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REVIEW

# Health policy evolution in Lao People's Democratic Republic: context, processes and agency

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During the last 20 years Lao People's Democratic Republic has successfully developed and adopted some 30 health policies, strategies, decrees and laws in the field of health. Still, the implementation process remains arduous. This article aims at discussing challenges of health policy development and effective implementation by contextualizing the policy evolution over time and by focusing particularly on the National Drug Policy and the Health Care Law. Special attention is given to the role of research in policymaking. The analysis was guided by the conceptual framework of policy context, process, content and actors, combined with an institutional perspective, and showed that effective implementation of a health policy is highly dependent on both structures and agency of those involved in the policy process. The National Drug Policy was formulated and adopted in a short period of time in a resource-scarce setting, but with dedicated policy entrepreneurs and support of concerned international collaborators. Timely introduction of operational health systems research played a crucial role to support the implementation, as well as the subsequent revision of the policy. The development of the Health Care Law took several years and once adopted, the implementation was delayed by institutional legacies and issues concerning the choice of institutional design and financing, despite strong support of the law among the policymakers. Among many factors, timing of the implementation appeared to be of crucial importance, in combination with strong leadership. These two examples show that more research, that problematizes the complex policy environment in combination with improved communication between researchers and policymakers, is necessary to inform about measures for effective implementation. A way forward can be to strengthen the domestic research capacity and the international research collaboration regionally as well as globally.

**Keywords** Policy process, policy implementation, research to policy, National Drug Policy, Health Care Law

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## KEY MESSAGES

- Policymaking and policy implementation should be understood as processes shaped by historical legacies, context and timing.
- Continuous communication of research findings together with active support from policymakers, as well as institutionalized international collaboration, is essential in order to meet the challenges of complex policy implementation. Both health system research and policy analysis are required.
- Research embedded in policymaking focusing on pragmatic solution for implementation challenges increases the chance to inform policy. Thus, policymakers and practitioners should be involved in problem formulation, priority setting and implementation planning together with the researchers.

## Introduction

Since 1993, Lao People's Democratic Republic (Lao PDR) has adopted some 30 health policies, strategies, decrees and laws in the health field (MoH 2012). However, despite success in policy formulation, challenges remain in terms of effective implementation. The aim of this article is to discuss some of these challenges of health-policy development and effective implementation in Lao PDR in relation to context and over time. We have chosen to focus on one policy and one law for closer scrutiny, namely the National Drug Policy (NDP) and the Health Care Law. The NDP was the first of its kind in 1993 (Paphassarang *et al.* 1995) and the Health Care Law of 2005 is one of the most recent laws in the field of health. Both are also relatively well documented through published articles and translated policy documents, and in both cases international collaboration has played a role in the policy development (Jönsson 2002; Boupha *et al.* 2005) and in conducting research to improve implementation (Tomson *et al.* 2005; Jönsson *et al.* 2007). We have deliberately chosen to focus on research in policymaking, as evidence-informed policymaking has gained ground in recent years (Buse *et al.* 2012). In spite of the fact that use of research still plays a relatively limited role in health policymaking in Lao PDR, there are important lessons to draw from the experiences gained thus far.

In general, there is a lack of policy analysis studies from low- and middle-income settings (Gilson and Raphaely 2008), and in the case of Lao PDR such studies are extremely rare. Our intention is to address this gap with a theoretically informed analysis of Lao health policymaking. In the sections below, the analytical framework is presented followed by a background description of the health situation in Lao PDR. The third part of the article contextualizes the policy development historically, whereas the fourth part focuses on more contemporary policy processes and actors in order to understand how issues appear on the policy agenda and how they fare once there. The final section summarizes the arguments and looks into the future of health policy analysis in Lao PDR.

## Methods

### The case

This is a retrospective case study of health policy development in Lao PDR. The methodology contains cases within the case by including two specific policy processes in order to capture the development in further detail, and to enable cross-case

comparisons that in turn contribute to a more robust case study (cf. Walt *et al.* 2008). The implementation of the NDP was the result of long-term bilateral collaboration between the Lao Ministry of Health, the Swedish International Development Cooperation Agency (Sida) and the Karolinska Institutet in Stockholm, a collaboration that had already begun in the initial phase of developing the policy. The project was unique in its approach through the introduction of health systems research (HSR) in 1998 as part of the institution building and capacity strengthening, in which all authors have been involved in various capacities. All authors also participated from 2005 to 2009 in a research project funded by the European Commission with researchers from 10 institutions in six countries, focusing on poverty and ill-health with the ambition to feed research evidence into health policy in Lao PDR, Cambodia and China through lessons drawn from sub-projects in the three countries (Bloom *et al.* 2008; Meessen *et al.* 2008; Ir *et al.* 2010; Bloom 2011; Syhakhang *et al.* 2011). Policymakers at the highest level in the Ministry of Health were consulted during the development of the research project, and the Health Care Law was chosen as a topical case of policy implementation in one of the sub-projects.

### Material

This article is based on literature collected through PubMed and social science databases. Besides published material, various policy documents, reports, doctoral and master theses, workshop papers, newspaper articles, evaluations and other grey material from the last 20 years have served as sources of information. In addition, we have used the results from 35 interviews that were conducted in 2008 for the poverty and illness project with policymakers and senior officials about their participation and knowledge of the development and implementation of the Health Care Law. Although quite a few articles have been published about health in Lao PDR in general, only a limited number has a policy focus. For instance, Jönsson (2002) analysed the development of the Lao NDP, Paphassarang *et al.* (2002b) assessed the implementation of the NDP, Tomson *et al.* (2005) studied the usefulness of research evidence in the implementation of the NDP, Boupha *et al.* (2005) wrote a report on exemption policy covering the time from 1975 to 2005, Annear *et al.* (2008) studied equity in health, Patcharanarumpol *et al.* (2009) analysed health care financing for the poor, and Ahmed *et al.* (2013) discussed organizational and institutional challenges of universal health coverage. Other articles have focused on the functioning of

health insurance (Annear *et al.* 2011; Syhakhang *et al.* 2011; Alkenbrack *et al.* 2013) or the health system and infectious diseases (Mounier-Jack *et al.* 2010). Hence, the authors' first hand knowledge of the policy processes has fed into the analysis, which has enriched the case descriptions and filled some of the gaps caused by the scarcity of written sources on the topic. Besides being part of the policy processes in question, either as health official, consultant, lecturer or researcher, the authors of this article have jointly published a substantial number of academic articles within the field of pharmaceuticals, health systems and policy implementation in Lao PDR. In addition, local stakeholders were consulted through informal communication on specific elements of the policy processes to ensure accuracy.

We are aware that being close to the object of study may affect our objectivity during the analysis. However, our different disciplinary backgrounds and professional positions have contributed to a reflective writing process by providing complementary perspectives on the subject matter regarding both theoretical and empirical aspects. The first author (K.J.), who has a political science background and wrote the first draft of the article, represents an outsider's view of the policy evolution in Lao PDR. The second author (B.P.) has a key position in health policymaking in Lao PDR and has participated in the two policy processes that are discussed in this article. The two last authors (R.W. and G.T.) have expertise in health policy and systems research and represent (together with B.P.) insiders' views in terms of their involvement in the policy process albeit in different capacities. Consequently the writing process involved negotiations about the focus of the article and as a result some aspects of the policy evolution have been highlighted, such as the role of contextualization and of research collaboration, whereas others have been omitted, such as assessment of the policy processes *per se*. It also became apparent that depending on our respective involvement in the policy processes we would perceive some issues differently and hence had to reach a consensus on the issue in question. This was achieved by using several sources and types of material, by cross-checking data and by applying a theoretically informed framework. Thereby we have done what we have found possible to ensure that we have provided a nuanced, if only partial, picture of the health policy development in Lao PDR. Our intention is subsequently to contribute with one specific perspective on policymaking that may complement others.

### Theoretical framework

Our overall ambition is explanatory, meaning we want to investigate both 'what' happened and 'why' it happened. Accordingly, contextualization of the case is crucial (cf. Gilson and Raphaely 2008). Drawing on research in policy studies and institutionalism, this article analyses the policy evolution in the Lao health sector at large, as well as specific health policy processes. In the first instance, health policy is defined as the politics of health in a broad sense. It describes initiatives, reforms and practices in the health sector over time. In the case of providing in-depth knowledge of the two specific policy processes, health policy is defined as a specific initiative articulated in written policy documents containing objectives, priorities and strategies. The health policy triangle by Walt and

Gilson (1994) serves as an overall framework for the analysis. The triangle comprises context, process and content with actors as the fourth component, which affects or is affected by the other three components. In practice the four components can be difficult to separate, but as analytical concepts they enable us to problematize the challenges of effective policy implementation.

Contrary to many other articles about health policy, context gets special attention in the analysis. According to Leichter (in Buse *et al.* 2012, pp. 11–2), four systematic factors are particularly useful when analysing the context: situational factors or focusing events such as wars; structural factors such as political system, type of economy, demographic features, technological advance or national wealth; cultural factors such as formal hierarchies or inequalities in society, for example based on gender or ethnic origin; and international or exogenous factors, such as international co-operation (cf. Lavis *et al.* 2012). All of these factors will be discussed throughout the text, but situational and structural factors will be specifically highlighted in the first half of the article and international factors in the second half. Cultural factors are to some extent discussed in the background section.

In the second part of the article, policy processes and actors will be analysed. Ideas, interests and power of different actors and stakeholders shape the policy process and thus also policy content (cf. Gilson and Raphaely 2008). In the case of the policy evolution in Lao PDR, policy diffusion and international research collaboration have played an important role at the different policy stages and will therefore be emphasized in relation to the NDP and the Health Care Law. A diffusion perspective helps to explain how policies end up on the policy agenda and how they are translated into practice, that is, how they are implemented (Jönsson 2002). The institutional perspective is added as it highlights the legacy of previous decisions and reforms, together with the tension between different institutions. An institution can be defined as either a formal or informal arrangement, or rule of the game, that guides individual behaviour and human interaction (Pierre *et al.* 2008), such as formal financing mechanisms and informal health care seeking behaviour. An institutional perspective contributes to our understanding of why implementation of new policies and ideas can be difficult and take time, and why a policy that is good in theory does not always work as intended in practice. Although we focus on policy processes, we do this in relation to the health care system at large, as it contributes to a more holistic understanding of the health policy evolution and subsequent implementation in Lao PDR (cf. Bigdeli *et al.* 2013). Ultimately, we want to contribute to the literature on the research–policymaking connection by contextualizing and problematizing how and under what circumstances research may inform policymaking (cf. Lavis *et al.* 2009, 2012; Gilson 2012).

## Results and discussion

### Health indicators and health care systems

Lao PDR is a sparsely populated country situated on the Indochina peninsula with borders to Cambodia, China, Myanmar, Thailand and Vietnam. It is a republic guided by

the Lao People's Revolutionary Party. The country has moved towards a liberalized economy since the introduction of the New Economic Mechanism in the mid-1980s. In 2011 the World Bank pronounced that Lao PDR had become a lower middle-income country after several years of high economic growth, due mainly to increased extraction of natural resources (World Bank 2012). The country is mountainous, which affects service delivery and makes some rural and remote areas difficult to reach. An increasing number of the nearly 6 million population live in urban or semi-urban areas, but a substantial number still live in remote areas without road access. This means that they have little contact with the authorities leading to low demand-side expectations among the population (Annear *et al.* 2008).

The health situation in Lao PDR has progressively improved during the last two decades, but health indicators remain relatively low in a regional perspective and the health care system is insufficiently developed at all levels, particularly with regards to primary health care. This can historically be explained by a high burden of diseases (Coker *et al.* 2011) combined with an overall underfinanced health sector, inequitably distributed resources, lack of incentives for health workers and inadequate training. This has led to geographical maldistribution of health workers with a concentration of skilled professionals in the urban areas, and central hospitals that are over-utilized, whereas the rest of the health system is under-utilized (Dodd *et al.* 2009; Kanchanachitra *et al.* 2011).

Government expenditure on health has been low, hovering at about 4% for most of the last two decades but is expected to change as the National Assembly in 2011 decided that the government expenditure should increase to 9%. The expenditure has mainly supported capital investments such as salaries and administration (Tangcharoensathien *et al.* 2011). The out-of-pocket expenditure on drugs and hospital services has been among the highest in the world (over 60%). Donors and grants or loans have financed most of the disease control, as well as investment, training, and management and administration costs, whereas hospitals and curative activities at health centres are dependent on user fees (48–83% of the budgets). Only a few per cent has been paid by tax revenue (Thomé and Pholsena 2009). Mass organizations, such as the Lao Women Union and the Lao Youth Union, play a role in health service delivery, often in collaboration with international non-governmental organizations. Increased co-ordination has been advocated and partly implemented during the last few years in line with the Paris Declaration and the Vientiane Declaration on Aid Effectiveness (Thomé and Pholsena 2009) because of competing and overlapping donor demands (WHO 2008, p. 175).

The strengthening of the health care system is a national goal (Boupha *et al.* 2005) and there is a commitment to achieve universal health coverage by the year 2020 (Annear and Ahmed 2012). Consequently, the Ministry of Health has recently undergone organizational restructuring in order to meet current changes in the health sector.

### Policy evolution contextualized

Many layers of influence over the last century have shaped the Lao health sector, its institutions and different parts of the health care system: French colonialism (1893–1953), American

presence during the American-Vietnam war (1963–73), Marxism–Leninism and the one-party structure, and influence from United Nation (UN) agencies and donor countries together with the liberalization of the market. The legacy of the French has been limited as the health care system basically only catered to French expatriates in urban areas and the ruling elite (Stuart-Fox 1997, p. 44). During the civil war, which lasted until 1973, the USA provided some training and education related to health, but the aid was primarily military (Stuart-Fox 1997, p. 154; Phraxayavong 2009, p. xii). The American-Vietnam war, which resulted in massive bombing of east and northeast Lao PDR by US planes, deepened the division of the Lao people, one part loyal to the royal government and one part loyal to the communist-led Pathet Lao. Until 1975 there were two 'health zones' in Lao PDR: one that was controlled by the Royal Lao Government, mainly in urban areas, and one that was controlled by the Pathet Lao, where there was a network of military hospitals and health centres set up in caves or hidden in the forests to avoid the heavy bombing (Boupha 1997).

From 1975 and onwards, the new Pathet Lao government had to rely mostly on bilateral assistance from primarily Soviet Union and Vietnam but also on assistance from International Monetary Fund, the World Bank and the UN, together with aid from Australia, France, Japan, Sweden and some Non Governmental Organizations (NGOs) (Phraxayavong 2009, p. xvi). The health care sector followed the socialist system and a large number of young Lao people spent years abroad in different socialist countries for higher education. This resulted in a medical workforce that was trained in a great variety of standards and medical practices. Between 1975 and 1985 a co-operative-based health system was developed but it later collapsed, and the coverage for basic health services fell dramatically (A Noel, unpublished data).

Health became prioritized in the mid-1980s (Boupha *et al.* 2005). Until 1995 health care was free of charge in Lao PDR, but the public health care system was under serious constraints as support from socialist countries had ceased (Boupha 1997). There was a lack of medical equipment and drugs and the low quality of health care services did not encourage people to use hospitals. During this time private pharmacies started to mushroom, from 32 in 1986 to about 1850 in 1995, and many health care seekers chose to skip medical consultation, buying drugs directly from pharmacies. Many of the drug sellers had no or limited pharmaceutical training and fake or substandard drugs, often smuggled, appeared on the market in worrying numbers (Stenson *et al.* 1997, 2001; Syhakhang *et al.* 2001). Hence, in 1993 the NDP was endorsed to counter this problem; this was the first ever comprehensive national health policy in Lao PDR (Paphassarang *et al.* 1995).

The current constitution was adopted in 1991, which enabled the development of new legislation. In 1995, the Prime Minister's Decree 52 was promulgated, which aimed to provide fair and equal access of health care for all Lao citizens, and to enhance the quality of services by introducing drug revolving funds and a cost recovery system with user fees following the Bamako Initiative of 1987 (Ebrahim 1993). Previously, the drug outlets had been dependent on unreliable deliveries from the central level and donations that could contain both expired and inappropriate types of drugs (Thomé and Pholsena 2009).

However, the reform resulted in a heavy burden for those who used the services, paying out-of-pocket for examination and treatment, due to the lack of budgetary means from the government. Children, monks, disabled persons, students, military personnel and the poor were in principle exempted from paying. Civil servants and pensioners were covered by a social welfare scheme, but in practice they would ask for exemption at the hospitals in order to avoid the cumbersome paperwork of reimbursement (Paphassarang *et al.* 2002a, p. 80; Boupha *et al.* 2005, pp. 21–2). The village leaders were supposed to provide a referral letter for the poor households, but this did not work well in practice (Patcharanarumpol *et al.* 2009). However, drug revolving funds have been implemented in almost all public health facilities and today they are one of the major sources of funding at curative health facilities (Thomé and Pholsena 2009).

In 2005, the Decree 52 was revised and supplemented by the new Health Care Law. The new law covers administration of the health care sector, national health financing and social health insurance. There are four social health protecting schemes in Lao PDR, all implemented from 2001 and onwards: the Social Security Office scheme targeting salaried workers of both state and private enterprises and their families, the State Authority for Social Security scheme targeting civil servants and their families, the community-based health insurance (CBHI) scheme targeting the self-employed and informal sector, and health equity funds (HEFs) (Annear and Ahmed 2012). HEF is a kind of social security fund, which involves a third party identifying the poor and paying user fees on their behalf. In order to achieve universal health coverage in 2020, the government has endorsed the merging of the current four social health protection schemes into one National Health Insurance Authority (Ahmed *et al.* 2013; Alkenbrack *et al.* 2013). There is a consensus among health officials of the need for strong leadership and an autonomous national authority (Annear and Ahmed 2012), and the design of the health financing institutional arrangements is proceeding to be approved by the National Committee of Health Insurance. In 2013, the Decree 349 was endorsed to replace the Decree 52.

### Actors and processes

By highlighting systematic factors in relation to health care reforms and policy development, it becomes quite apparent that context matters. The health policy evolution is intrinsically linked to global, national and local political-administrative and socio-economic structures, processes and issues. The context sets the boundaries for the policymaking processes, and the legacies of previous decisions and institutions influence current decisions and practices. The narrative above also shows that different components of the health care system have evolved in an uneven way, and that the history and context of the Lao health care system and policy evolution in many ways have been exceptional.

In Lao PDR the actual decision-making power is concentrated to a relatively limited group of people and the policy processes are largely opaque for an outsider, even if the health sector is more open than other sectors (Tomson *et al.* 2005). The Party directs the overall policy framework, whereas the Government, the Ministry of Health and other governmental institutions are the main providers in the health sector and responsible for the

development of policy and service delivery. Yet, in practice, the situation is more complex than that with a range of actors exercising influence in different phases of the policy process because of the reliance on external collaboration and funding and a partially privatized health sector (Thomé and Polseña 2009). Many of the new policies and laws in Lao PDR have been developed with the assistance of foreign experts (Paphassarang *et al.* 1995; Boupha *et al.* 2005), which has contributed to well-designed policies in line with global expertise. However, not all foreign experts are well-acquainted with the local particularities (Owen 2010), such as cultural context, the role of the political processes, inter-ministerial and administrative organization, and the situation for those affected by the implementation of the adopted policies and reforms. There is also a tension between long-term nature of policy development and effective implementation and the short-term nature of research funding and project-based international collaboration. For example, in some cases donors have determined the prioritization of projects, which has led to multiple standards and uneven coverage (Boupha *et al.* 2005).

The Lao system is highly administrative and co-operation from public authorities in the implementation of public programmes is essential (Annear *et al.* 2008). However, there is a low awareness of laws and regulations among the population and a lack of enforcement capabilities (Sengdara 2011). Prior to 2006, there were no formal co-ordination mechanisms in the field of health or a formal process for legislation and policymaking. However, since 2012 the Law on Legislation Adoption has regulated the development of new laws. This law states that there must be a consultation process with workshops and meetings during the drafting of a new law, opportunities for the public to comment on the law before adoption and dissemination of new legislation; all of this opening up for wider societal input to policymaking. There has been organizational restructuring within the Ministry of Health in recent years, but the basic administrative structure has remained the same since the development of the NDP.

### The NDP: a case of policy diffusion

The setting when the NDP was developed and adopted was special in many ways. When the Lao government sought help from Sida, which resulted in a number of fact-finding and problem identification missions in 1990–91, the situation in the field of pharmaceuticals was getting increasingly precarious with extensive self-medication and a proliferation of substandard and fake drugs. In the remarkably short period of 1 year a completely new policy was formulated and adopted, much thanks to a few dedicated individuals, who acted as policy entrepreneurs from 1992 and onwards both on the Lao and Swedish sides (Jönsson 2002). The Lao officials were initially particular about getting a drug quality control laboratory, but in 1992 a review mission (which included the last author and Lao and Thai consultants) made it clear that a more comprehensive approach was needed. This would include an NDP, new legislation, a procurement system, improved distribution, quality control, monitoring and rational use of drugs. The administrative capacity to develop such a wide-ranging policy was limited at the time. Hence, there were regular meetings and seminars, including national drug seminars with international

participants, both with the aim to get feedback on the draft NDP as well as for information and dissemination purposes and for discussions about the implementation of the NDP. Lao teams prepared background papers prior to the meetings and experiences from other NDPs and World Health Organization (WHO) manuals facilitated the process. External actors contributed in the agenda-setting phase and provided technical expertise, but the actual policy formulation was a domestic affair with 10 ministries, representatives from 18 provincial health offices, representatives of various professional groups of the industry, the Lao Women's Union and some NGOs involved in the process (Paphassarang *et al.* 1995). Even so, the policy adoption was a top-down process and the draft NDP received less feedback than anticipated. There were few channels for feedback to policymakers at the central level, no tradition of societal pressure, and hence little input from a broader audience (Jönsson 2002, p. 86).

The collaboration paved the way for the next phase within the bilateral Lao National Drug Policy Programme, which continued for 10 years (1993–2003). Initially the Ministry of Health and Sida provided special support for the implementation of the NDP for three of the most populated provinces. Two more provinces were added after 2 years, but after a while it became evident that the implementation did not proceed as expected. In order to enhance the process in a context-relevant way, the consultants (third and fourth authors) from Karolinska Institutet recommended that HSR training should be part of the programme through collaboration between researchers, policymakers and practitioners. The training started in 1998 and continued for 2 years. A second round was conducted between 2001 and 2003. An essential component of the process was the overall approach to engage the Lao counterparts in priority setting of HSR topics directly related to constraints in the NDP implementation. The move was innovative and proved to be crucial for the progress of the policy implementation (WHO 2004, p. 50). The lack of information and research on which policy decisions could be based was a challenge at the time (Jönsson *et al.* 2007), and through the inclusion of some 40 health officials in nine different HSR projects in a number of provinces and districts, research capacity could increase at the same time as research results could be generated for policy decisions at the central level. Operational research was thus added as one of the core elements of the NDP when it was revised in 2001 (Paphassarang *et al.* 2002b; Tomson *et al.* 2005), and international experts considered this part of the NDP implementation as a success (Helling-Borda and Andersson 2000). These positive experiences led to continued collaboration and additional HSR projects during the following years. Several of the participants in the research projects have since the conclusion of the HSR training achieved high positions in the health administration with the possibility to make other policymakers aware of evidence-informed policymaking. Also, some of the researchers participating in the HSR today serve as lecturers at Masters programmes increasing the domestic research capacity further (Jönsson *et al.* 2007).

It should be noted that the NDP met no resistance from vested interests such as the pharmaceutical industry. Two out of six existing factories were state owned and produced 90% of the value of drugs in the country at the time (Jönsson 2002,

p. 97). All stakeholders that were consulted agreed upon the need for a policy to control the use and quality of pharmaceuticals and to increase access, even if there was some initial scepticism towards the project and some would have liked more time 'for thinking and discussing' (Jönsson 2002, p. 97). Unlike in many other places, both the pharmaceutical and medical professions were involved in the policy process, and the medical profession actively asked for support. There was a general will to improve the drug situation and disagreement concerned organizational matters rather than the content of the policy. The trust between the consultants and the Lao counterparts also played an important role in convincing the leadership of the need for an NDP (Paphassarang *et al.* 1995; Jönsson 2002, p. 97). Finally, the policy was completely new and was not bound by previous decisions or institutional arrangements.

### The Health Care Law: old and new institutions

The trajectory of the Health Care Law was in many ways different from the NDP. Although the NDP was the first of its kind, the Health Care Law was adopted as a response to the flawed implementation of Decree 52, which did not adequately care for the poorest in the society as intended. It had created discontent among both health providers and health care recipients (Boupha *et al.* 2005). The government acknowledged that health financing needed to be improved, and the focus on health financing and health insurance schemes was in line with the international trend, such as the World Health Assembly Resolution in 2005 on financial protection (Tangcharoensathien *et al.* 2011).

The law was first drafted already in 1997 and was finally endorsed at the National Assembly in 2005. Contrary to the NDP, the Health Care Law development was not part of bilateral collaboration. The development of the law was led by the steering committee of the Ministry of Health in collaboration with WHO consultants. In addition, consultations were held with the Asian Development Bank (ADB), some donor countries and representatives from local communities. Existing reports rather than specifically designed field studies fed into the policy process, and laws in Vietnam, Thailand, France and Canada also served as sources of inspiration (cf. Boupha *et al.* 2005). The law was adopted by the National Assembly and endorsed by the President after reviews, revisions and amendments through a legal process involving the Government, the Ministries of Health and Justice and the National Assembly. There was no formal sector-wide co-ordination at central or provincial levels, and the law was disseminated at central and provincial levels, but not at district and village levels.

Interviews conducted with policymakers in 2008, while confirming a strong political support of the Health Care Law, also expressed uncertainty as to how it would be implemented and financed. Similarly to Ahmed *et al.* (2013), the interview material revealed that unresolved issues concerned organization and responsibility. There has also been a lack of public demand of health insurance schemes. According to a survey by the National Institute of Public Health, people did not want to become members of health insurance organizations because it was considered to be too expensive and the benefits were unsatisfactory (Leukai 2008). People would like to buy insurance, but only if the hospitals improved their services. Those

who could afford to buy health insurance would rather do it from foreign companies providing high-quality medical treatment abroad (Phouthonesy 2009). Other studies have suggested that the CBHI penetration was very low among the poor because medicines were not covered (Vialle-Valentin *et al.* 2008), and the voluntary approach made it possible for people to leave the scheme when they were short of money, making the schemes unsustainable (cf. Annear and Ahmed 2012; Alkenbrack *et al.* 2013). Further, there is evidence that insured patients had lower expenditure than that of non-insured during hospital stays, although receiving higher quality care (Syhakhang *et al.* 2011; Patcharanarumol *et al.* 2012). Studies have also shown that demand-side targeted approaches, such as HEFs, work better than an exemption policy (Tangcharoensathien *et al.* 2011), and that it is more costly to purchase premiums from community health insurance than direct reimbursement from HEFs (Annear *et al.* 2011).

As of February 2014, the Health Care law is being reviewed in collaboration with WHO in order to identify gaps in meeting the on-going health sector reform strategy and the studies mentioned earlier could feed into that process. The Ministry of Health has identified a number of implementation challenges concerning targeting the poor, deciding benefits, managing service delivery coverage and quality, accommodating the needs of ethnic minorities, developing administrative and payment mechanisms, managing the relationship between different schemes and solving the issue of sustainability (Annear *et al.* 2008). Another challenge is to increase the financial capacity of the health insurance schemes. Only a minority of the population was insured in 2011, many of them chronically ill, which puts a heavy burden on health insurance providers (Tangcharoensathien *et al.* 2011).

The European Union-funded collaborative research project on poverty and illness was conducted at a crucial point in time insofar that the health sector was at the beginning of implementing the new law. Findings from the project contributed to a better understanding of health care for the poor and the role of financing. For example, contextual factors such as geographic and demographic characteristics together with the specific nature and distribution of poverty were identified as challenges for HEFs (Annear *et al.* 2008) together with reliable funding and appropriate identification of the eligible poor. Nevertheless, findings from the research collaboration were only used to a limited degree in policymaking. One reason might be partly insufficient quality of some of the studies conducted within the project caused by the complex context and the prevailing unfamiliarity of some policymakers to use research results in decision-making, but there are also other reasons revealed by a comparative perspective.

### Lessons from a comparative perspective

The NDP and the Health Care Law processes were similar insofar as they were facilitated by global policy diffusion and lessons drawn from other countries. The consultations with different stakeholders and policy entrepreneurs were also comparable, even if a larger number of external actors were involved in the Health Care Law process compared with the NDP development. Sweden was one of the few bilateral donors in Lao PDR in the

early 1990s and the only one in the field of pharmaceuticals. WHO, United Nations Children's Fund (UNICEF), ADB and a few international NGOs provided only limited support (Jönsson 2002, p. 102). The good relationship between Lao PDR and Sweden dated back to time when the country had limited contact with the rest of the world. The Swedish support to several sectors was recognized and there was a familiarity to collaborate with Swedish counterparts among high-ranking officials. Since then the country, and the Ministry of Health, has gradually become more open, allowing a larger number of external actors to be active in the health sector.

Further, both the NDP and the Health Care Law have had challenges related to effective implementation, but for somewhat different reasons. The NDP was a completely new initiative being welcomed by the stakeholders, but there was also a lack of local knowledge and capacity to inform decisions related to the implementation process, hence the introduction of HSR. The Health Care Law had to build on and relate to previous initiatives and legislations in the field, such as the previous exemption policy, drug revolving funds and several parallel health insurance schemes (cf. Annear and Ahmed 2012). Because of its wider scope and attached financial commitments it was also more arduous to implement and perhaps also more contested by different stakeholders despite the support of the law *per se*, including parts of the public that still may not see the benefits of the different schemes.

According to Ahmed *et al.* (2013), the Health Care Law faces challenges of limited resources and capacity for planning, administration and implementation as well as for how to cover the large informal sector. Crucial barriers to address are accordingly context, the sequencing of reforms and the timescale needed for implementation. In the case of the NDP, Sida provided financial support during a long period of time facilitating policy implementation. For instance, training was supplied on financing, management, law implementation and enforcement, such as the development of indicators for rational use of drugs and good pharmacy practice. In the case of the Health Care Law no additional resources were allocated for its implementation and there have not been any specific research projects supporting the implementation of the law, even if there has been training and technical support relevant to policymaking on universal health coverage. However, the government has acknowledged that efforts need to be intensified in order to achieve the Millennium Development Goals in line with the health reform strategy approved by the National Assembly (Leukai 2013).

The two sub-cases illustrate the interdependence of different parts of the health care system. For example, the NDP implementation, which primarily but not only, addressed medicines and technology, faced difficulties because of the lack of human resources and health information, whereas the Health Care Law implementation was delayed by unresolved issues related to financing, service delivery and leadership.

Many Lao health officials view the NDP policy process, with its HSR component, as a role model for evidence-informed policymaking. It paved the way for the concomitant poverty and illness project, even if the latter project did not have the expected impact on policymaking but merely had an enlightenment function (cf. Jönsson *et al.* 2007). An explanation to the different outcomes could be that although higher officials at

ministry levels were involved in both research processes, there was a clear dispersion of responsibility at the operational level in the case of the NDP. Also, the management of the NDP was formed in direct collaboration between the Ministry of Health and Karolinska Institutet as partners. In the case of the poverty and illness project on the Health Care Law, there was no such formal collaboration. Instead, the contacts were informal with endorsement from the top level in the Ministry. In addition, the results from the HSR conducted in conjunction with the NDP could more directly support the improvement of the health care service quality. Hence, an important difference between the NDP and Health Care Law was the embedded HSR in the NDP implementation process, which was based on acknowledged principles of how to support evidence-informed policymaking (see Lavis *et al.* 2009) such as problem identification involving decision-makers, priority setting exercises, support workshops with decision-makers and practitioners analysing research results, discussing implementation strategies and writing reports (Paphassarang *et al.* 1995; Jönsson 2002). This illustrates that not only more research is needed but also that research specifically supporting policy implementation is crucial (cf. Freitheim *et al.* 2009).

Beyond the two specific cases of research co-operation highlighted in this article, there has been collaboration with a number of other actors on specific health issues that to various degrees may have benefited the development and implementation of the NDP and the Health Care Law. For instance, in the mid-1990s a Lao-Thai health sector co-operation committee was established in order to benefit from Thai expertise without having to rely on interpreters (the Thai language is widely understood in Lao PDR). Several research projects have been conducted in the field of health financing and universal health coverage. For example, the International Labour Organization has supported research on social protection systems for the Ministry of Labour and Social Welfare, there has been collaboration between the International Health Policy Program in Thailand and the Ministry of Health including Ph.D. candidates, and researchers at the Nagasaki University in Japan have supported the development of health sector reform plans. In addition externally funded studies, for example by the Burnet Institute, Swiss Red Cross, Belgium, Luxembourg, ADB, World Bank and WHO, have been conducted on HEFs and CBHI. Hence, there are many cases to be investigated that could contribute to knowledge about the research-policy-making nexus in Lao PDR.

The challenges in the health care sector are not unique for Lao PDR (cf. Buse *et al.* 2012, pp. 52–4). Many barriers can be identified which are common for other low- and middle-income countries that have limited resources for public health initiatives. Research that informs policy and practice is scarce in the whole region (Coker *et al.* 2011). Yet, as the health systems are highly divergent for geographical and historical reasons, this must be reflected in the policymaking (cf. Perks *et al.* 2005; Phommasack *et al.* 2005; Chongsuvivatwong *et al.* 2011).

## Conclusions

In conclusion, we have contributed with a theoretically informed analysis in order to problematize the complex

nature of health policymaking and how to get research into policymaking. By applying an analytical framework that contextualizes the policy process and agency, the challenges for policy development and effective implementation can be better understood. We do not, however, claim to have given the full picture of the health policy evolution in Lao PDR or to assess the policy processes *per se*.

The Lao health care system has over the years been built on several layers, each of them influenced by various structures, actors and ideas, domestic as well as external. There has been a fair amount of institutional changes affecting different parts of the health care system, and the low awareness of laws and regulations among the population and a lack of enforcement capabilities allow informal practices to contradict formal ones. This, together with geographic circumstances and the nature and distribution of poverty, affects both policy choices and opportunities for effective implementation.

The policy changes are initiated both by the government and by client demands and market changes aided by pressures from external relations and international trends. Systemic factors together with ideas and interests of the participating actors shape the boundaries for agency and what is possible to achieve at a specific moment in time. The adoption of the NDP may be viewed as part of a global trend of regulating the pharmaceutical sector, but it can also be explained by the occurrence of a window of opportunity where policy entrepreneurs managed to provide a solution to a pressing problem that the policymakers could accept (cf. Kingdon 2003). In the case of the Health Care Law the policy process largely appeared to have been influenced by institutional legacies and initial indecisiveness on how to conduct the implementation, even if the revision of the Health Care Law may serve as window of opportunity for research to influence future implementation similarly to what happened in the case of the NDP in 2001. By comparing two policy processes and the role of research in policymaking we want to illustrate that not only the context *per se* is important for the policy formulation and implementation but also the timing. Still, both cases show that without contextual knowledge and domestic implementation capacity the policy in question risks producing unintended effects or being delayed.

The NDP process, and the poverty and illness project to a lesser extent, could be viewed as steps towards evidence-informed policymaking in the health sector. A weakness with our analysis is that there are fewer publications on the Health Care Law than on the NDP, in particular research focusing on how research influences policymaking, and we strongly encourage further studies in this area. Yet, our review indicates that sustained health system-oriented research and provision of local evidence for policymaking are needed if research is going to have a significant impact on policy (cf. Bennett *et al.* 2011). The comparative perspective reveals the importance of research embedded in policymaking over time focusing on implementation planning and actual policy implementation, which involve researchers as well as policymakers and practitioners. Arguably, there is also a need for policy analyses of the changing context over time and the influence of domestic as well as international policy processes and actors. Thus, there is a need to build health systems research and health policy analysis capacity at all levels.

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