Government Expenditure On Health In Lao PDR

Overall Trends And Findings From A Health Center Survey

May 2016

WORLD BANK GROUP

CURRENCY EQUIVALENTS

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LIST OF ABBREVIATIONS

ANC	Antenatal care
DALYs	Disability-adjusted life years
DPT	Diphtheria polio tetanus
DHOs	District health offices
DFO	District finance office
EAP	East Asia and the Pacific
FYs	Fiscal years
GDP	Gross domestic product
GGHE	General government health expenditure
GNI	Gross national income
HEFs	Health equity funds
HC	Health center
IHME	Institute for Health Metric and Evaluation
LECS	Lao Expenditure and Consumption Survey
LSIS	Lao Social Indicators Survey
MDGs	Millennium development goals
MCH	Maternal and child health
MMR	Maternal mortality ratio
MOH	Ministry of health
NCDs	Non-communicable diseases
NHA	National health accounts
OOP	Out-of-pocket
PFO	Provincial finance office
PHOs	Provincial health offices
PvtHE	Private health expenditure
RDFs	Revolving drug funds
SDs	Standard deviations
THE	Total health expenditure
UFGE-CNP	Umbrella Facility for Gender Equality – Community Nutrition Project
UHC	Universal health coverage
WaSH	Water, Sanitation, and Hygiene
WDI	World development indicators
WHO	World Health Organization

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The findings and interpretations expressed here are those of the authors and do not necessarily reflect the views of the World Bank Group, its Executive Directors, or the countries they represent.

CONTENTS

LIST OF FIGURES

EXECUTIVE SUMMARY

This policy note provides an overview of government health financing in the Lao People's Democratic Republic (PDR), with an added focus on health center financing. The note summarizes overall trends in health outcomes and government health financing over 2000-2014 and analyzes trends in planned and realized government budgetary health spending data covering fiscal years (FYs) 2000/01 to 2013/14 and planned expenditures for FYs 2014/15, updating a previous assessment conducted in 2012. In addition, this note summarizes findings from health center financing data collected as part of the UFGE-CNP facility survey which collected information from a nationally-representative sample of 120 health centers in 2013-14. This policy note is one of a series designed to disseminate findings of the World Bank's program of analytic and advisory activities for health in Lao PDR.

Key Messages

- Lao PDR has made notable progress in improving maternal and child health outcomes and is on-track to attain maternal and child health-related MDGs, which compares performance today with a 1990 baseline. However, by current global and regional standards, Lao PDR still has some of the worst maternal and child health (MCH) outcomes. Furthermore, Lao PDR is currently off-track to attain nutrition-related MDGs, with about one-third of children under-five underweight and almost half stunted.
- These poor population health outcomes are associated with low and inequitable utilization of health services, and worsening measures of financial protection. The incidence of catastrophic health expenditure has worsened in 2012-13 to 5.0 percent from 3.8 percent in 2007-08, and large inequalities in health service delivery and health outcomes, across economic, urban-rural, geographic, and ethnic dimensions remain.
- From a health financing standpoint, Lao PDR is characterized by low but increasing levels of government spending, associated with high levels of out-of-pocket (OOP) spending and unsustainable dependence on external financing.
- The Government of Lao PDR has committed to increasing government health expenditure to 9 percent of overall government expenditure by 2015, which is to be affirmed, although considerable challenges remain in ensuring not just an increase in the quantum of spending, but also to increase the allocative and technical efficiency, and the effectiveness of spending to achieve desirable population health outputs and outcomes.
- Concurrent commitments and initiatives to expand coverage and financial protection for the poor, via the use of pooled and prepaid financing, through health equity funds (HEFs), and the removal of user charges for maternal and child care (MCH) services, with an overall policy aim of attaining universal health coverage (UHC) by 2025, are important adjuncts to ensure that spending results in expanded health service delivery to those most in need of these services.
- Inclusion of technical revenues and external financing in the 9 percent target however, reduces the clarity of health sector goals intended by such a target – as technical revenues (and RDFs) undermine the financial protection goal of the health system and is indeed antithetical to the goals of UHC – while inclusion of external financing weakens the accountability for the 9 percent target.
- The national health financing context is reflected, at the health center-level, with dependence on revolving drug funds (RDFs) – paid for directly by users of health services as OOP - and external financing for 58 percent and 20 percent of health center revenue respectively. Yet, despite extracting finance from end-users through RDF revenues, the availability of essential medicines remains poor.
- In moving towards UHC and in order to reap the economic and social benefits of improved health status and greater financial protection, Lao PDR will need to decrease reliance on OOP-financed revenues from RDFs, increase domestic government health financing, and increase pooled and pre-paid financing via strengthened pre-payment mechanisms.

1. Introduction

1. This policy note provides an overview of government health financing in the Lao People's Democratic Republic (PDR), with an added focus on health center financing. The note summarizes overall trends in health outcomes and government health financing over 2000-2014 and analyzes trends in planned and realized government budgetary health spending data covering fiscal years (FYs) 2000/01 to 2013/14 and planned expenditures for FYs 2014/15, updating a previous assessment conducted in 2012.[1] In addition, this note summarizes findings from health center financing data collected as part of the UFGE-CNP facility survey which collected information from a nationally-representative sample of 120 health centers in 2013-14. This policy note is one of a series designed to disseminate findings of the World Bank's program of analytic and advisory activities for health in Lao PDR.

[1] World Bank (2012). Government Spending on Health in Lao PDR: Evidence and Issues, Vientiane.

2. Background and Health Outcomes

1. Lao PDR is a landlocked country with a population of 6.4 million, where the majority of the workforce is engaged in agriculture and 70 percent of the population lives in rural areas. As a result of rapid economic growth, poverty reduction over the past two decades has been impressive. The proportion of the population living below the poverty line fell from 45 percent in 1992 to 23 percent in 2012. The World Bank now classifies the country as lower middle-income with a gross national income of US$1,450 per capita. However, income and other inequalities are prominent. Poverty remains high especially in remote and highland areas where access by road or river is difficult; and rural areas continue to have poor access to sanitation and electricity. Ethnic minorities, who tend to live in the highlands and mountain slopes, are particularly disadvantaged even though they comprise almost one-half of the population.

2. Lao PDR has made steady and significant progress on several key population health outcomes over the past few decades. Life expectancy has increased steadily to almost 68 years in 2013, up from 49 years in 1980 (Figure 1). Under-five and infant mortality rates have also declined significantly over the same period: the under-five mortality rate declined from 201 per 1,000 live births in 1980 to 71 per 1,000 live births in 2013. At current trends, Lao PDR is projected to meet the child health Millennium Development Goal (MDG) which calls for a two-thirds reduction in under-five mortality over the period 1990-2015.[2] Lao PDR also appears also to be on-track to attain the maternal health MDG, which calls for a 75 percent reduction in the maternal mortality ratio (MMR) over 1990-2015, although not on-track for nutrition-related MDGs.[3] Furthermore, despite notable progress, considerable challenges remain. Lao PDR continues to have some of the worst maternal and child health (MCH) outcome indicators, both globally as well as in the East Asia & Pacific (EAP) region. Under-five and infant mortality rates are below average relative to GDP per capita (Figure 2). Although there is some uncertainty regarding exact numerical values, at 220 per 100,000 live births Lao PDR's MMR is high and much higher than that of neighboring Cambodia and more than four times the estimate for Vietnam (Table 3).[4]

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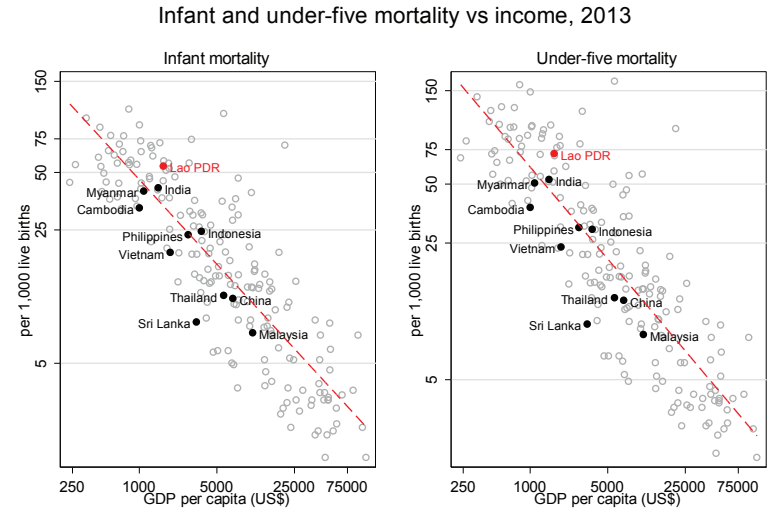
[2] Government of the Lao PDR and United Nations (2013). The Millennium Development Goals Progress Report for the Lao PDR 2013.

[3] WHO/UNICEF/UNFPA/World Bank (2014). Trends in Maternal Mortality: 1990 to 2013. Estimates by WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division

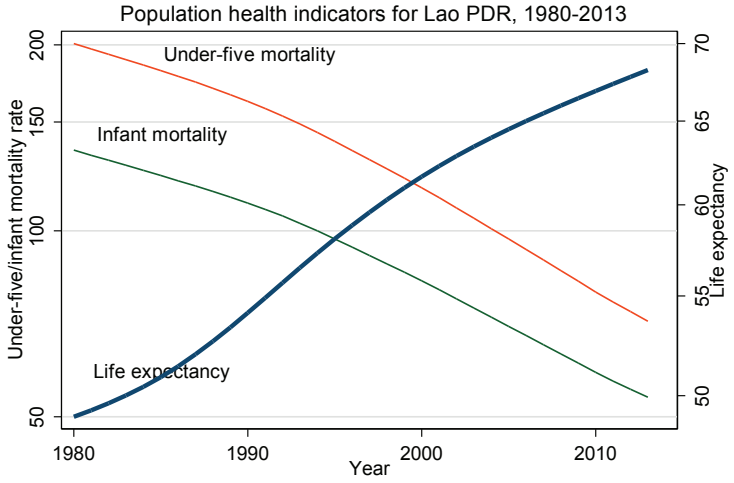
[4] Ibid.

Figure 1: Infant and Under-five Mortality Relative to Income, 2013



Sources: WDI & WHO
Note: x-scale and y-scale logged

Figure 2: Key Trends in Population Health Outcomes in Lao PDR, 1980-2013

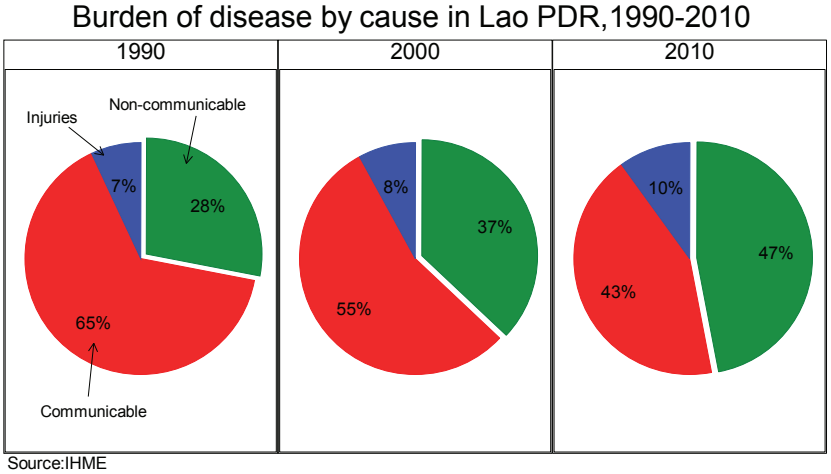


Source : WDI
Note: y-scale logged

3. About a third of all children under five remain underweight and almost half are stunted. At current trends, Lao PDR is off-track on the nutrition MDG. Underlying poor MCH outcomes include low levels of coverage for key MCH utilization indicators such as antenatal care (ANC), skilled birth attendance, and immunization for measles and DPT, and contribute towards suboptimal growth conditions during the crucial first 1,000 days of life, beginning at conception. Low quality of health care remains a key challenge facing the health sector.

4. Like several other countries in the region, Lao PDR is undergoing a rapid epidemiological transition. NCDs now account for the largest share of the burden of disease in the country. Whereas in 1990 only about 28 percent of morbidity and mortality in Lao PDR was due to NCDs, by 2010 this number had risen to 47 percent (Figure 3). Lower respiratory infections were responsible for the largest share of the overall disease burden, causing 8.8 percent of all disability-adjusted life years (DALYs) lost due to morbidity and premature mortality in 2010 (Table 1). Ischemic heart disease's and stroke's share of DALYs has been rising rapidly over the period 1990-2010. Smoking tobacco is one of the five main risk factors, accounting for substantial burden of disease in Lao PDR, where the other risks are household air pollution from solid fuels and dietary risks[5] (see Table 2).

Figure 3: Burden of Disease by Cause in Lao PDR, 1990-2010



Source:IHME

Table 1: Top Ten Causes of Disease Burden in Lao PDR, 1990-2010

Rank in 2010	Top ten diseases/conditions in 2010	DALYs lost share		
		1990	2000	2010
1	Lower respiratory infections	15.1	12.0	8.8
2	Ischemic heart disease	2.5	3.3	4.4
3	Diarrheal diseases	11.2	7.8	4.7
4	Congenital anomalies	4.3	4.6	4.1
5	Stroke	2.2	3.0	3.9
6	Preterm birth complications	3.8	4.0	3.8
7	Tuberculosis	3.3	3.5	3.3
8	Unipolar depressive disorder	1.3	2.0	2.8
9	Road Injury	1.2	1.8	2.7
10	Neonatal encephalopathy	2.1	2.3	2.3
	DALYs per 100.000	80,944	55,494	41,187

Source: IHME

[5] http://www.healthmetricsandevaluation.org

Table 2: Top Ten Risk Factors by Disease Burden in Lao PDR, 1990-2010

Rank in 2010	Top ten risk factors	DALYs lost share		
		1990	2000	2010
1	Malnutrition	30.2	26.3	13.9
2	Air pollution	6.3	7.3	9.0
3	Dietary risk	2.8	4.6	7.1
4	Tobacco	4.3	4.9	6.8
5	High blood pressure	2.6	4.1	6.7
6	Water, Sanitation, and Hygiene	17.0	11.9	5.2
7	Alcohol & drug use	1.8	2.5	4.9
8	High fasting plasma glucose	1.6	2.3	3.7
9	High body-mass index	1.1	1.8	3.3
10	Occupational risks	0.4	1.1	2.1

Source: IHME

Table 3: Key Population Health Indicators for Lao PDR and Country Comparators, 2014[6]

	GNI per capita (US$)	Maternal mortality ratio	Skilled birth attendance (%)	At least one ANC visit (%)	Under-five mortality rate	DPT3 coverage (%)	Measles coverage (%)	Stunting prevalence[7] (%)
Bhutan	2,390	120	64.5	97.3	36.2	97.0	94.0	33.6
Cambodia	1,010	170	74.0	89.1	37.9	92.0	90.0	40.9
China	7,380	32	99.8	95.0	12.7	99.0	99.0	9.4
India	1,610	190	52.3	75.2	52.7	72.0	74.0	47.9
Indonesia	3,650	190	83.1	95.7	29.3	85.0	84.0	36.4
Lao PDR	1,600	220	41.5	54.2	71.4	87.0	82.0	43.8
Nepal	730	190	36.0	58.3	39.7	92.0	88.0	40.5
Philippines	3,440	120	72.8	95.5	29.9	94.0	90.0	33.6
Sri Lanka	3,400	29	98.6	99.4	9.6	99.0	99.0	14.7
Thailand	5,410	26	99.6	98.1	13.1	99.0	99.0	16.3
Timor-Leste	3,120	270	29.3	84.4	54.6	82.0	70.0	57.7
Vietnam	1,890	49	92.9	93.7	23.8	59.0	98.0	23.3
Low income	636	517	53.7	80.5	86.9	77.4	75.3	37.8
Lower middle income	2,409	195	74.0	86.5	46.5	86.1	85.4	30
East Asia & Pacific	2,502	145	75.2	84.7	39.0	82.6	84.1	37

Source: WDI & WHO (latest data available, 2006-2014).

[6] WDI and WHO (latest data available from 2006-2014).
[7] Prevalence of stunting (height-for-age; -2 SDs) among under-fives.

5. There are significant economic, urban-rural, geographic, and ethnic-group related inequalities in health outputs and outcomes in Lao PDR (Table 4). Inequalities related to economic status and ethnicity are particularly large: whereas skilled birth attendance amongst the richest quintile was 91 percent, it was only about 17 percent among the bottom 40 percent; skilled birth attendance among the Lao-Tai was 59 percent whereas among Hmong-Mien it was only 18 percent; stunting prevalence among the bottom 40 percent was double that of the richest group. DPT immunization coverage rates among the bottom 40 percent were half of those among the richest 20 percent. The Central region generally had better indicators for skilled birth attendance and ANC visits, but lagged behind other regions in immunization coverage. Whereas health outcomes in some provinces are comparable to those found in richer countries such as Indonesia, infant and under-five mortality rates in several provinces are similar in magnitude to those found in much poorer countries such as Sierra-Leone (Figure 4).

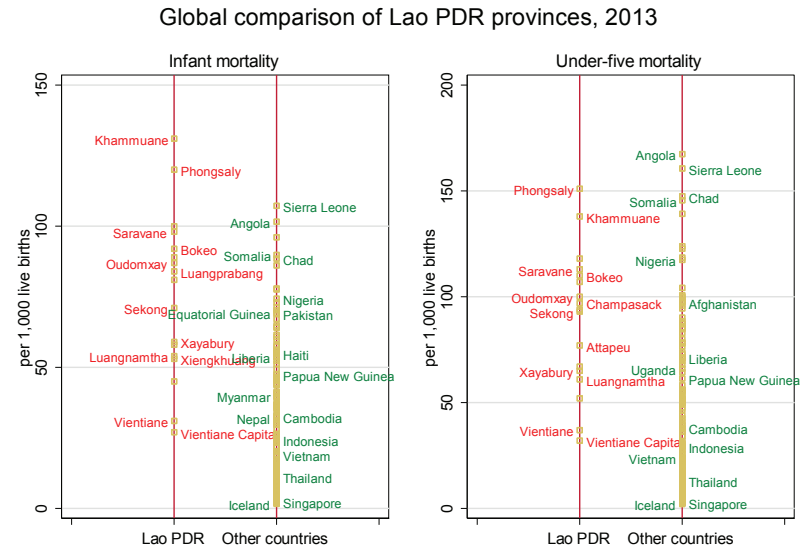
Table 4: Key Population Health Indicators, by Sociodemographic Characteristics in Lao PDR

	Skilled birth attendance (%)	At least one ANC visit (%)	DPT coverage (%)	Measles coverage (%)	Malnutrition prevalence among under-fives (weight for age) (%)	Stunting prevalence[8] (%)
Residence	79.6	83.4	67.7	71.7		27.4
Urban	30.7	45.9	51.7	61.2	16.1	48.6
Rural					29.3	
Region	31.0	45.0	56.2	62.1		51.4
North	52.8	63.3	52.6	59.5	26.2	38.1
Central	33.1	48.6	60.6	75.1	23.1	46.6
South					34.7	
Wealth status						
Bottom 40%	17.4	32.5	41.7	53.1	33.1	55.4
Middle 40%	54.7	69.6	63.5	70.5	22.3	36.8
Richest 20%	90.7	91.7	81.4	81.9	12.1	19.7
Language group						
Lao-Tai	58.5	71.5	66.9	72.7	21.5	33.4
Mon-Khmer	20.8	36.2	49.1	61.3	36.7	55.5
Hmong-Mien	17.8	23.9	26.6	35.3	21.3	60.5
Chinese-Tibetan	18.3	24.6	31.5	44.2	42.8	60.9
All	41.5	54.2	55.5	63.7	26.6	44.2

Source: Lao Social Indicators Survey (2012).

[8] Prevalence of stunting (height-for-age- -2 SDs) among under-fives.

Figure 4: Global Comparison of Lao PDR Provinces, 2013[9]



Sources: LSIS & WDI

[9] The rates may not be strictly comparable, but nevertheless the point about variations remains.

3. Health Financing Context

1. From a health financing perspective, Lao PDR's health system has transitioned from a centralized Soviet-style health system providing free health services to all prior to the 1990s to a system that increasingly relies on OOP payments by patients. In recent years however, the system has attempted to scale back its reliance on OOP payments, moving towards provision of free care for selected health services (such as MCH) and for selected populations (such as the poor, via health equity funds), and the government has committed to attaining universal health coverage (UHC) by 2020.[10, 11, 12] At present, separate social insurance mechanisms exist for civil servants and for private formal sector workers; and community-based health insurance coverage for some of the non-poor informal sector. Estimates suggest that only about 20 percent of the country's population has some form of formal coverage, including about 40 percent of the poor covered under health equity funds.[13]

2. The free MCH policy endorsed by the Prime Minister (decree number 178/PM) makes all pregnant women and children under-five exempt from fees related to deliveries and child health at all health centers and public hospitals, although implementation has been geographically limited. On the supply side, the policy provides fixed-fee reimbursement to health facilities depending on the type of service and the location of service provision. The Free MCH packages consist of antenatal care, postnatal care, and institutional deliveries, and well-baby clinic examination (including inpatient and outpatient services) for children under-five. Implementation was rolled out in 2013, first in poor districts and governmental focus sites for development. There is a plan to expand the free MCH program in year 2014 with three options, ranging from US$2.9 million to US$5.5 million per year.[14] A World Bank assessment (2013) of the new policy notes that the policy's removal of user fees may not be sufficient to improve utilization and inequalities across the country.[15] The policy should be accompanied by supply-side interventions and community focused demand-side interventions as well as greater financial or other incentives to improve utilization rates among the poorer sections of the population.

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[10] TGovernment of the Lao People's Democratic Republic (2012). Decree on National Health Insurance, No 470/GO. Vientiane.

[11] WHO (2014). The Lao People's Democratic Republic health system review. Health Systems in Transition, Vol. 4 No. 1.

[12] Ministry of Health, Lao PDR Department of Finance (April 2014). Draft Health Financing Strategy, Lao PDR 2014-2025..

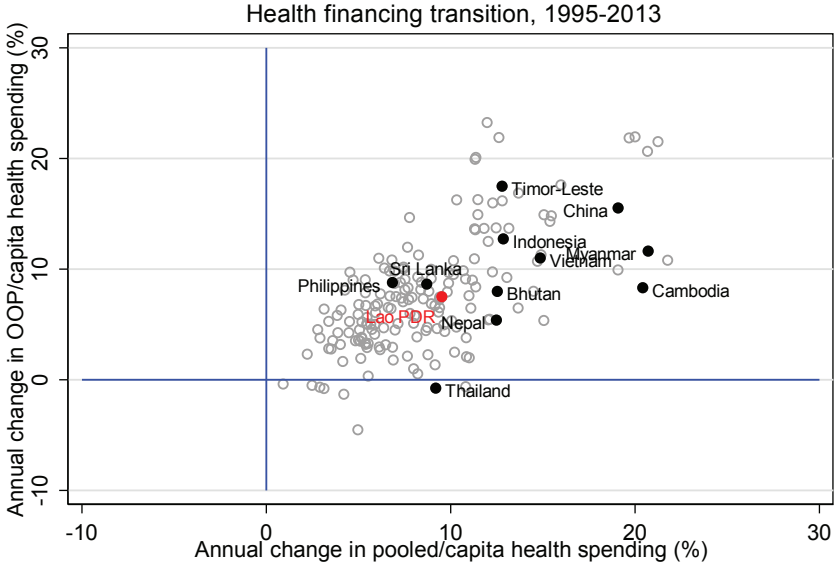
[13] Ibid.

[14] Rough projection for Free MNCH for FY2014/15, MoH/DoF. Option 1= Cover the whole country (US$5.5 million); option 2 = All districts except provincial town (US$4.0 million); option 3 = Existing districts only (US$2.9 million).

[15] World Bank (2013). Maternal Health Out-of-Pocket Expenditure and Service Readiness in Lao PDR.

3. By international standards, Lao PDR is characterized by low levels of government spending, associated with high levels of OOP spending and reliance on external financing. On the positive side, there is some evidence to suggest that Lao PDR is undergoing an appropriate health financing transition, with an increase in total health expenditures per capita and a rising share of financing from pooled sources, but it is doing so at a very slow rate (see Figure 5).[16] Based on WHO NHA estimates, general government spending on health (MOH budget and social security expenditures on health) as a share of GDP in 2013 was only 1.0 percent in Lao PDR, against 2.6 percent in Nepal, 3.6 percent in Thailand, and 2.5 percent in Vietnam (Table 5 and Figure 6). At the same time, Lao PDR has substantial dependence on external finance in total health spending (greater than that of Nepal and Bhutan, for example). International evidence suggests that the government health spending share of GDP would need to increase to lower the OOP share of total health spending – although because the financing gap is so large, even an increase of government health spending by one percentage point of GDP, would still leave Lao PDR behind countries like Nepal, Thailand, and Vietnam.

Figure 5: Annual Change in OOP vs Pooled per Capita Health Spending, 1995-2013



Source: WHO

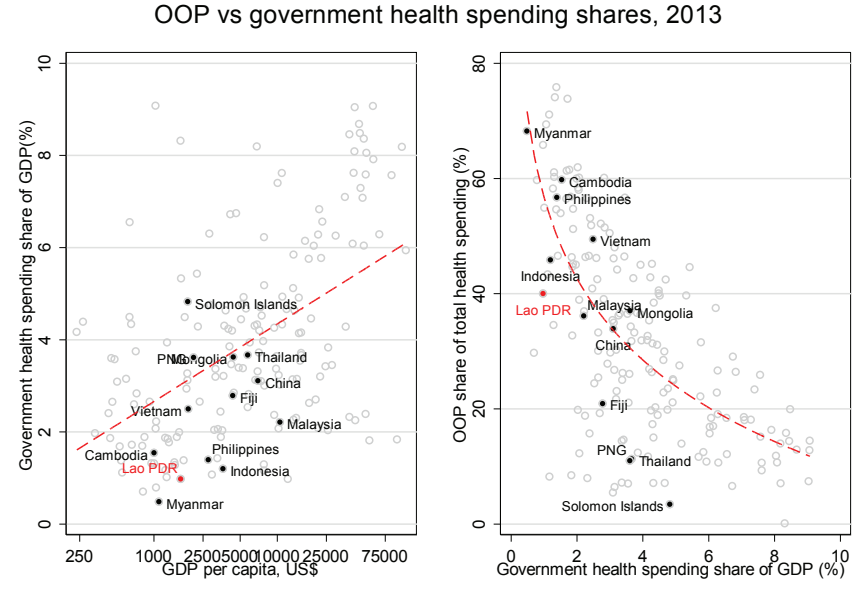
[16] Fan, V.Y. and W.D. Savedoff (2014). "The Health Financing Transition: A Conceptual Framework and Empirical Evidence," Social Science & Medicine, 105: 112-121. Countries in the bottom right quadrant of Figure 5 can be characterized as undergoing a rapid health financing transition as pooled health spending is growing and OOP spending is declining (such as Thailand); those in the upper right quadrant below the 45-degree line are those where pooled spending is growing at a faster rate than OOP spending and therefore they are transitioning relatively slowly (such as Lao PDR); countries in the upper right quadrant and above the 45-degree line are regressing as OOP spending is growing at a faster pace than pooled health spending (such as Philippines).

Table 5: WHO NHA-based Key Health Financing Indicators for Lao PDR, 1995-2013

Indicators	2000	2005	2010	(2012)[17]	2013
Total expenditure on health / capita at market exchange rates	US$11	US$20	US$ 26	US$ 36	US$32
Health expenditure, total (% of GDP)	3.3	4.3	2.4	2.8	2.0
Annual real growth rate in total health expenditure in previous 5 years (%)	-5.4	0.7	-29.1	-	11.9
GDP growth (annual %)	5.8	7.1	8.5	-	8.5
General government expenditure on health (GGHE) as % of THE	35.1	17.0	40.7	38.5	49.3
General government expenditure on health as % of GDP	1.2	0.7	1.0	1.1	1.0
GGHE as % of General government expenditure	5.8	4.1	4.3	4.1	3.5
Social security funds as % of GGHE	1.2	7.2	6.9	N/A	3.1
Private expenditure on health (PvtHE) as % of THE	64.9	83.0	59.3	52.8	50.7
OOP health expenditure (% of total expenditure on health)	59.6	62.5	46.4	44.4	40.0
OOP expenditure as % of PvtHE	91.8	75.3	78.2	84.1	78.8
External resources on health as % of THE	29.2	16.5	31.9	19.3	26.8

Source: WHO NHA & WDI, 2015

Figure 6: International Comparison of Government Health Spending and OOP share, 2013



Source: WHO and WDI

[17] These NHA data were presented during a meeting between the Department of Finance, MoH, and stakeholders, on April 2015.

4. The heavy reliance on OOP payments in Lao PDR results in considerable financial barriers to utilization of health services, contributing to low and inequitable utilization of health services, with significant health-related financial risk. Analysis of the Lao Expenditure and Consumption Survey (LECS) LECS V 2012/13 indicates inequitable utilization of health services between the poorest and richest quintiles, which is not accounted for solely by differences in the incidence of reported illness, as this inequity remains even among those reporting illness. Although the richest quintile utilizes more services than the poor even in public facilities, the utilization patterns vary substantially between the poorest and richest quintiles (see Table 6).

Table 6: Outpatient Utilization of Health Services in the Past Four week by Economic Quintile, 2012/13[18]

Percent of those reporting illness, who used outpatient services in the past four weeks	All (%)	Poorest (%)	Q2 (%)	Q3 (%)	Q4 (%)	Richest (%)
Any illness or injury	10.4	9.3	9.2	10.7	10.8	13.0
Seeking care when ill	31.2	25.0	26.1	31.7	34.3	39.5
Seeking care in public facilities when ill	24.4	21.6	21.2	26.4	26.7	26.7
Seeking care in private facilities when ill	11.0	6.6	7.6	8.9	14.5	18.1

Source: WB Staff Calculations From LECS V 2012/13

5. Further analysis of LECS V in Table 7 demonstrates the weakness of financial risk protection, which has deteriorated since the previous LECS in 2007-08. Defining catastrophic expenditure payments as 10 percent or more of the total household consumption, 5.0 percent of households incur catastrophic health expenditure. This has increased from 3.8 percent in 2007-08[19] to 5.0 percent in 2012-13.

Table 7: Incidence and Intensity of Catastrophic Health Care Spending, 2003-1320[20]

Incidence	Catastrophic threshold as a share of total household consumption				
	5%	10%	15%	20%	25%
Incidence (2002-03) (%)		4.2			
Incidence (2007-08) (%)		3.8			
Incidence (2012-13)(%)	9.8	5.0	3.1	1.9	1.4
Standard error (%)	0.0	0.0	0.0	0.0	0.0
Overshoot (%)	1.0	0.6	0.4	0.3	0.2
Standard error (%)	0.0	0.0	0.0	0.0	0.0

Source: WB Staff Calculations From LECS V 2012/13

[18] LECS V, 2012/13; World Bank staff calculations.

[19] The World Bank (2010). Out-of-pocket Spending and Health ServiceUutilization in Lao PDR:. Evidence from the Lao Expenditure and Consumption Surveys.

[20] LECS V, 2012/13; World Bank staff calculations. Earlier years: Powell-Jackson, T., and Magnus Lindelow (2010). Out-of-Pocket Spending and Health Service Utilization in Lao PDR: Evidence from the Lao Expenditure and Consumption Surveys.

6. There are socioeconomic variations in financial protection, which are likely to reflect the inequitable utilization and access of households to health services. Wealthier households have both a higher incidence of catastrophic health expenditure and expend a greater proportion of consumption on health care. There are further regional and urban-rural variations, which likely reflect variations in utilization and access to health facilities. For example, households living in urban areas spend 2.3 perent of their total consumption compared with 1.7 percent in rural areas; and about 6.6 percent of urban households are exposed to catastrophic health spending compared with 4.6 percent in rural areas (see Table 8).

Table 8: Incidence of Catastrophic Health Care Spending by Household Characteristics, 2012/13[21]

Characteristics	OOP spending on health as share of total household consumption (%)	Incidence of catastrophic health care spending (10% threshold) (%)
Type of residence		
Rural	1.7	4.4
Urban	2.3	6.6
Region		
Vientiane	2.3	7.2
North	1.7	4.2
Central	1.7	4.6
South	2.1	5.6
Household consumption quintile		
Poorest	0.7	1.1
Q2	1.2	2.6
Q3	1.8	5.2
Q4	2.3	6.7
Richest	3.4	9.5
Total	1.9	5.0

Source: WB Staff Calculations From LECS V 2012/13

7. Although contributory health insurance/coverage schemes can play an important role in strengthening financial risk protection, there are considerable challenges. These include the size of the informal sector - with large numbers of the population engaged in subsistence farming – and the incidence of poverty, that need to be addressed if coverage of such schemes is to be expanded successfully. Hence, as underscored in the government's own draft Health Financing Strategy for 2014-2025[22], increasing the quantum and improving the effectiveness and efficiency of existing government health spending is likely to be the most viable strategy for improving access to health care services and enhancing financial protection in the near term.

[21]LECS V, 2012/13; World Bank staff calculations.

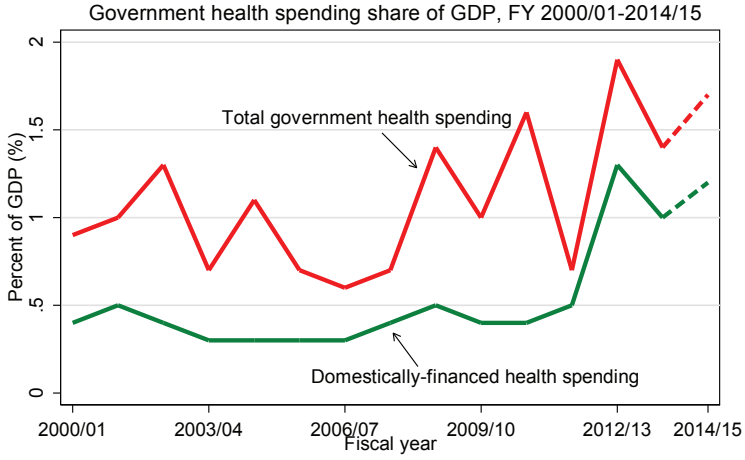
[22]Lao PDR Department of Finance, Ministry of Health (April 2014). Draft Health Financing Strategy, Lao PDR 2014-2025..,

4. Budgetary Government Spending on Health

1. Budgetary government spending on health in Lao PDR has been increasing, albeit from a very low and erratic base. In FY 2013/14, based on the latest financing data provided directly by MoH, realized government budgetary spending on health at the central and subnational levels totaled LAK1,339 billion, roughly 1.4 percent of GDP (≈US$24 per capita).[23] This estimate shows a decline of government health spending per capita in FY 2012/13, and includes both recurrent and capital expenditure from both domestic and external sources, but does not include health spending by other ministries nor social security spending. Planned government expenditure on health for FY 2014/15 is expected to be much higher - 1.7 percent of GDP.

2. However, due to dependence on external financing, government health spending has been erratic over time (see Figure 7), although progress in weaning off external financing especially since FY 2012/13 is acknowledged. If only domestically-financed spending is considered, government health expenditure accounted for only 1 percent of GDP in FY 2013/14, almost triple compared to the previous decade. As part of the Seventh Socioeconomic Development Plan, a modest portion of revenues from the Nam Theun 2 hydropower project has been allocated to eligible health programs (and as discussed later in the policy note, several health centers indeed report receiving support from the Nam Theun 2 Power Company). Furthermore, planned domestically-financed government expenditure on health for FY 2014/15 is expected to be 1.2 percent of GDP and realizing this increase in actual spending will be an important step for Lao PDR to attain health sector goals.

Figure 7: Government Spending on Health as Share of GDP, FY 2000/01-FY 2014/15

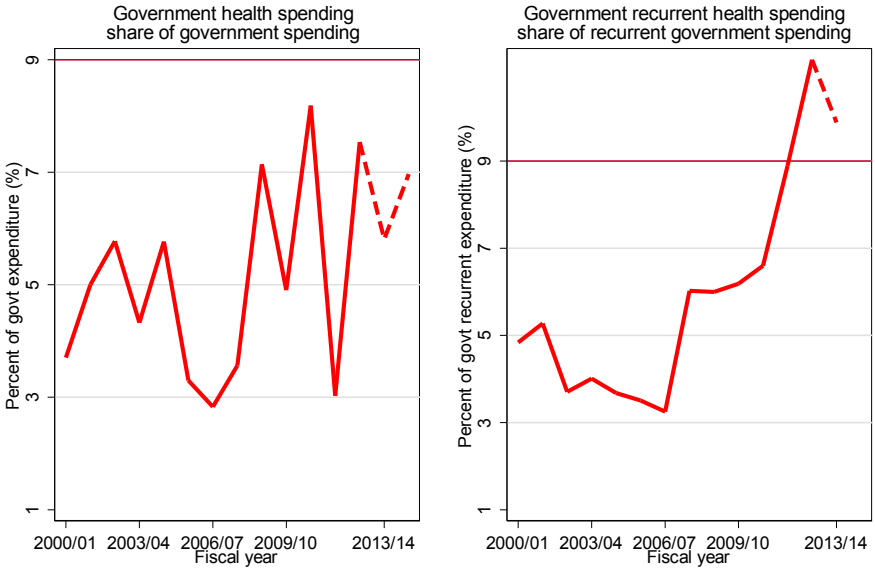


Note: Actual 2000/01-2012/13; DOF-MoH 2013/14 (personal correspondence)
Planned 2014/15
Source: Official Gazette & State Budget Plan (various years)

[23] Lao PDR Department of Finance, Ministry of Health (personal correspondence). The authors note the differences in health financing indicators from the two sources of data – WHO NHA (Table 5), which includes private OOP spending, and latest MOH budgetary records presented here – although the temporal coverage is different due to the nature of FYs. For this section on 'Budgetary Government Spending on Health', the value of the 'freshness' of government spending was judged to be important in informing current policy considerations and hence these health financing indicators were included, with irregularities transparently presented. The authors further consider relevant the challenges in obtaining timely and consistent health financing indicators, as a finding of this analytic process.

3. The Government of Lao PDR, in the latest draft Health Financing Strategy 2014-25, has committed to increasing government health expenditure to 9 percent of overall government expenditure by 2015.[24] Unfortunately, this target includes both technical revenue and external financing which will make accountability for the target unclear and may indeed override important health sector goals such as financial protection. Technical revenues contribute towards OOP paid for by users of public health services, but may have implications on the access, financial risk protection, and equity. Furthermore, dependence on external financing given that Lao PDR has ascended the ranks of middle-income countries appears to be an increasingly unsustainable solution. Clarity and accountability for this modest target would be improved by setting a specific target for domestically-sourced government health expenditure excluding technical revenues and external financing, especially as actual and planned government expenditure is approaching this 9 percent target (see Figure 8, left).

Figure 8: Share of Government Health Expenditure to Total Government Expenditure FY 2000/01-2013/14



Note: Actual 2000/01-2012/13; DOF-MoH 2013/14 (personal correspondence); Planned 2014/15
Source: Official Gazette & State Budget Plan (various years)

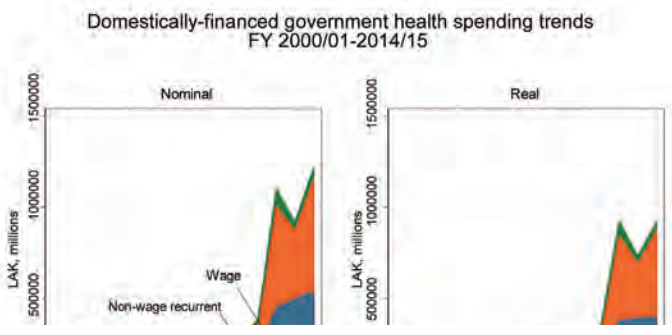
[24] Ministry of Health, Lao PDR Department of Finance (April 2014). Draft Health Financing Strategy, Lao PDR 2014-2025.

4. In addition to the quantity of government health spending, the composition of government health spending, which is heavily weighted towards capital and wages, also needs to be considered. In Lao PDR, most government health spending is allocated towards capital expenditure and wages, leaving little room for critical non-wage recurrent spending (including purchasing critical health-related commodities and financing operational plans) in an already tight resource environment. Capital expenditures have been relatively high, averaging over 50 percent of government health spending in the past decade (with 80-90 percent of capital expenditures on health being externally financed). About 35 percent of government health expenditures went to capital spending in FY 2013/14, and another 35 percent was wage-related recurrent expenditure. The remaining 30 percent was non-wage recurrent expenditure, down from a generally about 35 percent share in previous years, totaling LAK374 billion (≈US$6.7 per capita) in FY 2013/14. This low level of non-wage recurrent will have big implications for the provision of health care and bolstering supply-side readiness, which is noted to be weak at health centers (as discussed in the next section). In absolute terms, domestically-financed government health expenditure increased from LAK65.7 billion in FY 2000/01 to LAK918 billion in FY 2013/14, representing an average annual increase of 20 percent in nominal terms and 13 percent in real terms (Figure 9). Planned domestically-financed government health spending in FY 2014/15 was LAK1,215 billion.

5. Dependence on external financing also skews the apparent investments in capital, as all external financing is classified as capital expenditure. External sources of finance account for almost 90 percent of total capital expenditure, even if in reality, operational expenditures and the purchase of commodities are being financed. This will be discussed later in this policy note when analysis of data from health center surveys is presented.

6. Domestically-sourced government health spending is increasingly focused on wages. This reverses a trend in which the share of non-wage spending in recurrent expenditures decreased from 41 percent in FY 2000/01 to 17 percent in FY 2006/07, but has been increasing steadily ever since and was 43 percent in FY 2013/14. There was a notable reduction 30 percent jump in wage-related recurrent expenditure in FY 2011/12 from FY 2010/11, but this was matched by an increase in non-wage recurrent expenditure of a similar magnitude. This is discussed in a separate policy note in this series - Lao PDR Health Center Workforce Survey: Findings from a nationally-representative health center and health center worker survey.

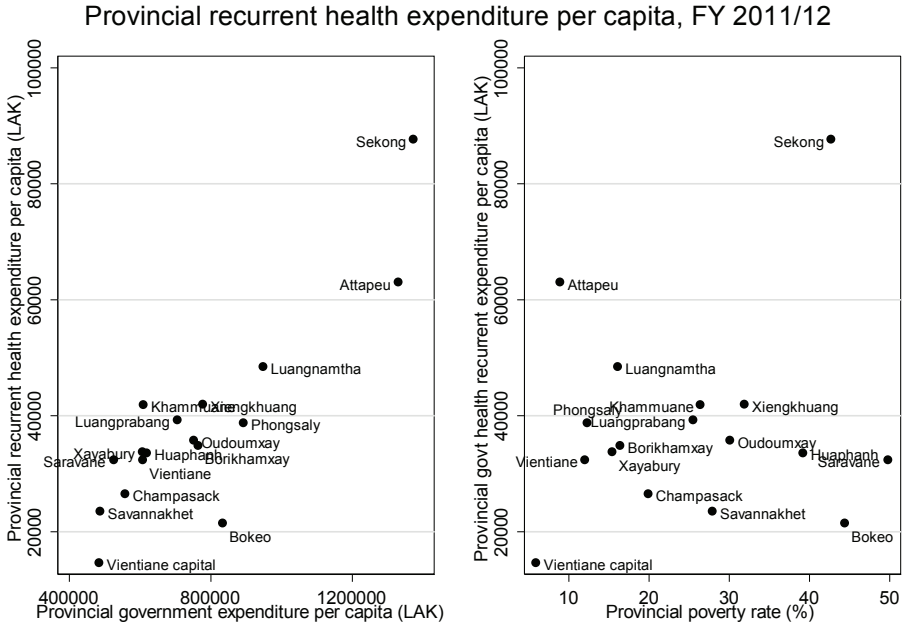
Figure 9: Domestically-financed Government Health Spending Trends, FY 2000/01-2013/14



7. A further concern is the distribution of government health spending, which is concentrated at the national-level, and inequitably distributed between provinces. In FY 2013/14, less than half (44 percent) of government health spending occurred at the sub-national, that is, provincial and lower–level. Planned subnational expenditures on health for FY 2014/15 were also roughly half of government health spending. In 2013/14, 100 percent of subnational expenditure went to recurrent expenditure, of which 66 percent is wage spending; this is possibly due to most of external capital expenditures being categorized as central expenditure, even if it was spent at subnational levels.

8. Provinces differed not only in the share of total government spending dedicated to health, but also in the actual amount spent per capita. Not surprisingly, provinces with higher levels of overall government spending per capita also tend to spend more on health (particularly, recurrent health expenditure) (see Figure 10). Some of this variation appropriately reflects an attempt to address inefficiencies. For example, per capita government spending on health is higher in sparsely populated and poorer provinces such as Sekong and Attapeu, where health needs are likely to be greater, as opposed to in wealthier provinces such as Champassak, Savannakhet, and Vientiane Capital.

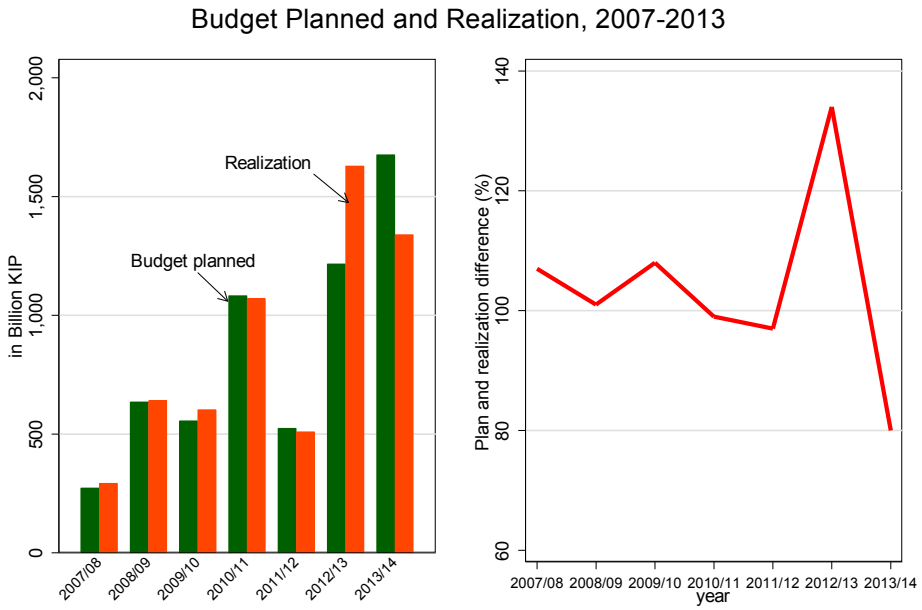
Figure 10: Provincial Recurrent Health Expenditure per Capita, FY 2011/12



Source: Official Gazette: State Budget Revenue-Expenditure Implementation of FY 2011/12

9. Budget execution has been reasonable between FY 2007/08 and FY 2011/12, but since FY 2012/13, there have been large discrepancies in budget planning and execution – with actual spending far exceeding the budget plan in FY 2012/13 but this was followed by underspending by an equivalent quantum, thus reflecting weaknesses in the budget planning and execution processes (see Figure 11).

Figure 11: Government Budget Planned and Realization, FY 2007/08-FY 2013/14



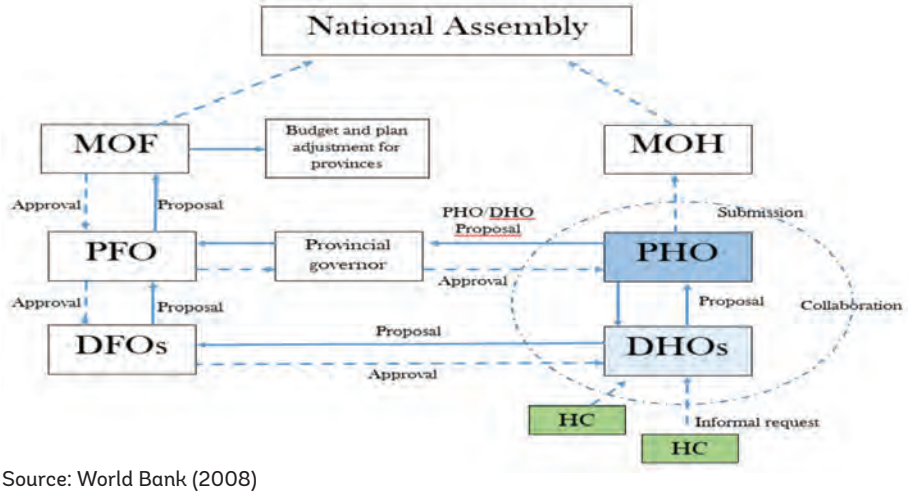
Note: Realization 2007/01-2012/13; DOF-MoH 2013/14 (personal corespondence)
Source: Official Gazette & State Budget Plan (various years)

5. A Financing Snapshot from Health Center Data

1. This section summarizes some health financing information collected from 120 health centers sampled as part of the UFGE-CNP survey 2013-14. The regional distribution of the sampled health centers is: 36 from the North region; 36 from the Central region; and 48 from the South region. A total of 81 health centers were rural and the remaining 39 were urban.

2. As part of the background on health center financing, the budgeting process in the health sector in Lao PDR is described (Figure 12). Budget preparation in Lao PDR begins at the district level (as health centers only make informal requests for resources but are not actively involved in the formal budget proposal procedures).[25] Links between health centers and District Health Offices (DHOs) in the budget process can be significantly strengthened. Most health centers do not prepare or submit budget proposals nor discuss the annual budget with DHOs. DHOs receive guidance and instructions from Provincial Health Offices (PHO) on budget planning and use current, historical, and the proposed budget to decide on the total annual budget proposal. DHOs prepare annual budget plans and submit proposals to the District Finance Office (DFO) for approval, and to PHOs, for official acknowledgement. PHOs consolidate budgets received from DHOs without adjusting the proposed budgets and submit consolidated budget proposals to the Provincial Finance Office (PFO). PHOs also submit budget proposals to the MOH directly, although not for approval. PFOs receive health budget proposals from PHOs and DFOs, and submit provincial budget proposals, which include health budget proposals, to MOF. When PFOs receive budget approvals from MOF (generally as per approval by the National Assembly), they approve budgets to PHOs according to the budget ceiling the MOF has determined, although the MOH may reallocate funds within the sector. The budgets are then approved for transfer to DFOs, which in turn approve budgets to the DHOs. However, due to the often large difference in approved and proposed budgets, after receiving approval of annual budget by PFO, PHO officers submit quarterly budget proposals to request additional non-wage recurrent financing. Health facilities at the district- and provincial-level are also required to transfer all technical revenue (from user fees) to the relevant DFO/PFO, and to submit a formal expenditure application to use these revenues although the finance office may decide to reallocate these to the non-profit generating sector.[26]

Figure 12: Budget Process in the Health Sector[27]



Source: World Bank (2008)

[25] World Bank (2008). Lao PDR Public Expenditure Tracking Survey in Primary Education and Primary Health. Vientiane.

[26] Implementing Prime Ministerial Decree No. 349. Working Paper. Unpublished.

[27] Diagram revised from an earlier version from World Bank (2008). Lao PDR Public Expenditure Tracking Survey in Primary Education and Primary Health. Vientiane.

3. Health centers receive financing from five potential sources, as summarized in Table 9, with the prominence of revolving drug fund (RDF) revenue and external financing as the two largest sources of revenue, reflecting the national health financing context. Prior to 1990, health services were provided for free at all health centers (and all public hospitals) in Lao PDR. Limited financing for non-wage recurrent expenditure resulted in the subsequent introduction of user fees and RDFs with nation-wide formalization of implementation of both policies in 1995. RDFs are implemented by the Ministry (and donors) and provided initial financing for the purchase of drugs. RDF regulations and guidelines allow facilities to charge a mark-up of 25 percent on the purchase price of drugs and other commodities, however a recent report indicates that adherence to this mark-up varied widely and some facilities exceeded this 25 percent ceiling.[28] Health facilities were given some degree of flexibility in the use of revenues from user fees and RDFs. As noted above, budgetary transfers tend to primarily cover wage-related recurrent expenditures whereas facilities rely on technical revenues and RDFs for non-wage recurrent expenditure, some capital expenditure, and payments for contractual staff. In addition to RDFs, technical revenues, and budgetary transfers, donors/NGOs and insurance reimbursements are two additional sources of revenue for health centers.[29]

Table 9: Sources of Health Center Revenue

Source of health center revenue	Share of total health center revenue (%)
1. Revolving drug funds (RDFs), collected through the sale of drugs to patients at facilities	58
2. External financing, including from donors and nongovernmental organizations (NGOs)	20
3. Government budget, including support for wage and non-wage recurrent costs[30]	11
4. Insurance scheme reimbursements	7
5. Technical revenues or user fees, collected at point-of-service from patients	3

Source: WB Staff Calculations From UFGE-CNP 2013/14

[28] Health Action International (2014). Medicine Prices, Availability, Affordability and Price Components in Lao People's Democratic Republic. Report of a survey conducted in November and December 2013.

[29] As noted earlier, in recent years the government has removed user fees and RDFs for MCH and replaced them with utilization-based budgetary transfers to facilities. Large-scale introduction of this so-called free MCH policy began in 2013.

[30] This is part of the decentralized budget allocated to provinces by the MOF.

4. Utilization of health centers is relatively low, with a mean of 66 overnight observations[31] and 818 outpatient attendances over a six-month study period (Table 10). Most outpatient visits were for child health services, followed by antenatal and postnatal care. Only about a third of DPT3 immunizations were conducted at health centers, the remainder occurring during outreach activities.

Table 10: Mean Health Center Utilization (six-month study period)

	IPD	OPD	Antenatal (out-patient)	Postnatal (out-patient)	Well-baby (out-patient)	DPT3 (total)	DPT3 (out-reach)	Deliveries at health center	Skilled attendance (outreach)	Referrals	No. of women whot paid OOP for delivery
Residence											
Urban	68	819	70	21	151	60	14	9	12	2	5
Rural	62	817	85	23	148	65	27	8	15	5	5
Region											
North	57	665	46	12	59	56	15	3	9	3	3
Central	71	764	82	19	98	57	16	12	13	1	11
South	69	974	91	30	253	69	21	11	15	4	1
All	66	818	75	21	150	61	18	9	13	3	5

Source: WB Staff Calculations From UFGE-CNP 2013/14

5. Health centers reported average semi-annual revenues of LAK39.4 million and average semi-annual expenditures of LAK27.9 million. In per capita terms, based on the estimated catchment area population for each health center, semi-annualized revenues and expenditures – representing resources for non-wage recurrent purposes -- averaged around US$2-4 per capita per year, similar in magnitude to estimates derived from budgetary data (see Table 11).

Table 11: Semi-annual Revenues and Expenditures per Capita

	Revenues		Expenditures	
	LAK	US$	LAK	US$
Residence				
Urban	15,708	1.9	9,147	1.1
Rural	11,329	1.4	7,799	1.0
Region				
North	21,469	2.6	9,925	1.2
Central	14,257	1.8	10,184	1.2
South	8,773	1.1	5,600	0.7
All	14,273	1.8	8,692	1.1
All (Annualized)		3.6		2.2

Source: WB Staff Calculations From UFGE-CNP 2013/14

[31] The median population catchment area of sampled health centers is 3,515.

6. Almost all (97 percent) of the 120 UFGE-CNP survey health centers reported using RDFs as a source of operational financing. This includes all the sampled health centers in the North and Central regions and 92 percent of those in the South region that reported utilizing RDFs.[32] About 95 percent of rural and all urban health centers reported using RDFs. Although there were variations across health centers, on average RDFs were also the largest source of revenues for health centers. RDFs often sourced more than half of all non-wage recurrent spending for many of health centers in the sample, consistent with previous findings and those reported elsewhere.[33] Health centers in the Central region generally had the highest share of operating revenues coming from RDFs, followed by those in the North and South regions. There was no significant different between RDFs sourcing shares among rural and urban health centers.

[32] North: Phongsaly, Luangnamtha, Oudumxay, Bokeo, Luangprabang, Huaphanh, Xayabury, Xiengkhuang; Central: Vientiane Province, Borikhamxay, Khammuane; South: Savannaket, Saravane, Sekong, Champasack, Attapeu.

[33] World Bank (2008). Lao PDR Public Expenditure Tracking Survey in Primary Education and Primary Health: Making Services Reach Poor People, Poverty Reduction and Economic Management Sector Unit, East Asia and Pacific Region.

[33] Murakami, H., B. Phommasack, R. Oula, and S. Sinxomphou (2001). "Revolving Drug Funds at Front-Line Health Facilities in Vientiane, Lao PDR," Health Policy and Planning, 16(1): 98–106.

7. Despite dependence of health centers on RDF revenues, the availability of essential medicines at health centers was generally poor indicating problems with planning, budgeting, and/or supply-chain management. Table 12 summarizes the availability of the WHO list of essential medicines across the sample of health facilities at the time of the survey: the average availability of essential medicines was only 55 percent, with health centers in the South region being worse than those in the North and Central regions. The differences in average across urban and rural health centers were not significant. The availability of essential medicines such as diazepam, magnesium sulphate, metronidazole, enalapril, procaine benzyl penicillin, zinc tablets, and folic acid tablets was particularly low across all health centers. Almost none of the health centers in the sample reported availability of all medicines in the WHO list.

Table 12: Availability of WHO Essential Medicines

Essential medicines/commodities	All (%)	Region (%)			Residence(%)_	
		North	Central	South	Rural	Urban
Combined oral contraceptive pills	69.2	63.9	63.9	77.1	71.6	64.1
Combined injectable contraceptives	55.8	50.0	61.1	56.3	56.8	53.8
Progestin-only injectable contraceptives	55.8	75.0	47.2	47.9	59.3	48.7
Male condoms	72.5	75.0	72.2	70.8	71.6	74.4
Diazepam	28.3	30.6	38.9	18.8	27.2	30.8
Oxytocin	80.0	77.8	86.1	77.1	82.7	74.4
Magnesium sulphate	9.2	8.3	8.3	10.4	6.2	15.4
Ampicillin	86.7	86.1	97.2	79.2	85.2	89.7
Gentamicin	70.0	61.1	86.1	64.6	74.1	61.5
Metronidazole	32.5	38.9	27.8	31.3	34.6	28.2
Intravenous solution with infusion set	96.7	94.4	100.0	95.8	95.1	100.0
Enalapril tablet	38.3	47.2	52.8	20.8	37.0	41.0
Amoxicillin syrup/suspension	76.7	94.4	83.3	58.3	75.3	79.5
Procaine benzyl penicillin powder for injection	38.3	50.0	50.0	20.8	43.2	28.2
Oral rehydration salt sachets	91.7	91.7	88.9	93.8	91.4	92.3
Zinc tablets	20.0	16.7	13.9	27.1	19.8	20.5
Vitamin A capsules	62.5	61.1	75.0	54.2	64.2	59.0
Mebendazole cap/tab	61.7	69.4	66.7	52.1	59.3	66.7
Iron tablets	44.2	38.9	58.3	37.5	43.2	46.2
Folic acid tablets	17.5	13.9	22.2	16.7	18.5	15.4
Iron and folic acid combined tablets	55.0	61.1	41.7	60.4	53.1	59.0
Antibiotic eye ointment	46.7	63.9	52.8	29.2	48.1	43.6
All of the above	0.8	0.0	0.0	2.1	1.2	0.0
Average	55.0	57.7	58.8	50.0	55.3	54.2
Health centers (N)	120	36	36	48	81	39

Source: WB Staff Calculations From UFGE-CNP 2013/14

8. MOH and donors/NGOs were generally the second-most prominent source of revenues in the sample, each accounting for about a 20 percent share. Health centers in the South region tended to have a noticeably higher dependence on donor/NGOs for revenues as compared to those in the North and Central regions. Rural health centers had a three-fold higher share of revenues from donors/NGOs than did urban health centers. Table 13 summarizes the proportion of health centers reporting receiving support from selected donors/NGOs. As can be seen, several donors such as UNICEF, Asian Development Bank, and World Bank support recurrent expenditures such as for medicines/commodities, training, and outreach activities at the health center level even though all external support is classified under capital expenditure in government budgetary classifications in the country.

Table 13: Proportion of Health Centers Reporting Receipt of Support from Selected Donors/NGOs

	Support from donors/NGOs to health centers (%)					
	Renovations/ upgrades	Medical equipment	Medicines/ commodities	Training	Outreach	Other
Nam Theun 2 Power Company	1.7	1.7	2.5	1.7	4.2	2.5
UNICEF	0.8	1.7		5.0	5.0	1.7
World Vision	1.7	3.3		1.7	1.7	
World Health Organization	2.5	2.5	0.8	2.5	6.7	1.7
World Food Program				0.8		
Lux – Development	7.5	12.5	6.7	9.2	20.0	17.5
Asian Development Bank	7.5	5.0	2.5	1.7	4.2	2.5
World Bank	6.7	5.8	4.2	14.2	10.0	5.8
United Nation Development Program	0.8	1.7	0.8			
International Planned Parenthood Federation	0.8	0.8	0.8	0.8		
Global Fund	1.7	0.8		2.5	0.8	0.8
Medecins Du Monde	0.8	0.8				0.8
Swiss Red Cross (SRC)			0.8	1.7	0.8	
European Union			0.8	0.8		
GAVI					1.7	

Source: WB Staff Calculations From UFGE-CNP 2013/14

9. Technical revenues and insurance payments were not a prominent source of revenues, accounting for less than a 5-10 percent share across the 120 health centers.

10. Approximately 60 percent of expenditures at the health centers were reported to be for "medicines and supplies"; 20 percent were for "routine maintenance"; and the remaining 20 percent, on average, were utilized for staff incentives. Prior assessments have highlighted important financial management capacity constraints that need to be addressed to improve revenue management at central and local levels, including at health centers.[34]

[34] World Bank (2012). Government Spending on Health in Lao PDR: Evidence and Issues, Vientiane.

6. Conclusions

11. Lao PDR has made notable progress in improving maternal and child health outcomes and is on-track to attain maternal and child health-related MDGs, which compares performance today with a 1990 baseline. However, when compared across countries, current MCH indicators in Lao PDR are some of the worst globally and in the EAP region. Furthermore, nutrition outcomes remain very poor with almost half of under-fives stunted; and Lao PDR is hence off-track with regard to attainment of nutrition-related MDGs. Although the MDG-agenda remains unfinished, Lao PDR is undergoing a rapid epidemiological transition with the rise of NCDs associated with tobacco, indoor air pollution, and poor diet. In addition to poor outcomes, the distribution of outcomes is inequitable across socioeconomic dimensions such as income, ethnicity, and geography.

12. These poor and inequitable health outcomes are associated with low utilization of health services, which vary by economic quintile, even among individuals already reporting illness. Further analysis of the LECS V (2012-13), in comparison with earlier LECS surveys indicates that financial risk protection, as measured by the incidence of catastrophic health spending (10 percent threshold), has worsened in 2012-13 to 5.0 percent from 3.8 percent in 2007-08. Ironically, due to inequitable utilization and access to health services, the poorest quintile of households has a lower incidence of catastrophic expenditure compared with the richest quintile.

13. These poor population-level health outcomes and financial risk protection measures are reflected in the health financing context of Lao PDR, where this policy note finds extremely low (albeit increasing since FY 2012/13) levels of government expenditure on health, which are associated with high levels of OOP expenditures (40 percent of THE in 2013) and high (given Lao PDR's ascendency to middle-income-country status) reliance on external financing, which has resulted in erratic year-by-year health expenditure trends and a composition of health expenditure skewed towards capital expenditure. The composition of domestically-sourced health expenditure, meanwhile, has been directed increasingly to wages (57 percent in FY 2013/14) rather than prioritizing the purchasing of health commodities and operational budgets required under non-wage recurrent expenditures.

14. The distribution of government health expenditure is suboptimal – where less than half of domestically-sourced health financing is directed at the subnational level – such that only approximately US$1 per capita of non-wage recurrent health expenditure is allocated at the subnational level, although there is substantial variation between provinces (after per capita adjustments).

15. This policy note further presents new findings from the analysis of a nationally-representative health center survey. Given the national health financing context, the findings are unsurprising and confirm at the ground-level, the dependence of health centers on revenues from RDFs (the sale, at a markup, of drugs to patients) and external donors, which account for 58 percent and 20 percent of health center revenues (amounting to approximately US$2-4 per capita per year at the health center-level). The extraction of unpoooled financing from end-users of the health system (in the form of user fees/technical revenue or through RDFs) is antithetical to the stated objections of the government of Lao PDR to attain UHC. Furthermore, despite the ability of health centers to extract revenue to cover the purchase of drugs by imposing inequitable and inefficient OOP expenses on households, the supply-side readiness of health centers – with significant deficiencies in life-saving maternal health drugs such as oxytocin and magnesium sulphate (present in only 80 percent and 9 percent of health centers respectively) – is very weak.

16. Recently announced increases in government health spending are welcome, although the inclusion of external financing and technical revenues in the 9 percent target reduces the clarity (especially with regard to the aim to reduce OOP, as per the goals of UHC) and financial accountability (where neither the government nor donors would be incentivized to make commitments) of this target and these increases must also be accompanied by increases in the efficiency of spending and accountability for results. With regard to increasing efficiency, this would require more than just a reduction in waste but equitable allocation of resources to the right level of service delivery (greater emphasis on frontline health service delivery units such as health centers and district hospitals), the right place (to remote and poor provinces and districts with the greatest needs), and the right mixtures of expenditures – to enable health workers to work optimally with appropriate capital investments and the availability of life-saving commodities to enable health workers to be effective. With regard to accountability for results, this should include focus on the level and equity of population health outputs/outcomes such as immunization rates, skilled birth attendance, institutional delivery rates, need-based outpatient and inpatient utilization rates, and adequate levels of financial protection from health shocks.

17. Likewise, the policy directions of Lao PDR – in providing critical services free-of-user fees (for example, the free MCH policy) and in providing a package of services to specific vulnerable populations (for example, health equity funds for the poor) – are to be affirmed. However, these require greater accountability for results, greater supply-side investments, and demand-side initiatives to increase the uptake of these services in remote and poor areas, as detailed in another policy note in this series - Maternal and Child Health Out-of-Pocket Expenditure and Service Readiness in Lao PDR: Evidence for the National Free Maternal and Child Health Policy from a Household and Health Center Survey (2013 Update).

18. The purchasing function of insurers needs to be further advanced, as the health insurance system evolves in Lao PDR. This would include appropriate credentialing, provider payment mechanisms, and benefits packages, which should be strengthened to ensure sustainable and high-quality health services (especially preventative services) are incentivized for delivery to those most at need of these services.

19. Finally, in order to allow key government policymakers to make timely and informed decisions, the health financing information systems need to be strengthened such that financing flows, accountability, and intended results should be detailed clearly across financing channels, providers, and beneficiaries. This should also allow for timely presentation of policy and advocacy-relevant products such as the national health accounts and system of health accounts.

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