*The MoF is in favour of a subsidy, but there is no information from the MoPH on the informal sector. We need to work more on this issue with the MoPH, and the process may take a long time (Key informant #6).*

*Donors will require evidence before giving a funding subsidy. Mechanisms for funding need to be agreed, and this could be through funding a special program or a project. It should be for the real benefit of the poor and not based on any political decision on the poor. Donor funds are not always sustainable, and funding from the different sources should be mobilised (Key informant #12).*

Several options for providing subsidies were raised. Some key informants suggested that cross-subsidisation from the SASS and SSO schemes could provide funding for the informal sector. Low insurance membership in the formal sector, however, limits the opportunities for this. Key informants argued that the poor should receive a 100 per cent subsidy of user fees and the near poor a partial subsidy, and each be issued with an identification card, which would help to improve the information system. The process has been thought of in terms of priority needs:

**Priority 1:** Implementation of the established policy in favour of free maternal, newborn and child health (MNCH) services (including under-5 care).

**Priority 2:** Providing a full subsidy for the poor.

**Priority 3:** Providing subsidised premium discounts for the rest of the population according to a package of essential services designed for the non-poor informal sector.

The SASS and SSO schemes have a compulsory contribution collection system, and the HEF schemes (as direct subsidies) do not require contributions. However, the collection of voluntary contributions for CBHI currently is not timely, membership is low, and the drop-out rate is significant. Key informants could not provide a definite solution to the problem of collecting contributions from CBHI members. Some suggested the contributions could be made compulsory or collected indirectly either alongside the land tax or through the village head, though village tax collection systems are weak.

*People in the informal sector are usually poor, and they don’t have regular income. They may object [to compulsory membership] as they don’t have sufficient income to pay the premium (Key informant #9).*

Compulsory membership for the informal sector will not be sustainable without direct subsidies from the government or donors. However, key informants identified a number of barriers, including:

- It is not certain that fiscal resources will be available for demand-side subsidies, and the government is yet to make a formal commitment; the agreement of the Ministry of Finance will first be required as well as policy agreement across government.
- Agreement on cross-subsidisation from the formal sector to the informal sector has not yet been achieved.
- There is currently no information on the size of the population requiring subsidies, no comprehensive beneficiary identification system is yet in place, and no uniform eligibility criteria have been defined.
- The implementation and enforcement of subsidy programs require a control system with good monitoring, which is not currently in place.

**Level of coverage**

Population coverage of the SASS and SSO schemes is still incomplete (79 per cent and 27 per cent of the target populations respectively). CBHI covers 4.7 per cent of the target population nationally, and HEF coverage is 19.6 per cent of the poor population. Direct subsidies, improved compliance and some form of compulsory CBHI membership are the options being considered to
increase coverage. Key informants expressed concern, saying that demand for quality care will be increased with compulsory CBHI membership, but ensuring high quality for all the members will be challenging. Although the draft decree raises the issue of compulsory CBHI membership, no decision has yet been made:

There will be a need for strong legislation ... for compulsory membership. There is no available information [that can be used to accurately] to identify the poor and [the non-poor in] the informal sector. This is not an easy option, and the process will take time (Key informant #1).

Risk pooling and financial protection

It was argued that inclusion of all population groups in the risk pool would make the pool more sustainable. Informants proposed that subsidies for the poor and the informal sector be included in the risk pool so that it would be more representative of the population. Creating a uniform system in which all funds were pooled and distributed among the four schemes would play a significant role in risk equalisation. However, informants suggested that the MoLSW may not support the creation of a single risk pool with cross-subsidisation because it would have to underwrite the system with its own resources. While a narrowly based risk pool would not sustain the national insurance system, a broader base may not be achieved:

There is a possibility that the risk pool will be composed mainly of the formal sector and a selective population who will be included from the informal sector (Key informant #9).

Some key informants recommended that there should not be immediate unification of all the four schemes and suggested that merging could happen in stages, beginning with the merger of the SASS and the SSO and later merging with the CBHI and HEF schemes. A proposed policy guideline will outline the process of unification.

Equity, efficiency and cost-effectiveness of the benefit package

Some key informants recommended adoption of a uniform minimum package of services between the different schemes. Because it is critical to achieve uniform geographic coverage, the benefit package must cover primary, secondary and tertiary care. One suggested option was to offer a uniform primary benefit package and vary the secondary and tertiary benefit package according to circumstances:

The benefit package should include low-cost and effective essential services so that it can be accepted by the population at all levels and will not have an impact on the budget (Key informant #15).

Initially the package could be wider for the formal sector as they pay higher premiums and initially for the informal sector a well-defined package of low-cost, effective essential services should be ... implemented. The benefit package can be made uniform once this arrangement operates for several years. We have to go through trial and error and look at the lessons (Key informant #10).

Key informants also raised concerns that the management authority of some schemes may not like the idea of a unified benefit package. Different populations have different needs, and the formal sector may have particularly high demands. Currently, the different schemes cover different services for different population groups, and reaching a decision for a uniform benefit package will be complex.

Administrative efficiency

It was anticipated that a single fund for all schemes under the NHIA would minimise the fragmentation of financing and management and reduce transaction costs overall. Through the unification of management, accounting and statistical reporting, a common computer system and centralised monitoring, the MoPH, MoLSW and other concerned ministries would share administrative costs and responsibilities. National, provincial and district management and monitoring could be arranged, with internal and external auditing, through existing procedures. Improving capacity, particularly for monitoring and enforcement, will be required, and high-level political intervention will be needed to control transaction costs through efficiencies in coordination between the participating ministries and agencies.

Key informants argued that inefficiencies in funding services may be reduced through implementation
of a consistent and well-designed provider payment mechanism. Different provider payment mechanisms for the NHIA, such as capitation payment, fee for service and case payment (diagnosis related group: DRG), were proposed. The informants generally preferred a mix of payment mechanisms, using (for example) capitation payment at the primary level and DRG and fee for service at the secondary and tertiary levels. Costing and pricing information and disease-specific information (for DRG) will be required to establish a mix of payment mechanisms, though this is currently not available. A majority of key informants emphasised the need for enforcing and monitoring quality standards and eligibility of the health providers.

**Potential impact on health financing performance indicators**

The possible impact of reform initiatives linked to the establishment of a NHIA, and the barriers that may confront policy makers in addressing these challenges, are summarised in Table 2 against the nine health financing indicators proposed by Mathauer and Carrin (Figure 1).

## DISCUSSION

The national health insurance draft decree proposes a compulsory and non-profit national health insurance

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**TABLE 2. POTENTIAL IMPACT OF THE NHIA ON THE NINE HEALTH FINANCING INDICATORS**

<table>
<thead>
<tr>
<th>#</th>
<th>Indicators</th>
<th>Possible impact</th>
<th>Barrier</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Level of funding</td>
<td>Funding from the government for subsidies will increase general government expenditure on health. Higher collection of premiums through enrolling new members from the informal sector.</td>
<td>Limited availability of funding for subsidies from the government and other sources. Difficulty of implementing compulsory contributions from the informal sector.</td>
</tr>
<tr>
<td>2</td>
<td>Level of population coverage</td>
<td>Higher percentage of population is covered by a social health protection scheme.</td>
<td>Inclusion of the informal sector under compulsory membership may not be possible.</td>
</tr>
<tr>
<td>3</td>
<td>Level of equity in financing</td>
<td>Higher percentage of households will have equal proportions of expenditure for health.</td>
<td>Agreement on cross-subsidisation from the formal sector is not certain. A system to identify beneficiaries for a subsidy is not yet evident.</td>
</tr>
<tr>
<td>4</td>
<td>Degree of financial risk protection</td>
<td>Minimising percentage of households experiencing catastrophic expenditure in each scheme.</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Level of pooling</td>
<td>Risk pooling will be maximised through compulsory membership, and NHIA will establish equalisation of risk across population groups.</td>
<td>Agreement on single pooling for all the schemes is not guaranteed.</td>
</tr>
<tr>
<td>6</td>
<td>Level of administrative efficiency</td>
<td>Reduction of administrative costs through adoption of a common financial management, accounting and information system.</td>
<td>Coordination between participating agencies and ministries will require high-level political intervention.</td>
</tr>
<tr>
<td>7</td>
<td>Equity in benefit package delivery</td>
<td>A common, equitable and efficient benefit package (based on budget constraints and society’s preferences) implemented at different levels of service.</td>
<td>Policy decisions required for a uniform benefit package to ensure equity at the primary, secondary and tertiary levels may not be agreed to.</td>
</tr>
<tr>
<td>8</td>
<td>Efficiency in benefit package delivery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Cost effectiveness and equity in benefit package definition</td>
<td>Delivery of services equally and equitably across the whole population at the least cost.</td>
<td>Resources will not be available to fund a uniform and inclusive equity package.</td>
</tr>
</tbody>
</table>

Source: Based on Mathauer and Carrin 2011.
system covering the formal sector (civil servants and private-sector employees), the informal sector and the poor. Such a system would be based on market principles, with cost-sharing and revenue-raising, under which premiums would be deducted from salaries or purchased by informal-sector workers and farmers. The poor will be enrolled and subsidised through health equity funds. Funding for a national health insurance agency will come from premium collections, the state budget, contributions from the community as well as domestic and international organisations and investment returns on deposited NHIA funds.

Challenges to Establishment of the NHIA

The draft decree provides legal authorisation for the creation of the NHIA and outlines its structural elements. The decree does not, however, answer questions related to the institutional design or health financing functions of the NHIA:

- how to guarantee compliance in the formal sector
- how to enforce collection of compulsory premiums in the informal sector
- how to fund compulsory membership for the poor
- how to develop a form of cost sharing that is affordable and equitable
- how to make risk pooling effective and enforce positive cross-subsidisation.

These are key policy challenges now facing the MoPH.

The findings from this research indicate that key informants agree on the need for strong leadership, good governance and the independence of an autonomous national authority. They also emphasise the need to draw on the experiences of the concerned ministries in making changes. There is, however, no common agreement on the next steps or the way forward to achieve the ultimate aims, and a wide range of institutional issues and health financing design questions are still to be resolved. The NHIA will not be set up in one step; the adoption of the draft decree will in fact open a period of design, piloting and implementation that realistically will be a phased project extending over many years. Establishing the institutions and the health financing arrangements and extending coverage across the whole population remains a challenging and lengthy process.

The key institutional issues that will soon have to be resolved are:

- Who will provide the leadership and the political support needed to implement the decree on national health insurance?
- Which ministry will be responsible for coordination and implementation of the plan for a NHIA, and how will it be made genuinely autonomous?
- What mechanisms will be adopted to facilitate coordination between ministries?
- How and when will the existing agencies and programs be combined?
- How and when will the existing staff of the SASS, the SSO and the CBHI-HEF office at the MoPH be brought together in a common office with adequate coordination, good management and appropriate incentives?
- How will membership compliance be enforced?
- How will health care providers be certified, and what will be the relationship between private providers and the NHIA?

The most important financing issues to be resolved include:

- What sources of government funding will be allocated to support the NHIA? How will donor funds be accessed and assigned to the authority?
- How will the subsidies needed for NHIA administration, extending coverage and financing contributions from the informal sector and the poor be guaranteed?
- How will membership compliance in the formal sector be strengthened, how will compulsory membership in the informal sector be implemented, and what mechanism will be used to extend coverage to all the poor?
- What criteria will be used to define the poor, and what arrangements will be implemented for beneficiary identification?
- How will positive cross-subsidisation from higher to lower socio-economic groups be arranged in accordance with normal insurance procedures?
- What procedures will be put in place to enable the NHIA to leverage improved quality of care at health facilities?
- What additional support will the government provide to strengthen health care delivery, especially at health centres?
- How will the Revolving Drug Fund system of user-fee collection be reformed, and how will the provider payment system be amended, to overcome perverse incentives to providers?
Barriers to Implementation

The concept of ‘barriers’ is not negative. It is a method for identifying needs, establishing priorities and finding a way forward. Our research indicates that the opportunity now exists to reach agreement on the next steps, establish inter-ministerial collaboration, strengthen the capacity for management and administration, identify the resources needed to implement activities and programs, reform user-fee and provider payment systems and raise the quality of health services.

A significant barrier is the lack of clarity on decision-making structures. The OPM is best placed to facilitate coordination between line ministries and will need to play an active role. While the draft decree designates the MoPH as the point for coordination between all line agencies, no decision has been made about how this will be implemented. To take the next step, plans need to be finalised for the creation of an autonomous office for CBHI and HEF under the MoPH. The MoPH does not currently have the personnel, resources or capacity required either for scaling up CBHI and HEF or for amalgamating the four SHP schemes.

The slow expansion of population coverage under the four schemes threatens their financial viability. Employer compliance with compulsory membership under the SSO is incomplete, the expansion of CBHI coverage is difficult, and scaling up HEF is possible. Additionally, a limited definition of poverty has created a narrow base for the implementation of HEF programs, which threatens to restrict coverage and underestimate the need for social protection.

As experience within the SSO and SSAS indicates, the NHIA will need an office structure and a capable team to manage central, provincial and district funds. Capacity for management and administration of a national health insurance scheme is limited and will take time to develop. The SSO and SSAS offices and staff provide a basis for initiating this capacity building and may be strengthened by closer cooperation with the CBHI and HEF schemes. Decisions are needed about office location and facilities, the number and quality of staff, ongoing staff training and an incentive structure that will encourage the most capable staff to remain and to lead the work.

The major health financing barriers include both the limited funding base and a lack of clarity about the purpose and function of the NHIA. The health financing strategy recommended by the WHO concludes that achieving universal coverage while total health expenditure is less than 5 per cent of GDP is extremely difficult. The fiscal space for increased government commitments is extremely limited, and donor support is essential. Current policy settings, however, see SHP as a co-financing activity that will raise revenue from the population to help finance the health system. This model cannot succeed and will have to change.

It is understood that a national SHI system cannot be based financially on contributions from the formal sector, which is too narrow a base. While the informal sector includes a very large proportion of the population, it is clear that the current CBHI is not adequate for extending coverage. No strategy has yet been developed to implement the proposal for compulsory CBHI membership and no arrangements yet agreed for funding it. Premiums will provide revenue for the NHIA, but international experience shows that a national insurance scheme cannot operate without extensive subsidies for both membership and administration.

The financial viability of the system depends on maintaining effective demand for health services. Without the correct financial and administrative incentives, health care providers will not deliver the quality of care that is needed to support a national insurance system. Two clear barriers to this are the current user fee system and the methods of provider payment. While the Revolving Drug Fund has in the past provided revenue for facility operational costs, this method of user fee collection creates incentives for over-supply of drugs and may not be appropriate for an insurance system. At the same time, capitation rates paid by CBHI are regarded as below the marginal costs of service provision and are regarded by the health providers as creating a loss. As well, there are wide variations among the different schemes in the rates paid to providers.

Options for Policy Development

To achieve the desired outcomes, the NHIA must be conceived as a social health protection agency that aims to reduce out-of-pocket health costs and provide services mostly free to patients at the point of service, and not simply as a device for raising revenue. It is possible now to create the basic institutional structures
of the NHIA; this will be the first positive step on the longer road to achieving social health protection, which may take many years.

The NHIA cannot be fully established immediately and at once, but will require a step-by-step process in which different parts of the authority will be set up over time. The timing and the order in which essential initiatives are taken are critical. It is likely that it will be necessary to do the following:

- Establish an inter-ministerial committee under the OPM to coordinate the first steps in establishing the NHIA.
- Establish the NHIA executive board and appoint the president; the executive board would meet at this stage only to make decisions about priorities and next steps and not yet to administer the NHIA.
- Adopt through the executive board a detailed plan and calendar for the establishment of the NHIA, a priority list of activities and a timetable for implementation.
- Agree on a date and a plan to amalgamate the SSO and SASS offices under the direction of the MoLSW.
- Agree on a date and a plan to put the CBHI and HEF offices under a common administration within the MoPH.

The two road map documents provide the most comprehensive view of the policy questions that must be resolved and the best guide to implementation, and offer a way forward. Bringing the four existing social health protection schemes under one administration is recommended. This would provide a context for addressing, over time, the outstanding institutional and financing issues. The road map recommends the parallel development of compulsory and voluntary membership schemes at the same sites, administered through the NHIA. A first step may be the amalgamation of the SASS and SSO schemes within the MoLSW. While the CBHI and HEF schemes could come under a joint administration at the MOPH, keeping their membership base and financial arrangements separate is necessary in the short term.

Adopting a new concept of membership and revenue sources could open the way for a more rapid expansion of coverage. Enforcing membership and compliance in the formal sector would cement the compulsory membership base. Under the current model, the expansion of CBHI coverage will continue to be unacceptably slow. However, compulsory membership in the informal sector can be achieved only through some form of earmarked taxation or village collection system (sin taxes, property taxes, a head tax or something similar), or by attaching premium payments to an unavoidable public service such as school enrolment. In either case it will involve a concerted approach by the government to achieve adequate compliance. Such measures can be implemented only within the requirements of equity and affordability if social stability is to be maintained.

Logically, the most effective and most immediate means for increasing coverage in the informal sector is to expand HEF coverage quickly. This is administratively simple, the basic structures are already in place, it is relatively low cost and the program has donor support. It also quickly provides additional revenues for service providers and helps to improve the quality of service delivery. The number of HEFs has grown quickly in recent years, the schemes are low-cost and they are cost effective. Rapid expansion of HEF coverage would build a firm foundation for the wider expansion of NHIA coverage into the informal sector.

The benefits of risk pooling—including positive cross-subsidisation of the poor by the rich—will be achieved only when there is broad population coverage under a combined scheme. It is premature, however, to form a single financial pool from the four SHP schemes. In order to prevent cross-subsidies moving from the poor to the rich (for example, when HEF funds are used to support CBHI), it is necessary to earmark subsidies that are targeted on the poor. It is not yet clear how direct subsidies for the poor through the health equity funds will be integrated into the new system while avoiding negative cross-subsidisation.

Resources are, of course, limited, and the NHIA will not have the funds to provide unlimited health care. Careful consideration of the benefit package will be needed to ensure that it is both affordable and attractive to beneficiaries. The delivery of free MNCH care, funded through government revenues, has been considered as a way to accelerate the progress towards achieving MDGs 4 and 5. Clearly, the delivery of essential services without user fees has important implications for improving access, equity and health outcomes. However, further consideration needs to be given to how the proposal is to be integrated with
health insurance mechanisms and subsidies for the poor without eroding the proposed benefit package, especially considering the risk that the attractiveness of CBHI will decline even further and continued complications with the provider payment system. A more consistent option may be to provide all primary health care (including MNCH services) fully and free at health centres (including meeting staff salary costs and the costs of providing basic drugs) with funding from the government and donors.

The NHIA is mandated by the draft decree as a ‘service purchaser’, though none of the existing schemes plays this role strategically or effectively at the moment. One option is to take some initial steps towards building an effective purchasing function for the NHIA. Reviewing and reforming the fee collection system—perhaps replacing the Revolving Drug Fund method with some form of scheduled fee for service, at least for hospital admissions—could be considered as a means to make fee collection transparent and administratively efficient. As well, by developing a more formal approach to contracting service providers through the NHIA (and perhaps in the short term sub-contracting some functions such as promotion and monitoring, as performed by the HEFs), the purchasing function of the authority could be used in negotiations with care providers to help improve both facilities’ financial viability and the quality of services.

CONCLUSIONS

Our study has highlighted the institutional reforms, policy options and health financing issues that arise in the creation of a national agency for health insurance in the Lao PDR. A remaining challenge is to continue providing adequate support for government stewardship of the main health financing functions (collection, pooling and purchasing) in the establishment and operation of the NHIA. Since the establishment of the NHIA will involve reasonably high start-up and operational costs, funds to cover these expenditures must be made available from both domestic and external sources. Various sources of funding can be tapped to meet these needs and channelled by the government to the NHIA as an autonomous and accountable authority.

With the anticipated adoption of the decree on national health insurance, the focus of policy development will shift to the implementation arrangements for the NHIA. This is a complex process that requires careful planning, the provision of adequate resources and an extended period of institutional development. Attention will now be directed back to the road map to identify again how the detailed institutional and health financing arrangements will be made. Confirming the official status of the road map, or developing a new program and timetable for implementation of the decree, is the next step.

A new perspective based on our research is to recognise that, as a first step, it is necessary to extend the mechanisms and programs designed to identify and protect the poor across the whole country. Experience shows that this can provide an effective basis for extending broader arrangements for insurance in the informal sector. It provides rapid population coverage and promotes equity in access. There is an opportunity now to begin work on the many policy challenges that still exist, beginning with agreement on a common plan and a timetable for implementation. Coverage of the informal sector is the most difficult challenge, along with arranging risk pooling in a way that equitably shares the burden. Built on past experience, the opportunity now exists to move ahead.
REFERENCES


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