Executive Summary

MANAGING TRANSITIONS

Reaching the Vulnerable while Pursuing Universal Health Coverage

Australian Aid

Gavi The Vaccine Alliance

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Reaching the Vulnerable while Pursuing UHC

As Lao PDR prepares to graduate from Least Developed Country (LDC) status by 2020 to become an upper-middle-income country by 2030, it also expects to face declining funding from external sources and the need to increase domestic financing for health. This report aims to provide a snapshot of the current health financing system of Lao PDR and to identify critical constraints and opportunities facing the health care system as the country undergoes transitions in demographics, epidemiology and health financing. In addition to reviewing the overall health financing system, the report includes an in-depth analysis of key bottlenecks and sustainability challenges for immunization services as a marker for implementation constraints in the face of rapidly reducing external financing.

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Lao PDR in Transition

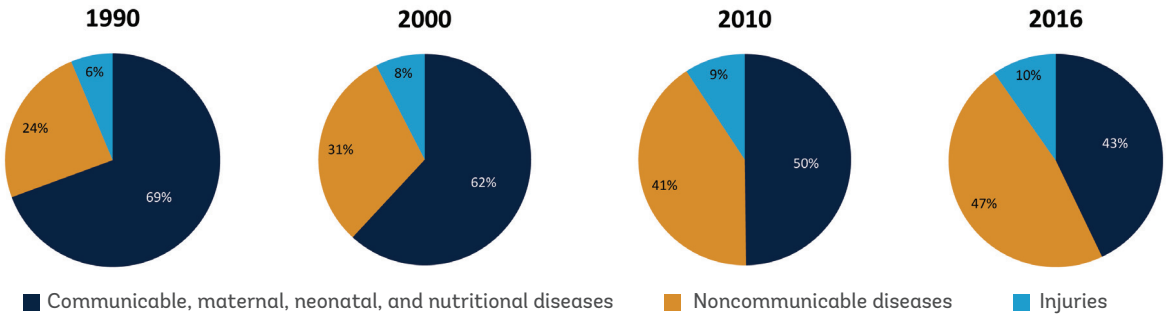
Demographic and Epidemiological Transitions

In 2015, the estimated population of Lao PDR was around 6.5 million with an expected peak at 9.3 million around 2060. The population growth rate was 1.7 percent in 2015. The total fertility rate has steadily declined from 6.4 births per woman in 1984 to 3.0 in 2014 and is expected to decline further in coming years. The country still has a predominantly young population, with the median age at 23.5 years in 2015; however the country's demographic composition is expected to change by 2050. Roughly one-third of the population was under 15 years in 2015; this is projected to decrease to around 20.1 percent by 2050. Only around 4 percent of the population is older than 65 years but the share is projected to reach 11 percent by 2050.

Despite improvements in national averages, there are persistent and high disparities in health outcomes across socioeconomic groups, by ethnicity, provinces, and educational level of mothers, and not all population groups are benefitting from these improvements. Infant and under-five mortality rates as well as stunting of children under five years are four to five times higher in the provinces with the highest rates compared to the province with the lowest rate. Residents of rural areas without access to roads are particularly disadvantaged and depend to a large degree on outreach services for both preventive and basic curative care.

As in several other countries in the region, the health system in Lao PDR is facing an epidemiological transition, from the burden of disease (BoD) being dominated by communicable diseases to a pattern in which noncommunicable diseases (NCDs) have taken a leading role (Figure 1). In 1990, 69 percent of BoD was caused by communicable diseases, maternal and neonatal disorders, and nutritional deficiencies, and only 24 percent by NCDs. In the following years the share of NCDs in BoD increased steadily while the share of communicable diseases diminished, and by 2016 the proportion of NCDs (47 percent) had surpassed that of communicable diseases (43 percent).

Figure 1: BoD by Cause (Share of DALYs Lost) (1990–2016)



Source: Institute for Health Metrics and Evaluation database (IHME) 2017.
Note: DALYs: Disability-adjusted Life Years. DALYs refer to aggregated healthy years of time lost at the population level as a result of disease-related morbidity and premature mortality.

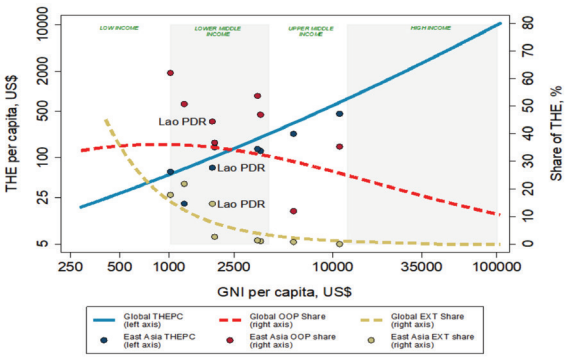
Undernutrition remains a significant challenge. In 2011, more than one-quarter of children aged under five years (26.6 percent) in Lao PDR were underweight and more than 44 percent were stunted. About one-third of the deaths of children under five years are attributed to child malnutrition. The total economic loss due to child malnutrition was estimated to be at least US$200 million annually, representing 2.4 percent of the country's GDP in 2013.

Health Financing Transition

Sustained economic growth is often accompanied by significant changes in health financing systems in many countries. In parallel to the demographic, epidemiological, and nutrition-related transitions faced by countries as they grow and develop, countries face what some have called a "health financing transition" or an increase in the level of total health expenditures accompanied by a rise in the domestically-financed prepaid or pooled share of total health expenditure. This trend is driven by a range of factors including changes in population priorities, institutional development, medical technology, demographic or epidemiological shifts, as well as changes in the financing and management of health care. In addition to the broader health financing transition, there is also an important sub-transition that occurs as countries move from low-income to lower- and upper- middle-income status, that is, the transition from externally-financed health programs. These are programs that are financed by bilateral and multilateral agencies as well as from development partners such as Gavi (Global Alliance for Vaccines and Immunization, now known as Gavi, The Vaccine Alliance) and Global Fund (GF).

Lao PDR's health system is clearly following this path and is undergoing a health financing transition. Despite the fact that some indicators fluctuate widely, there is some evidence of an appropriate, albeit slow, health financing transition that is taking place in Lao PDR. There has been a consistent increase in health expenditure per capita, a decrease in out-of-pocket (OOP) expenditure on health as a share of total health expenditure (THE), and a rising share of financing from pooled sources. As the country's economy is projected to grow rapidly with the expected decline of external financing, this transition is expected to figure more prominently in coming years (Figure 2).

Figure 2: Health Financing Transition in Lao PDR



Source: World Bank 2017; WHO 2017.
Note: Data for Lao PDR is based on the NHA FY2012-2013 to 2015-2016, Vientiane 2017. (i) Both x and y axes in log scale. (ii) THEPC = THE per capita; EXT= External.

Lao PDR has entered the accelerated transition phase (as defined by Gavi)[1] and has begun the process of phasing out from Gavi support, as their GNI per capita on average over the previous three years increased beyond the eligibility threshold. A plan has been prepared for moving towards full domestic financing of the immunization program. It is highly likely that both UNICEF

[1] Countries enter the accelerated transition phase if their average GNI per capita over the previous three years increases beyond the eligibility threshold. The accelerated transition phase is characterized by gradually increasing co-financing requirements over a period of five years to achieve full domestic financing thereafter.

and WHO will also substantially reduce their technical assistance to the immunization program – as an important part of their support is financed by Gavi. The Gavi transition is among the earliest ones being witnessed by the country, but will also help generate lessons for similar transitions that may affect programs funded by other development partners in due course.

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Current Status

Macroeconomic Context

During the period 2005-15 Lao PDR had one of the fastest growing economies in the world – with an average GDP growth rate of 7.8 percent per annum and GDP per capita growth rate of 6.1 percent per annum. Growth has been boosted by the resource sector and by accommodative macroeconomic policies on both the fiscal and monetary fronts. Natural resources – including mining, hydropower and forestry (accounting for 44 percent of total wealth in 2014) – have been key drivers of growth

in recent years. During the 2000s, growth was driven by mining; but a decline in prices, lower grade reserves, and sector regulation issues have more recently lowered its contribution to growth.

By 2011 the country had reached the status of a lower-middle-income country. GNI per capita and GDP per capita have continued to increase and reached US$2,353 and US$2,150 respectively in 2016. Strong economic growth has been accompanied by a significant decline in poverty rates. The national poverty rate declined from 33.5 percent in 2002 to 23.2 percent in 2012. In 2012 about 47 percent of the population lived on less than US$3.10 a day and about 15 percent on under US$1.90 a day. Sharing of the benefit of growth could, however, be improved. Despite the decline in extreme poverty defined as less than US$1.90 a day, the increasing poverty of some of the nonLao-Tai ethnic groups and rising income inequality are increasing concerns with the evidence that growth should be shared more equitably.

While government expenditures generally followed increasing revenues until 2012, the gap has begun to widen since then and there are indications that this further deteriorated in fiscal 2016 due to a shortfall of revenues. The shortfall is largely attributed to lower commodity prices as well as lower grants from development partners. Grants declined from 5.4 percent of GDP in 2014 to 2.3 percent in 2015. As a result, total revenues as a ratio of GDP are estimated to have declined to 19 percent in fiscal 2016 from 23 percent of GDP in fiscal 2015 and the fiscal deficit has widened.

Outstanding public debt at the end of 2015 was almost 66 percent of GDP which is relatively high compared to regional neighbors such as Cambodia and Myanmar and is, in fact, higher than the European Union Maastricht Treaty benchmark of 60 per-

cent of GDP. As a consequence, the 2016 Joint IMF-World Bank Debt Sustainability Analysis (DSA) has elevated the risk of debt distress in Lao PDR from moderate to high. The fiscal balance, however, is expected to gradually consolidate over the medium term.

Inequity

The progress in achieving health outcomes in Lao PDR varies hugely by province. In 2011-12, for example, infant mortality and under-five mortality rates were four to five times higher in the provinces with the highest rates compared to the province with the lowest rates. Rates of stunting of children aged under five years were more than three times higher in the provinces with the highest rates than in the province with the lowest rates. The problem is even more challenging for the residents of remote rural areas without access to roads, that depend to a large degree on outreach services for both preventive and basic curative care.

There are also huge disparities by economic status – with the share of institutional births ranging from 87 percent in the wealthiest quintile to only 11 percent in the poorest quintile. Lao PDR is grappling with the difficult challenge of being one of the world's least equitable countries with regard to coverage and outcomes of MCH services between the rich and the poor.

Notably, the ethnic minorities lag behind the Lao-Tai ethnic majority in several dimensions of welfare including health, with the poor among ethnic minorities being worse off than the poor among the Lao-Tai, and the better off among ethnic minorities still being poorer than the nonpoor Lao-Tai. High levels of OOP spending deter health service utilization by the poor and reduce the potential redistributive capacity of the health-financing system. Estimates from the Lao Social Indicators Survey of 2012 show that the total fertility rate among the Lao-Tai in 2012 was around 2.6, compared with 4.2 and 5.5 among the Mon-Khmer and Hmong-Mien, respectively. In general, the fertility rate is highest among less educated women, who are much more likely to be married and have their first child while out of school teenagers.

Service Availability and Readiness

While the overall health worker to population ratio is within WHO minimum standards, the rate of qualified health personnel (doctor, nurse, midwife) is below this benchmark. Compared to the WHO 2006 minimum requirement of 23 physicians, nurses and midwives per 10,000 population, Lao PDR had reached 32 staff per 10,000 population by 2016. Of these, however, only 43 percent have a mid-level education, bringing the professional workforce down to 12.3 professionally trained staff per 10,000 population. A 2014 study also found substantial gaps in the clinical abilities of the frontline workers related to MDG achievements – indicating that provision of a basic package of services may be less than optimal unless major investments are made in preparation of job-descriptions, defining functional responsibilities, preparation of job-aides and supportive supervision.

Shortage of qualified manpower is further compounded by an uneven distribution of health workers across provinces. The density of doctors to population in Vientiane is four times that of the rural areas. Similar but less pronounced differences exist for high-level nurses and midwives. A World Bank (2016) workforce study conducted in 2014 found maldistribution of staff (by geography, level and type), substantial gaps in clinical knowledge, and a mismatch be-

tween the type of in-service training provided and the knowledge needed to perform the service required.

The Health Personnel Development Strategy does include measures to address human resource management; while the 2015 mid-term review found some progress in its implementation, an agreed action plan for implementation of the strategy with reporting mechanism would facilitate achievement of the agreed targets and goals. Since 2014 a large number of newly graduated community midwives have been posted at the front-line health centers thereby substantially improving the availability of MCH service provision. There however remains the huge task of aligning the skills and competencies of staff with the health services where and when they are needed.

According to the findings from the 2014 Service Availability and Readiness Assessment (SARA), the overall general service readiness index for Lao PDR was 59 percent in 2014 – meaning that, on average, 59 percent of facilities had the required tracer items and amenities to provide basic health services to the population. Service readiness was generally found to be higher in the Central Region than in the North or South Regions and slightly higher for district hospitals than for health centers.

Health Financing

Health financing in Lao PDR is characterized by low and erratic levels of government spending on health and correspondingly high reliance on OOP health expenditure and external assistance for health. The high levels of OOP spending deter health service utilization by the poor and reduce the potential redistributive capacity of the health financing system. Furthermore, the poor and the near poor are frequently impoverished or pushed deeper into poverty as a result of high OOP spending on health. At the same time, Lao PDR has substantial dependence on external finance in particular in priority health programs including TB, Malaria and immunization programs.

Financing for health in Lao PDR comes mainly from four sources: (i) government budgetary sources; (ii) social health insurance (SHI); (iii) OOP payment from households; and (iv) external sources. The country spent US$ 50 per capita, or about 2.9 percent of GDP, in 2014. The composition of health expenditures has changed over the 15 year period until 2014, although OOP spending has remained the largest source. In 2016, nearly one-half of THE (48.2percent) is financed by private spending. This includes OOP spending by households which is 45.1 percent of THE. Public expenditure on health – which includes external financing – was 51.8 percent. The contribution from SHI was 4.4percent of GGHE in 2016.[2]

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[2] The data on government health expenditure in the WHO Global Health Expenditure Database (http://apps.who.int/nha/database) is different from the official expenditure data reported in the Government Official Gazettes and Budget Plans in Lao PDR. This is partly due to difference in the Government fiscal year and calendar year and a methodology used. For international comparison and presentation of health expenditure data (from public, private, domestic and external sources), the latest data available from the WHO database is used. Data for 2016 are based on the NHA FY 2012-13 to 2015-16 report that is subject to the final approval by the government.

(i) Government budgetary expenditure

Health's share of the government budget is relatively low. According to WHO data, several countries – including neighboring Cambodia and Vietnam – devote a much larger share of the budget to health, which indicates that Lao PDR's prioritization for health is on the lower side in global comparisons. However, there has been significant increase in the government budgetary spending on health since its inclusion in the Seventh Socioeconomic Development Plan 2011–15. A modest portion of revenues from the Nam Theun 2 hydropower project has been allocated to eligible health programs including the Free Maternal, Neonatal and Child Health (FMNCH) program and the Health Equity Fund (HEF) targeted for the poor. According to Lao PDR's State Budget Plan for fiscal year 2015-16, health's share of the national budget is 6 percent.

In the past, most government health spending in Lao PDR had been allocated towards capital expenditure and wages, leaving little room for critical nonwage recurrent spending in an already tight resource environment. In fiscal year 2007-08, more than 70 percent of the government health expenditure went to wage-related recurrent expenditure. Only 17 percent was available for nonwage recurrent expenditure, including purchasing critical health-related commodities and financing operational plans. There has, however, been a measurable increase in the share of nonwage recurrent expenditures since 2012. In fiscal year 2015-16, the share of nonwage recurrent expenditures increased to 35 percent of the total government health budget.

(ii) Social health insurance

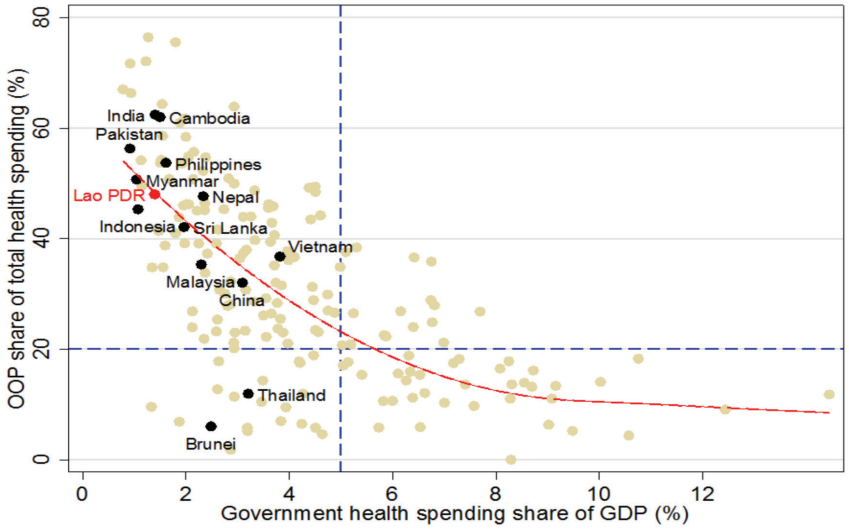
Social Health Insurance (SHI) expenditures account for a small share of THE in Lao PDR. Various pilots and policy measures to address the challenges of limited access to health services and lack of financial protection for the poor and the vulnerable have been initiated and several social health protection schemes have been introduced over the past decades. In 2016, SHI expenditures, primarily from formal sector schemes, were 4.4 percent of GGHE. The share of SHI expenditures is expected to increase in coming years as a result of the government's recent decision to launch the NHI scheme in 2016, which integrates these multiple social health protection schemes and will expand its coverage nationwide by 2018. NHI targets the entire informal sector population through the integration of three schemes, namely, the Health Equity Fund (HEF), Community-Based Health Insurance (CBHI), and the FMNCH program. Following its initial operation in three provinces, NHI has rapidly rolled out to 15 provinces in 2017, and is expected to achieve nationwide coverage by 2018.

Despite the rapid expansion of social health protection schemes in Lao PDR, while in transition, they remain fragmented and also duplicate administrative infrastructure. While expansion of NHI is under way, a process of consolidation or integration of the various schemes can create confusion in health facilities and beneficiaries around eligibility and coverage. Separate vertical procedures for monitoring and financial reporting are also being set up. Mitigating this through better alignment and communication will be important as the noncontributory NHI scheme (also with very low copayment for using public health services) expands its coverage and reaches its target of 80 percent population coverage by 2020.

(iii) OOP spending

Despite the significant decline of OOP as a share of THE from more than 60 percent in 2000 to 45 percent in 2016, OOP payments remain the largest source of financing for health in the country (Figure 3). The high levels of OOP spending deter health service utilization, especially affecting the poor, and reduce the potential redistributive capacity of the health financing system. The heavy reliance on OOP spending results in considerable financial barriers to access health services and increases vulnerability of the poor to health shocks.

Figure 3: OOP Share of THE (2014)



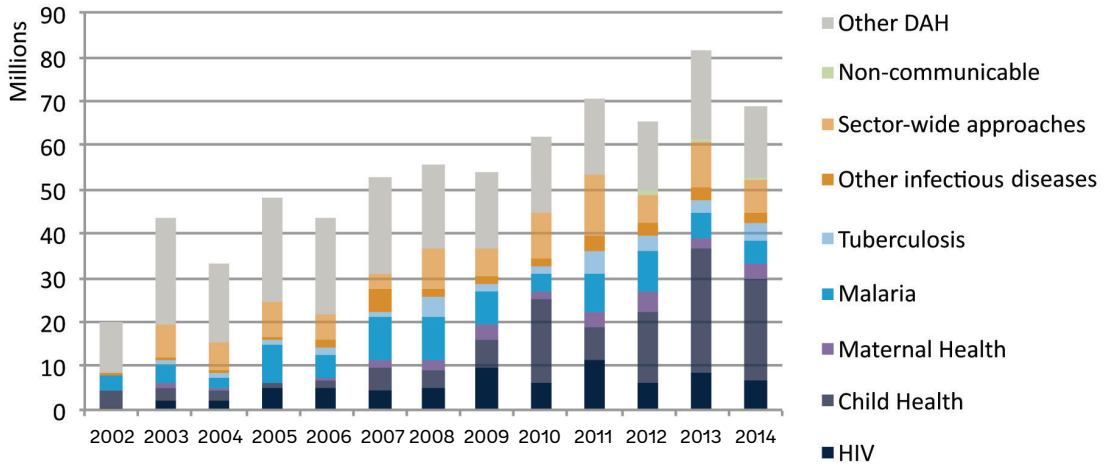
Source: World Bank, 2017.

(iv) External financing

The level of dependency of health spending from external sources is higher than expected for the income level of the country and higher than in neighboring countries like Cambodia or Vietnam. While the share of externally financed health spending in Lao PDR has been steadily increasing in the first decade of the century, it appears to have leveled off between 15 and 18 percent of total health spending in recent years. Externally financed health spending per capita has increased from US$3.13 in 2000 to US$10.35 in 2014.

Figure 4 illustrates the general trends in development assistance for health (DAH) by health focus area. A significant share of the increase in DAH in recent years can be attributed to the country's focus on maternal and child health, nutrition and immunization. While development aid earmarked for specific disease programs such as HIV, TB, and Malaria accounts for a large share of the total DAH, maternal and child health (MCH) accounted for 21 percent of total DAH over the 2002 to 2014 period, increasing to 31 percent since 2010, and peaked in 2014 at 38 percent. General health system strengthening has been another focus area in recent years.

Figure 4: DAH by Health Focus Area (2002–14) and (US$ millions)



Source: IHME 2017a.

From a health financing perspective, one of the major challenges for Lao PDR is to continue expanding service coverage for key health programs that have been traditionally financed by the donors, and accelerate and sustain the progress toward universal health coverage (UHC). The country has to achieve this feat while effectively managing the transition from external financing and by ensuring sustainable financing for UHC. Integration of externally funded programs into a well-functioning health system and reducing fragmentation in financing and service delivery is key to ensuring future sustainability and enhancing health outcomes. While several key donors have initiated dialogue around transition, it is critical for the country to develop a clear transition strategy or plan to ensure its smooth transition from externally funded programs to domestically financed, integrated and sustainable health programs.

Key Messages

Lao PDR is undergoing rapid transition in its demography, epidemiology and composition of health financing. While the country has made the attainment of UHC by 2025 an explicit public policy goal, financing UHC in a fiscally sustainable manner will be challenging in the context of these transitions. There are several key areas that the country can consider and prioritize in its path toward attaining UHC.

Increased domestic financing and decreased reliance on OOP spending is key in moving towards UHC. This may be achieved by

- expansion of social health protection schemes while increasing the efficiency of the health services delivery systems; and
- increasing government health spending to reduce the financial burden on households. Much of this funding will need to come from domestic sources, given the unpredictability and vulnerability associated with external financing, which is declining.

To ensure sustainability, it is essential to increase efficiency and effectiveness of health spending. This may be achieved by

- increased levels of spending along with increased **efficiency and effectiveness of spending to ensure sustainability of financing for health and desirable public health outputs and outcomes;**
- improved financial management and expenditure tracking systems at all levels including the health center;
- priority setting to identify where limited resources should be invested. This will involve an evidence-based determination and prioritization of the investments yielding the best returns in terms of health outcomes, improved equity, improved financial protection, sustainability and other important health system objectives; and
- innovations to cut costs, such as encouraging facility-based services for Zone 1, and integrating outreach for Zones 2 and 3. Mainstreaming of programs also allows multitasking by multiskilled staff, which is difficult to achieve in vertically run programs.
- responding to the changing BoD and addressing the increasing burden and potential economic impact of NCDs while addressing the unfinished agenda to meet the health MDG targets and challenges of undernutrition and stunting.

UHC service package needs to integrate vertical health programs and be costed to ensure sufficient and sustainable financing. This may be achieved by

- planned integration and mainstreaming of the multiple, often parallel, implementation modalities leading to efficiency gains;
- careful determination of the content, processes and modalities, as well as the costing of the essential service package (being considered as the first step towards UHC) to project future financing needs for UHC;
- a costed essential service package for mainstreaming vertical health programs, such as HIV, TB, Malaria and immunization services. Immunization and other key health programs financed and delivered through vertical structures create duplication and

inefficiency (for example, in supply chain management, reporting and service delivery); and
- a medium-term expenditure framework for the health sector for assessing the fiscal space for health and ensuring adequate, predictable and sustainable financing for health.

Gradual and functional integration is imperative for successful transition and sustainability. This may be achieved by:
- full integration and mainstreaming of data systems under the unified district health information system (DHIS 2) to reduce unnecessary burden at the facility level, while concentrating on efforts to improve data quality and end use of the information for monitoring, planning and policymaking;
- integrating or streamlining multiple mechanisms for financing and delivery of health programs and services;
- strengthening the institutional capacity for managing the integrated schemes and steering purchasing functions for improved health system performance;
- leveraging the information systems, monitoring and purchasing capacity in an integrated system to improve the quality of service delivery.

Careful design and implementation of the Essential Service Package. This may be achieved by:
- giving due consideration to the needs of population health and addressing the changing BoD when designing the Essential Service Package
- including facility-based as well as community-based services, and defining the optimal extent to which facility-based services must be delivered through outreach to population groups who do not seek or have access to services
- evaluation of all services included, based on cost effectiveness, supply-side readiness, fiscal capacity, equity and other criteria relevant to the country context
- adequate and sustainable funding to cover the services for the poor and other target groups exempt from co-payment
- ensuring that services are available to the poor and underserved – and that 'elite capture' is avoided.

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