Lao People’s Democratic Republic: a primary health care case study in the context of the COVID-19 pandemic

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Acknowledgements

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Executive Summary

The Lao People’s Democratic Republic Ministry of Health (MoH) has overseen the development of an extensive network of health services from the community level through to tertiary referral hospitals, with the aim of improving efforts to move towards universal health coverage (UHC). This case study draws on published demographic and health service data and policy documents to identify key enabling factors, pathways and future directions for primary health care (PHC) incorporating lessons learned during the COVID-19 pandemic between January 2020 and July 2022.

The health care system is predominantly government owned with a growing number of privately managed pharmacies, clinics and hospitals. The National Health Insurance (NHI) scheme was launched in 2016 and integrates multiple social health protection schemes including the health equity fund, community-based health insurance, and the family planning, maternal, newborn and children health programme. The NHI covers 94% of the population. The District Health Information System 2 (DHIS2) was also introduced to enable health service data to be captured in a national system. Findings suggest that the DHIS2 could be strengthened to obtain regular information to assess the effectiveness and efficiency of primary care service indicators.

Key PHC challenges include limited management capacity to translate PHC policy statements into programme implementation. Maldistribution of services and human resources, particularly in rural and remote areas, is also a challenge. Moreover, communicable diseases, noncommunicable diseases (NCDs) and road traffic injuries are increasing – resulting in a double burden of disease; yet the capacity of the health workforce to respond to this burden remains limited. Efforts to address chronic diseases in primary care settings will require an overhaul of competencies, information systems and modalities of working.

To support PHC there is a need to strengthen public-private partnerships and sector-wide coordination. Coordination with donors working in the health sector, multisectoral collaboration, and empowered people and communities, supported by effective health governance, could also support efforts to strengthen integrated primary care and essential public health functions.
Introduction and national context

With a population of 7.5 million people, Lao People’s Democratic Republic has undergone major transitions in demographics (1–4), epidemiology and health financing (5). It has one of the youngest populations in South-East Asia and is experiencing growing urbanization (6). The annual population growth rate declined from 2.4% in 1970 to 1.5% in 2020, during which period the total fertility rate also declined from an average of 5.9 children per woman of childbearing age in 1970 to 2.6 in 2020 (7–11). Rapid and/or sustained inflation, severe commodity price shocks, infectious disease, cost of living crisis, and unemployment/livelihood crisis were listed as the top five risks identified in a national survey in 2023 (12).

The World Bank UHC Index rating for Lao People’s Democratic Republic increased from 26.0 in 2000 to 50.0 in 2020 (5). Between 2007 and 2017, immunization coverage for the first dose of measles vaccine increased from 40% to 82% of children under 1 year of age; and the three-dose diphtheria, pertussis and tetanus (DPT) vaccine increased from 50% to 85% of infants (5). However, the health system is facing an epidemiological transition, from a burden of disease dominated by communicable infections to a pattern in which NCDs are the leading cause of morbidity and mortality. The rise in NCDs likely reflects socio-demographic and lifestyle changes including population ageing (13,14). In addition, the health system is undergoing a health financing transition with increasing health expenditure per capita, decreases in out-of-pocket (OOP) expenditure on health as a share of total health expenditure (THE), and a rising share of financing from pooled sources (5,15).

Primary care services are delivered through district health system networks comprised of district health offices (DHOs), district hospitals, health centres (HCs) and communities. The functions of the HCs include disease prevention, health promotion, and disease diagnosis and treatment. Under the supervision of the DHO, health centres supervise and monitor village health volunteers (VHVs) and coordinate between the village and district levels to assist in integrated outreach activities, provide health education, deliver community health promotion services, offer basic health care, facilitate antenatal care, perform vital event surveillance, and deliver malaria and tuberculosis (TB) education. The PHC workforce in rural areas was recently strengthened through the introduction of village health workers – VHVs who undergo additional training to become skilled health workers.

The MoH plays a stewardship role in the governance and regulation of the health sector. Provincial Health Departments (PHDs) include 17 provincial health offices (PHOs) and one Vientiane capital health office, which are responsible for managing and allocating available resources. The PHDs supervise 17 provincial hospitals, five of which have become regional referral hospitals to coordinate and support nearby provincial hospitals. The district health system consists of the DHO, district hospitals, health centres and drug kits in rural areas. The DHOs supervise the services of the district hospitals and health centres (5,15). Private sector health facilities are regulated under the MoH at district, provincial and central levels.
Since 1978, the government has officially supported the concept of PHC and the development of a primary care network. During the 1990s, primary care services were predominantly provided by vertical programmes through technical centres of the MoH such as Maternal and Child Health Centres; Malaria, Parasitology and Entomology Centers; the Centre of Information and Education for Health; and the Centre of Environmental Health and Water Supply. Effective horizontal coordination across these programmes is often reported as a key challenge (16).

In urban settings, primary care services, including those for disease prevention, health promotion and curative care, are provided by a range of public and private health care facilities, including health centres. In rural areas, each health centre offers primary care services including the treatment of common diseases, vaccinations, antenatal care, birth assistance, postnatal care and home visits to patients suffering from chronic conditions or with poor mobility.

Starting in 2012, Lao People’s Democratic Republic implemented health sector reforms to increase geographic access to primary care services by increasing and improving the district health system and rural health infrastructure and by increasing the supply of primary care providers (17). The government invested in building rural district hospitals and health centres (18). In 2015, the DHO became the public health unit responsible for both preventive and curative services at the district level. Each district with a population of 30,000 to 80,000 residents has one district hospital (143 district hospitals in total) (5, 15). In 2020 there were 1057 health centres providing primary care services including disease prevention, diagnosis and treatment, according to their capacity (19). The private health sector, which comprises pharmacies, practitioners of traditional medicine and private clinics, has expanded in recent years alongside increasing demand for better services (5,15). Table 1 offers a summary of demographic, macroeconomic and health profile and PHC priorities.
Table 1. Summary of demographic, macroeconomic and health profile and PHC priorities

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| Demographic profile | The early stages of a demographic transition, including changing patterns of mortality and fertility, are becoming apparent. Urbanization and economic development have contributed to increased population movement and cross-border migration. | - Providing sexual and reproductive health education.  
- Promoting lifestyle modifications to address obesity, substance abuse and other NCD risk factors.  
- Meeting increasing demand for health care services.  
- Ensuring access to contraceptives.  
- Improving knowledge of HIV and other health issues.  
- Addressing specific health concerns facing regular and irregular migrant and mobile populations. |
| Macroeconomic profile | The country has seen a steady reduction in the poverty gap and poverty severity over time. However, the poverty rate in rural areas is 2.9 times that of urban areas and inequality has increased, notably within urban areas.  
Efforts to boost domestic government investment in health care are underway. | - Expanding health insurance coverage.  
- Increasing access to essential health services in rural settings.  
- Developing public–private partnerships to support PHC. |
| Health profile | There is a double burden of disease. Mortality from road traffic injury has also increased, potentially associated with alcohol consumption. | - Revising and strengthening multisectoral action on NCD prevention and control.  
- Strengthening health governance capacity and developing integrated health services with primary care and essential public health functions, enabled by empowered people and communities and multisectoral action.  
- Strengthening donor coordination in the health sector. |

Source: The authors, drawing on data from (5, 12-15)

Methodology

This case study examines PHC in Lao People’s Democratic Republic to inform future policy and practice, incorporating lessons learned during the COVID-19 pandemic between January 2020 and July 2022. The study identifies specific pathways that have contributed to notable successes, failures and opportunities to promote learning and strengthen PHC.
Demographic and health service data was accessed from online data repositories including WHO Western Pacific Country Health Information Profiles, the National Statistical Bureau, the World Bank, the United Nations Children’s Fund (UNICEF), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA) and databases of the Lao People’s Democratic Republic MoH. Primary Stakeholder consultations were also conducted with 20 individuals working within different levels of the health care system relevant to PHC (including in PHC system development, policy formulation, health service planning and implementation and academia). Information was gathered on service planning, health system development, PHC financing, related research and health information systems, the implementation of health sector reform and other major changes driven by the COVID-19 pandemic, as well as efforts to address priority issues.

Narrative syntheses were produced to collate basic information on the health system profile and history and context of PHC. Data were synthesized narratively against the five strategic actions from the WHO Regional Framework on the Future of Primary Health Care in the Western Pacific Region (20), namely: i) appropriate service delivery models, ii) empowered individuals and communities, iii) fit-for-purpose PHC workforce, iv) PHC financing and v) a supportive and enabling environment.

Appropriate service delivery models

Most stakeholders consulted in the study understood PHC service delivery functions to include disease prevention, health promotion and surveillance. As the population ages and multimorbidity becomes the norm, the role of the PHC health workforce has become increasingly important (21).

Primary care facilities constitute a grassroots-level network, covering all districts and communities. At the grassroots level, a health centre in each community with at least two health staff provides health care services to patients for a payment of 5000 kips (approximately US$ 0.3) per visit. These centres manage mild illnesses, antenatal services, normal delivery, postnatal care, child vaccination, the provision of outreach activities and monthly integrated vaccination days with health education. All departments within the health sector play a crucial role in primary care management and implementation under the oversight of the Department of Hygiene and Health Promotion. In addition, the private sector plays a major role in service provision, and it is expanding to meet the demands and expectations of the growing population.

In villages further away from the health centres (5-10 kilometres or more than one-hour of travel), disease prevention and health promotion are provided through outreach services (e.g., immunization, integrated maternal and child health outreach services) by health centre staff. Health promotion is a national public health priority and includes a focus on tobacco control (15). The availability of accommodation in some health centre areas for health staff has ensured
the availability of personnel for 24-hour services. The most effective outreach activities appear to be those in which regular supportive supervision and monitoring are provided, either by a DHO or PHO staff (22).

Maternal and child health services have been used as an entry point for primary care service strengthening efforts. Since 2010, free services have been implemented for all antenatal care, postnatal care and delivery services, as well as free health services (including inpatient treatment) for children under 5 years. These services are financed by pooled government and donor funding (5,15). While maternal and child health is an area of focus under the current PHC policy (23), there are gaps in services for people living with disability and migrant workers.

The public sector accounts for the majority share of inpatient and outpatient utilization of health services. While utilization of preventive and promotive services and treatment has increased over the last twenty years, there are still significant differences across provinces and by economic status (5). Moreover, some primary care facilities in rural and remote areas have relatively poor infrastructure and working conditions (18). Limited basic amenities, diagnostic capacity and essential medicines underlie low service readiness in some health facilities (24). For example, while a World Bank assessment in 2014 found the service readiness index to be higher in district hospitals in the central region of the country, over 40% of district hospitals in the region did not have a system in place for infection control (25).

A key service delivery challenge reported by stakeholders and in documents during the COVID-19 response was “forgone care” – or reduced health care utilization. According to the People’s Voice Survey in Lao People’s Democratic Republic (2022), publicly managed health centres were often bypassed for hospitals during the COVID-19 response. It was reported that 17% avoided seeking health care due to a belief that their illness was not serious, high cost of care, or fear of contracting COVID-19 (26).

Information technology (IT) infrastructure has been developing since 1995 and the application of IT in the health sector has been introduced with almost all health staff owning a mobile phone. Health information management is carried out through two systems. Population-based household surveys are conducted regularly by the Lao Statistical Bureau – for instance, the LSIS I (2012) and LSIS II (2017) (7). In addition, the MoH also conducted a national health survey in 2000 (27) and 2006 (28); and a STEPS survey on NCD risk factors in 2013 (29) and 2020 (30). Facility-based health information systems are also used. The DHIS2 (31) was introduced into the health system in 2013. The ability to establish shared standards for both the DHIS2 system and for data reporting has been particularly important, as this has enabled different health programmes to overcome problems around fragmentation of reporting systems and the use of competing software systems (32). However, the quality of data is a challenge in some service delivery areas (32).
During the COVID-19 pandemic, there were calls for the MoH and partners to prepare and strengthen the capacity of health care providers to deliver long-term mental health services at the primary care level. The MoH responded by implementing tools, guidelines and recommendations on mental health and psychosocial support. The MoH identified primary care as an ideal platform, specifically at the village level, to improve and promote mental wellbeing (33). A training module on people-centred care – one of the four modules on local governance and community engagement in health centre training – was field tested and is likely to be integrated in future pre-service training.

**Empowered individuals and communities**

There are many barriers to accessing essential health care among vulnerable and largely rural populations. Obstacles include poor relationships between villagers and health service providers, and a lack of local ownership over decisions to support villagers and pregnant women to access essential health services. Interventions to improve health care access among hard-to-reach communities include targeted provision of vaccination and other maternal and child health services; equipment and supplies to disseminate information-education-communication (IEC) messages for ethnic groups; information dissemination about immunizations and other essential health care; ethnocultural competencies; and behavioural interventions for health care service providers and communities (5).

Evidence suggests that trust and communication between health care users and providers is key to community health (34). The quality of relationships between these stakeholders also influences health care quality and access (35). A 2021 study (22) found that shared decision-making between communities and health care providers – where communities set priorities for change that are then shared with district authorities – was an effective way to empower and improve community health. The study demonstrates a need to invest in relationships and trust-building between communities and service providers.

Community members and health stakeholders identified community-delivered integrated approaches to malaria elimination as a successful primary care delivery model. Accordingly, it was suggested that the model could be further developed and expanded to include interventions for the prevention, diagnosis and treatment of dengue fever, diarrhoeal diseases, influenza, skin infections, TB and other infectious diseases. Such a model should consider the available resources and integrate efforts across existing targeted programmes and policies (36–39).

The COVID-19 pandemic prompted an immediate whole-of-society response and greater local government attention to health. This provided an opportunity to strengthen community engagement and showed the importance of decentralized approaches in health emergency responses. Community engagement was pivotal in the COVID-19 response, especially for surveillance efforts, which required community trust in the health system to support reporting of suspected clusters. Multisectoral action was demonstrated at local levels,
drawing on existing community structures and capacities to shift power and ownership back to the community (22). A key challenge and imperative will be to sustain these community engaged and multisectoral approaches beyond COVID-19.

**Fit-for-purpose PHC workforce**

The number of health workers stagnated after 1998, and by 2012 the ratio of total health workers per 1000 population was 2.24, lower than the WHO recommended standard of 2.5 HCPs per 1000 population. Over the last decade, the MoH has invested in multiple measures to strengthen the health workforce. The annual quota of posts allocated to the MoH by the Ministry of Home Affairs (MoHA) increased in 2013 and 2014, resulting in an increase in the ratio of health staff in health facilities from 1.8 per 1000 population in 2010 to 3.2 in 2015-2016 (40). In addition, measures were introduced to strengthen the information system on health workforce numbers and distribution. A large quota for new appointments was introduced in 2015 for newly graduated community midwives. A 2019-2020 MoH report showed that 190 health centres out of 1057 (17.9%) were staffed by one–two health personnel, 686 health centres (64.9%) were staffed by three–five health personnel, 154 health centres (14.5%) were staffed by six–eight health personnel and 27 health centres (2.5%) were staffed by nine or more health personnel (19). In the same period, 742 health centres (70%) employed at least one or more mid-level midwife, and 54 health centres (5%) employed no physician, nurse or midwife (19).

At the village level, health care providers include VHVs, members of community health committees, traditional birth attendants, traditional healers and private health practitioners. The VHVs assist health centre staff in the delivery of integrated outreach activities, health education, community health promotion services, basic health care, antenatal care, vital event surveillance, and education and disease surveillance for malaria and TB. From 2009 to 2010, there were 53 676 local community members involved in health activities, of whom 14 812 were VHVs, 6128 were traditional birth attendants, 1222 were traditional healers and 31 514 were members of village health committees (41). In 2020, there were 14 227 VHVs (40). However, as the package of services provided by VHVs is developed according to operational feasibility requirements of the MoH rather than in response to community consultations, the services may not reflect local health care priorities.

To further expand the PHC workforce in rural areas, the MoH introduced village health workers (VHVs – VHVs who complete a six-month training programme) to engage closely with communities. The responsibilities of the VHVs include promoting PHC across the country. The VHVs are from the local community, which helps ensure that they fully understand the cultural context of their community’s health care needs and can provide appropriate physical and emotional support to individuals and families. VHVs also support the prevention and control of malaria and other infectious diseases in rural communities. VHVs who receive a further six months of training become skilled health workers (SHWs). With the introduction of training programmes for VHVs and SHWs and
increasing numbers of these higher skilled workforce cadres, it is expected that VHV roles will be gradually phased out (15).

Despite these investments, a key workforce challenge is the maldistribution of human resources against demand for services. The capacity of health workers to respond to the double burden of communicable diseases and NCDs also remains limited, and addressing chronic diseases in primary care settings is likely to require very different competencies, information systems and modalities of working (5).

To address inequitable access to quality health care services, ensuring appropriate health workforce distribution is a key government priority. The health sector reform Phase 3 (2021-2025) therefore identifies a need to ensure availability of skilled health workers, improve quality, performance and productivity of health staff at all facility levels, and to offer continuous professional development (16).

PHC financing

Health care system financing leverages several sources, including government funding, social health insurance (SHI), OOP payments from households and external sources. During 2011–2015, government spending on health services increased significantly. While more than 80% of the population seek health care from public providers, the remaining 20% access private clinics and hospitals and some seek treatment abroad (e.g., in Singapore, Thailand and Viet Nam), often financed by OOP or private individual health insurance. Despite a significant decline in OOP as a share of THE, such payments remain the largest source of health financing and consequently represent a financial barrier to health care access. The dependency of health spending on external sources has steadily increased through development assistance by health focus area (Table 2).

The health sector has transitioned from a fee-for-service model to selected free services, including health care for the poor. As part of efforts to move towards UHC, a single-coverage national health insurance (NHI) programme commenced implementation in 2016. The government finances public health facilities through input-based line-item budgets for staff, equipment and capital. The NHI scheme pays public providers capitation for outpatient visits and case-based payments for most inpatient admissions. The benefit package covers all consultations and admissions including drugs, tests and surgery. It excludes elective procedures, private facilities, brand name drug requests and services already paid under vertical programmes. Drugs, vaccines, tests and other commodities for immunization, TB, HIV, malaria and family planning have historically been provided separately by vertical programmes (5,15).

There have been some challenges in implementing the NHI scheme, especially at the lower levels of the health system (42-45). In a 2020 study, Chaleunvong et al. (46) found that 28% and 18% of outpatients at the provincial and district/health centre levels, respectively, reported additional payments to health facilities. To improve the NHI scheme, which was rolled out nationwide, joint work was conducted with support of development partners to cost an Essential Health
Service Package and scale this up by 2025. The aim is to develop and support sector-wide coordination and evolution of PHC. Between 2015 and 2020, the MoH implemented a performance-based financing project in the priority area of maternal and child health services, using several indicators to measure service delivery. External verification was performed annually to provide evidence of the achievement of performance targets.

Government investments have been supported by official development assistance for civil works to improve health facilities, equipment, supplies, drugs and staffing (24). These investments have improved health staff training in provincial and district hospitals and necessary infrastructure, equipment and essential drugs. There are ongoing discussions on donor transitions to improve sustainability and efficiency gains through integration across programmes. Supporting this, the Health Financing Strategy 2021–2025 and Vision 2030 include a focus on domestic funding for health in the context of donor transition and accountability in public financial management (45).

Table 2. National Health Accounts, based on key health financing indicators, 2000-2019

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<tr>
<td>THE per capita (US$)</td>
<td>10</td>
<td>20</td>
<td>30</td>
<td>50</td>
<td>59</td>
<td>59</td>
<td></td>
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<tr>
<td>Government health expenditure (GHE) per capita (US$)</td>
<td>3</td>
<td>3</td>
<td>14</td>
<td>25</td>
<td>33</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>THE (% of GDP)</td>
<td>3.3</td>
<td>4.3</td>
<td>2.7</td>
<td>2.9</td>
<td>3.0</td>
<td>2.4</td>
<td>2.6</td>
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<tr>
<td>GDP growth (annual %)</td>
<td>5.8</td>
<td>7.1</td>
<td>8.5</td>
<td>7.6</td>
<td>7.3</td>
<td>7.0</td>
<td></td>
</tr>
<tr>
<td>General GHE (GGHE) (% of THE)</td>
<td>33.1</td>
<td>17.0</td>
<td>46.5</td>
<td>49.5</td>
<td>55.2</td>
<td>51.8</td>
<td></td>
</tr>
<tr>
<td>GGHE (% of GDP)</td>
<td>11</td>
<td>0.7</td>
<td>1.0</td>
<td>1.4</td>
<td>1.7</td>
<td>1.3</td>
<td></td>
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<tr>
<td>GGHE (% of general government expenditure)</td>
<td>5.2</td>
<td>4.1</td>
<td>5.2</td>
<td>4.6</td>
<td>6.3</td>
<td>5.9</td>
<td></td>
</tr>
<tr>
<td>Social security funds (% of GGHE)</td>
<td>1.3</td>
<td>6.9</td>
<td>5.5</td>
<td>3.3</td>
<td>2.9</td>
<td>4.4</td>
<td></td>
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<tr>
<td>Private expenditure on health (% of THE)</td>
<td>66.9</td>
<td>83.0</td>
<td>53.5</td>
<td>50.5</td>
<td>44.8</td>
<td>48.2</td>
<td></td>
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<tr>
<td>OOP health expenditure (% of THE)</td>
<td>61.4</td>
<td>62.4</td>
<td>41.8</td>
<td>48.0</td>
<td>42.3</td>
<td>45.1</td>
<td>41.8</td>
</tr>
<tr>
<td>External resources on health (% of THE)</td>
<td>30.0</td>
<td>16.7</td>
<td>28.7</td>
<td>15.8</td>
<td>19.0</td>
<td>17.7</td>
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Sources: WHO, 2017 (8); World Bank, 2017 (5); MoH & NHA, 2019 (47); data for 2014-2016 (except for GDP growth) are based on the Lao NHA FY2012-2013 to 2015-2016 reports.
A supportive and enabling environment

A supportive and enabling environment for PHC is underpinned by MoH leadership and commitment to invest in PHC infrastructure through the development and implementation of PHC-supportive policies and regulations and strengthening of health monitoring and health information systems. The establishment of the NHI Bureau to oversee UHC, decentralization and commitments to multisectoral collaboration and engagement are also key enablers. PHC strengthening has been identified as a core pathway to achieve UHC by the government and it has been based on the government’s overall decentralization policy which is called “Sam Sang” or “Three Builds”: 1) provinces provide direction and strategy; 2) districts develop and fund a sustainable plan; and 3) villages implement the plan.

Since 1993, several policies and laws have been developed to advance PHC. The PHC Policy (released in 2000 and revised in 2019) affirms the importance of the PHC concept, approaches and principles and guides activities including the expansion of the health care network (23). The 9th National Socio-Economic Development Plan (NSEDP) sets countrywide priorities and guides the planning and implementation of different sectors and activities at the subnational level (48). The MoH is responsible for the 9th Health Sector Development Plan (9th HSDP), which outlines the government’s and the MoH’s long-term goals, policies, directions, targets and strategies for health (15). Work in the health sector is implemented according to a long-term 9th HSDP (2021-2030), a five-year HSDP (2021-2025) (49) and an annual operational plan. The government’s decentralized approach involves strengthening of district-level management and planning, and more room given for comprehensive planning and budgeting at the district level for locally owned activities (17).

The 9th Health Sector Development Plan (49) and the Health Sector Reform Strategy (17) also highlight the importance of training health workers to improve quality and safety of care. The first quality management tool from 2003 set a minimum of 10 requirements to ensure patient-centred care and data tracking (50). In 2016, the Department of Health within the MoH developed a framework for clinical quality improvement under existing quality of care (Dok Champa) guidelines (47) and the six-point quality checklist for the performance-based financing project (51). The development of a quality of care measurement tool is likely to support these efforts (52).

In addition, under the Community Health System Strengthening Action Plan, the government and development partners have committed to strengthening the integrated Health Management and Information System (HMIS) on the DHIS2 platform and ensure interoperability of other systems with HMIS. This is expected to improve coordination efforts and support service delivery integration based on the government’s priorities and plans (49).

Key regulatory enablers of PHC include the endorsement of the Health Care Law in 2005 (revised in 2015) (53) to regulate and govern both health professionals and health facilities. The Law covers the registration and planning of human
resources and determines the required qualifications, responsibilities, rights and ethical conduct of health care professionals. Under this Law, Article 20 regulates private facilities, Article 21 regulates clinics, and Article 22 regulates public-private health facilities. The Medical Profession Council and the MoH’s Department of Health Care are responsible for regulating and governing health care professionals. Implementation and enforcement of regulations in the private sector is challenging for the MoH, especially in the context of current reforms around hospital privatization.

In addition, the Drugs and Medical Products Law (54) was adopted in 2000 and revised in 2011 to regulate and govern pharmaceuticals and medical devices and aids. It determines the principles, rules and measures relating to the manufacture, import, export, distribution, sales, possession and utilization of drugs and medical products. The policy provides directions for the cost-effective use of medical equipment through the efficient selection, procurement, supply and maintenance of medical equipment at different health facility levels. Moreover, capital investment is regulated under the Law on Investment (55) and related legislation determined by the Ministry of Planning and Investment (MPI). Under this Law, the MoH and the PHOs and DHOs are required to develop capital investment proposals to be submitted to the respective planning and investment offices. All proposals for the health sector are reviewed and consolidated by the MPI and then submitted to the government and the National Assembly for approval.

The central MoH, central hospitals and specialized centres aim to coordinate and work effectively through multisectoral collaboration, which is another key enabler of PHC. There are multiple examples of specific multisectoral policies and actions to support PHC. For example, The Multisectoral National Action Plan on Antimicrobial Resistance was announced in 2015, which was jointly developed by the MoH and the Ministry of Agriculture and Forestry (56). In addition, in 2019 the MoH together with other ministries launched a multisectoral approach to improve access to health and nutrition services and scale up water, sanitation and hygiene services. The approach has included health promotion and disease prevention activities - for example, regular growth monitoring and efforts to improve immunization coverage rates and antenatal services have been conducted in 882 villages across 12 districts of the four northern provinces (57). A multisectoral action plan on NCD prevention and control was also released in 2014 (58).

The COVID-19 pandemic demonstrated a unique opportunity to strengthen multisectoral collaboration and stimulate greater government attention towards health from local authorities and communities. The pandemic also underscored the importance of decentralized approaches. Provincial and district governments established emergency operation centres with vice-governors as the chair which coordinated multisector responses to the pandemic. The involvement of the health sector as one component of the broader emergency response demonstrates that both health sector-wide and multisectoral coordination are critical components of an effective health care system.
Conclusion and lessons learned

Lao People’s Democratic Republic has experienced major transitions in the demographic, epidemiologic and financial landscape of its health care system. In response to the changing needs of the population, the government has provided greater investment in the health sector, including PHC. The current PHC Policy (23) is a valuable tool to enable effective and efficient implementation of primary care to achieve UHC.

Overall, PHC indicators have improved significantly, with several key enablers. Strong political commitment has shaped government investments in developing the district health system and establishing the NHI scheme. Decentralized governance of services, support for and upskilling of VHWs and application of a whole-of-society approaches (as seen in the COVID-19 response) also support effective PHC. To improve coordination of health care planning, donors and the government agreed on joint funding and common strategies for health sector development and a unified primary care system, leveraging experiences from COVID-19.

Key PHC challenges include managing vertical programmes for diseases such as malaria, HIV and TB, which have increased technical and management responsibilities at lower levels of the health system. In addition, although health insurance coverage is increasing, access to essential health services is likely to be challenging for primary care facilities at the grassroots level in rural and remote areas, partly due to maldistribution between the demand for services and the allocation of human resources. At district and health centre level, challenges also include weak planning and management capacity.

Strengthening PHC requires efforts to address equity gaps in health care access and commitment to enhancing community trust in the health system to improve health-seeking behaviour, especially utilization of health services at the primary care level. Study findings also suggest a need for continued investment in professional development and health care infrastructure, especially in rural and remote areas. New curricula may be needed to improve the competency of the health workforce to engage in management of NCDs as well as communicable disease prevention and control.
References


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This case study was developed by the Alliance for Health Policy and Systems Research, an international partnership hosted by the World Health Organization, in collaboration with the WHO Regional Office for the Western Pacific (WPRO) and WHO country offices. In 2015, the Alliance commissioned the Primary Health Care Systems (PRIMASYS) case studies in twenty low- and middle-income countries (LMICs) across WHO regions. This case study builds on and expands these previous studies in the context of the COVID-19 pandemic. This case study aims to advance the science and lay a groundwork for improved policy efforts to advance primary health care in LMICs.