ORIGINAL RESEARCH:

Constraints to the expansion of health insurance in Lao PDR

BOUNKHAM Viengmany[1]

Abstract

This paper examines the planned expansion of the coverage of health insurance schemes in Lao PDR. The purpose of the study is to identify the factors that impede the expansion of health insurance and whether or not co-payment for healthcare services should be introduced to improve the quality of care for insured people in Lao PDR. The study applies qualitative methods after reviewing the existing relevant literature and documents, by interviewing key informants involved in the implementation of health insurance schemes in Lao PDR, as well as providers of health services at various levels from the ministry down to the district level. The results of the study show that low capitation fees, overutilization of health services, unclear roles and mandates of institutions responsible for health insurance schemes, weak law enforcement, and low levels of social solidarity are crucial factors that have slowed the expansion of health insurance schemes in Lao PDR. In regard to co-payments, concerned authorities have different perspectives on the introduction of this scheme; the health service providers' perspective is that a co-payment is necessary to improve the quality of care and eliminate abuse of healthcare services. However, the view of health policy makers and health insurance managers is that co-payments should not be introduced in Laos at this point in time, because it may discourage people from joining health insurance schemes.

Keywords: Health insurance schemes, Factor affecting its expansion, Co-payment.

Introduction

The Lao People's Democratic Republic (Lao PDR) is one of the least developed countries in Southeast Asia. Its total population is around 6.49 million. There are 47 officially recognized ethnic groups (National Statistics Bureau, 2015). The economy of the Lao PDR has experienced substantial progress during the past five years; the Gross Domestic Product (GDP) per capita has increased from $1,281 USD in 2011 to 1,725 USD in 2015 and about 70% of population works in the informal sector (National Statistic Center, 2012; Lao Statistics Bureau, 2015). The country has achieved significant progress reducing poverty. For example, the poverty rate has decreased from 26.7% in 2010 to 23% in 2015 (Ministry of Planning and Investment, 2010; Lao Statistic Bureau, 2015). However, health expenditures in the Lao PDR highly rely on household out-of-pocket payments from user fees in health care service facilities that can have an adverse effect on healthcare service utilization, and, consequently, health outcome. This contributes to the impoverishment of households (Xu et al, 2003 and Patcharanarumol et al, 2009).

Recognizing the adverse effect of user fees, the government established social protection through health insurance schemes to mitigate the effect of user fees for healthcare in the Lao PDR. Currently, there are four health insurance schemes. In 1993, the government established the first comprehensive social security scheme which was applied to civil servants, police, and military through the Prime Minister Decree 178/PM. The target was around 11% of the population; the scheme provided healthcare benefits, child birth benefits and grants, covered for employment injury or occupational diseases, permanent loss of working capacity, sickness, old age pension, survivor and funeral grant benefits. For healthcare benefits, the fee for service system was used at the point of healthcare services in public health facilities, with a ceiling, and the reimbursement model (Sonthany, 2008). This model had the problem of over prescription by hospitals and late reimbursement by the department of social security due to time-consuming procedures, and fragmented contacts between the Ministry of Labor and Social Welfare and healthcare providers. Therefore some civil servants could not claim their healthcare bill from responsible agencies (Jürgensen, 2005). As a result, the scheme was reformed and replaced by the capitation system with the Decree No. 70/PM in 2006. Then, the

[1] Graduate School of Asia Pacific Studies, Ritsumeikan Asia Pacific University, Beppu, Oita, Japan. E-mail: vienbo14@apu.ac.jp

name of the scheme was changed from civil servant scheme to State Authority for Social Security scheme or SASS.

In 1999, the Social Security Organization (SSO) was created and started to operate in 2001. It is a compulsory scheme that would apply to all employers with more than ten employees, with a contribution rate of 9.5% (5% from employer and 4.5% from the employee's salaries). The target groups are employees of the state, private, and partnership enterprises, which comprise approximately 9% of the population. The scheme provides the same benefits and provider payment methods as the SASS (International Labor Organization, 2015).

In 2002, the Ministry of Health piloted a Community Based Health Insurance program in five locations; two districts in Vientiane city, and one district in each of the three provinces Luangprabang, Champasack and Vientiane. CBHI aims at providing better access to health services by a regular pre-payment of a small amount. It is a non-profit and voluntary organization (World Bank, 2010). This scheme is a health insurance scheme for the informal sector and non-salaried population, targeting roughly 65% of the population. This scheme provides for a health benefit package and referral to hospitals at the district, provincial, and central levels (Ron, 2006).

In 2004, the Health Equity Funds (HEF) was created with the aim of improving access to health services for the poorest households. The Lao government, the Lao Red Cross, and the Swiss Red Cross finance this scheme, the latter two organizations allowing for third party payment. HEF either reimburses the providers or provides a combination of capitation and case-based reimbursement on healthcare benefits, food and accommodation allowances. The target of this scheme is roughly 15% of the population. In addition to these schemes, since 2010 the government introduced the free healthcare policy for mothers, and children under five years old, known as Free Maternity for All and Free Healthcare for Children under five years old respectively, to accelerate the achievement of the MDG goals by 2015 (Ministry of Health, 2005).

The expansion of health insurance schemes to reach universal coverage by 2025 would require a sufficient budget from various sources such as the government, Official Development Assistance, and households. An additional and sustained financial resource for healthcare is crucial; it is estimated that universal health insurance in the country needs a budget of around $30 million USD or 0.94% of GDP per year (ILO, 2007). Despite this, government spending on health sector is low. According to the National Health Account data, the Total Health Expenditure (THE) was only 2.8% of GDP in 2011 (MOH and WHO, 2013). It was much lower than that of its neighboring countries. For instance, the total health expenditure as percentage of GDP was 9.3% in Vietnam, 8.5% in Cambodia, and 14.2% in Thailand (WHO, 2010). The average total health expenditure per capita was around $37 USD in 2011, of which 39.7% came from households out of pocket payments, 19.9% from government sources, and 31.9% from foreign assistance, while the percentage of government expenditure on health for Social Health Insurance fund was 2.8% (World Bank, 2010, WHO, 2013 and Akkhavong, 2014).

Over the past years, the Lao government has tried to allocate more of budgets to the health sector. In 2012, the National Assembly endorsed a commitment to allocate 9% of General Government Expenditure (GGE) to the health sector to improve health outcomes and increase health service access for the poor. The government has also allocated revenue from Nam Thun 2 hydropower to provide free delivery and child healthcare for children under five years old, as well as Health Equity Fund's resources for the poorest in some priority districts. The General Government Health Expenditure (GGHE), including revenue collected from user fees and Official Development Assistance (ODA) increased gradually from 2001 to 2003 and then fluctuated from 2004 to 2011 due to the change of ODA (see figure 1).

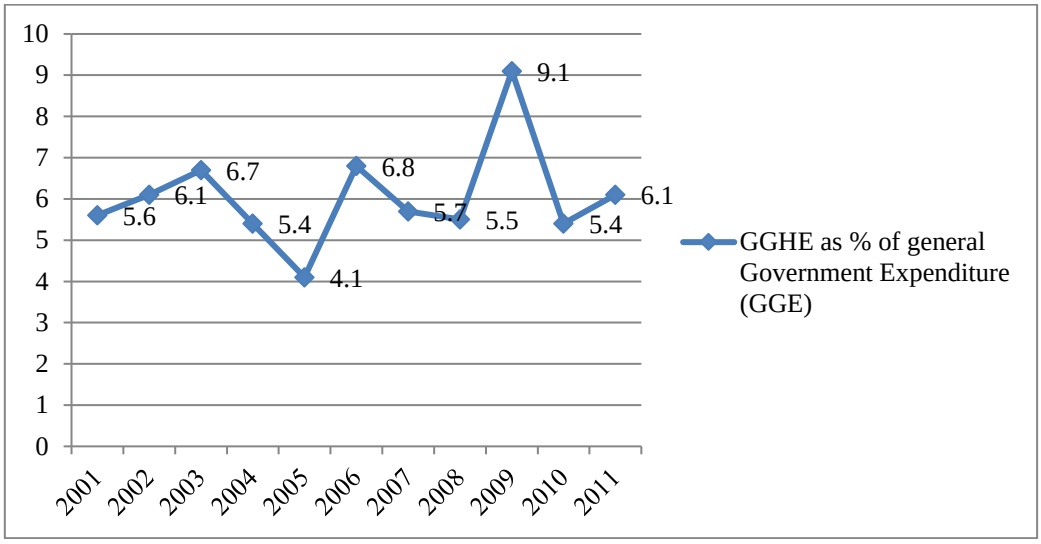

Figure 1: Trends of General Government Health Expenditure as percentage of General Government Expenditure from 2001-2011 (Ministry of Finance, 2001-2011; World Health Organization, 2013)

Although, the Lao government's aim of achieving universal coverage by 2025 is clearly defined, the government of Lao PDR has long been struggling to promote universal health coverage and equity access to health services for all ethnic groups nationwide. The population coverage of all health insurance schemes is far from the target of reaching 50% of the total population in 2015. As of 2014, health insurance covered only 28.04% of the total population. It was estimated that 11% of the total population or 418,039 people were covered by the SASS scheme, and about 2.43% of the total population, or around 183,600 people, were covered by the SSO. The community-based health insurance scheme covered around 2.61% of the total population or 161,905 people, while the Health Equity Fund covered 12% of the total population, or 1,171,913 people (see figure 2).

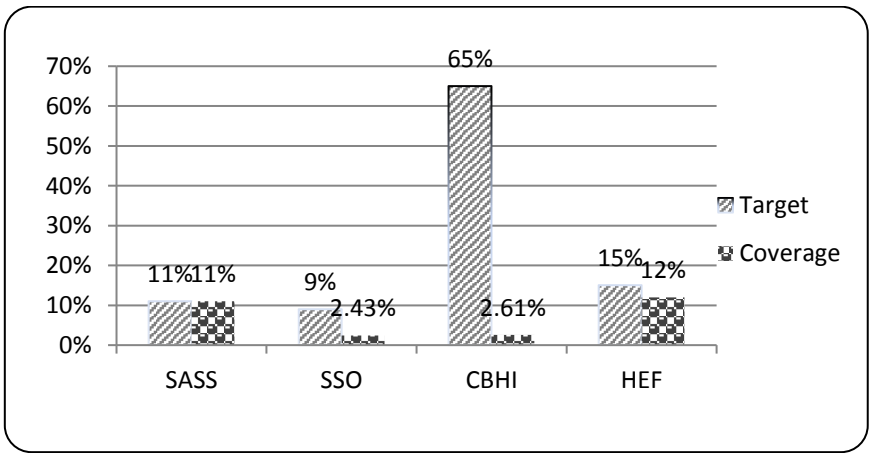

Figure 2: Target population coverage by health insurance schemes in 2014 (The National Social Security Fund and National Health Insurance Bureau, 2015)

This paper attempts to examine what caused the health insurance schemes failure to achieve their expansion targets. It also seeks to answer whether or not co-payments should be introduced to improve the quality of healthcare services for insured people.

Methodology

The existing relevant literature including policies and legal documents were reviewed, and a qualitative

research method was applied by interviewing 15 key informants involved in the expansion of health insurance schemes. The key informants were authorities from the Ministry of Health, four central hospitals, one district hospital, four health insurance schemes, the Ministry of Labor and Social Welfare, the Ministry of Finance, Vientiane Capital Health Department, Xaythany's Governor's Office, and the District Health Office. The interviews were conducted in Lao language based on a semi-structured questionnaire, and before conducting interviews a consent form for the interview was provided to explain the purpose of the interview for all informants. The interviews focused on factors impeding the expansion of health insurance and the perception of health service providers in providing healthcare for insured people. The questions cover the interviewees' background, the function of their organization, information related to health insurance schemes, their reflections on health insurance implementation, especially challenges and counter measures to overcome challenges, as well as their perspective on co-payment for healthcare service. The discussions were recorded and translated by the researcher. The data was then analyzed and discussed as follows.

Findings and Discussion

Weak institutional capacity

The research found that a weak institutional capacity, including the lack of resources, unclear roles and mandates, a weak administrative system of institutions responsible for health insurance are critical factors impeding the expansion of health coverage in Lao PDR. Most institutions responsible for health coverage expansion have limited resources, particularly financial resources to perform their duty effectively. Although data on the deficit or surplus of health insurance schemes is limited, *Table 1* below shows that three out of four health insurance schemes experienced deficits from 2006 to 2014. The SASS experienced an increase in annual budget deficit form about 2.1 billion LAK in 2012 to 10.7 billion LAK in 2013 before going down slightly in 2014. Similarly, CBHI and HEF experienced some annual budget deficit, though the amount was much lower than that of the SASS (see *Table 1*). The budget deficit may have resulted from the high utilization of healthcare services as discussed above and the absence of a payment ceiling for insured members. The interview with key informants revealed that:

> "…In some cases, health insurance members were financed by the social security scheme up to 40 to 50 million Kip[2] because there is no ceiling on spending for treatment of each member especially accident cases, but if treatment lasts longer than six months, the patient is required to contribute to the cost of treatment and the health insurance fund does not cover treatment expenditures for very high treatment cost, such as heart operations, as the fund does not have such capacity." (Key Informant 2, Implementer).

Sometimes, the SASS provides spending coverage for treatment overseas when an insured member travels aboard on an official mission and becomes ill and needs treatment, or when domestic hospitals certify that the health problem of its members needs to be treated abroad.

In some cases, the organizations responsible for the health insurance implementation do not receive the budgets to perform its activities. For example, the National Health Insurance Bureau NHIB operates under the Department of Finance of the Ministry of Health though it claims to have the same status as the Department of Finance. However, it does not have its own budget and lacks human resources, and there are no clear job descriptions for each type of staff. One key informant from the Ministry of Health mentioned that:

> "…One reason for the slow expansion of health insurance coverage on the part of informal workers is limited resources to conduct awareness campaigns especially in distant rural areas. The

[2] 1 USD = 8,000 Lao Kip (LAK) on March 2015

government is committed to contribute 50% of the National Health Insurance Bureau required budget annually, but this organization still hasn't received any budget. Therefore, we don't have money to expand health insurance coverage to reach 50% of MOH's target by 2015." (Key Informant 3, Implementer).

Surplus or deficit by all facilities VS user fees (Million Lao Kip, 1USD = 8,000 LAK)	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
State Authority Social Security Scheme	NA	NA	NA	NA	NA	1,413	-2,137	-10,728	-10,611
Social Security Organization Scheme	35	232	2,802	2,084	NA	NA	NA	NA	NA
Community-Based Health Insurance Scheme	0	-237	-235	-111	NA	68	-76	NA	NA
Health Equity Fund	0	NA	NA	0	0	0	NA	212	-14

Table 1: The amount of surplus or deficit by all contracted hospitals (The National Social Security Fund and National Health Insurance Bureau, 2015)
Note: NA = Not Available data.

The study also found about unclear roles and mandates of institutions responsible for universal health coverage. For example, NHIB was established in 2013 and its mandate is for health insurance functions of pooling, purchasing/contracting, claims processing, payments and conflict resolution. According to the Prime Minister's Decree No.470, NHIB is composed of SASS, SSO, CBHI, and HEF. In practice, however, NHIB is composed of only the health insurance, or health benefit component, under SASS and SSO and will receive only 2% of the fund collected through these schemes by the Ministry of Labor and Social Welfare. Currently, no agreement on health insurance between the Ministry of Health and the Ministry of Social Welfare has been reached. Based on the interview of the staff for health insurance in the Ministry of Health, the Ministry of Labor and Social Welfare submits the capitations only to the contracted health facilities, while the Ministry of Health is demanding some money for administrative costs as well (extensive interview, February 24, 2015). With the absence of roles and mandates of the institutions responsible for health insurance in the Ministry of Health and the Ministry of Labor and Social Welfare, it becomes difficult to effectively manage and expand health insurance schemes in Lao PDR. Both ministries were waiting for the problem to be solved, but there is no middle institution or government intervention on the issue.

Another crucial factor that weakens institutional capacity for health insurance expansion and management is the poor administrative system of some institutions responsible for health insurance. The NIHB, for example, has insufficient authority to perform its duties as a health insurance institution and does not have the capacity to pool and manage funds from social security, nor the capability to create and operate a unified management and information system. At the moment, NHIB manages CBHI and HEF (HEF supported by government budget); the proportion of total revenue from CBHI scheme to service providers is 90% of contribution pooled at the provincial and district administrative health offices and 10% for administration and monitoring payment, while HEF is 95% pooled at district hospitals and 5% for administration payment. NHIB did not receive any revenues collected by CBHI.

In addition, CBHI did not have a proper system for receiving contribution payments. In general, CBHI members can pay their contribution at village, district hospitals or provincial hospitals. The contribution is usually paid every three months. CBHI did not have its own staff at the village level and has

to hire a villager to collect the contributions. The problem was that, in some cases, the CBHI assigned individuals to collect the money from villagers, but they did not give it to CBHI. Villagers who paid their contribution did not receive any benefits from CBHI. More importantly, NHIB has a weak reporting system to get accurate data from health insurance schemes, which leads to limited progress in achieving a unified and harmonized process for collecting, processing and reporting information. CBHI did not have a system or resources to monitor the contribution payments made at different levels of health services. The key informant from this organization emphasized that:

> "…the budget to conduct monitoring at provincial and district levels is not available. Therefore, we assigned provincial staff to monitor the implementation and quality of services provided to insured patients at district hospitals in order to get feedback to NHIB. We also don't have enough budgets to organize regular meetings with healthcare providers to access real implementation issue and solve the problem." (Key Informant 5, Implementer)

The finding was supported by the study conducted by Hernan (2014) that NHIB was established without a careful design and with no implementation plan, and supported by the study conducted in Vietnam by Rousseau (2014), which revealed that weak management system was partly responsible for inefficiency in the implementation of health insurance. It implies that with the budget deficit, unclear roles and responsibilities, poor administrative and contribution collection systems, it would be extremely difficult for the health insurance implementers to effectively perform their tasks. This will have an adverse consequence on the satisfaction of their customers, which will in turn affect the expansion of health insurance coverage.

Weak law enforcement

Another factor affecting the expansion of a social protection scheme is weak law enforcement. For example, the expansion of SSO failed to achieve its target simply because private enterprises ignored the law and regulations and state authorities seem to do nothing about it. There is no doubt that a large number of private enterprises do not participate in the SSO scheme. For example, in Xaythany district 35 out of 238 companies have so far joined the SSO scheme to provide social protection and health insurance to their workers. The finding was supported by the study conducted by Alkenbrack and her colleagues (2015). Despite such a large number of companies ignoring the law and regulations, nothing has been done to make them comply with the law and regulations. The Lao Trade Union (LTU), which is responsible for private employee protection has not attempted to solve the problem. The results of their study also revealed that small family owned businesses were less likely to enroll in social security schemes compared with large firms. This is against the Law on Health Care passed in 2005 and the 2013 Law on Social Welfare. Weak enforcement could be explained by various factors, including the lack of political will, weak institutional capacity and inappropriate social security law enforcement mechanisms. Weak enforcement of social security laws also occurs in neighboring countries including Vietnam. As pointed out by Rousseau (2014) that Social Security of Vietnam has low power and capacity to control and follow up the implementation of health insurance schemes.

Low capitation payment and social solidarity

The study found that the concerned authorities believed that low capitation fees and high utilization rates have had a significant negative impact on the expansion of healthcare coverage. In general, contracted hospitals would receive a capitation of around 85,000 LAK per person per year ($10.62 USD/person/year); the current capitation rate can cover only one Outpatient Department (OPD) and about 0.2 to 0.4 Inpatient Deparmtent (IPD) per year per person. It was more than three times lower than capitation rate of Thailand that was about $50 USD in 2007 (Limwattananon, et.al, 2013). Despite the small capitation, the utilization

rate of insured people was high by Lao standards given that the number of insured people was low. During the extensive interviews conducted on February 24-25, 2015, the key staff in three central hospitals (Setthathirath, Mahosot and Mitaphap) claimed that the utilization rate of health services by insured people was too high. The data from the National Health Insurance Bureau also revealed that among all health insurance schemes, SASS and CBHI experienced the highest rates of outpatients and inpatients between 2008 and 2013, accounting for 1.25% and 0.94% of all insured people of each scheme respectively (see *Figure 3* and *4*).

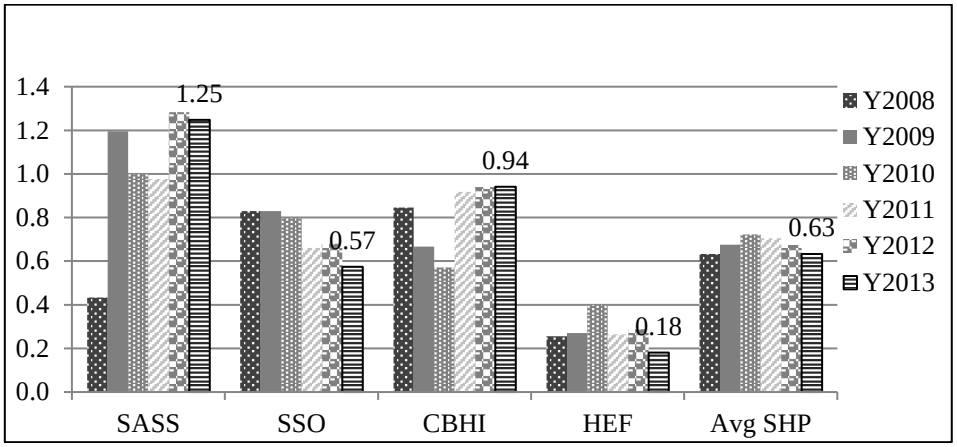

Figure 3: Trend in OPD utilization rate by health insurance schemes (National Health Insurance Bureau, 2015)

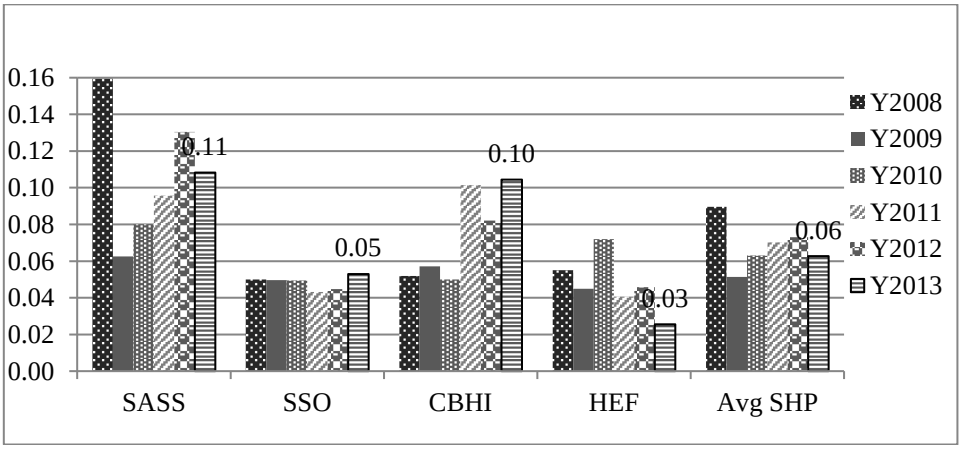

Figure 4: Trend in IPD utilization rate by health insurance schemes (National Health Insurance Bureau, 2015)

With small capitation, hospitals are facing significant losses annually. Although the amount of losses was not available for all healthcare facilities, it has been widely echoed among health service providers that they lost a lot of money from providing care to insured people. According to the staff in charge of the health insurance division in Mahosot Hospital in Vientiane, the hospital faced a budget deficit of about 2 billion LAK (Lao kip) annually due to low capitation and the high utilization of healthcare services (extensive in-depth interview, February 24, 2015). Similarly, the staff responsible for health insurance division at Setthathilath Hospital in Vientiane acknowledged that the hospital faced a budget deficit from providing care to insured people (extensive interview, February 24, 2015). Mitaphab Hospital had a similar experience, facing financial problems in providing healthcare to insured people (extensive interview, February 25, 2015). The findings were supported by the study conducted in Vietnam by Phoung and her colleagues (2015) in that a district hospital faced a critical budget deficit due to the low capitation rate. It is obvious that with the budget deficit, hospitals would not be able to provide good quality healthcare services to insured people.

Only a minimum benefit package was provided; many diseases were not covered and drug supplies were extremely limited. This would certainly result in low satisfaction with healthcare services among insured people. This would hinder health insurance schemes from expanding the coverage. The uninsured population will not join the health insurance schemes, and some insured people may be reluctant to renew or opt to terminate their memberships. The concerned authorities should attempt to widely launch an advocacy of right-balanced capitation so that service quality can be improved to meet the expectations of the insured population.

Moreover, the lack of social solidarity has also impeded the social protection schemes. A lot of people just do not see the importance of social protection if they do not have health problems. The experience of CBHI perfectly illustrates the issue associated with the lack of social solidarity. According to personal communication with the staff responsible for CBHI in the Ministry of Health, adverse selection is too common. People often pay contributions only when feeling sick and stop paying after that. This has resulted in high drop-out rates and failure in achieving the targets. People do not see the importance of contributions they make to the health insurance schemes, which can help to save other people's lives.

Copayment

Health service providers experience critical budget deficits due to a high utilization rate of health care service, and thus a copayment is often proposed to solve the problem. In Lao PDR, the introduction of a copayment is being debated among health care providers and health policy makers. The results of this study reveal that perceptions on the issue of copaymenta were widely divided among the concerned staff in Lao PDR. From the health provider perspective, co-paymenta should be introduced for two main reasons. First, copayments would help to reduce budget deficits. Second, copayments would help to change the behavior of insured people to reduce unnecessary utilization of health services, and improve reasonable treatment for patients because NHIB can monitor expenditure based on copayments collected in hospitals. The staff in charge of health insurance in Mahosot Hospital contended that:

> "…Copayment policy is very useful for hospitals for quality improvement, and reduces the over utilization of insured member. A copayment should be 10% in order to provide the best quality of care to insured members, and subsidize the exemption scheme. Recently, there is some copayment of health insurance members existing in the hospital for kidney dialysis, VIP room for admission. However, before introducing this policy, the government should pass the Law and enforce it effectively." (Key Informant 6, Service provider).

On the contrary, most of Lao health policymakers and health insurance implementers are reluctant to introduce copayments. They believe that it will affect the health insurance scheme expansion negatively because the public is not ready for a copayment. They do not understand the limitations of health insurance schemes and demand for more and more from them. The health staff responsible for health insurance in the Ministry of Health said that even without a copayment, it is still difficult for a volunteer scheme like CBHI to expand its coverage. She further contended that:

> "…copayments should not be introduced in Laos at this point in time because we are now encouraging people to join health insurance schemes. Copayments may be possible in 2030, when the country achieves full universal coverage (UC), but it should not exceed 10% in order to change the healthcare seeking behaviors of the insured people." (Key Informant 2, Policymaker)

Conclusion

After the introduction of user fees in the mid-1990's, four health insurance schemes have been implemented

to alleviate the adverse consequences of user fees for healthcare services in Lao PDR. Currently, there are four health insurance schemes, namely the Social Security Organization (SSO), the State Authority Social Security (SASS), the Community Based Health Insurance (CBHI) and the Health Equity Funds (HEF). However, the expansion of social protection by these four schemes has been below their targets. The coverage of all health insurance schemes were expected to cover 50% of the total population in 2015, but only 28.04% of the total population was covered by social protection schemes in 2014. Among these schemes, CBHI, which is a voluntary scheme, could achieve only 2.61% in 2014 out of 65% of its target set by 2015. Even a compulsory scheme like SSO could achieve only 2.4% out of 9% of its target population.

There are several factors that impede the expansion of social protection schemes in Lao PDR. Low capitation of healthcare services causes health facilities to face critical financial problems. Major hospitals in Vientiane complain that they lose a huge amount of money annually from providing healthcare services to insured people. It has affected the quality of care provided and discouraged people from joining health insurance schemes. In connection to the lack of funds, the budget deficits of health insurance schemes could also affect the expansion of social protection because there are not enough financial resources to raise public awareness about the importance of health insurance schemes, particularly voluntary schemes like CBHI and HEF.

The unclear role and mandates of institutions responsible for health insurance schemes and weak law enforcement also impede the expansion of social protection coverage. The National Health Insurance Bureau was established, but without having clear mandates and adequate resources it could not perform its duties effectively. Compulsory health insurance schemes like SSO have failed to expand their coverage simply due to weak law enforcement. Several private enterprises do not comply with the relevant laws and regulations, but nothing has been done to address the issue.

A poor administrative system of institutions responsible for health insurance has also affected the expansion of health insurance schemes, especially the CBHI. There was no proper contribution payment system in place. CBHI did not have accurate information about its finance at different levels. In some cases, the persons assigned by CBHI to collect contribution payments did not hand in the revenues they collected. This made villagers angry because they could not receive the benefits in accordance with their contribution.

There is no common ground on the issue of copayments. From the perspective of healthcare service providers, a copayment is necessary to improve the service quality. With copayments, there will be more financial resources, and insured people may change their health seeking behaviors by not seeking unnecessary healthcare. However, some high-ranking officials in the Ministry of Health and in social protection schemes believe that it is not the right time to introduce copayments because they may negatively affect the health service utilization rate.

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