People's Voice Survey in Lao PDR

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Quality Evidence for Health System Transformation

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Introduction

The Lancet Global Health Commissionon High-Quality Health Systems (HQSS Commission) defined a high-quality health system as one that "consistently provides care that improves or maintains health, is trusted by the people, and responds to changing population needs." To understand whether health systems are meeting these goals, it is critical to understand the experiences and perspectives of the people it is intended to serve. However, in many low- and middle-income countries, governments have limited information on the population's experiences and perspectives. Information about the dynamics of how the population uses (or does not use) the primary care system, the coverage of key primary care services, and the population's trust and confidence in the system can play an important role in informing health system improvements.

People's Voice Survey

The People's Voice Survey (PVS) is a novel phone-based survey designed to integrate people's voices into primary care performance measurement. It enables rapid assessment of primary care performance from the population perspective to inform health system improvement. It includes information on utilization patterns, coverage of primary care services, perceptions of health system quality (e.g., user experience and perceptions of care competence), and trust in the overall health system. By using mobile phone-based data collection, the PVS can provide timely and locally representative data on health system performance. The PVS brings added value beyond existing data from tools such as the Service Availability and Readiness Assessment (SARA) and Service Provision Assessments (SPA) by incorporating the perspective of the overall population and not only current health system users.

PVS in Lao PDR

This report details the implementation and findings of the first PVS conducted in Lao People's Democratic Republic (Lao PDR) between May and August 2022.

ABBREVIATIONS AND ACRONYMS

BCG	Bacille Calmette-Guérin vaccine
DHO	District Health office
EKNZ	Ethikkommission Nordwest und Zentralschweiz
GDP	Gross Domestic Product
HQSS	High Quality Health Systems
Lao PDR	Lao People's Democratic Republic
Lao TPHI	Lao Tropical and Public Health Institute
LMICs	Low and Middle Income Countries
LSIS	Lao Social Indicator Survey
MICS	Multiple-Indicator Cluster Survey
MOH	Ministry of Health
NECHR	National Ethics Committee for Health Research
ODK	Open Data Kit
OOP	Out of Pocket
PCA	Principal Component Analysis
PHO	Provincial Health Office
PVS	People's Voice Survey
QuEST	Quality Evidence for Health Systems Transformation
Swiss TPH	Swiss Tropical and Public Health Institute
THE	Total Health Expenditure
TB	Tuberculosis
UHC	Universal Health Coverage
VHW	Village Health Worker

1. INTRODUCTION AND BACKGROUND

Despite increased coverage of essential health care services in low-and middle-income countries (LMICs) as part of their SDG commitments, five million people die each year from treatable conditions due to poor quality health systems and an additional 3.6 million lose their lives because of poor access to health care.[1] There is evidence that both technical quality of care (i.e., care that is in line with evidence-based clinical guidelines) and non-technical quality of care (i.e., care that is respectful of patients) play an important role in shaping health outcomes. People who trust their health systems are more likely to use health care services, adhere to medications, continually participate in their health care, and adhere to health-related behavior[2], while low perceived quality and satisfaction with care may contribute to reduced utilization of health services.[3,4] A cross-sectional survey of 12 LMICs, including 3 countries from Asia (China, India, Indonesia), found high levels of health systems dissatisfaction, which may be dampening utilization of health care services.[5]

To improve health system performance, it is important to understand people's experiences with care and their satisfaction with their health systems. Information about the dynamics of how the population uses (or does not use) the primary care system, the coverage of key primary care services, and the population's trust and confidence in the system can be valuable inputs for informing health systems improvement. However, there is limited research that explores experience and satisfaction across the population among both users and non-users of healthcare. This may be because satisfaction can be difficult to measure and interpret; for example, studies often show unexpectedly high rates of satisfaction even when health services are objectively poor.[6,7] There is also limited evidence on patient satisfaction: research is often limited to vertical or siloed health programs (e.g., maternal health), making it difficult to draw generalizations across the health system and the larger population's health needs.[4]

The People's Voice Survey (PVS) is a newly developed survey that enables rapid assessment of primary care performance from the population perspective to inform health system improvement. It includes information on utilization patterns, coverage of primary care services, perceptions of health system quality (e.g., user experience and perceptions of care competence), and trust in the overall health system. The PVS brings added value beyond existing data from tools such as the Service Availability and Readiness Assessment (SARA) and Service Provision Assessments (SPA) by incorporating the perspective of the overall population and not only current health system users. Laos is among the first countries in which it is being used while QuEST research teams in Ethiopia, India, Kenya, and South Africa are also in different phases of implementation.

We conducted a national survey in Laos using the PVS to inform the country's ambitions of achieving universal health coverage (UHC) by 2025 and the quality improvement agenda. Through phone interviews with adults over a 3.5-month period in 2022, we measured health care utilization patterns, coverage of primary care services, perceptions of health system quality, and trust in the overall health system.

1.1 Economic trends and health status in Lao PDR

Lao PDR experienced rapid economic growth over the past three decades and, along with it, substantial improvements in population health outcomes. Life expectancy increased from 48 years in 1980 to 66 in 2020 and under-5 mortality decreased from 206 to 44 per 1000 live births, respectively in the same period.[8] There are, however, large and rising inequities between the poor ethnic minorities who tend live in the mountainous regions with limited road access compared to the ethnic majority Lao-Tai, who tend to live in urban centers.[9,10]

Poverty rates among minority populations, particularly Mon-Khmer and Hmong (approximately 40 percent of whom live below the poverty line), are nearly three times higher than that of the majority Lao-Tai (15 percent) and rates of stunting among the poorest quintile (48 percent) are greater than three times the rates of children in the richest quintile (18 percent) with higher

levels among Hmong-Mien ethnic group (50 percent).[11] Rates of malnutrition and maternal mortality remain among the highest in the Southeast Asia region with the poor, ethnic minorities, rural populations carrying a disproportionate burden.[12,13] The under-five mortality rate is twice as high in rural areas and 2.5 times higher in rural areas without road access compared to urban areas of the country.[9]

1.2 Health care system in Lao PDR

The health care system in the Lao PDR is largely government-owned with a growing number of privately managed pharmacies, clinics and hospitals.[14] A large informal network of traditional health providers such as herbal and spiritual practitioners, and retired nurses also operate across the country, particularly among rural communities. This network remains loosely regulated by the MOH.[15] The government-owned health system consists of three tiers: district, provincial and central levels. At the district level, District Health Offices (DHOs) manage a network of health centers, referred to as small hospitals by the MOH, for delivery primary health care services and conduct outreach VHW (Village Health Workers) and a district hospital. Provincial Health Offices (PHOs) provide technical backstopping to districts and are responsible for referral-level provincial hospitals.[14] At the central level, the Ministry of Health (MOH) develops regulations, policies and plans for the entire sector and oversees the operation of central hospitals and University of Health Sciences.[14]

1.3 Health system challenges

Overall government expenditure on health is low and inequitable, accounting for 33.2% of total health expenditure (THE) or 0.9% of Gross Domestic Product (GDP).[10] The high level of out-of-pocket (OOP) spending (45% of THE) places a significant burden of healthcare financing on individuals and families, which can impact timely care seeking.[10] Resource constraints in the health sector have contributed to staff shortages (especially in rural areas), gaps in supply availability, and unmet need for health worker training.[16,17]

Utilization of essential health services among poor, rural and ethnic minorities remains low despite ambitious policies aimed at UHC by 2025.[9,14] According to Lao Social Indicator Survey (LSIS), in 2017, 84 percent of women living in urban areas delivered in health facilities, compared to 37 percent living in rural areas.[11] Bacille Calmette-Guérin (BCG) vaccine coverage of newborns, a proxy indicator for initial contact, was 16 percentage points lower among Hmong ethnic minority compared to Lao-Tai (71% compared to 87%).[11] Communicable diseases are major causes of morbidity and morbidity with high prevalence of tuberculosis (TB), malaria and dengue, particularly among rural populations that are difficult to reach, identify and treat. [14] Additionally, the country faces an increasing burden of non-communicable diseases, challenging an already burdened health system.[14]

Reasons for low uptake of health services include socio-cultural practices, transportation networks, time, education levels, health literacy, cultural differences, and linguistic barriers.[18-20] Women of ethnic minorities in rural areas are particularly disadvantaged because they are less likely to speak Lao, the official language, than males and are often accompanied by a male to a health facility.[14,15,18]

1.4 Evidence on care experience, quality and satisfaction in Laos

There is limited evidence on user experience, confidence, and patient satisfaction in Lao PDR, and existing research is largely focused on maternal and child care among rural communities, making it difficult to draw generalizations across different socio-economic status and range of health conditions.[21-27]

However, the available evidence does point to several important themes in health system satisfaction in Laos. It suggests that disrespectful care, low competency of health staff, poor

communication, and insufficient privacy and cleanliness are reasons for low satisfaction with public health services.[21-27] Women who chose to deliver in health facilities found it to be convenient and they perceived health facilities to better equipped at managing emergencies and complications, compared with home delivery. Availability of medicines and equipment bolstered these positive perceptions.[28] Feeling healthy, shy and considering delivery to be an ordinary issue were identified as reasons for not using delivery related services in public health facilities.[26,28] A study of satisfaction across socio-economic characteristics did not find significant differences but it was likely due to a homogenous sample taken from one rural district.[22] There are important questions to be answered about people's care experiences, satisfaction and their level of confidence with the health system across the diverse population and health conditions in Lao PDR.

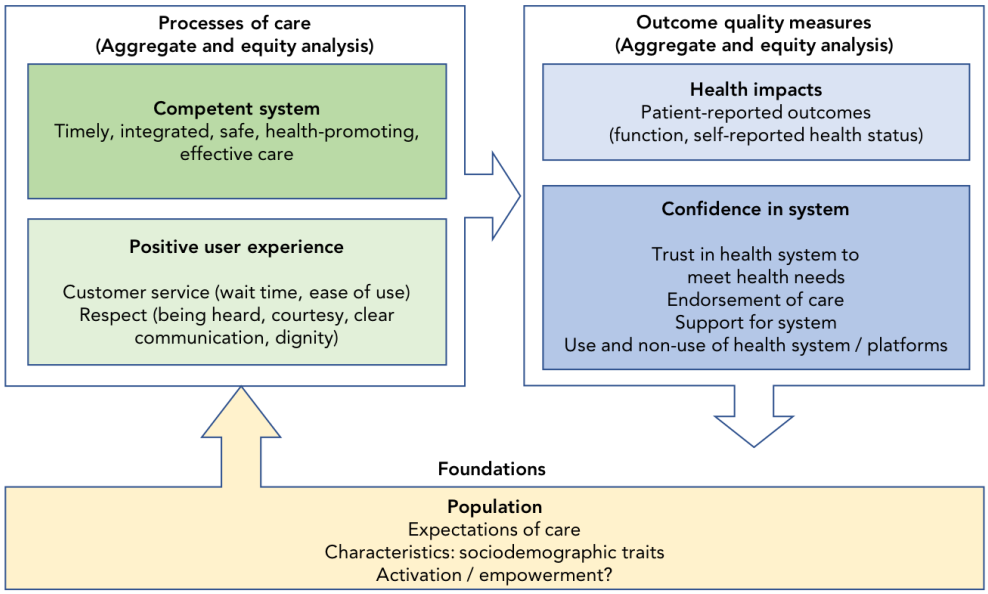
1.5 Conceptual Framework

The People's Voice Survey (PVS) is inspired by the key principles of health systems proposed by the Lancet Commission on High-Quality Health Systems (HQSS Commission)[6]:

1) Health systems are for people;
2) People should be able to receive good quality, respectful care within their country's resource capacity; and
3) High-quality care should be the "raison d'être" of health systems.

The HQSS framework for health systems motivates the research objectives, which focuses on people (foundations), user experience (process of care) and the resulting confidence (outcome quality measure) in health systems of both users and non-users. Figure 1 is a modified HQSS framework prepared by the QuEST network.[4]

Figure 1. Priority domains of HQSS framework informing the thesis



2. SURVEY OBJECTIVES

The overall aim of the PVS was to better understand people's experience and perceptions of the health system in Lao PDR. The PVS is a novel approach to capture confidence, satisfaction and people's experience with health care using a phone survey. This report documents national-level findings as well as variation by gender, age, geographic region, location of residence, education level, and wealth quintiles. Findings from the PVS will be used to inform the UHC policy discourse in Laos by shedding light on inequities in health care

quality, identifying the magnitudes non-use of care and bypassing of public health institutions, and benchmarking health care quality vis-à-vis other countries.

3. RESEARCH METHODS

We conducted the cross-sectional survey in the general adult (18+) population in Laos. The study protocol was approved in Switzerland by Ethikkommission Nordwest und Zentralschweiz (EKNZ) on 25 January, 2022 (AO_2022-00001), and in Laos by the National Ethics Committee for Health Research on 17 March, 2022 (023/NECHR).

A database of existing mobile phone lines was purchased from Sample Solutions, an international market research company. Sampling was stratified by age (18 to 45, 45 and higher), gender (male, female), region (north, south, and central), and geographic area (urban, rural) based on a target sample size consistent with recent nationwide household surveys. The survey targeted a sample of 2,000 completed interviews; target sample sizes by strata are shown in Table 1. We called 11,835 unique phone numbers to reach 2,008 completed interviews, which translates to a response rate of 17%.

While phone-based surveys present an attractive means for data collection, there are some potential errors that can result in biased sample estimates, which need to be minimized.[29] These errors primarily arise because of non-coverage error (i.e. differences between those who own and those who do not own mobile phones) and non-response error (differences between those who respond and those who do not respond to surveys).[30] Strategies recommended by Nagpal et al. to minimize such errors have been incorporated in the design, implementation and analysis phases of the study.[30] In Lao PDR, more than 90% of households have a phone, which makes it an attractive country to deploy phone-based survey methods and minimize non-coverage error.[11,29] We developed a structured callback protocol to improve response rates and minimize non-response errors, where each sampled number was called at least five times at different times of the day.

Table 1. Target sample sizes by group for phone survey

North			
	Urban	Rural	**Total**
Male (18 to 45)	55	149	204
Male (Age 45+)	31	76	107
Female (Age under 45)	58	148	206
Female (Age 45+)	31	83	114
Central			
	Urban	Rural	**Total**
Male (Age under 45)	121	182	303
Male (Age 45+)	73	102	175
Female (Age under 45)	136	188	324
Female (Age 45+)	81	110	191
South			
	Urban	Rural	**Total**
Male (Age under 45)	27	90	117
Male (Age 45+)	16	49	65
Female (Age under 45)	28	92	120
Female (Age 45+)	19	55	74
Total	676	1324	2000

4. SAMPLE SIZE CALCULATION

The proposed survey will be part of the QuEST global data collection program, with an agreed-upon sample size of N=2000 per country. The target sample is consistent with national phone surveys such as Afrobarometer and Latinobarometro.[31,32]

5. DATA COLLECTION

Data collection for the survey took place between 9 May, 2022 and 19 August, 2022. Prior to the survey, we conducted the following key activities: translated the questionnaire in Lao, Hmong and Lao, recruited and trained interviewers, conducted cognitive interviews and a pilot. These activities are described in detail below.

Translations of the questionnaire and trainings

The standard questionnaire in English was translated to Lao-Tai, the official language, and verified for accuracy via back-translations in English. Five interviewers, recruited by Lao TPHI, were initially trained using the Lao script. One of the interviewers was proficient in Hmong and another in Khmou, the second and third most common ethnic languages spoken in Laos[33], respectively. Their training also included how to interpret survey questions and explain them to respondents using standardized explanations, data entry procedures in the tablet for ODK, manual logging of call outcomes and practiced making calls with pre-selected respondents

Written Khmou and Hmong questionnaires were prepared following the training and verified using verbal back-translations.

Cognitive interviews

Cognitive interviews were conducted in all three languages. At least five respondents per ethnic language were interviewed from villages 17 to 30 kilometers from Vientiane, the capital city. Verbal consent was obtained for cognitive interviews. During cognitive interviews, participants rephrased interview questions in their own words and their responses were used to inform revisions to the questionnaire to better explain key terminologies and concepts while maintaining their original intent.[34]

Pilot interviews

We conducted pilot data collection between 28 and 30 May 2022. The pilot consisted of 48 completed calls. We used the pilot to confirm the feasibility of our procedures such as recruitment, verbal consent, tracking outcome of calls, and data entry in ODK, and to confirm that research questions were well-understood by respondents. The mean time to complete a call was 30 minutes compared to our estimate of 25 minutes. Open-ended questions that we added to capture people's improvement ideas for the most recently visited facility contributed to longer interview times. To shorten the survey after the pilot, these were categorized into multiple-choice responses.

Conducting the survey and quality checks

We conducted the survey between 9 May and 18 August 2022. The data collection team initially included 4 interviewers; an additional team member was trained and began working in the second month. We maintained a daily log of calls and continuously monitored coverage of the sampling frame. Additionally, we performed quality checks by observing interviews, checking survey entries for completion and accuracy, and monitoring coverage of the sampling frame. We conducted daily de-briefing meetings with interviewers for the first two weeks to address issues and conducted a weekly review session, thereafter, for the remainder of the

study. Once per month, we measured progress against each strata relative to the targets in Table 1 and reviewed a summary of the results. After sample targets were surpassed in particular strata, we filtered these strata out of the sample going forward. Open Data Kit (ODK) was used for data entry on tablets and anonymized data were saved on the Swiss TPH server.

5.1 Survey weights

Raw data were weighted to reflect population demographic characteristics. Sample weights were calculated using an iterative proportional fitting algorithm known as raking.[35] Population parameters were calculated using weighted data from the 2017 Multiple Indicator Cluster Survey (MICS) in Laos[11] and scaled to the total population size in 2022. The sample weights were chosen to match the national population with respect to age structure (proportion of adult population 18-29, 30-49, or 50+), gender (male or female), region (Central, North, or South), urbanity (urban or rural), urban gender share and urban age structure.

5.2 Wealth quintiles

Wealth quintiles were calculated based on household assets. During survey design, questions about 8 household assets were selected for inclusion in the survey based on their value in predicting household poverty levels in the 2017 MICS in Laos. The survey instrument asked about household ownership of: a cement or ceramic roof, a clock, electricity, a bicycle, a motorcycle or scooter, a mobile phone, a computer, and a car. A principal component analysis (PCA) was conducted using the asset questions, and the first principal component (describing 26% of overall variation) was extracted. Asset quintiles were defined based on this first principal component, incorporating sampling weights.

5.3 Sample demographics

A total of 11,835 mobile numbers were called to complete 2,007 interviews. *Figure 2* shows the flowchart of call outcomes.

Figure 2. Sample flowchart

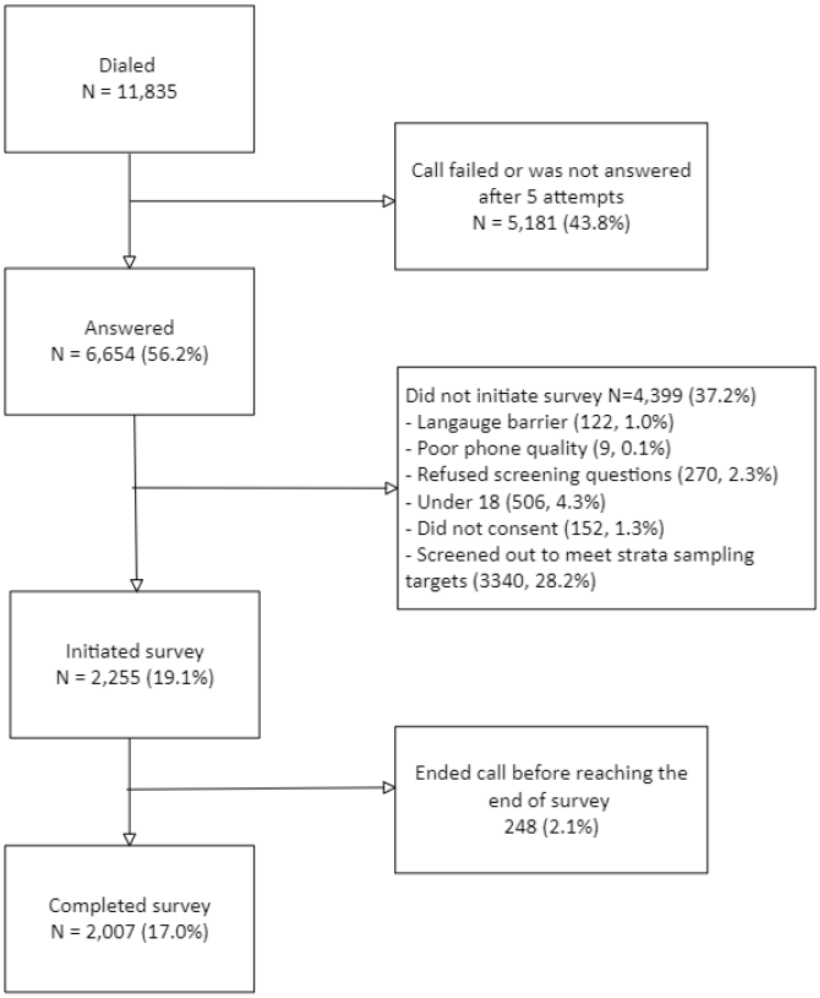


Table 2 shows the demographic characteristics of the weighted and unweighted sample compared to population estimates from MICS conducted in 2017.

Table 2. Sample demographic characteristics

Characteristics	Unweighted sample N (%)	Weighted sample N (%)	Population estimate from MICS 2017 (%)
Gender			
Male	1,137 (56.5%)	974 (48.5%)	48.5%
Female	871 (43.4%)	1,034 (51.5%)	51.5%
Age group			
18-29	518 (25.8%)	622 (31.0%)	31.0%
30-49	823 (41.0 %)	813 (40.5%)	40.5%
50+	667 (33.2%)	572 (28.5%)	28.5%
Location			
Urban	1,184 (59.0%)	678 (33.8%)	33.8%
Rural	824 (41.0%)	1,330 (66.2%)	66.3%
Region			
North	518 (25.8%)	634 (31.6%)	31.6%
Central	1,258 (62.7%)	996 (49.6%)	49.6%
South	232 (11.6%)	378 (18.8%)	18.8%
Educational achievement			
Primary of less	309 (15.4%)	1,133 (56.4%)	56.4%
Lower or upper secondary	872 (43.3%)	582 (29.0%)	29.0%
Post-secondary or tertiary	827 (41.2%)	293 (14.6%)	14.6%
Ethnicity			
Lao-Tai	1,590 (79.4%)	1,423 (71.0%)	66.7%
Mon-Khmer	220 (11.0%)	320 (16.0%)	22.0%
Hmong-Mien	151 7.52%)	219 (11.0%)	7.7%
Chinese-Tibetan	14 (0.70%)	14 (0.72%)	2.6%
Other	28 (1.40%)	26 (1.28%)	1.0%

6. SURVEY RESULTS

6.1 Patient activation

Empowered patients may be more likely to be involved in their care, follow through care plans and take an active role in decision-making. The first section of the PVS, on patient activation, asks two key questions related to patient empowerment or activation: the extent to which people feel able to control their health, and their confidence in communicating with their health care provider. Eighty-five percent were very confident or somewhat confident that they controlled their own health (see *Table 3*) with twice as many women (20%) as men (10%) reporting that they were not too confident or not at all confident about controlling their health. People in the lowest wealth quintile, those with the lowest level of educational attainment, and the young (<30 years old) were the least confident about controlling their health. An overwhelming majority (95%) were confident about communicating with care providers about their problems when they are not asked (see *Table 4*).

Table 3. Control over their health (N=2000)

	Very confident	Somewhat confident	Not too confident	Not at all confident
	%	%	%	%
Total	**59**	**26**	**15**	**0**
Gender				
Male	65	25	10	0
Female	53	27	20	0
Age				
18-29	52	28	19	1
30-49	58	28	14	0
50+	67	21	12	0
Location				
Urban	57	27	15	1
Rural	59	25	15	0
Region				
North	60	24	16	0
Central	57	26	16	0
South	60	27	13	0
Educational achievement				
Primary or less	59	24	17	0
Lower or upper secondary	57	28	15	1
Post-secondary or tertiary	59	31	9	1
Ethnicity				
Lao-Tai	60	25	15	0
Hmong-Mien	55	25	19	1
Mon-Khmer	55	28	17	1
Other	56	30	13	1
Wealth quintile				
1	59	22	19	0
2	60	23	17	1
3	57	30	13	0
4	52	34	13	0
5	65	25	10	0

Table 4. Confidence in ability to communicate with the provider (N=2001)

	Very confident	Somewhat confident	Not too confident	Not at all confident
	%	%	%	%
Total	**84**	**11**	**3**	**1**
Gender				
Male	85	12	2	0
Female	83	11	4	2
Age				
18-29	76	14	6	4
30-49	87	10	2	0
50+	88	9	2	0
Residence type				
Urban	79	13	6	2
Rural	86	10	2	1
Region				
North	88	10	1	0
Central	84	11	4	1
South	75	15	4	5
Educational achievement				
Primary or less	86	11	2	2
Lower or upper secondary	81	12	6	1
Post-secondary or tertiary	84	12	3	1
Ethnicity				
Lao-Tai	83	13	4	1
Hmong-Mien	93	3	4	0
Mon-Khmer	85	10	3	1
Other	83	7	1	9
Wealth quintile				
1	82	11	5	2
2	84	10	5	0
3	87	10	3	0
4	79	16	1	4
5	87	10	3	0

6.2 Usual source of care

Understanding people's preferences for health care may offer insights into more efficient and cost-effective health care delivery systems. We asked participants if there was a place they normally went for health care. People who answered in the affirmative were also asked about the type of place they visited. We allowed people to identify non-health care facilities where health care may not be provided by a health worker but rather a pharmacist or a traditional healer.

Ninety-one percent of respondents indicated they had a usual place to seek health care and two-thirds of them identified public hospital as their usual place for care (see *Table 5*). Only 1% identified private hospitals as their usual place for care and 13% identified privately managed clinics. Low utilization rates of private providers reflect the relatively small number of private providers across the country.

Table 5. Usual place for health care

	People who have a usual place for care (N=1996)	Usual place visited for health care (N=1871)						
		Gov. hospital	Gov. health center	Private hospital	Private clinic	Private pharmacy	Traditional healer	Other
	%	%	%	%	%	%	%	%
Total	91	**64**	**16**	**1**	**13**	**5**	**0**	**0**
Gender								
Male	89	60	17	1	13	6	1	1
Female	92	67	14	1	13	4	0	0
Age								
18-29	94	63	16	1	13	6	1	0
30-49	89	63	18	1	15	3	0	1
50+	90	68	13	1	11	7	0	0
Residence type								
Urban	92	72	4	3	17	4	0	0
Rural	90	60	22	0	11	5	0	0
Region								
North	90	63	21	1	11	4	0	1
Central	90	66	11	2	15	5	1	0
South	94	61	20	0	12	7	0	0
Educational attainment								
Primary or less	88	62	20	0	12	5	1	0
Lower or upper secondary	94	66	15	2	12	5	0	0
Post-secondary or tertiary	96	68	4	3	20	4	0	0
Ethnicity								
Lao-Tai	94	66	13	2	14	4	0	1
Hmong-Mien	93	57	21	1	13	5	4	0
Mon-Khmer	59	49	27	0	5	19	0	0
Other	97	66	24	1	10	0	0	0

	People who have a usual place for care (N=1996)	Usual place visited for health care (N=1871)						
		Gov. hospital	Gov. health center	Private hospital	Private clinic	Private pharmacy	Traditional healer	Other
Wealth quintile								
1	91	53	26	0	13	7	1	0
2	90	77	16	1	5	1	0	0
3	90	64	20	1	9	6	0	0
4	96	68	9	2	14	6	0	2
5	91	68	3	3	22	3	0	0

We asked respondents to rate the quality of care at the place where they usually seek care (see *Table 6*). We asked people to consider only health facilities, not pharmacies or traditional healers; respondents who had identified a pharmacy or traditional provider as their usual source of care were given the opportunity to identify a second location for this and subsequent questions. Only 16% rated the quality of care as excellent or very good, and 28% rated it fair or poor. A large proportion of Hmong (49%) and people in the northern region (33%) and people in the lowest wealth quintile (33%) rated it fair or poor.

Table 6. Quality rating of usual place of care[1] (N=1619)

	Excellent	Very good	Good	Fair	Poor
	%	%	%	%	%
Total	**3**	**13**	**55**	**24**	**4**
Gender					
Male	4	13	52	27	5
Female	3	14	57	22	4
Age					
18-29	5	17	47	27	4
30-49	3	11	58	23	5
50+	2	11	59	23	4
Residence type					
Urban	5	16	52	23	4
Rural	2	12	56	25	4
Region					
North	2	13	52	27	6
Central	4	13	56	24	4
South	5	14	56	21	3
Educational achievement					
Primary or less	3	13	57	22	5
Lower or upper secondary	4	12	53	27	4
Post-secondary or tertiary	3	15	51	27	4
Ethnicity					
Lao-Tai	4	12	58	22	4
Hmong-Mien	5	15	31	47	2
Mon-Khmer	0	25	45	22	8
Other	0	13	49	29	9
Wealth quintile					
1	4	13	51	24	9
2	3	18	55	23	1
3	2	10	59	25	4
4	4	15	53	24	3
5	4	12	57	25	2

[1] Only includes people who visited the health facility in the previous 12 months

6.3 Utilization patterns

Understanding how people access care can help to better tailor health care delivery systems to their needs and preferences. Sixty-five percent of the adult population visited health facilities at least once in the previous 12 months and, of those that sought care, more than two-thirds went to 1 or 2 facilities (see *Table 7*). More women visited health care facilities than men (68% to 61%), as did the highly educated relative to those that did not have any education (70% to 64%) and people in the highest wealth quintile relative to the lowest (69% to 61%).

People also used different means to access care: 5% used telemedicine and 8% received home-visits. Additionally, 11% of the adult population spent at least one night in a hospital (see *Table 9*).

Table 7. Number of visits to health care facilities in previous 12 months (N=1990)

	0 visits	1 to 4 visits	5 to 9 visits	10+ visits
	%	%	%	%
Total	**35**	**55**	**6**	**4**
Gender				
Male	39	55	3	3
Female	32	54	9	5
Age				
18-29	36	54	5	5
30-49	33	57	8	3
50+	38	53	5	4
Residence type				
Urban	34	56	5	5
Rural	36	54	7	3
Region				
North	35	56	6	3
Central	36	53	7	4
South	34	58	4	4
Educational achievement				
Primary or less	36	55	6	3
Lower or upper secondary	37	53	6	4
Post-secondary or tertiary	30	58	7	5
Ethnicity				
Lao-Tai	33	58	6	3
Hmong-Mien	47	43	5	5
Mon-Khmer	49	41	4	7
Other	32	53	7	8
Wealth quintile				
1	39	51	7	3
2	34	60	3	2
3	36	54	5	5
4	34	53	7	6
5	30	60	7	2

Table 8. Number of health facilities visited in the previous 12 months (N=1257)

	1 to 2 facilities	3 to 4 facilities	5+ facilities
	%	%	%
Total	**95**	**4**	**1**
Gender			
Male	96	3	0
Female	94	5	1
Age			
18-29	93	6	1
30-49	97	2	0
50+	94	6	1
Residence type			
Urban	96	4	1
Rural	95	5	1
Region			
North	96	3	1
Central	93	6	0
South	98	2	1
Educational achievement			
Primary or less	96	4	0
Lower or upper secondary	95	4	1
Post-secondary or tertiary	93	6	1
Ethnicity			
Lao-Tai	95	5	1
Hmong-Mien	92	5	2
Mon-Khmer	98	1	1
Other	95	5	0
Wealth quintile			
1	93	7	1
2	98	1	1
3	98	2	0
4	96	4	0
5	94	5	1

Table 9. Other interactions with health care in the previous 12 months

	Stayed overnight at a hospital (N=1988)	1 or more home visits by health workers (N=1996)	1 or more telemedicine calls (N=1989)
	%	%	%
Total	**11**	**8**	**5**
Gender			
Male	8	7	4
Female	13	8	6
Age			
18-29	13	6	2
30-49	10	6	5
50+	10	8	4
Residence type			
Urban	13	5	5
Rural	10	8	4
Region			
North	10	10	4
Central	11	5	5
South	12	8	4
Educational achievement			
Primary or less	11	8	2
Lower or upper secondary	11	7	4
Post-secondary or tertiary	10	4	9
Ethnicity			
Lao	11	7	5
Hmong	7	4	4
Khmou	4	12	2
Other	18	6	7
Wealth quintile			
1	13	6	3
2	7	9	3
3	10	12	2
4	10	3	4
5	10	4	9

6.4 System competence in population health

Health system competence and its performance are important measures for population health. There are three unique measures of system competence used in the PVS. We asked participants whether they had received routine health examinations in the previous year (see *Table 10*), if they experienced a medical error in their last visit (see *Table 11*), and whether they had skipped care even when needed (*Table 12*).

Overall, there were low rates of utilization of public health examinations. 13% of women over 50 years old received a mammogram and 17% of all women received cervical cancer screening. Rates of oral and vision checks were also low across the adult population at 16% and 18% respectively. Higher proportions had tested for blood glucose (35%), cholesterol (37%) and blood pressure (58%) in the previous year. Only 1% of the public received mental health examinations. There are large disparities in access to these health examinations with people in the lowest wealth quintile and with primary education or less least likely to receive them.

The overwhelming majority (95%) of respondents did not believe that they had experienced a medical error during the last health care visit.

Nearly 1 in 5 (17%) respondents reported not using seeking care even when they needed it in the previous 12 months.

Table 10. Proportion of people receiving health examinations in the previous 12 months

	Blood pressure (N=2007)	Mammo-gram[2] (N=268)	Cervical cancer screening[3] (N=869)	Vision check (N=2007)	Teeth check (N=2007)	Blood glucose (N=2006)	Blood cholest-erol (N=2005)	Mental health examination (N=2007)
	%	%	%	%	%	%	%	%
Total	**58**	**13**	**17**	**18**	**16**	**35**	**33**	**1**
Gender								
Male	54	NA	NA	18	14	34	31	1
Female	62	13	17	18	18	36	36	1
Age								
18-29	50	NA	16	14	13	21	20	0
30-49	62	NA	19	19	17	38	36	1
50+	62	13	14	22	19	47	45	1
Residence type								
Urban	60	22	21	24	25	43	41	1
Rural	57	7	14	15	12	32	30	1
Region								
North	60	6	17	17	15	33	31	0

[2] All women were asked about cervical cancer screenings

[3] Women older than 50 were asked about mammograms

	Blood pressure (N=2007)	Mammo-gram[2] (N=268)	Cervical cancer screening[3] (N=869)	Vision check (N=2007)	Teeth check (N=2007)	Blood glucose (N=2006)	Blood cholest-erol (N=2005)	Mental health examination (N=2007)
	%	%	%	%	%	%	%	%
Central	59	17	17	20	18	38	36	1
South	55	11	15	17	13	33	30	1
Educational achievement								
Primary or less	57	11	15	17	14	34	33	0
Lower or upper secondary	57	23	20	17	15	31	30	1
Post-secondary or tertiary	66	18	19	27	27	47	43	2
Ethnicity								
Lao-Tai	63	15	18	20	19	39	37	1
Hmong-Mien	45	0	27	15	10	23	23	1
Mon-Khmer	31	0	1	12	8	18	15	0
Other	61	0	20	15	8	31	29	0
Wealth quintile								
1	50	9	9	14	10	26	26	0
2	60	0	8	14	13	33	27	0
3	54	15	15	11	9	29	27	0
4	63	12	25	23	17	38	35	0
5	69	24	28	31	33	56	52	3

Table 11. Experienced medical error in treatment in the previous 12 months (N=1403)

	Experienced medical error
	%
Total	**5**
Gender	
Male	4
Female	5
Age	
18-29	8
30-49	4
50+	2
Residence type	
Urban	6
Rural	4
Region	
North	3
Central	6
South	5
Educational achievement	
Primary or less	2
Lower or upper secondary	8
Post-secondary or tertiary	8
Ethnicity	
Lao-Tai	5
Hmong-Mien	9
Mon-Khmer	5
Other	3
Wealth quintile	
1	5
2	4
3	5
4	5
5	5

Table 12. Non-use of care

	None use of care (N=2004)	Reasons for non-use (N=338)									
		High cost	Far distance	Long waiting time	Poor healthcare provider skills	Staff don't show respect	Medicines / equipment not available	Illness not serious enough	COVID-19 restrictions	COVID-19 fear	Others
	%	%	%	%	%	%	%	%	%	%	%
Total	**17**	**7**	**3**	**0**	**1**	**0**	**0**	**77**	**2**	**6**	**2**
Gender											
Male	13	8	5	0	3	1	1	72	5	1	5
Female	20	7	2	0	0	0	0	80	0	9	1
Age											
18-29	24	11	3	0	2	1	1	65	4	12	3
30-49	15	7	0	1	0	0	1	89	0	1	1
50+	10	1	10	0	2	0	0	82	0	1	4
Residence type											
Urban	19	3	1	0	2	0	0	82	0	8	3
Rural	15	10	4	0	1	0	1	74	3	5	2
Region											
North	16	4	7	0	3	0	1	77	5	1	3
Central	16	5	1	0	0	0	0	87	0	1	3
South	19	17	2	0	1	0	0	55	0	24	1
Educational achievement											
Primary or less	15	8	3	0	0	0	0	75	3	10	1
Lower or upper secondary	18	9	5	0	3	1	1	76	0	1	4
Post-secondary or tertiary	21	3	1	1	2	0	0	84	0	3	5
Ethnicity											
Lao-Tai	16	5	1	0	1	0	0	88	0	1	2
Hmong-Mien	12	12	8	0	6	0	6	24	39	0	6
Mon-Khmer	12	2	0	0	0	0	2	91	0	0	4
Other	31	17	12	0	0	0	0	41	0	29	1
Wealth quintile											
1	16	8	0	0	1	1	1	74	5	8	3
2	20	4	6	0	0	0	0	71	0	18	2
3	11	1	6	0	1	0	0	87	0	3	2
4	19	16	0	1	3	0	0	73	0	1	4
5	17	3	8	0	1	0	1	83	0	1	2

6.5 User experience

Positive patient experiences and satisfaction are important components of healthcare quality. In this section we explore people's experiences with health care in their most recent visit to a health facility. A health facility is defined as a place where a licensed health worker administers care and, in Laos, this means one of the following: health center, hospital, or a clinic.

A large majority of health facilities in the country are government-owned with a small but growing number of privately managed clinics and hospitals. Clinics are exclusively private and health centers are exclusively government-owned. Hospitals can be either public or private. The preference for publicly-owned hospitals in the responses reflects the relatively small number of private hospitals that are mostly in urban densely populated areas.

People used hospitals by a wide margin (65%) relative to a health centers (16%) or clinics (18%) (see *Table 13*). Older people used clinics (21%) more than younger people (14%), as did people in the highest wealth quintile (24%) compared to people in the lowest (17%). Five percent of the wealthiest used health centers compared to 26% of those in the lowest wealth quintile.

Table 13. Most recent health facility visited (N=1812)

	Hospital	Health centre	Clinic	Other
	%	%	%	%
Total	**65**	**16**	**18**	**1**
Gender				
Male	62	17	19	2
Female	67	15	17	1
Age				
18-29	69	17	14	1
30-49	63	16	19	1
50+	63	14	21	1
Residence type				
Urban	73	5	21	1
Rural	61	21	17	1
Region				
North	62	20	17	1
Central	67	11	21	2
South	66	20	14	0
Educational achievement				
Primary or less	64	17	18	1
Lower or upper secondary	64	18	17	1
Post-secondary or tertiary	71	7	21	1
Ethnicity				

	Hospital	Health centre	Clinic	Other
	%	%	%	%
Lao-Tai	65	14	20	1
Hmong-Mien	58	23	20	0
Mon-Khmer	59	24	16	0
Other	73	16	8	3
Wealth quintile				
1	56	26	17	2
2	69	18	12	0
3	68	15	15	2
4	69	8	23	0
5	69	5	24	1

Table 14. Ownership of hospital (N=1245)

	Public/ Government	Private (for-profit)	NGO/Faith-based
	%	%	%
Total	**97**	**3**	**0**
Gender			
Male	97	3	0
Female	96	3	0
Age			
18-29	97	3	0
30-49	96	4	0
50+	98	2	0
Residence type			
Urban	93	6	0
Rural	99	1	0
Region			
North	98	2	0
Central	96	4	0
South	98	2	0
Educational achievement			
Primary or less	98	2	0
Lower or upper secondary	96	3	0
Post-secondary or tertiary	95	5	0
Ethnicity			
Lao-Tai	97	3	0
Hmong-Mien	92	8	0
Mon-Khmer	100	0	0
Other	99	1	0
Wealth quintile			
1	99	1	0
2	100	0	0
3	98	2	0
4	94	5	0
5	95	5	0

When asked about the reason for their most recent health facility visit, the most common response was “care for an urgent or new health problem” (47%), followed by “preventive care or a visit to check on your health.” Older respondents were more likely than younger respondents to say that their most recent visit was for “follow-up care for a longstanding illness or chronic disease.”

Table 15. Reason for most recent health facility visit (N=1799)

	Care for an urgent or new health problem	Follow-up care for a longstanding illness or chronic disease	Preventive care or a visit to check on your health	Other
	%	%	%	%
Total	**47**	**8**	**37**	**8**
Gender				
Male	49	8	36	8
Female	45	9	38	8
Age				
18-29	59	2	29	9
30-49	41	8	40	10
50+	41	14	41	4
Residence type				
Urban	44	9	36	11
Rural	48	8	38	7
Region				
North	43	9	40	8
Central	47	8	36	9
South	53	6	35	6
Educational achievement				
Primary or less	46	9	37	8
Lower or upper secondary	47	7	38	8
Post-secondary or tertiary	50	6	36	9
Ethnicity				
Lao-Tai	45	9	40	7
Hmong-Mien	64	4	15	17
Mon-Khmer	60	0	23	17
Other	38	14	46	2
Wealth quintile				
1	51	6	35	8
2	49	11	34	6
3	53	9	32	6
4	43	8	37	12
5	38	9	45	7

There was substantial variation in reported waiting time across respondents, with 37% reporting that they waited less than 15 minutes before seeing a provider and 30% responding that they waited 45 minutes or more (Table 16). Respondents in the lowest wealth quintile were more likely to report long waiting times than respondents in the highest wealth quintile. Once they saw providers, visit times also varied, with the majority (59%) of respondents reporting visits of less than 15 minutes, but a substantial proportion (17%) reporting much longer visits of 45 minutes or more.

Table 16. Waiting time in minutes during the most recent visit (N=1297)

	<15 min	15-29 min	30-44 min	≥45 min
	%	%	%	%
Total	58	17	11	14
Gender				
Male	59	19	9	13
Female	56	16	13	15
Age				
18-29	54	19	14	13
30-49	60	16	9	15
50+	59	16	11	13
Residence type				
Urban	59	17	11	12
Rural	57	17	11	15
Region				
North	56	14	13	17
Central	61	17	11	11
South	53	23	8	16
Educational achievement				
Primary or less	59	18	10	14
Lower or upper secondary	55	16	13	16
Post-secondary or tertiary	59	17	12	11
Ethnicity				
Lao-Tai	60	16	11	13
Hmong-Mien	59	16	8	17
Mon-Khmer	69	17	5	9
Other	31	25	21	24
Wealth quintile				
1	70	12	6	11
2	45	26	14	15
3	51	20	14	15
4	53	15	14	18
5	58	19	12	11

Table 17.Consultation time in minutes with the health care provider during most recent visit (N=1293)

	<15 min	15-29 min	30-44 min	≥45 min
	%	%	%	%
Total	63	26	7	4
Gender				
Male	66	25	6	3
Female	61	27	9	4
Age				
18-29	58	31	6	5
30-49	64	23	9	4
50+	67	25	6	2
Residence type				
Urban	53	31	10	5
Rural	68	23	6	3
Region				
North	70	22	6	3
Central	60	28	7	5
South	60	27	10	3
Educational achievement				
Primary or less	67	24	6	3
Lower or upper secondary	61	27	9	3
Post-secondary or tertiary	54	31	10	5
Ethnicity				
Lao-Tai	65	23	8	3
Hmong-Mien	48	34	5	13
Mon-Khmer	53	33	9	5
Other	65	33	1	1
Wealth quintile				
1	67	23	6	4
2	69	22	6	3
3	61	33	5	2
4	57	27	11	5
5	60	28	9	3

Only (28%) of respondents rated the overall quality of care in their last visit as excellent or very good (see *Table 18*). Lower proportions rated the quality of individual components as excellent or very good, particularly provider knowledge about previous visits and inclusion in decisions about their care by the provider.

When asked about the likelihood of recommending the facility to friends or family on a scale from 1 to 10 with 10 being highly likelihood to recommend, a high proportion (90%) of respondents responded with a 6 or higher (see *Table 19*).

Table 18. Quality rating for most recent visit to a health facility (Proportion Choosing Excellent or Very Good)

	Overall (N=1860)	Knowledge and skill of health provider (N=1854)	Equipment and supplies (N=1846)	Respect shown by provider (N=1859)	Provider knowledge about previous visit (N=1815)	Provider explanations (N=1859)	Involvement in decisions about care by provider (N=1854)	Time spent by provider (N=1859)	Waiting time (N=1860)	Staff respectfulness other than provider (N=1847)
	%	%	%	%	%	%	%	%	%	%
Total	**28**	**22**	**19**	**20**	**14**	**22**	**17**	**24**	**20**	**19**
Gender										
Male	29	25	19	21	15	25	20	24	23	19
Female	26	19	18	19	14	19	14	24	18	19
Age										
18-29	32	22	18	22	14	25	18	24	22	18
30-49	23	21	18	19	14	21	16	23	17	18
50+	31	23	21	19	15	22	17	24	24	21
Residence type										
Urban	34	25	21	24	20	28	20	27	21	22
Rural	25	21	17	18	11	19	15	22	20	17
Region										
North	27	19	16	18	11	21	17	20	18	16
Central	29	22	21	21	17	23	18	24	21	21
South	25	26	17	22	13	23	17	28	25	19
Educational achievement										
Primary or less	28	22	18	18	14	21	16	24	20	20
Lower or upper secondary	26	22	19	23	14	23	16	21	19	15
Post-secondary or tertiary	29	26	21	26	19	26	21	25	24	22

	Overall (N=1860)	Knowledge and skill of health provider (N=1854)	Equipment and supplies (N=1846)	Respect shown by provider (N=1859)	Provider knowledge about previous visit (N=1815)	Provider explanations (N=1859)	Involvement in decisions about care by provider (N=1854)	Time spent by provider (N=1859)	Waiting time (N=1860)	Staff respectfulness other than provider (N=1847)
	%	%	%	%	%	%	%	%	%	%
Ethnicity										
Lao-Tai	28	23	18	21	15	23	17	23	22	19
Hmong-Mien	24	19	8	16	5	26	22	22	22	6
Mon-Khmer	34	23	28	18	20	17	19	34	23	27
Other	16	19	18	22	12	10	9	23	9	16
Wealth quintile										
1	27	20	16	13	11	19	16	20	21	15
2	30	22	16	25	14	22	12	30	23	15
3	16	20	16	22	15	21	18	19	16	20
4	32	25	25	22	18	26	20	26	22	23
5	30	25	21	26	18	26	19	25	21	25

Table 19.Likelihood of recommending the health facility (1=definitely would not and 10=definitely would) (n=1841)

	1-5 rating	6-8 rating	9-10 rating
	%	**%**	**%**
Total	**10**	**46**	**44**
Gender			
Male	10	52	38
Female	10	40	50
Age			
18-29	13	52	35
30-49	10	46	43
50+	7	38	54
Residence type			
Urban	7	48	45
Rural	12	45	43
Region			
North	11	43	47
Central	10	47	43
South	10	48	42
Educational achievement			
Primary or less	10	40	50
Lower or upper secondary	12	50	38
Post-secondary or tertiary	8	59	33
Ethnicity			
Lao-Tai	10	44	45
Hmong-Mien	9	58	33
Mon-Khmer	7	69	24
Other	12	34	53
Wealth quintile			
1	11	47	41
2	14	38	48
3	13	51	35
4	7	44	48
5	7	46	47

6.6 Health system assessment

People's quality assessments can provide a critical measure of the quality of public health services vital to their health and well-being. We asked interviewees to assess the quality of care for a range of public health services, including of ones they may have not used themselves (see *Table 20*). Approximately 1 in 4 rated pregnancy, post-pregnancy and child-care services excellent or very good and even lower proportions rated chronic and mental health care as excellent or very good. Lower proportion of women consistently rated pregnancy, post-partum and care for children as excellent or very good compared to men. People with at least post-secondary education, Lao-tai ethnicity, living in urban areas and ones with the wealthiest quintiles tended to more critical of public health services.

Table 20. Quality rating for public health services (proportion choosing Excellent or Very Good)

	Pregnancy (N=1919)	Post-partum care (N=1913)	Children (well or sick) (N=1936)	Chronic care (N=1804)	Mental health care (N=1623)
	%	%	%	%	%
Total	**26**	**25**	**26**	**12**	**11**
Gender					
Male	29	29	30	12	11
Female	23	22	23	12	11
Age					
18-29	27	24	28	12	9
30-49	24	23	25	13	10
50+	27	29	26	10	14
Residence type					
Urban	24	22	26	12	10
Rural	27	27	26	12	11
Region					
North	22	25	28	11	13
Central	23	22	23	11	10
South	40	32	33	14	8
Educational achievement					
Primary or less	29	29	30	12	12
Lower or upper secondary	22	20	22	12	10
Post-secondary or tertiary	19	17	22	10	8
Ethnicity					
Lao-Tai	23	22	23	11	10
Hmong-Mien	25	34	40	15	13
Mon-Khmer	39	38	35	18	17
Other	31	26	28	9	7

	Pregnancy (N=1919)	Post-partum care (N=1913)	Children (well or sick) (N=1936)	Chronic care (N=1804)	Mental health care (N=1623)
	%	%	%	%	%
Wealth quintile					
1	30	30	31	10	10
2	39	31	26	17	12
3	17	16	21	13	13
4	24	25	25	14	12
5	17	17	21	8	8

6.7 Overall assessment

We asked people to assess their confidence in the larger health system in Laos, particularly, trends in its performance and their perceptions of quality of the public and private health care services. Additionally, we explored their confidence in their ability to receive quality and affordable health care if they became very sick.

Eighty-three percent of respondents were confident that they would receive quality health care if they became very sick and 82% were confident they will be able to afford it (see *Table 21*). Lower proportions of the young people (18-30 years old) (77%) and Hmong ethnic group (69%) were confident in their ability to receive quality care.

Approximately 1 in 4 rated the entire system of public and private health providers as excellent or very good (see *Table 22*).

While a large majority (85%) felt that the system is getting better (see *Table 23*), almost two-thirds (61%) wanted major change or a complete rebuild of their health system (see *Table 24*).

Table 21. Confidence rating (proportion choosing Very confident or Somewhat confident)

	Confidence in receiving good quality health care when very sick (N=2003)	Confidence in ability to afford health care when very sick (N=1996)	Confidence that the government considers the public's opinion when making health care decisions (N=1971)
	%	%	%
Total	**83**	**82**	**79**
Gender			
Male	84	81	81
Female	82	84	77
Age			
18-29	77	71	72
30-49	82	86	80
50+	91	87	84

	Confidence in receiving good quality health care when very sick (N=2003)	Confidence in ability to afford health care when very sick (N=1996)	Confidence that the government considers the public's opinion when making health care decisions (N=1971)
	%	%	%
Residence type			
Urban	80	82	75
Rural	84	83	81
Region			
North	83	85	83
Central	82	80	76
South	83	80	80
Educational achievement			
Primary or less	83	83	80
Lower or upper secondary	83	80	78
Post-secondary or tertiary	81	84	77
Ethnicity			
Lao-Tai	84	83	78
Hmong-Mien	69	77	74
Mon-Khmer	84	81	80
Other	78	81	85
Wealth quintile			
1	79	77	76
2	87	84	79
3	81	76	75
4	88	86	83
5	85	92	83

Table 22. Quality rating of public and private health care (proportion choosing Excellent or Very Good)

	Government hospitals and health centers (N=2005)	Private hospitals and clinics (N=1960)
	%	%
Total	**26**	**26**
Gender		
Male	25	25
Female	26	27
Age		
18-29	26	30
30-49	22	24
50+	29	25
Residence type		
Urban	24	32
Rural	26	23
Region		
North	26	24
Central	23	26
South	32	32
Educational achievement		
Primary or less	28	24
Lower or upper secondary	26	28
Post-secondary or tertiary	20	29
Ethnicity		
Lao-Tai	23	26
Hmong-Mien	26	24
Mon-Khmer	35	36
Other	31	21
Wealth quintile		
1	28	27
2	39	34
3	17	22
4	26	27
5	20	25

Table 23. People's perception of health system trends over time (N=1993)

	Getting better	Staying the same	Getting worse
	%	**%**	**%**
Total	**85**	**13**	**1**
Gender			
Male	85	13	2
Female	86	13	1
Age			
18-29	79	18	3
30-49	87	13	1
50+	90	9	1
Residence type			
Urban	86	12	2
Rural	85	14	1
Region			
North	86	13	1
Central	84	14	2
South	88	12	0
Educational achievement			
Primary or less	86	13	1
Lower or upper secondary	85	13	2
Post-secondary or tertiary	82	16	2
Ethnicity			
Lao-Tai	87	12	1
Hmong-Mien	85	13	2
Mon-Khmer	75	22	3
Other	82	17	1
Wealth quintile			
1	88	11	1
2	82	18	1
3	84	14	3
4	86	13	1
5	84	14	2

Table 24. People's evaluation of overall health system performance (N=1994)

	Our healthcare system has so much wrong with it that we need to completely rebuild it.	There are some good things in our healthcare system, but major changes are needed to make it work better.	On the whole, the system works pretty well and only minor changes are necessary to make it work better.
	%	**%**	**%**
Total	**6**	**56**	**38**
Gender			
Male	6	56	37
Female	6	56	38
Age			
18-29	6	55	39
30-49	6	57	37
50+	6	56	38
Residence type			
Urban	6	60	34
Rural	6	54	39
Region			
North	10	58	32
Central	5	56	40
South	3	54	42
Educational achievement			
Primary or less	5	55	40
Lower or upper secondary	8	55	38
Post-secondary or tertiary	6	64	30
Ethnicity			
Lao-Tai	5	55	40
Hmong-Mien	22	60	19
Mon-Khmer	3	63	34
Other	4	59	37
Wealth quintile			
1	5	53	42
2	4	51	45
3	9	58	33
4	4	59	37
5	8	63	29

6.8 Expectations of health care quality

Expectations of health care quality can influence how people experience care and assess its quality. Low expectations can lead people to be satisfied with low quality care. We measured people's expectations of health care quality through two vignettes – one designed to depict low quality care (see *Table 25*) and another designed to depict high quality care (see *Table 26*). People provided their judgements about the quality of care following the reading of each respective vignette.

> **Low quality vignette** – At the health facility, the doctor does not ask about his symptoms or examine her body; the doctor gives him pain medication and does not give him the diagnosis. How would you rate the quality of care provided?
>
> **High quality vignette** – Now Mr. Noy goes to another clinic. There the doctor examines him and orders a blood test. The doctor tells him it is not serious, advises a light diet, and asks him to come back if it gets worse. How would you rate the quality of care provided?

The results suggest that people are fairly good at recognizing low quality care. Eighty-nine percent of the respondents assessed the objectively low quality vignette as 'fair' or 'poor' However, a lower proportion (41%) rated the good quality vignette as excellent or very good.

Table 25. Quality assessment of low quality vignette (N=2004)

	Excellent	Very good	Good	Fair	Poor
	%	%	%	%	%
Total	**0**	**0**	**0**	**10**	**89**
Gender					
Male	0	0	0	12	87
Female	0	0	0	9	90
Age					
18-29	0	0	0	11	89
30-49	0	0	1	11	88
50+	0	0	0	9	90
Residence type					
Urban	0	0	1	10	89
Rural	0	0	0	11	89
Region					
North	0	0	0	11	88
Central	0	0	1	9	90
South	0	0	0	12	88
Educational achievement					
Primary or less	0	0	0	10	89

	Excellent	Very good	Good	Fair	Poor
	%	%	%	%	%
Lower or upper secondary	0	0	0	10	90
Post-secondary or tertiary	0	0	1	11	87
Ethnicity					
Lao-Tai	0	0	1	8	91
Hmong-Mien	0	0	0	15	85
Mon-Khmer	0	0	1	17	82
Other	0	0	0	17	83
Wealth quintile					
1	0	0	0	11	89
2	0	0	0	10	90
3	0	0	1	9	89
4	0	0	0	11	88
5	0	0	0	9	90

Table 26. Quality assessment of high quality vignette (n=2004)

	Excellent	Very good	Good	Fair	Poor
	%	%	%	%	%
Total	**14**	**27**	**42**	**17**	**1**
Gender					
Male	15	26	42	16	1
Female	13	27	42	17	1
Age					
18-29	17	36	34	12	1
30-49	13	22	44	20	1
50+	12	23	47	17	1
Residence type					
Urban	16	25	43	15	1
Rural	13	28	41	18	1
Region					
North	9	27	44	19	0
Central	15	26	42	16	1
South	19	29	37	13	1
Educational achievement					
Primary or less	15	24	41	18	0
Lower or upper secondary	11	31	42	15	1
Post-secondary or tertiary	13	28	43	13	2
Ethnicity					
Lao-Tai	11	25	44	19	1
Hmong-Mien	13	35	38	10	3
Mon-Khmer	35	33	26	6	0
Other	13	28	44	16	0
Wealth quintile					
1	19	30	34	15	1
2	11	27	46	16	1
3	12	26	41	21	0
4	11	24	50	14	1
5	12	26	44	17	2

7. SUMMARY

This report summarized the results of the first PVS conducted in Lao PDR in 2022. The survey and report provide important insights into population perspectives on health care, and contain detailed data on utilization patterns, coverage of primary care services, perceptions of health system quality, and trust in the overall health system in Laos.

The results presented show that nearly two-thirds of the adult population visited health facilities at least once each year in Laos. Eight percent received care from health workers at home, 5% used telemedicine and 10% of the adult population stayed over-night at a hospital.

Among respondents with a “usual place of care”, almost two-thirds (64%) visited government hospitals. Respondents in rural areas were more likely to identify government-managed health centers (22%) as their usual source for care than of urban residents (4%). The least wealthy also tended to use health centers more frequently (26%) than the wealthiest (3%).

Generally, respondents gave negative reviews of the quality of care available in the facilities they use. When asked about the quality of care of their usual facility, only 16% rated it excellent or very good.

While nearly 6 out of 10 respondents (58%) reported having their blood pressure checked in last year, less than half of the adult population had their vision checked (18%), teeth checked (16%), blood glucose measured (35%), blood cholesterol checked (33%) and only 1% had a mental health examination. Less than 1 in 5 (17%) women underwent cervical cancer screening and a lower proportion (13%) of women over 50 years old had a mammogram in the previous year. There are large disparities in coverage among with the poor receiving these examinations at roughly half the rate as wealthier counterparts.

Nearly 1 in 5 respondents (17%) avoided seeking health care in the last year when they had a health problem; the most common reason was that respondents felt that their illness was not serious enough (77% of those who reported not seeking care). Seven percent attributed it to the high cost and another 6% avoided care due to COVID fear.

In terms of user experiences, nearly 1 in 3 respondents (30%) waited 45 minutes or longer to see the health provider and the majority (59%) received less than 15 minutes of consultation with the medical provider.

Less than 1 in 3 (28%) rated the overall quality of care excellent or very good, with even lower ratings for individual components of quality: knowledge and skill of health provider (22%), equipment and supplies (19%), respect shown by provider (20%), provider explanations (22%), inclusion in decisions about care by provider (17%), time spent by provider (24%), waiting time (20%) and staff courtesy other than provider (19%). Despite the relatively low quality assessment, the majority of respondents said that they would recommend the health facility to family and friends: 70% responded with 8 or higher on a 1 to 10 scale, where 1 indicates that they would definitively not recommend the facility and 10 indicates they would definitely recommend.

Approximately one in four adults rated pregnancy care, including ante-natal care, post-partum care and child-care (well or sick) as excellent or very good. Even lower proportions rated chronic care (12%) and mental health care (11%) as excellent or very good. Only 1 in 4 respondents rated the overall quality of government hospitals and health centers as being excellent or very good (and a similar proportion gave positive ratings to the overall quality in private health facilities).

Despite respondents’ low assessment of the quality of care provided in health facilities, approximately 8 out of 10 people were confident that they could receive good quality care (83%) and afford health care (82%) if they became very sick and nearly two-thirds (62%) felt that the health system needs a major change or a complete rebuild.

Key takeaways

This study has several key takeaways. First, we found that there is significant bypassing of publicly managed health centers for hospitals in Laos. Almost two-thirds normally sought care in hospitals and a similar proportion also reported going to hospitals for their last visit. Compared to hospitals, only 16% percent turned to health centers as their usual source of care. Only 3% of respondents in the highest wealth quintiles chose health centers compared to 26% in the lowest wealth quintile.

Second, the adult population in Laos generally gave very low ratings to the quality of care available in health facilities in their country. Only 28% rated their health care experience in the last visit as excellent or very good, with even lower ratings for specific components such as provider knowledge about previous visit and inclusion in decisions about care by provider. Approximately 1 in 4 rated pregnancy, post-pregnancy and child-care services excellent or very good and a lower proportion, approximately 1 in 10, rated chronic and mental health care as excellent or very good. When asked to assess the quality of care in health facilities overall, only 1 in 4 gave positive ratings; similar ratings were given to public and private facilities. Despite this, a large majority of adults reported that they health system was getting better (85%), and that they were confident they could receive and afford high quality care if they were very sick (71%).

Finally, there is evidence of significant inequities in health system utilization patterns and in quality of care. While utilization of routine health examinations is low, their use by the people in the lowest wealth quintile is significantly lower. There is almost a three-fold difference of women receiving mammogram examination and cervical cancer screening between the wealthiest and least wealthy. And twice as many among the wealthiest had vision, teeth, blood glucose and cholesterol checked compared to the least wealthy.

It is important to consider strategies to reduce the significant bypassing of public health facilities while MOH attempts to achieve UHC by 2025. New initiatives to further improve quality of care and uptake of public health services, particularly among the poorest may be needed.

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