Equity, privatization and cost recovery in urban health care: the case of Lao PDR

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Along with the shift from a planned to market-oriented economy, as in many other developing countries, Lao PDR has promoted health care partnerships with the private sector, and cost recovery in public hospitals, to increase resources in the public sector, while at the same time attempting to ensure appropriate access to health care for those without means to pay. In a multi-case design, this study compares two neighbourhoods of different socioeconomic status comprising 10 households, representing urban districts in three provinces. In-depth interviews were conducted over a 1-year period with three visits to each household. Members of the households were interviewed on their perceptions and utilization of health care services. Focus group discussions of public providers and individual interviews of private providers, leaders of the villages and hospital administrators provided complementary perspectives. The study found that both socioeconomic groups utilized private health services as their first choice, including private clinics and treatment abroad for those with high socioeconomic status, while the low socioeconomic group preferred private pharmacies. The unwelcoming attitudes of health staff and procedural barriers have led both groups to meet their health care needs in the private sector. Here the health care they receive is strictly limited to what they can pay for. For the poor, in most cases, this means drugs alone, i.e. no examination, no diagnosis and only limited advice. Limited financial resources often means receiving inappropriate and insufficient medication. Equity in health care remains theoretical rather than practical and the social goals of the reform have not been achieved.

Key words: cost recovery, privatization, equity, fee exemption, Lao PDR

Introduction

Privatization of health care and cost recovery have been proposed as strategies to alleviate developing countries’ resource constraints. Cost recovery was believed to generate revenue to improve services, and private health services would make those who could afford them choose these services – thus freeing up the scarce government resources which could then be employed to provide public health services and essential clinical services for the poor. In this way, privatization and cost recovery would be instruments for more equitable access to health care (Akin et al. 1987; World Bank 1993; Creese and Kutzin 1995; Chawla 2000; van der Geest 2000). The research presented in this paper sets out to examine whether privatization and cost recovery strategies in the Lao People’s Democratic Republic (Lao PDR) facilitate equitable access to health care.

With an annual per capita income of US$331 (NSC 2000), the Lao PDR is among the poorest countries in the world. The health system is under-developed and seriously under-funded (Pharm 1994). The life expectancy at birth is 59 years, infant mortality rate is 82 per 1000, and maternal mortality rate is 530 per 100 000 (MOH 2000a). The World Health Report 2000 ranks Lao PDR 147 for health goal achievement, 159 on fairness in financial contribution, and 165 for system performance out of the 191 Member-States (WHO 2000).

The health care system is today composed of a public and a private sector. The public sector comprises 2 central, 5 regional, 6 specialized, 13 provincial and 122 district hospitals, as well as 533 rural health care centres. The private health sector includes licensed pharmacies and private clinics as well as unlicensed providers. There are three categories of licensed private pharmacies classified according to the qualification of the owner or manager of the pharmacy, i.e. pharmacists, assistant pharmacists and pharmacist technicians/any other health personnel. Eighty per cent of the private clinics are located in urban areas, mostly in the capital city, Vientiane (MOH 2000b). Vientiane, Luang Prabang and Champassak are the three provinces with the fullest range of public–private health care provider options.

After the proclamation of Lao PDR in 1975, the country underwent a period of central planning, including a state monopoly providing free public health services. However, serious under-financing and inadequate supplies of essential drugs and equipment resulted in low service utilization (Paphassarang 1995).

The New Economic Mechanism policy, adopted in 1986, meant a shift to a market-oriented economy, which contributed to rapid economic growth (Stenson et al. 2001). In the health sector, this resulted in the development of private health facilities. The number of private pharmacies increased from 32 in 1986 to 1990 in 1999, and private clinics from none...
in 1986 to 261 in 2000 (MOH 2000b). Beside the social goal of access to quality health care for all, the reform policy promoted private investment with four aims, i.e. to reduce the financial burden on the government, reduce patient flows abroad, ensure better quality services through competition and to provide more job opportunities. Cost recovery in hospitals was introduced to generate revenue with school- and to provide more job opportunities. Cost recovery in hospitals was introduced to generate revenue with school-

Since the reform, no in-depth study has been conducted on how households are affected by the privatization and cost recovery policies and how the social goals of the reform have been met. Internationally, there has been, for some time, increasing concern regarding how such reforms influence access for poor segments of populations (WHO 1996, 2000; UNDP 2000; World Bank 2000). The body of published studies on actual experience is still small but there is a significant number underway (Carr et al. 1999). The study reported on in this article examines, from the household perspective, how health service utilization and equity are influenced by privatization and cost recovery.

Braveman (1998) defines equity in health care as meaning that health care resources are allocated according to need, health services are received according to need, and payment for health services is made according to ability to pay. She further distinguishes between potential and real access, the latter requires overcoming the many different barriers to accessing available services. Real access can only be determined by measuring the quantity, nature and quality of the services that people actually receive as well as by investigating the reasons, whether experienced or perceived, for not seeking or receiving appropriate care for legitimate needs. Exploring if equity between different socioeconomic groups exists with regard to health care utilization and seeking explanations for why or why not eventual differences exist can, therefore, be a complex undertaking. One needs to go far beyond merely collecting and analyzing service data and other quantifiable measures to look at perceptions among population groups as well as the full range of service providers from the public and private sectors. While the public health sector is likely to keep service records, the private – in particular the informal sector – is less likely to do so. Even if accurate records existed, they would never capture the situations of those who, for various reasons, are not seeking care from these public and private providers.

Methodology

The study sets out to investigate a contemporary phenomenon within its real-life context with opaque boundaries between the phenomenon and the context. The study design must, therefore, be able to cope with a situation in which there will be many more variables of interest than data points. It must also rely on multiple sources of evidence, with data needing to converge in a triangulating fashion. A multiple-case study design (Yin 1994) was consequently chosen.

The study compares two population groups with different socioeconomic status, their utilization of health care services and the determinants for choice of providers. The main approach to data collection was qualitative, seeking to explore and understand the rationales for choices. These qualitative data were supported by quantitative data on social indicators, health events, care utilization, payments, etc. The units of study, i.e. the cases, were neighbourhoods of 10 households with the individual households and their providers of health services as sub-units. The method of analysis was pattern replication (see Figure 1):

- Literal replication, to analyze whether the three cases, which were supposed to represent similar socioeconomic characteristics, really did so, and whether this led to similar patterns of health events and experiences with health care.
- Theoretical replication, to analyze whether the two groups of cases were indeed different and whether this difference led to a dissimilar pattern of health events and health care utilization, which could be explained by the difference in socioeconomic characteristics.

Three provinces were selected to represent the three parts of the country where the fullest range of alternative choices for seeking health care were available, i.e. Luang Prabang in the North, Vientiane municipality in the centre and Champassak in the South. In each province, one urban district was selected as a study site and two neighbourhoods of 10 households with different socioeconomic status were selected, to give three

Figure 1. Multiple-case study design and analytical model with two sets of three cases representing high and low social status, respectively; each case constitutes a neighbourhood with 10 households.
cases of neighbourhoods with high socioeconomic status (SE1) and three cases of neighbourhoods with low socioeconomic status (SE2). A multi-stage selection process was applied, including selecting villages within the districts based on relative number of electricity counter meters and electricity consumption. Neighbourhoods within each village were then identified based on observation of physical conditions of housing. Finally, 10 individual households were selected randomly within each neighbourhood from the list maintained by the village chief. The physical characteristics of the selected neighbourhoods and their households are summarized in Table 1.

The disease pattern and need for health care in Lao PDR is seasonal. In order to follow health care events and experiences of health care service use, as well as to build a rapport with the household members, each household was followed through three visits each over the course of one year, i.e. from December 1999 to December 2000. Sixty households with a total of 356 members were followed during this period. A structured questionnaire (data sheet) was used to collect factual data about socioeconomic indicators, health care utilization, medicine consumption, etc. This questionnaire was applied during the first visit and updated during subsequent visits. An interview guide with open-ended questions was used during all three visits to explore experiences, perceptions, views about health and health care services, as well as the general living conditions and problems faced by the households. During the visits a total of 117 individuals were interviewed, including 60 women. Of the 117 interviewed, 47 were heads of households, of whom 11 were women.

In order to cover the provider perspective, the study attempted to trace those providers who were experienced or mentioned by the households. Twelve focus group discussions with from 5 to 11 participants were conducted with a total of 42 physicians and 43 nurses from outpatient departments and mother and child care clinics in six public hospitals that were experienced or mentioned by the household members. Topics of the discussions were the trend of disease patterns, socioeconomic background of patients, pricing methods for services, fee-exemption policies and practices.

In-depth interviews using structured questionnaires and in-depth interview guides took place with 14 licensed private practitioners, 7 licensed private pharmacies, 2 unlicensed practitioners as well as 1 petty drug vendor, all of whom had been used at least once by the households of the cases. Topics covered were: their background, client background and reasons for attending, health problems presented, how and how much they were charged for services, how patients were referred, etc. Additional interviews were also made with the village chiefs and hospital administrators for clarification about fee-exemption practices.

Each interview session was conducted by two researchers, one doing the interview, the other taking notes. Interviews were taped, transcribed, coded, content analyzed and compared with information from other sources about the same case. All interviews were conducted in Lao and taped, and transcript summaries were translated into English. The final analysis of similarities and differences between cases was based on pattern replication analysis.

Results

Socioeconomic characteristics of cases

The SE1 households are large with few children and often several generations live together. The under-15 to over-15 years-of-age ratio ranges from 0.2 to 0.4 and the education level is high (Table 2). All houses are of permanent material and with modern amenities, and many of the families have private cars (Table 1). The main source of income in all the households is from their own businesses. The houses are located on main roads and less than 1 km from hospitals, private clinics or pharmacies.

The SE2 households consist of fewer members, i.e. children living with either their parents or grand parents. The ratio of under-15s to over-15s varies from 0.6 to 0.8. The majority of the heads of households have either no or incomplete primary schooling (Table 2). Only one of the houses is built of bricks, the rest are built of bamboo with few modern amenities (Table 1). The income originates from casual manual labour, construction work, subsistence farming and
Table 2. Demographic and educational characteristics of the households in each neighbourhood (6 cases/neighbourhoods of 10 households each)

<table>
<thead>
<tr>
<th>Socioeconomic neighbourhood by province</th>
<th>Mean number of members by case over study year</th>
<th>Vital data</th>
<th>Education of head of HH</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&gt;5 years old (1)</td>
<td>5–15 years old (2)</td>
<td>Adults and adolescents (3)</td>
</tr>
<tr>
<td>SE1</td>
<td>Champassak</td>
<td>6.3</td>
<td>12.3</td>
</tr>
<tr>
<td></td>
<td>Luang Prabang</td>
<td>6.7</td>
<td>18.0</td>
</tr>
<tr>
<td></td>
<td>Vientiane</td>
<td>6.7</td>
<td>13.7</td>
</tr>
<tr>
<td>SE2</td>
<td>Champassak</td>
<td>0.0</td>
<td>10.3</td>
</tr>
<tr>
<td></td>
<td>Luang Prabang</td>
<td>3.7</td>
<td>8.7</td>
</tr>
<tr>
<td></td>
<td>Vientiane</td>
<td>12.3</td>
<td>9.3</td>
</tr>
</tbody>
</table>

1 US$ = 8000 Kip.
petty trading. The houses, in general, are located in unfavourable environments, unsafe from disasters or standing on rocky land, preventing digging wells and constructing pit latrines. The neighbourhoods are situated 2–3 km from services such as schools, hospitals and pharmacies.

Health situation

In the SE1 households, 58 out of the 203 members (28%) experienced a total of 155 illness episodes during the year of study (Table 3). One birth and two deaths occurred during the year (Table 2).

In the SE2 households, 73 out of 152 members (66%) suffered from a total of 127 illness episodes (Table 3), and three births and one death occurred during the year (Table 2).

Utilization of health services

In all the SE1 cases, private health care providers were used for the majority of health care services sought by the individual households. Visits to private providers constituted 38 out of a total of 46 visits in Champassak, 28 out of 45 in Luang Prabang and 65 out of 77 in Vientiane. For SE1 households in Champassak, treatment abroad was the preferred choice, accounting for nearly half of all health-care service use, followed by licensed private pharmacies. In Luang Prabang, far inland, and where the only private clinic catered mainly for hill-tribe people, private pharmacies were the first choice, followed by public hospitals. One-fifth of all care was sought from doctors in unlicensed private practices. In Vientiane licensed private clinics provided more than half of all care contacts, with private pharmacies coming second, followed closely by public hospitals and treatment abroad (Table 4). For simple cases, the SE1 households would use pharmacies or private clinics. For more severe or complicated cases they would typically use a combination of service providers in search for what they perceived as the most appropriate and responsive service.

The Vientiane mother who gave birth went for her prenatal consultation with a private doctor and subsequently delivered in Mahosoth hospital. The 45-year-old woman in Champassak, who later died after suffering from bowel and lung cancer, was first treated in the provincial hospital, then used herbal medicines, before she finally went for treatment to a clinic in Thailand.

When the SE1 households used unlicensed private practices, they were, with the exception of the monk in Vientiane, always provided privately by a physician employed at the government hospital who was known either personally to the household or to the neighbourhood.

Also, in the SE2 cases the majority of health care services were given by private providers, with 30 out of a total of 35 encounters in Champassak, 28 out of 35 in Luang Prabang and 42 out of 60 in Vientiane. For SE2 households, private pharmacies were the first choice in all provinces for minor as well as more serious illnesses. The public hospital was the second choice in Champassak and Vientiane, used only in serious cases. In Luang Prabang the second choice was shared between the public hospital and unlicensed private practice (Table 4). In the SE2 cases patients were only brought to public hospitals when serious. The households were unlikely to use multiple providers for the same episode and a determinant, even in severe cases, for where to seek care was the perceived cost, as illustrated by the following two examples.

In Luang Prabang, one 45-year-old mother of 11 children died from heart disease. Her eldest daughter reported that she died while sleeping. During the days prior to her death, she had fallen unconscious three times in the forest while gathering wild plants to sell at the market. She did not seek

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**Table 3. Total reported illness episodes by type of illness, socioeconomic neighbourhood and province (6 cases/neighbourhoods of 10 households each)**

<table>
<thead>
<tr>
<th>Socioeconomic neighbourhood by province</th>
<th>Acute illness episodes</th>
<th>Chronic diseases</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fevers</td>
<td>Body pain</td>
</tr>
<tr>
<td>SE1 Champassak</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>SE1 Luang Prabang</td>
<td>24</td>
<td>7</td>
</tr>
<tr>
<td>SE1 Vientiane</td>
<td>45</td>
<td>8</td>
</tr>
<tr>
<td>SE2 Champassak</td>
<td>22</td>
<td>5</td>
</tr>
<tr>
<td>SE2 Luang Prabang</td>
<td>10</td>
<td>17</td>
</tr>
<tr>
<td>SE2 Vientiane</td>
<td>33</td>
<td>25</td>
</tr>
</tbody>
</table>

*a* Fevers include symptoms described as malaria, flu, pneumonia, coughing and unspecified fever.

*b* Body pains include symptoms described as back pains, headache, pains in limbs, etc.

* Numbers in brackets indicate the number of persons chronically ill.
care from the hospital for fear of the cost it was likely to involve, but went to the market to buy drugs from a third level pharmacy. She, herself, had reported during our first visit that she was the main support for her large family because her husband, a migrant worker, spent most of his earnings on drinking. Investigation at the private pharmacy did not provide any clarification as the owner could not recall the dead person.

In a Vientiane household, headed by a widow, a 37-year old and illiterate daughter got seriously hurt by a cart while collecting items to sell, and this resulted in left lower thorax pain. The daughter said: “To reduce the pain, I massaged myself and hit the painful part with my hand. I didn’t go to hospital due to lack of money. Two days after, as the pain continued, I bought drugs from a private pharmacy. I explained what happened to the drug-seller who packaged two sets of three tablets with green and yellow colour to take twice a day, morning and evening.”

### Patient satisfaction

Twenty-one per cent of all encounters with health care providers for the SE1 neighbourhoods were with public health care. The main determinant for the households for choice of provider was perceived and experienced quality of service. Members of SE1 households found public service procedures complicated, with long waiting times and that staff were rude to patients: “I find that doctors are rude when they talk to patients. In case of a skull-trauma which was brought to the hospital, they asked for papers and relatives before they would do anything,” said one person interviewed in Vientiane. The households preferred going to private clinics, and for Champassak and Vientiane to Thailand, due to perceived good quality of services. “There is no waiting time, every service is in one place and doctors care for their patients. Thai services are of good quality, rapid and well equipped,” said a household head in Champassak. SE1 households in Luang Prabang preferred to see doctors privately to avoid the hassle of the public hospital. However, there were also views expressed regarding recent improvements in services. “People like to go to Mahosoth hospital [Vientiane] because it’s close to home and the biggest hospital in the country. The doctor in the private clinic advised me to give birth at Mahosoth. Now services have improved and facilities become cleaner,” said the Vientiane woman who gave birth there.

For SE2 households overall, 23% of all health service encounters during the year were with public hospitals, the majority of these being experienced in Vientiane. Among the SE2 households, there were distinct perceptions and established patterns regarding where health care was sought. “When people are sick, those who have money go to the provincial hospital, those who don’t, get an injection from whom they know. Some villagers like to go to a nurse living in Viengmay village. As for my family, we like to buy drugs from the pharmacy close to our home,” said one household head in Luang Prabang. Households commonly complained that the hospitals were costly and staff attitudes bad.
especially towards poor patients. “The public hospital is costly and does not allow debt”, said one woman in Champassak. “The attitudes of some staff in public hospital are bad. I saw staff busy with sunflower seeds while a child was suffering from fever convulsions,” said the head of one household in Vientiane. While only a few of the households had themselves experienced high costs and bad staff attitudes, these perceptions were shared by most of the household members interviewed. It was also a widely held view that procedures at the public hospitals were elaborate, incomprehensible and not friendly to poor people who would have to deal with a large number of staff during each visit for registration, medical procedures, as well as for payment issues.

Provider perspectives

In the focus group discussions, doctors and nurses explained that public hospitals predominantly served middle class and poor people and highlighted two main problems: first the high patient-load and the limited number of staff available, and secondly, the elaborate procedures. Patients must pay for a registration book, obtain an appointment number and then wait for consultation. After visiting the doctor, the patient has to bring the prescription to the hospital pharmacy where the amount to be paid for drugs is calculated. Then the patient has to pay at a different counter and return to the pharmacy with the receipt in order to obtain the drugs. If laboratory examinations are needed, the patient firstly has to pay the test fee at the counter, then obtain an appointment at the concerned para-clinic desk where he/she will be told to come another day. This all leads to delays from several hours to days.

Procedures at the private pharmacies are much less elaborate and patients can walk in from the street, present their problem and receive an immediate response. Interviews with licensed pharmacies revealed that about half the patients describe their symptoms and request the drug-sellers to give drugs. The other half request specific drugs themselves, while only very few come with prescriptions. However, while the patient may find the pharmacies provide an easily accessible service, the medical quality may be questionable. From observation made at the third-class private pharmacies, it was shown that, although licensed to a health professional, many of them use non-professionals, including relatives and even children, to dispense drugs.

Private licensed practitioners indicated in the interviews that the main reason for patients coming to them was to have easy, direct and personalized contact, limited or no waiting time, that all services and procedures were dealt with in one place, and that, if needed, further examinations and referral to other private or to public services would be efficiently facilitated by the private physician.

Payment for health services

The SE1 households spent considerable amounts on health care in absolute, as well as in relative, terms. In Champassak and Vientiane, households spent on average 5.4 and 6.5% of their total incomes on health care – most was spent in private clinics and for treatment abroad. Expenses in the private sector, including Thailand, were about 15 times what was spent on the public hospitals for Champassak and Vientiane. In Luang Prabang, where licensed private clinics and treatment abroad are not relevant options, households spent, overall, significantly less on health care, i.e. between one-tenth and one-fifth per person of what was spent in Champassak and Vientiane. The SE1 households in this province also had the lowest average income and spent only 2% of this income on health care. However, households in Luang Prabang spent slightly more on public hospitals and significantly more on unlicensed private practice compared with Champassak and Vientiane (Table 5). The SE1 households did not report any problem with payment for health care and some had even taken health and life insurances in Thailand.

Compared with the SE1 households, SE2 ones spent considerably less per person on health care. Spending per person by the SE2 neighbourhoods in Champassak and Vientiane was only 4 to 6% that of the SE1 households. For Luang Prabang, SE2 households’ spending was 18% that of the SE1 households. As a percentage of the average per person income, the SE2 neighbourhoods spent between 1 and 1.6% on health care. All of the SE2 households reported difficulties paying for health care. With the exception of Luang Prabang, the SE2 neighbourhoods spent more money in the private than in the public sector. In Luang Prabang, more than half the total amount spent on care from public hospitals related to one incident where a 6-year-old boy got a knee-injury with a large open wound after falling on a nail while running. He was brought to the hospital for surgery. Fortunately, this happened after his mother won a lottery of 300 000 kips of which 250 000 were spent for the treatment – otherwise, he would not have been taken to the hospital.

When faced with the prospect of major health care expenditures, the SE2 households either did not seek care, delayed care-seeking, borrowed money from relatives or neighbours, requested credit from private providers, or sought alternative provisions. There were several examples among the SE2 households during the year of study; typical examples were:

- A 20-year-old woman in Luang Prabang making a living from her labour, who suffered severe abdomen pain, first sought care twice from pharmacies where she paid 10 000 kips and 6000 kips, respectively, but after 3 days the pain became worse. Relatives and neighbours who came to visit advised her to go to the hospital, but she could not afford to. They then paid for her to go to the hospital where a doctor prescribed her medication costing 50 000 kips. After working for 5 days the pain returned, she went to an unlicensed practitioner (medical assistant) who gave her an injection which cost 15 000 kips and after 2 days she received another injection which cost 20 000 kips. She received assistance to the total of 60 000 kips from her brother and neighbours.

- Also in Luang Prabang, a young mother of a 9-month-old baby, and with an unemployed husband, had been bleeding from the uterus for 3 months. The family had already borrowed 100 000 kips from a neighbour who charged 30 000 kips in interest and now they could not afford to continue treatment.
Table 5. Payment for health care services by type of provider, socioeconomic neighbourhood and province in '000s Kips for the 12-month period studied (6 cases/neighbourhoods of 10 households each)

<table>
<thead>
<tr>
<th>Socioeconomic neighbourhood by province</th>
<th>Total health care expenditures per neighbourhood during 12 months</th>
<th>Health care expenditure and income per person</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Public hospital or clinic</td>
<td>Licensed private clinic</td>
</tr>
<tr>
<td>SE1</td>
<td>Champassak</td>
<td>1 991</td>
</tr>
<tr>
<td></td>
<td>Luang Prabang</td>
<td>2 158</td>
</tr>
<tr>
<td></td>
<td>Vientiane</td>
<td>1 104</td>
</tr>
<tr>
<td>SE2</td>
<td>Champassak</td>
<td>264</td>
</tr>
<tr>
<td></td>
<td>Luang Prabang</td>
<td>492</td>
</tr>
<tr>
<td></td>
<td>Vientiane</td>
<td>287</td>
</tr>
</tbody>
</table>

* Other include Traditional healers, monk.

1 US$ = 8000 Kip.
A 70-year-old woman in Vientiane, suffering from frequent urination, went to Mahosoth Hospital and was told to undergo blood and urine tests, which would cost about 100,000 kips. She could not afford this and went home without any treatment.

Unable to pay the amounts requested, or fearing what might be requested by the public hospitals, the private pharmacies provide a convenient alternative, where a treatment matching what the patient can afford is always available. Interviews with both households and private pharmacies showed that those who come to the private pharmacies with less money than the cost of a full course of treatment will get medicines according to how much money they have, and be told to return for the rest if and when they have more money.

**Exemption or reduced fee**

Full or partial fee exemption was supposed to be granted in cases where a patient is unable to pay for the service at the public hospitals. However, despite 130 encounters with the health care system, out of which 30 were with the public hospitals (Table 4), the SE2 households either did not know about the possibility for exemption or believed that the system and the procedures were such that it was unrealistic for them to attain. None of the SE2 household members reported that they had asked for, or received, any exemption from hospital fees during the 12-month study period. “I have used the public hospital and never heard about the fee exemption”, said one elderly man in Vientiane. Another man in Champassak, suffering from abdomen pain and heart disease, reported coming to the emergency service of the provincial hospital. He was prescribed with drugs costing 80,000 kips. He had only half of the amount available and went back home without requesting or being told about fee reduction and bought some drugs from a pharmacy. He asked the unlicensed midwife of the village to give the injection to him.

Interviews with the public relations staff and focus group discussions in the six hospitals revealed unclear implementation of the exemption policy; for example students and monks were asked to pay and non-target groups, such as government staff, in particular health staff, were exempted. It was reported to be rare that total fee exemption was given to the poor. One statement was: “The hospital does not give more than half reduction of the cost even if you bring the poverty certificate signed by the chief of the village.” Receiving an exemption would, in addition to the poverty certificate from the village chief, also involve seeing and achieving approval by several senior staff at the hospital.

The SE2 households received services from private licensed clinics as well as from unlicensed health professionals in all provinces (Table 4). In Champassak and Vientiane, between 31 and 35% of the total expenditures for health care was for care from these providers (Table 5). From the household and provider interviews it emerged that the private practitioners were applying a degree of flexibility with regard to both level of fees and mode of payment. In the in-depth interviews, private licensed practitioners mentioned that the fees are similar in the public and private sector and that those who know the doctor can obtain credit. One private practitioner reported that sometimes he received in-kind payment such as rice, fruit or animals for services provided to patients who had no money to pay.

An unlicensed practitioner, a 39-year-old woman, previously an auxiliary midwife in a district hospital in Champassak, reported that all her visitors were from low-income families: “They come to me because I don’t make any difference because of their social status and serve them anytime and place they want. I don’t have fixed fees, but let the patient give what they can. Often I advise them to go to the public hospital but they don’t.” A 73-year-old retired medical assistant reported that people who came to see him were mostly children suffering from fevers and diarrhea, and adults suffering from body pain and malaria. Around half of his patients were from low-income classes while the rest came from the middle and higher income groups. Also, he did not have fixed fees but let patients decide how much to pay. He claimed to give free services to the poorest if they really had nothing.

**Pattern replication**

The case study design chosen for this research uses analytical rather than statistical generalization. The underlying logic is prediction of similar results in similar circumstances within each of the two groups (literal replication) and contrasting results for predictable reasons between the groups (theoretical replication).

**Literal replication**

The socioeconomic characteristics of the SE1 neighbourhoods are very similar (Tables 1 and 2), except that the income per person (Table 5) in Champassak is two to three times higher than in the other areas, and that in Vientiane they had more cars (Table 2). In terms of health care needs (Table 3), the Luang Prabang neighbourhood had less chronic episodes, but otherwise the three provinces display a pattern. Luang Prabang stands out in terms of service utilization with the absence of private clinics and treatment abroad. It is clear, however, that all three neighbourhoods use a combination of their social status and purchasing power to obtain the best possible service. In Luang Prabang they partially compensate for the absence of licensed private clinics by obtaining private unlicensed services from hospital doctors and using relatively more private pharmacies than in the other two provinces. Champassak and Vientiane households spend significant sums on health care with the bulk spent on obtaining services from private clinics and abroad. In Luang Prabang, without these options, the SE1 households spend more on public hospitals and unlicensed private practices.

The SE2 neighbourhoods all have high child-dependency ratios and similar levels of income per person. With the exception of the television sets in Vientiane, few of the households have any of the indicator amenities (Table 1). The education level pattern is similar across the three neighbourhoods.
(Table 2). With the possible exception of body pains in Champassak, the illness episode and health-care service utilization patterns are similar in the three provinces, i.e. from licensed private pharmacies to petty vendors (Table 4). All neighbourhoods spent only small amounts in absolute, as well as in relative, terms on health care, with Champassak the highest (Table 5).

Theoretical replication

The two groups, SE1 and SE2, are distinctly different with respect to all the socioeconomic indicators used, i.e. demographic, household assets, education and income (Tables 1, 2 and 5). In terms of health care needs, the two groups show only apparent differences with respect to chronic diseases, which are higher in the SE1 group, and body pains, which are higher in the SE2 group (Table 3). The former could possibly be explained by a higher average age and better diagnostic opportunities, while the latter could be explained by different working and general living conditions.

While the health care needs, with the above exceptions, are not dissimilar, the way and extent to which the two groups cover them are. In the majority of health care contacts, the SE1 household members manage to be seen by a physician, whether abroad, in public hospitals or in licensed or unlicensed private practice. In the majority of contacts, namely at private pharmacies, the SE2 members are not examined but receive medicine dispensed on the basis of their own history or direct request. Also, when the SE2 households use an unlicensed private practice, a lower level of medical competence is reflected (Table 4). Although the SE1 households have much higher health care expenses, it appears that it is the availability of quality services that sets the limit and not the ability to pay. This is contrary to the SE2 households where there were multiple examples of ability to pay falling short of need and availability of service.

Discussion

There is potential access to a wide range of different health care services in all three provinces with the exception of Luang Prabang, which has no licensed private clinic catering for the town population and where the Thailand option is not relevant. Both groups (SE1 and SE2) are willingly using the private alternatives established by the reform policy, and are even going beyond by using informal services of health care professionals where formal private services are inadequate, such as in Luang Prabang for SE1, or where they are inappropriate, i.e. in all provinces, for SE2.

The concepts of paying for, and the free choice of, health care services appear to be accepted by both groups. However, it is only the SE1 group that can exploit the options provided. The SE2 group is pushed away from full medical services at the public hospitals to dispensing-only services at the private pharmacies – and even these services are often incomplete when a full course of treatment cannot be afforded.

There are three principal barriers in access to health care in Lao PDR, namely: cost of service, procedures and staff attitudes. These barriers are experienced differently by the two socioeconomic groups.

Cost of service

Cost was not a determining factor for where the SE1 households sought their health care, which is illustrated by the total health care expenditures being much higher in both absolute and relative terms in the two provinces where a wider range of provider alternatives are available, and the fact that cost of care was never mentioned in the interviews with these households. For the SE2 households, on the other hand, the cost, both the perceived and the actual, represented a major barrier in access to service. Among the SE2 households there were several examples during the course of the year where patients resorted to cheaper alternatives when presented with the cost of treatment – or sought low-cost treatment options in fear of the cost at the hospital. Fee exemption or reduction at the public hospitals, which could have ameliorated this barrier, were functionally non-existent to the SE2 households.

Procedures

Procedural barriers were experienced by both socioeconomic groups. Complicated systems and flows in the public hospitals create long delays and waiting times. These procedures appeared to be the main deciding factor for the SE1 households in choosing private providers, whether local or abroad. The same procedural barriers were also experienced by the SE2 households and contributed to the non-functioning of the fee exemption and reduction option, i.e. they supported or added to the cost barrier.

Staff attitudes

Bad staff attitudes towards patients were mentioned by members of both socioeconomic groups. While no-one likes to be treated badly, these attitudes are likely to have a larger impact on the SE2 group, whose members have a lower social and educational status than the staff, are often unable to pay the fees requested, and are unaware of their rights and the procedures for full or partial fee exemption. Bad staff attitudes not only make the encounter with the hospital system an unpleasant experience, they also add to the procedural barriers, which in turn can prevent the needy from benefiting from the fee exemption and reduction options. It was remarkable that in none of the 30 instances where the SE2 households used public hospitals during the year of the study, was the possibility of fee reduction or exemption brought up, even in situations where inability to pay turned the patient away, and in particular because all these households, from a poverty perspective, would have been entitled to full or partial exemption.

While actual or perceived cost in the first instance may appear to be the most concrete barrier in access to health care for poor people in Lao PDR, this may only be the case because the exemption mechanism is not functioning. Complicated procedures and bad staff attitudes invalidate this mechanism and make the experienced cost higher than it
needs to be, and thus contribute to the perception of high costs, which may deter SE2 members from seeking care from the public system.

Demand by a population group for health care services is influenced by a multitude of factors, including level of payment, income, cost of complementary services, cost related to consumption of the service, cost and availability of substitute services, state of the group's health, the supply of services, and the perception of the utility of the services (WHO 1994).

While the SE2 households accepted the concept of paying for publicly provided health care, in many cases they were not able to pay the fees demanded or were afraid of the amount they anticipated being charged, and consequently decided not to seek further care or sought the care where the price was perceived to be less. The influence of out-of-pocket payment or cost-sharing on demand and utilization of health care service is well documented in the literature (Zweifel and Manning 2000). Introduction of cost-sharing in poverty-stricken Zambia as part of its health sector reform resulted in an immediate and sustained decrease of 35% in overall utilization of outpatient services, despite the theoretical availability of fee exemption for the poor (Blas and Limbambala 2001). Gao et al. (2001) found a similar effect in China and demonstrated a negative relationship between utilization and level of income.

Benson (2001), in his study on the ecology of private health care in Tanzania, nicely demonstrated that a substantial increase in the number of private care providers did not lead to improvement in equality or equity of access to health care; equality in access being defined in terms of geographical distance and equity being defined in terms of need. The private providers clustered spatially and supply-wise where the greatest market value was found. In Lao PDR, we found that not only were the physical distances much shorter from the SE1 neighbourhoods to health facilities than from the SE2 neighbourhoods, but also that half of the SE1 households had private cars, which further reduced the experienced distance. We further found that the private pharmacies adapted their sales strategies to the purchasing power of each client by offering drugs based on cash-at-hand rather than on medical grounds.

Both social groups in Lao PDR frequently used private pharmacies for both diagnosis and drug supply. However, the SE2 households consistently had a higher use of pharmacies and were more likely to use these as the only source of health care than the SE1 households, which often used the pharmacies as part of a more comprehensive care-seeking strategy including both public and private providers. The SE1 household members were more likely to see a qualified physician than was the case for the SE2 household members. This observation corresponds to similar observations in Vietnam where it was found that in the lowest income quintile, for 46% of all illnesses cases, drug stores were the only source of care, while this was the situation for only 34–35% of cases in the upper income quintiles (Ensor and San 1996). In both China and Vietnam it has been found that the introduction of private markets has resulted in a wider choice of service, but the poor are less likely to consult qualified doctors and find it difficult to pay for the full course of drugs (Bloom 1998).

The above economic and geographic factors certainly put the SE2 households at a disadvantage in comparison with the SE1 households. Both household groups faced procedural barriers in accessing the public health care services in terms of long waiting times and overly complicated patient flows at the hospitals. However, in addition to these, the SE2 households also faced barriers related to ignorance and social status: the former, in terms of lack of knowledge about rights and exemption possibilities and mechanisms; the latter, in terms of lack of assertiveness, low self-esteem, as well as staff attitudes. This could lead to a conclusion that the poor are not facing a range of distinct individual factors, each creating its own disadvantages that can be dealt with individually, but face a complex package of inter-linked disadvantages that needs to be dealt with in a more holistic way at the system level. If this is correct, it is similar to the findings and conclusions reached from studying use of antenatal and delivery services among internal migrants in Shanghai (Zhan et al. 2002).

Mills et al. (2002) highlight the need to strengthen the position of the consumer in the private medical market and point out that very little information on this topic is currently available. They propose that consumer education could help inform patients about quality and prices of private care in order to facilitate an informed choice of provider. Our findings in Lao PDR suggest that such approaches may need to be expanded to include not only private sector options but also the public sector. The approaches need to inform not only which services are available at which quality and cost, but also about the rights of the patient, and how to access and use the services. In doing so, the approaches must take into account social disparities and that written and televised publications are unlikely to reach the target audience.

While the Lao reform policy may, in theory, be able to achieve its social goal, its practical implementation – at the moment – has resulted in a highly inequitable system where those better-off have access to unlimited quality health care options, while the poor's access to health care is very limited. The perceived and actual cost of care in both the public and private sector is beyond their ability to pay and they cope by either not seeking care at all, choosing the cheapest alternatives, adapting or truncating treatment regimens according to availability of cash, drawing on the extended family, borrowing money or receiving credit – thus escalating their economic problems.

Limitations of the study

Although the study covered only a relatively small number of households, 60 in total, the use of pattern replication within and between cases gives good support for the conclusions, and the results are likely to reflect the true situation in urban
settings in Lao PDR. The analysis is further supported by the use of converging multiple sources of evidence, including: in-depth interviews of the same households three times over a 1-year period, follow-up on health events of more than 350 individuals in these households over the same period, focus group discussions and interviews with the health care providers and administrators who were providing their health care services, as well as by direct observations.

Conclusion

The social goal of access to quality health care for all, as outlined in the Lao PDR reform policy, is not likely to be achieved with the current direction of development. Inequities between those who can afford comprehensive private services, such as through licensed private clinics, and those who have no access or have to settle for buying drugs on an ad hoc basis depending on their current resource situation, is huge and likely to grow as the private sector becomes further developed. Even if it was possible to clarify the exemption mechanisms, the attitudinal and procedural barriers in the public hospital system are immense and experienced almost insurmountably by all, irrespective of their socioeconomic status. Furthermore, it is highly questionable whether it is feasible to provide basic primary health care services through large hospital outpatient departments, which almost by necessity will become bureaucratic and cumbersome to use, in particular for poor and less educated people.

Further privatization aimed at the poorer segments of the population is not likely to improve the situation, as it is clearly demonstrated in the study, because they cannot even pay for the cost of the drug inputs, and any service targeting the poor needs to be heavily subsidized. One way ahead could be to establish a system of public neighbourhood health posts, staffed with a nurse or medical assistant, in urban areas with significant populations of low socioeconomic status. Functions of such neighbourhood health posts would be to strengthen the position of the ‘disadvantaged consumer’, for example through providing easy access to appropriate diagnosis and treatment for common uncomplicated conditions and administering a scheme of ability-to-pay graduated fees with direct participation of the community in its management. Also included in the function of such neighbourhood health posts would be to assist individuals of the neighbourhood in accessing higher levels of care, if they so need. This could include assisting in preparation and processing of the necessary documentation required to obtain exemption at the hospitals and possibly making appointments, as well as, at times, accompanying individuals who are uncomfortable facing the staff and bureaucracy at the big hospitals. If the health posts are staffed by out-posting and making this part of the career path of hospital personnel, it may even lead to education of the hospital staff and over time result in changed attitudes towards patients in these institutions.

Endnotes

1 Decree no 52/PM on Medical Services and Guide of the Public Health Minister No 2635 on the same, 1995.

References


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