Medicus Mundi Switzerland
Health for all

MMS Bulletin #144
Leaving no one behind - Reflections on the UN-Agenda 2030

The health financing reform of the Lao People's Democratic Republic (PDR)

Social Health Protection for all - Leaving no one behind?

By Jean-Marc Thomé and Monika Christofori-Khadka, Daniel Yu Sekeun

The Government of the Lao People's Democratic Republic (PDR) took a bold decision in 2016 to expand countrywide and largely subsidize the existing different social health protection schemes targeting the large informal sector including poor people, pregnant women and children and unite them into one national health insurance.

Nutrition education and demonstration at Tatou Health Centre, Laos. Photo: SRC

The Swiss Red Cross (SRC) has been for long a key partner of the Ministry of Health to pilot and prepare this major health financing reform with a focus on Sekong province, providing both technical and financial supports in building social health protection mechanism for all and in improving quality of maternal, neonatal and child care in the primary and secondary health care providers. Results of the interventions in Sekong province were evaluated in summer 2017 and showed that social health protection mechanism (including transport and food allowances for inpatient services) has greatly contributed to increase the utilization of health care and making access to health care more equitable. Despite the reduction of access barriers related to affordability and quality of care, the utilization rates continue to lag behind in the remote areas and among the poor. Distance to health facilities, traditional values, education and knowledge, and communication appear to be also important factors to utilization for these services.

Government commitment to Universal Health Coverage

The Government of the Lao PDR (GoL) is fully committed to fulfil the SDG target 3 related to good health and wellbeing by "ensuring healthy lives and wellbeing for all ages", and in particular reducing maternal mortality (target 3.1.); investing in sexual and reproductive health (target 3.7.); ending preventable deaths of newborn and children under 5 years of age (target 3.2.), as well as ensuring Universal Health Coverage for the whole population (target 3.8.) through substantial investment in health financing (target 3C). The Ministry of Health has emphasised in its policies universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

The GoL runs a well-structured network of public health facilities in all provinces, with only few private providers existing. The GoL pursues reforms aiming to cover 80% of population coverage with an essential package of services and appropriate financial protection by 2020, and achieve the Universal Health Coverage (UHC), as outlined in SDG target 3.8., even by the year 2025. For this, the GoL invests immensely in the health financing (goal 3.C). According to the strategy outlined in the 8th Health Sector Development Plan (2016-2020) and Health Sector Reform framework (Phase 2: 2016-2020), the Ministry of Health (MOH) aims to strengthen service delivery by increasing supply-side subsidies, and improve financial health protection through expanding SHP mechanism. These measures are targeted at improving quality of care and reducing the burden of out-of-pocket payments currently estimated at 46% of Total Health Expenditure (NHA 2016). The high share of out-of-pocket expenditures together with growing income inequalities are obstacles preventing access to health care for all, and reasons for exposure to catastrophic risk, in particular, for the poor and disadvantaged segments of the population. Additionally, the MoH reproductive, maternal, neonatal and child health (RMNCH) strategy 2016-2020 outlines measures to improve quality of care and address the high maternal mortality rate of 206/100'000 live births (Population and Housing Census 2015) and the under 5 mortality rate of 86/1'000 live births (Population and Housing Census 2015), both being the highest among countries of the South-East Asia region.

SRCs longstanding partnership with the Ministry of Health

In order to achieve its plans, the Government has requested support to the different multilateral and bilateral agencies, including the Swiss Red Cross (SRC). After piloting the first Health Equity Fund (1) to improve access for the poor in 2004 in Nambak district of Luang Prabang province, the SRC's work on social health protection in Sekong mainly started in 2008-09 where it contributed to the implementation of the Health Equity Fund, and subsequently in rolling out different other social health protection schemes launched by the Government, for example the free MNCH (2) and pilot health insurance scheme for the remaining informal sector non-poor population. Beneficiaries covered under these schemes are entitled to access health care services for free or at very low cost. In addition to the medical benefits, the poor households are supported by a transport allowance and food allowance for the time of an inpatient admission. In 2014, the "Contribution to Universal Health Coverage" project (CUHC) of the SRC started. The SRC team assumed together with other donors, an important technical advisory role to the MoH in relation to the SHP and UHC.

The support on SHP have also been accompanied by strengthening of health system management including development and institutionalization of governance arrangements, health information system, monitoring and verification mechanism as well as a financial management and drug accounting system for the provincial and district hospitals. Additionally, the project built the management and operational capacity of the staff of the newly established Provincial and District Health Insurance Bureau (PHIB/DHIB) to deal with the claims, reimbursements and provider payments. In order to improve the quality of the RMNCH services in provincial and district hospitals, and numerous health centres, especially in two remote districts (Khalum and Dakchung), the project provided technical assistance to the health staff to improve quality of care mainly by capacity building, on-the job training, provision of necessary equipment and light infrastructure support. A special emphasis was given to the capacity building and skill development of the professional cadre of "Community Midwife", which the GoL had newly introduced in 2009 to serve in remote areas.

So tasty! Photo: SRC

Measuring impact

By tackling the financial as well as quality barriers to access to care, the project assumed to "leave no-one behind" in Sekong province, enabling free access to quality services for all. In order to measure the impact of the project interventions in regards to performance of social health protection mechanism, household catastrophic health expenditure, effective MNCH service coverage and mother's knowledge of pregnancy risks and child health, the project conducted a household surveys in 2015 and 2017. The survey comprised of quantitative data collected through a two-stage stratified two-stage cluster sampling. The first stage included a cluster sampling of 60 villages across province by zone (3). Thirty villages were from the "pre-identification zone" (PreID zone) comprising of households, which are either not poor or were eligible for the Health Equity Fund. The other 30 villages were randomly selected from the so-called "geographic exemption zone" (GeoID zone), where all households, just by the mere location in a remote area, were exempted from service fees. The GeoID zone comprised all households in Khalum and Dakchung district and a small number of villages in Lamam district. In the second stage, households in selected villages are systematically random sampled using a list of poor households validated by the district authorities and maintained by the PHIB/SRC. The data collection was performed by the Indochina Research Limited company.

Table 1: The survey sample

Sampling method	**Stratified two-stage cluster sampling**
First stage	Cluster sampling of 60 villages across province by zone

	Pre-identification zone	30 villages (PreID; including poor and non-poor households)
	Geographic exemption zone	30 villages (GeoID)
Second stage	Random sampling of households within village by stratified group (ensuring enough mothers and children under 2 years of age are included)	

Sampled Household	PreID	GeoID	Total
Poor (HEF)	270	270	540
Non-poor	390	-	390
Total	660	270	930

An analysis was performed mainly comparing the results of the baseline and endline data. Findings were also cross-checked with the data from the district health information system 2 (dhis2), which is nationally rolled out in Lao PDR and other major surveys.

In addition to the quantitative approach, qualitative information was collected through key informant interviews and focus group discussions carried out with senior Ministry of Health representatives from the Department of Finance and National Health Insurance Bureau as well as senior provincial and district representatives with management responsibility from the Provincial Health Office, Health Insurance Bureau, and MNCH Centres in the four districts of Sekong province. A survey team also interview at least one nurse and/or doctor from the hospital and one nurse or doctor from two selected MNCH Centres in each district. In addition, the researchers also undertook opportunistic interviews with patients, from the hospital maternity ward, who had given birth. The team meet and interviewed at least one health center staff and also undertook opportunistic interviews with patients who were visiting the HC. In addition, they visited adjoining villages and meet with the village chief and villagers to discuss health and social issues that impact on their lives.

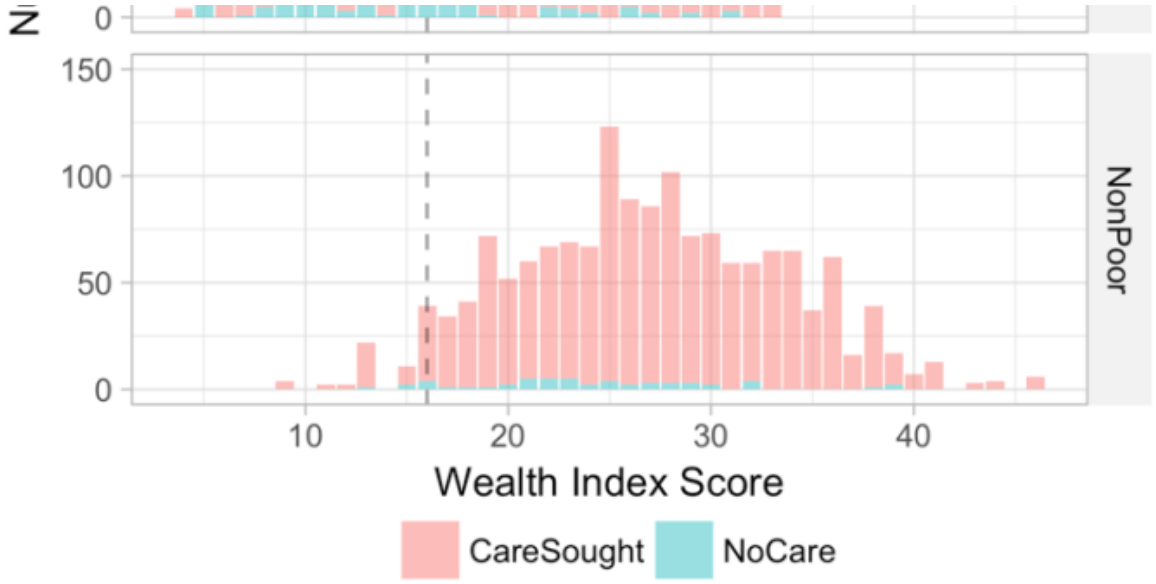
Financial protection and health care seeking behaviour

Despite the wealth index of the population under survey not differing over the years, the health seeking behaviour of the poor in remote areas appears to have positively changed partly thanks to the project interventions. Compared to the baseline, more proportion of people from GeoID group below the wealth index score of 16, who are considered as poor, sought health care (see figure 1 and 2). At endline, the poor who did not seek care during sickness event was at 15%, which is 5% points down from the baseline. A more equitable distribution of health care seeking among the different wealth index scores has been observed.

Figure 1 and 2. Health care seeking behaviour by wealth and stratified group; baseline 2014; endline 2017

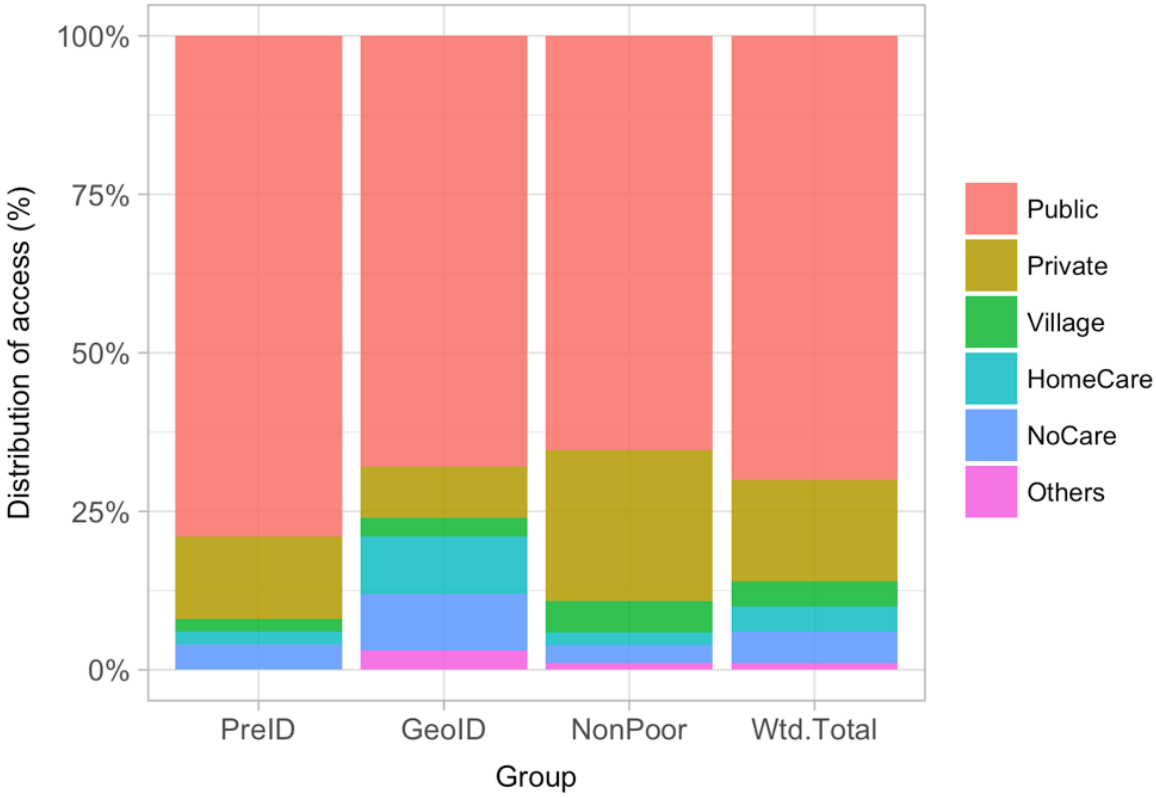

Number of Sickness
200
150
100
50
0
PreID
GeoID
NonPoor
10
20
30
40
Wealth Index Score
CareSought
NoCare


umber of Sickness
150
100
50
0
PreID
GeoID



Despite this progress, however, a substantial number of patients in GeoID zone still does not choose to seek health care and relies on traditional and home care (see figure 3).

Figure 3: Choice of health care provider by stratified group; endline 2017

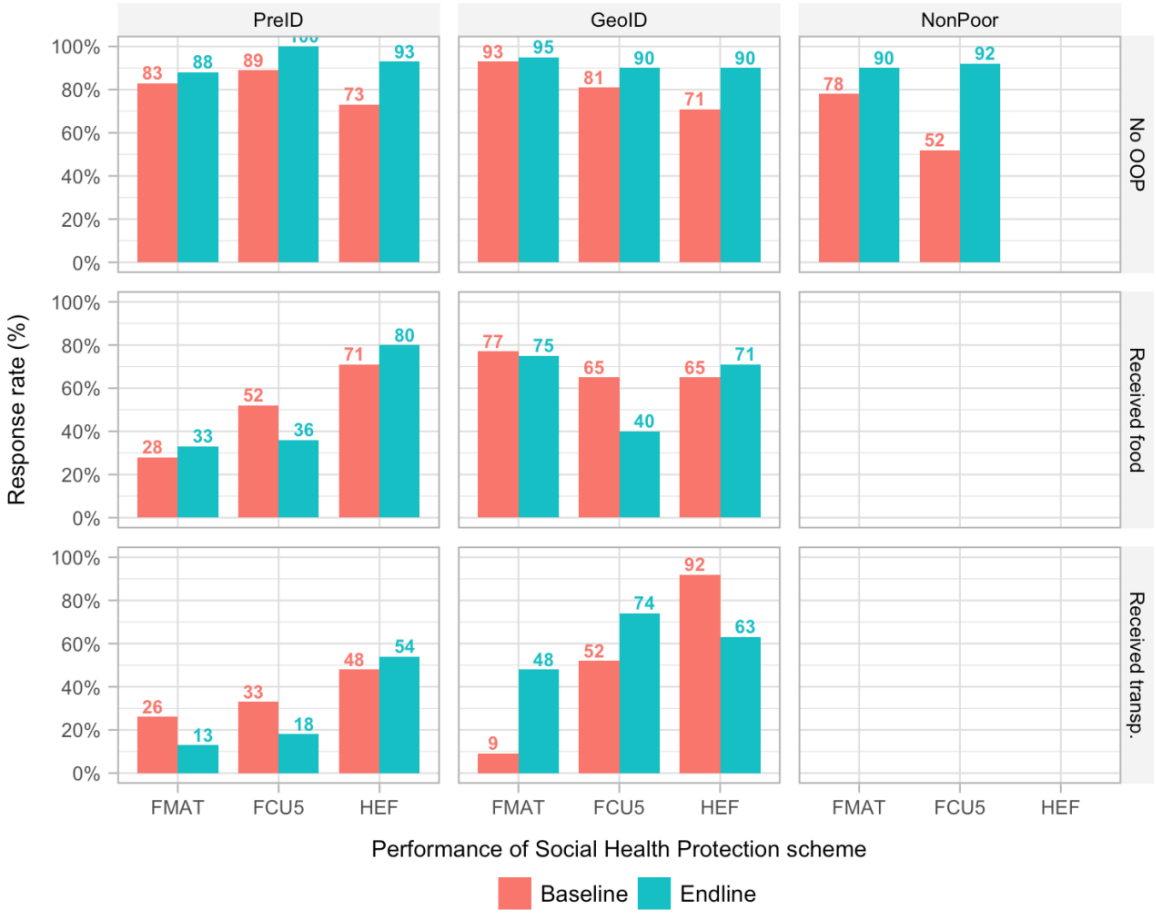


Thanks to the social health protection schemes, the percentage of households who spent more than 500'000 Lao KIP (local currency; around 60 CHF (4)) per care seeking episode decreased by 23% at provincial level. This was largely due to a substantial decrease observed for the non-poor population (from 67 % at baseline to 22 % in endline survey) and partly for the geographically exempted population (from 30% at baseline to 16 % at endline survey). In fact,

given the HEF/ free MNCH schemes were implemented before 2014 and the poor, pregnant women and children under 5 were normally already having free services in public facilities, no major changes were expected for the GeoID and for the poor in PreID zone. When a relative threshold is applied, the proportion of households paying more than 20% of their annual cash income for health care seeking episodes at provincial level has dropped only by 4% points from the baseline, leaving 26% of households still under potential negative effects of catastrophic health expenditure. This may be related to an overall decrease in household income by 25 % reported by the survey respondents of the NonPoor and PreID group.

Respondents of all groups have a high level of knowledge about the social health insurance systems, with knowledge rate in all three groups that the services are free. Also, more than 90% of the mothers, children under 5 and HEF members reported they were effectively exempted from any kind of out-of-pocket payments (including drugs, diagnostics, technical fee, document or informal payment to doctor) during their most recent admission events. However, results of providing food and transportation allowance are rather mixed with no consistency in change from the baseline to endline (see figure 4). While OOP payments have further decreased in all groups, food and transport allowances in all three SHP schemes have further scope for improvement. However, the GEO-ID group with poor beneficiaries from the remote areas have increasingly received their transport allowances. 48% of GeoID women received transport allowance, an increase of 40% towards the baseline survey. A similar pattern of change in trends can be observed also for the children under 5 and the poor. This can at least be partly attributed to a challenge in administering and monitoring food and transportation benefits at health facility level, but also a rather small number of samples collected in the survey.

Figure 4: Effectiveness of the different social health protection schemes in patients not paying out-of pocket payments; received food and transport allowance



FMAT = Free Maternal treatment

FCU5 = Free Treatment for children under 5 years of age

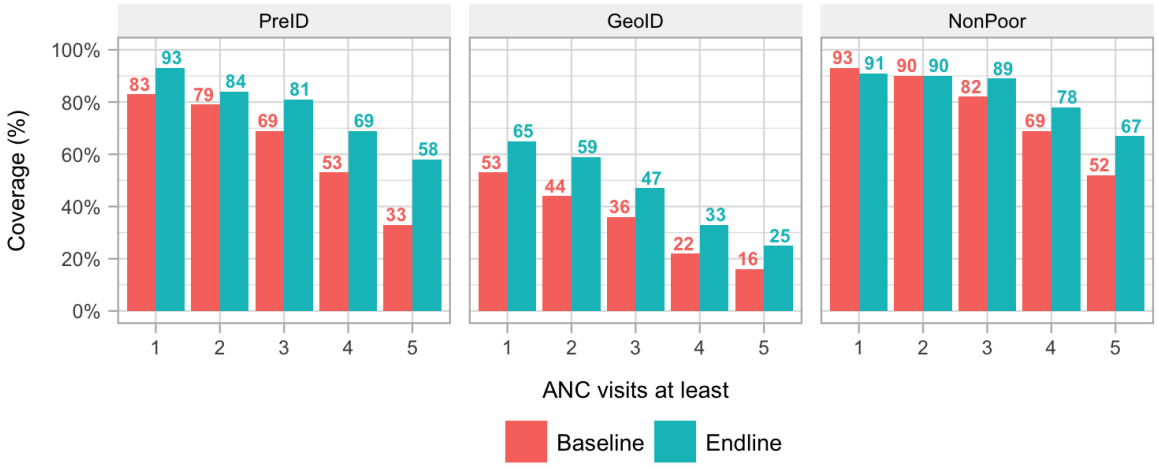
HEF = Health Equity Fund

Health outcomes

Besides their inclusion in the social health protection schemes, the population of Sekong benefitted from the different health interventions of the project to improve the access to quality RMNCH care in Sekong provincial and district hospitals as well as in selected health centers

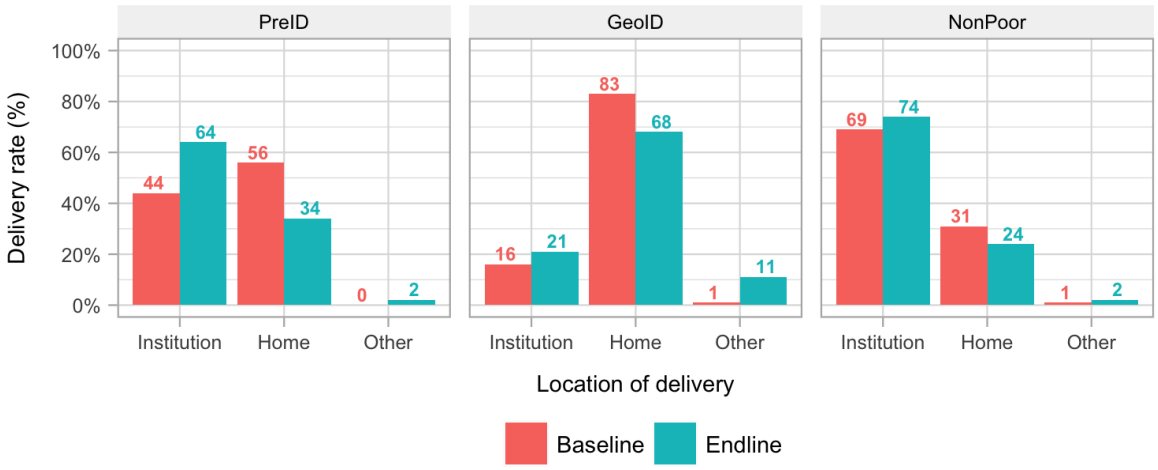
The endline survey showed a notable increase in the antenatal care (ANC) coverage in all groups. In the group of the NonPoor, an increase in the third to fifth visit in ANC was obvious, whereas the PreID and GeoID groups showed an increase in any of the ANC visits. However, an increase in ANC seeking behavior lacks behind in the GeoID group (see figure 5).

Figure 5: ANC coverage



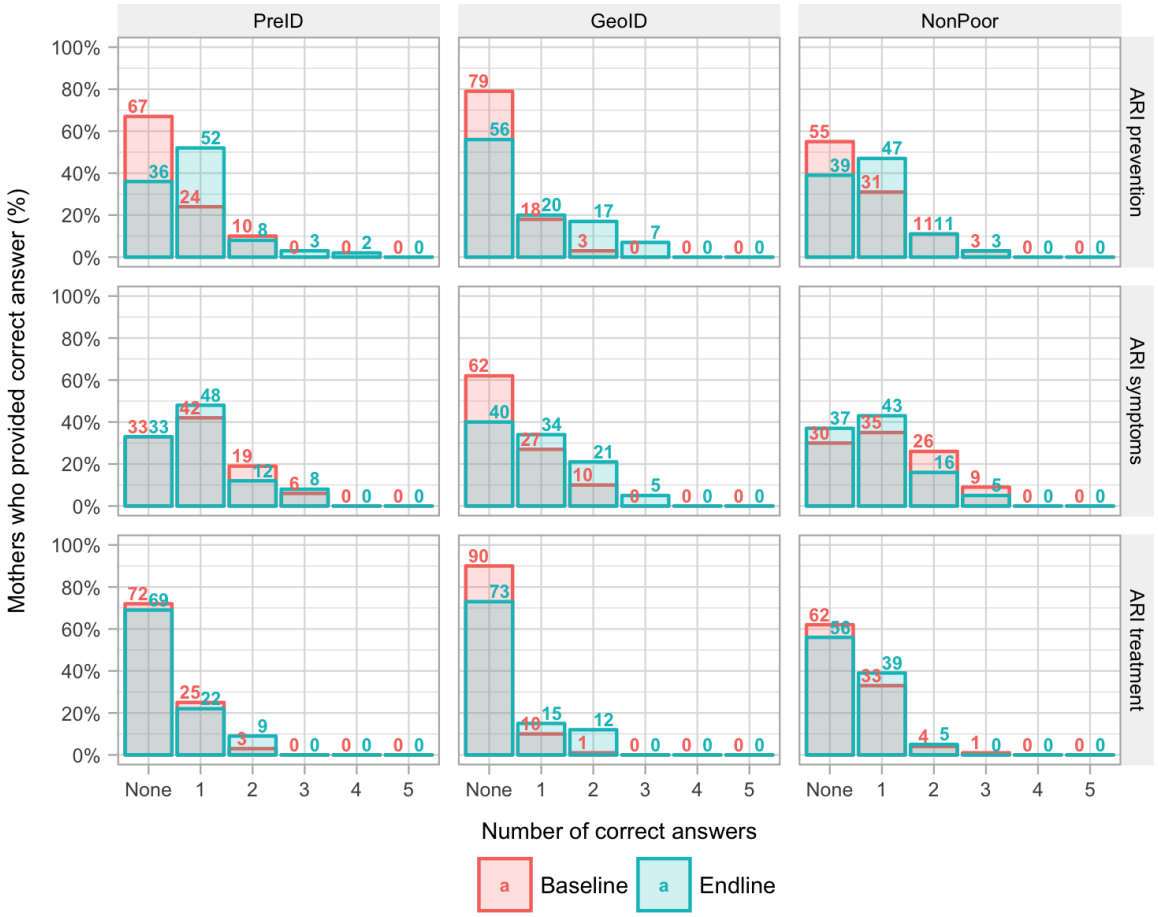
A similar trend is seen for institutional deliveries with skilled birth attendants (see figure 6). The survey result shows while PreID and NonPoor women increasingly deliver in a health care institution, rather limited increase in institutional deliveries has occurred with women in the GeoID zone, even though home deliveries diminished by 15% points. The free MNCH records from health facilities and DHIS2 data show more significant increase of at least 10% points for institutional deliveries from 2014 to 2017 than what is captured in the survey. Nevertheless, the absolute rate of institutional deliveries in remote areas is still substantially low.

Figure 6: Institutional deliveries



The knowledge of women related to childhood illnesses such as diarrhea and acute respiratory infection (ARI) has significantly improved in Sekong, partially due to an increase in understanding of good prevention and treatment practices. In particular, the result shows the increase has been significantly higher for mothers in GeoID zone. Despite the progress, however, the level of knowledge of mothers in GeoID zone continues to be the lowest amongst three stratified groups. Exemplary the results from knowledge on acute respiratory infection prevention, symptoms and treatment are seen in figure 7.

Figure 7: Knowledge on Acute Respiratory Infection



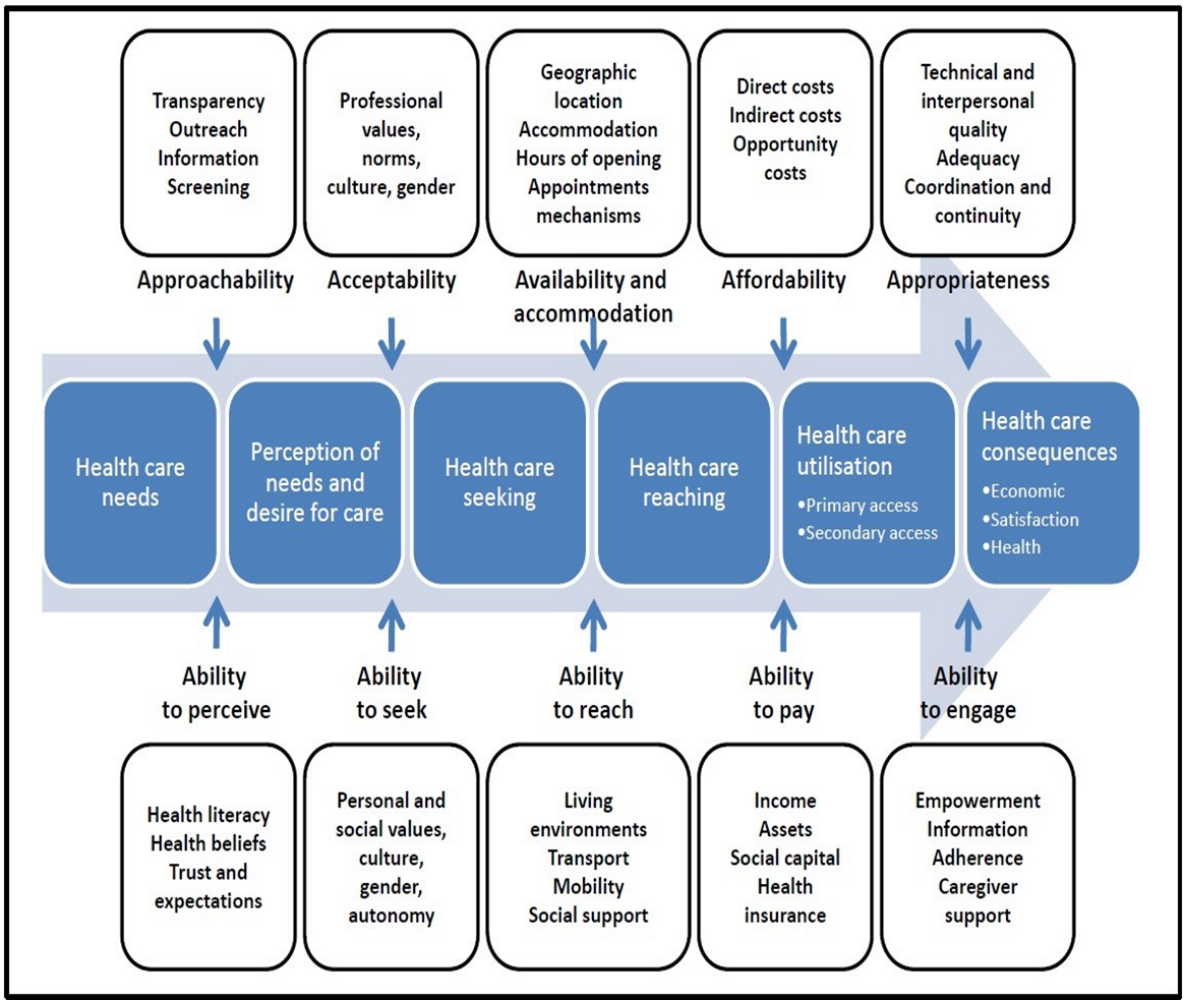
Child health outcomes have improved in all respondent groups, however, in GeoID group lower as in the other two. Figure 8 shows more than 80% of children in Sekong have received BCG and Hepatitis at birth (HepB0). A good progress has been achieved for DPT (except DPT1), Polio and MR with an increase of at least 10% in their respective coverage, although the rates are still considerably lower than the national estimates. The full immunization coverage has also increased but remains low with less than 40% of children of aged around one year completing BCG, DPT3, Polio3 and MR1. A substantial and consistently low immunization coverage of GeoID group highlights significant geographical disparities in access to the vaccine programs within Sekong.

Leaving no-one behind?

The GoL has taken a bold decision and made a commendable move towards providing Universal Health Coverage and thus tackling not only the important goal 3 for health, but also contributing to the fulfillment of goal 1 (no poverty), goal 5 and goal 10 (gender equality and reducing inequalities) as well as goal 17 (established partnerships) of the SDG agenda. The poor and people living in the remote areas of Sekong province have particularly benefitted by removing access barriers to health at policy and implementation level. The results are a much higher utilization rate of curative consultations and general admissions in Sekong. However, in comparison to the "better off" groups, access to maternal and child preventive services, surgical services as well as health outcomes of the poor, especially in remote areas of Sekong, continues to lag behind.

The framework of access to health care (see figure 8) developed by Levesque et al. (2013) describes ten access barriers from the health system side (supply side) as well as from the beneficiaries (demand side).

Figure 8: Framework of access to health



Using the framework of access to health care developed by Levesque et al. (2013), access barriers to health related to "affordability", "availability", "ability to reach" and "ability to pay" have been removed with the national health insurance system and its benefits. However, despite a high level of knowledge about the schemes, entitlements are either not paid or not claimed by the eligible people, and in particular the poor. Good and thorough information to the people about their rights and entitlements, empowering them to utter their voice to claim the entitlements, and their ability to engage has to be further fostered with better health communication strategies. Alongside, the continuation of a regular monitoring system to track from patients whether benefits were paid is important to hold the national health insurance bodies accountable. Another reason for unclaimed benefits may lie in the "ability to perceive" and "ability to seek" health care. Particularly in remote areas, cultural practices and traditions still prevail strongly. Health education and information about the benefits of "western" versus

traditional medicine are equally important to improve health outcomes and also ensure that benefits are claimed and received before patients return to their village to perform traditional health rites.

Free services stimulate service uptake in Tatou Health Centre, Laos. Photo: SRC

Welcome culture for all patients is needed

In Sekong province, the proportion of women delivering at health facilities has significantly increased with improved quality of care in the hospitals and health centers in particular for MNCH services in terms of "appropriateness", disparities in institutional delivery rate between the rural and the more urban areas remain substantial. This implies that the reason for low institutional delivery in GeoID zone maybe partially linked to a distance or cultural factors rather than purely a financial or quality reason. Other health services have been better utilized by the poor over the past project phase and have further scope to improve. Since financial barriers per se are removed through the social health protection mechanism, other factors, such as a still insufficient quality of care and in staff behavior towards poor patients from remote areas, which are mostly of ethnic minorities and also speak a different language, should be carefully investigated and addressed if needed. Further working on the "appropriateness" and "acceptability" in terms of further enhancing quality of care, fostering a welcoming culture for all patients as well as lobbying for the training and employment of health staff (and in particular community midwifes) from ethnic minorities and groups and staff with knowledge of different languages, will be a long-term asset in the system. Opportunities to remove social and cultural barriers with the introduction of health promotion days and outreach to improve information flow and knowledge and building peoples trust in the health care system should be explored further.

Removing financial access barriers alone are not sufficient to leave no-one behind. Where money is not the issue, other barriers have to be carefully analyzed and context-specific adaptations need to be made to ensure that the needs and concerns of the ones left behind are heard and taken up, including their active participation in implementation. The new project phase has foreseen an emphasis on the information and roll-out of the national health insurance system including village representatives to the health insurance committee meetings at district level so that their concerns and issues can be shared and addressed in a proper manner. The tight monitoring system of benefit payments will continue. A scale-up of quality improvement measures in the health facilities is foreseen together with training of community midwifes from remote locations and their placement in their local area.

In the coming years, further efforts of the GoL and its partners will materialize in addressing the SDG 3 goal on health. As all SDGs influence each other, working on all 17 SDGs will increase the leverage on the health impact. How the different interventions will create equal access and ensure that no-one is left behind, will be closely monitored over the next years and decade. Within this, the Swiss Red Cross will be a proud partner to assist the GoL in achieving the SDGs by 2030.

Annotations:

1. The health equity fund ensures a fee exemption for poor households. It purchases health care for those poor people from a health care provider, and also pays for all the associated costs.

2. Fee exemption system for women and children under 5 years of age.

3. Pre-identification zone comprising of households who are non-poor or were pre-identified as “poor” and are eligible for the Health Equity Fund”

4. Currency exchange rate: 1 CHF = 8‘250 Lao Kip (OANDA Exchange rate converter; accessed on 15.11.2017)

Reference:

- Levesque J.-R; Harris M., Russel G. (2013). Patient-centered access to health care: conceptualizing access at the interface of health systems and populations; International Journal for Equity in health 2013, 12:18 https://equityhealthj.biomedcentral.com/articles/10.1186/1475-9276-12-18

Disclaimer:

The SRC thanks the Indochina Research (Laos) Ltd. Research Team for their thorough evaluation and report conducted in August 2017.

***Monika Christofori-Khadka**: Health Advicer, SRC Headquaters; Switzerland. Contact: monika.christofori-khadka@redcross.ch*

***Daniel Yu Sekeun:** Social Health Protection Technical Adviser and M&E Officer; SRC Laos. Contact: sekeunyu@gmail.com*

***Jean-Marc Thome:** Country Coordinator and Team Leader of the "Contribution to Universal Health Coverage" project of the SRC; SRC Laos. Contact: jmthome.lao@gmail.com*

Kontakt

Deutschschweiz
Medicus Mundi Schweiz
Murbacherstrasse 34
CH-4056 Basel
Tel. +41 61 383 18 10
info@medicusmundi.ch

Suisse romande
Medicus Mundi Suisse
Rue de Varembé 1
CH-1202 Genève
Tél. +41 22 920 08 08
contact@medicusmundi.ch

Bank details
Basler Kantonalbank, Aeschen, 4002 Basel
Medicus Mundi Schweiz, 4056 Basel
IBAN: CH40 0077 0016 0516 9903 5
BIC: BKBBCHBBXXX