ADB

Report and Recommendation of the President to the Board of Directors

Project Number: 47137-003
August 2015

Proposed Programmatic Approach, Policy-Based Loan, and Technical Assistance Loan for Subprogram 1
Lao People's Democratic Republic: Health Sector Governance Program

Asian Development Bank

CURRENCY EQUIVALENTS

(as of 31 July 2015)

Currency unit	–	kip (KN)
KN1.00	=	$0.0001232
$1.00	=	KN8,115.500

ABBREVIATIONS

ADB	–	Asian Development Bank
HEF	–	Health Equity Fund
HSRS	–	Health Sector Reform Strategy
Lao PDR	–	Lao People's Democratic Republic
MDG	–	Millennium Development Goal
MNCH	–	maternal, neonatal, and child health care
MOF	–	Ministry of Finance
MOH	–	Ministry of Health
NHA	–	national health account
PAM	–	project administration manual
PHO	–	provincial health office
TA	–	technical assistance
UHC	–	universal health coverage

NOTES

(i) The fiscal year (FY) of the Government of the Lao People's Democratic Republic ends on 30 September. "FY" before a calendar year denotes the year in which the fiscal year ends, e.g., FY2015 ends on 30 September 2015.

(ii) In this report, "$" refers to US dollars.

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CONTENTS

PROGRAM AT A GLANCE

1. Basic Data — **Project Number:** 47137-003

Project Name	Health Sector Governance Program	**Department /Division**	SERD/SEHS
Country	Lao People's Democratic Republic	**Executing Agency**	Ministry of Health
Borrower	Lao People's Democratic Republic		

2. Sector

Sector	**Subsector(s)**	**ADB Financing ($ million)**
Health	Health insurance and subsidized health programs	10.50
	Health sector development and reform	7.50
	Mother and child health care	5.00
	Total	**23.00**

3. Strategic Agenda

Strategic Agenda	**Subcomponents**	**Climate Change Information**	
Inclusive economic growth (IEG)	Pillar 2: Access to economic opportunities, including jobs, made more inclusive Pillar 3: Extreme deprivation prevented and effects of shocks reduced (Social Protection)	Climate Change impact on the Project	Low

4. Drivers of Change

Drivers of Change	**Components**	**Gender Equity and Mainstreaming**	
Governance and capacity development (GCD)	Institutional development Institutional systems and political economy	Gender equity (GEN)	✓
Knowledge solutions (KNS)	Knowledge sharing activities		
Partnerships (PAR)	Civil society organizations Implementation International finance institutions (IFI)		

5. Poverty Targeting

		Location Impact	
Project directly targets poverty	No	Nation-wide	High

6. Risk Categorization: Low

7. Safeguard Categorization **Environment:** C **Involuntary Resettlement:** C **Indigenous Peoples:** B

8. Financing

Modality and Sources	**Amount ($ million)**
ADB	**23.00**
Sovereign Programmatic Approach Policy-Based Lending (Loan): Asian Development Fund	17.00
Sovereign TA loan: Asian Development Fund	6.00
Cofinancing	**26.40**
World Bank - LOAN	13.20
World Bank - GRANT	13.20
Counterpart	**0.25**
Government	0.25
Total	**49.65**

9. Effective Development Cooperation

Use of country procurement systems	Yes
Use of country public financial management systems	Yes

Source: Asian Development Bank

I. THE PROPOSAL

1. I submit for your approval the following report and recommendation on (i) a proposed programmatic approach for the Health Sector Governance Program, (ii) a proposed policy-based loan to the Lao People's Democratic Republic (Lao PDR) for subprogram 1 of the Health Sector Governance Program, and (iii) a proposed technical assistance (TA) loan to the Lao PDR for subprogram 1 of the Health Sector Governance Program.[1]

2. The proposed programmatic approach will support the government's Health Sector Reform Strategy (HSRS), which aims to (i) improve access to basic health care and financial protection by 2020; and (ii) achieve universal health coverage (UHC) by 2025, through more efficient use of public resources and expanded health financing.[2]

II. THE PROGRAM

A. Rationale

3. **Development problems.** The Lao PDR has made notable achievements in health outcomes since the 1990s. However, significant challenges remain to meet key Millennium Development Goal (MDG) targets. The maternal mortality ratio (MMR) decreased from 405 maternal deaths per 100,000 live births in 1995 to an MMR of 357, still well short of the MDG MMR target of 260. The infant mortality rate has fallen to 68 deaths per 1,000 live births in 2012 compared with the MDG target of 45 deaths per 1,000 live births. The child mortality rate (under 5 years) was 79 deaths per 1,000 live births in 2012, while the MDG target is 70. Only 37% of pregnant mothers have adequate anti-natal care (four visits to a health practitioner prior to birth). Further, only 41.5% of mothers have a skilled birth attendant at birth, and 37.5% have an institution-based delivery.[3]

4. Lao PDR's challenge in achieving its MDG targets in health arises because utilization of health services in the Lao PDR is relatively low; ambulatory care visits per capita per year have been below 1 in most areas of the country. Poor utilization of health services is due in part to the poor quality of health facilities, lack of staff, and low operational budget for outreach services. High user fees, including the cost of pharmaceuticals, constitute another major barrier preventing the poor, mothers and children from accessing health services. Fiscal year (FY) 2012 national health accounts (NHAs) report that out-of-pocket expenses constitute 44.5% of total health expenditures, amounting to $35.5 per capita.[4]

5. **Binding constraints.** The key binding constraints to improving utilization and quality of health services relate to insufficient funding of healthcare facilities, which in turn impedes access to healthcare facilities by the poor; weak public financial management in the healthcare sector (budget planning, execution, and reporting); and weak human resources in the sector. For example, while the number of health workers increased significantly in 2013–2014, but primary health care facilities often lack health staff. In 2013, 33% of health centers had a community midwife (compared with a target of 100%), and 90% of health centers had less than

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[1] The design and monitoring framework is in Appendix 1.

[2] The World Health Organization (WHO) defines UHC as "ensuring that all people can use the promotive, preventive, curative, rehabilitative, and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship." WHO. Health Financing for Universal Coverage. http://www.who.int/health_financing/universal_coverage_definition/en/; Ministry of Health. 2013. *Health Sector Reform Strategy, 2013–2025.* Vientiane.

[3] Lao Statistic Bureau. 2012. *Lao Social Indicator Survey 2011.* Vientiane.

[4] Ministry of Health. 2015. National Health Accounts for Fiscal Year 2011–2012. Vientiane.

four health workers (the target is at least five). Provincial health offices (PHOs) lack information on staff skills, health workforce development, and deployment plans. There is no functioning regulatory system for licensing and registration of health professionals. Private sector health care providers are concentrated in Vientiane and other major cities, and provide health services for the higher-income segment of the population. The regulation of the private health providers needs to be strengthened. Furthermore, while the planning and budgeting capacity of the Ministry of Health (MOH) has improved, the linkage between health service performance and budget allocation remains weak. Financial management systems do not capture the revenues generated by the sale of medicines and fees for services, which constitute about 50% of total revenues in health facilities (footnote 4). The development budget, including all budgets from aid-financed projects, is not disaggregated, and there is no institutionalized system of NHAs.[5]

6. **Government's sector strategy.** Since 2000, the government has introduced policies and strategies to guide health sector reforms aimed at achieving the MDGs, improving health financing and systems, setting standards, and strengthening health sector coordination. The government's Seventh National Socio-Economic Development Plan, 2011–2015 reflects its commitment to improve human development outcomes. To address key health sector constraints, in 2013 the National Assembly approved the HSRS, which aims to provide affordable, reliable, and accessible health services for all. A key objective of the HSRS is to improve (i) social protection for the poor, mothers, and children; and (ii) health service delivery. HSRS has identified a range of key governance, public sector management, and health program reforms to improve the performance and coverage of the health sector. It includes five priority areas: (i) health human resources development; (ii) health financing; (iii) organization and management; (iv) service delivery, with an emphasis on maternal and child care; and (v) information, monitoring, and evaluation. The objectives for 2025 UHC include (i) skilled health workers deployed in all health facilities according to needs, (ii) out of pocket expenses amount to less than 40% of total health expenditures, (iii) performance-based funding mechanisms are introduced, and (iv) health care quality assurance is introduced in all health facilities.

7. The National Assembly has committed to a target of 9% of general government expenditure for health. Expenditure for health increased to 7.5% of total government expenditure in FY2013, from 3% in FY2012; subsequently, the budget has fallen to an estimated 7% in FY2015. Critically, non-salary recurrent budgets at the provincial level have grown substantially (by a factor of 5–6) since FY2011. However, the system remains generally underfunded. External development assistance accounted for 35% of the total health expenditures in FY2014.

8. To make health services accessible to the poor, the government has introduced Health Equity Fund (HEF) schemes across the country.[6] HEF is a social protection scheme, targeting the poor as identified by village and district authorities. In 2014, the HEF schemes covered 46,870 poor families, or about 45% of all poor households.[7] The government uses the revenues generated by major hydroelectric investments to finance the social protection schemes, in conjunction with development partners. The government has also implemented a free maternal, neonatal, and child health care (MNCH) scheme, financed by a combination of government revenues and external assistance. However, the implementation, financial management, and

[5] NHAs describe the sources, uses, and channels for both public and private funds used in the health sector and are essential to optimize allocation and mobilization of health sector resources.

[6] The HEF, established in 2007, provides free public health care services for the poor by removing major barriers to health facility and/or health service access, such as transportation, the cost of pharmaceuticals, and other health care costs paid by those seeking care.

[7] Ministry of Health. 2014. *Summary Report on Implementation of Health Activities.* Vientiane.

monitoring mechanisms for these schemes differ, depending on the funding source. The government has established common rules, procedures, and management systems for the schemes to harmonize their implementation. It has created the National Health Insurance Bureau, which manages and coordinates the existing health insurance programs, HEF, and free MNCH. The government will progressively increase the number of beneficiaries of social health protection schemes and health insurance programs, which is the first step in moving towards providing health insurance to 80% of the population, one of the targets of the HSRS.

9. **Asian Development Bank value added in health sector.** The midterm review of the Asian Development Bank (ADB) Strategy 2020 recommends expanding operations in the health sector to 3%–5% of ADB's annual approvals.[8] ADB's country partnership strategy, 2012–2016, for the Lao PDR includes support to public financial management in the health sector.[9] The program is included in ADB's country operations business plan, 2015–2017 for the Lao PDR, and is aligned with the operational plan for health, 2015–2020.[10] ADB has supported health system development through several TA projects and programs focusing on governance and public financial management.[11] Previous ADB health projects and programs focused on infrastructure and staff capacity development in selected provinces, and helped to improve the health facility network and access to health services in these areas. Those interventions contributed to (i) establishing health service standards, (ii) provincial planning and budgeting, (iii) increasing the recurrent budget, (iv) human resource development, (v) MNCH policies, and (vi) financial management; ADB also has supported the HSRS through policy advisory TA that helped MOH develop a draft plan to implement health sector reforms.[12]

10. **Lessons.** Lessons from ADB engagement show the need for the government and development partners to develop and jointly finance national programs that focus on key health system constraints, rather than focusing on stand-alone projects. The design of the program will build on this previous work, informed by considerations of (i) alignment with government public sector management and health system reform priorities, and (ii) support to sustain ADB engagement on public sector management.

11. **Development partner coordination.** Major development partners in the health sector are the Global Fund for Malaria, AIDS, and Tuberculosis, the Japan International Cooperation Agency, the Luxembourg Development Agency, the World Bank, and the World Health Organization. The World Bank will support the HSRS through its Health, Governance, and Nutrition Development Program, a $13.2 million credit and $13.2 million grant in the form of parallel collaborative cofinancing, not administered by ADB.[13] It will coordinate with the program and will focus on health service delivery, including (i) strengthening the district health

[8] ADB. 2014. *Midterm Review of Strategy 2020: Meeting the Challenges of a Transforming Asia and Pacific.* Manila.
[9] ADB. 2011. *Country Partnership Strategy: Lao People's Democratic Republic, 2012–2016.* Manila.
[10] ADB. 2014. *Country Operations Business Plan: Lao People's Democratic Republic, 2015–2017.* Manila; ADB. 2015. *Operational Plan for Health, 2015–2020*. Manila.
[11] ADB. 2007. *Technical Assistance to the Lao People's Democratic Republic for Improved Public Financial Management Systems.* Manila; and ADB. 2012. *Report and Recommendation of the President to the Board of Directors: Proposed Programmatic Approach, Policy-Based Loan and Grant, and Grant Assistance for Subprogram 1 to the Lao People's Democratic Republic for the Governance and Capacity Development in Public Sector Management Program.* Manila.
[12] ADB. 2007. *Report and Recommendation of the President to the Board of Directors: Proposed Grant to the Lao People's Democratic Republic for the Health System Development Project.* Manila; and ADB. 2009. *Report and Recommendation of the President to the Board of Directors: Proposed Sector Development Program and Project—Asian Development Fund Grants to the Lao People's Democratic Republic for the Health Sector Development Program.* Manila; ADB. 2013. *Technical Assistance to the Lao People's Democratic Republic for the Health Sector Governance*. Manila.
[13] World Bank. 2015. *Lao PDR: Health Governance and Nutrition Development Project*. Washington, DC.

information system, (ii) operational and/or budget support for service delivery (basic package of services), and (iii) village-based nutrition improvements.[14]

12. **Key features of Health Sector Governance Program.** The program is part of ADB's consolidated support to the Lao PDR to help overcome major developmental challenges in the health sector and to lift health performance indicators as specified by the key MDGs targets. The use of a programmatic approach with a policy-based loan providing budget support and a TA loan for capacity development included in subprogram 1 leverages a longer term policy reform program in the health sector at the national and subnational levels. The programmatic approach comprises two subprograms that facilitate a concerted policy dialogue on the basis of an agreed policy matrix related to key health governance reforms and sector priorities. It will provide more effective and flexible ways to translate complex structural reform objectives into implementable policy actions. The program will improve the targeting accuracy and the coverage of poor families benefitting from the HEF scheme, increase the number of beneficiaries of the free MNCH scheme, and improve the financial management of the schemes to ensure value for money. The program focuses on chronologically sequenced reforms in line with the HSRS implementation plan, which includes reforms to improve health-related human resource management and overall public financial management of the health sector. The program achieves important socio-economic impacts. The first is the improvement in poor families access to healthcare through increased HEF scheme coverage. Second, improvement in public financial management will lead to gains from allocative efficiency. Third, improvement in human resources management will lead to better quality of health services. This should directly contribute to improve health outcomes.

B. Impact and Outcome

13. The impact will be UHC achieved by 2025. The outcome will be improved delivery of health services, particularly for the poor, women, and children. Subprogram 1 contains 15 policy actions of which eight are triggers, all of which have been accomplished. Subprogram 2 will continue and deepen reforms and contain 17 policy actions of which 11 are triggers, to be completed by July 2018.

C. Outputs

14. **Output 1: Health sector reform process improved.** Under subprogram 1, the government has established the National Commission on Health Sector Reform chaired by the vice-prime minister. The commission will oversee reform progress and remove or resolve any impediments to sustained implementation of reforms. The MOH has prepared a draft road map for HSRS implementation that details the key governance and public sector management reforms required to strengthen health human resource and health system financial management. The draft road map also sets out the TA and capacity development needed to design and implement the health reforms.

15. Under subprogram 2, the government will ensure that the National Commission on Health Sector Reform is fully resourced and continues to oversee and monitor HSRS implementation. The commission will approve and subsequently monitor annual HSRS implementation plans. The commission will approve the draft reform road map for strengthening health human resources and health system financial management and establish reform monitoring mechanisms for 2015–2025.

[14] Development Coordination (accessible from the list of linked documents in Appendix 2).

16. **Output 2: Implementation of the Health Equity Fund and free maternal, neonatal, and child health care schemes improved.** Under subprogram 1, the government has expanded the number of beneficiaries of HEF and free MNCH. By 2014, the HEF scheme covers 43% of poor families. The free MNCH scheme had been initiated in 88 districts for maternal care (out of a total of 146 districts). The MOH has harmonized the implementation guidelines for these social protection schemes. The National Health Insurance Bureau (under the MOH Department of Finance) will administer, coordinate, and develop the existing insurance program and social health protection schemes.

17. Under subprogram 2, the government will further implement these critical service delivery reforms and ensure their sustainability. The Ministry of Finance (MOF) will mobilize additional resources (government and official development assistance) to expand provision of free MNCH and HEF across the country. The target is that free MNCH services and HEF will be implemented in at least 131 districts by June 2018; by June 2019, HEF will cover 80% of poor families. The MOH will also undertake an impact assessment of the coverage, benefits, utilization, financial management, and provider-payment mechanism of the two social protection schemes after 2 years of program operation. The MOH will revise their implementation guidelines by July 2018 as appropriate.

18. **Output 3: Human resource management capacity strengthened.** Under subprogram 1, in 2014 the government increased the health workforce by 4,000 staff. The MOH has implemented a computerized provincial health personnel information system for better human resources management and planning. In recognition of the need for improved regulation of the health work force, the MOH has developed a competency framework for medical professions.

19. Under subprogram 2, the government will (i) improve the accuracy and enhance the capacity of the personnel information system with respect to information on training, gender, and ethnicity; and (ii) strengthen the capacity of the PHOs to use the information for management decision making. Each PHO will formulate and implement provincial workforce development plans designed to guide the training and deployment of staff in remote and hard-to-reach areas. In addition, the government, through the MOH, will issue appropriate decree(s) defining (i) a licensing and registration process for health professionals, including private sector health providers; and (ii) requirements for maintaining registration and accreditation.

20. **Output 4: Health sector financial management system strengthened.** Under subprogram 1, the MOH has developed staff capacity to adopt multiyear budgeting and a multiyear budget framework in preparation for implementation across the health sector. The MOH has issued implementation guidelines for Prime Minister Decree 349 that regulates use and accounting of health facility user fees. To improve information on mobilization and allocation of financial resources to the health sector, the MOH has produced and published NHAs for FY2011 and FY2012. To ensure timely and adequate allocation of funds to the PHOs and MOH departments, the MOF and the MOH are establishing a mechanism for adequate allocation and timely funding of free MNCH and HEF schemes, and of health service delivery.

21. For subprogram 2, the government, through the MOH, will adopt a system to monitor the source and application of funds at the health facility level; implementation will initially focus on district and provincial hospitals. The MOH will also establish a budget expenditure and disbursement monitoring system to document annual and quarterly expenditures and disbursement of provincial and central-level health department budgets. To improve decision making and transparency, the MOH will establish a new system for budgeting and monitoring development budget expenditures, including for all aid-financed projects. The MOH will also

institutionalize the production, publication, and distribution of NHAs for FY2013 and FY2014.

D. Development Financing Needs

22. To support its reform initiatives, the government has requested a loan in various currencies equivalent to SDR12,204,000 from ADB's Special Funds resources to help finance subprogram 1. The loan will have a 24-year term, including a grace period of 8 years, an interest rate of 1.0% per annum during the grace period and 1.5% per annum thereafter, and such other terms and conditions set forth in the draft loan agreement.

23. The loan amount for subprogram 1 takes into account the Lao PDR's increased fiscal space constraints and financing needs for development expenditure programs.[15] The size of the loan is based on the costs incurred by the government in implementing reforms. The government will use the local currency counterpart funds generated from this policy-based loan to support full implementation of the policy actions contained in the policy matrix and to ensure sustainability of the health reforms, with a focus on public financing for HEF and free MNCH schemes, health human resource management, and financial management improvements.[16] Para. 28 summarizes expected costs and benefits of the reforms, and the program impact assessment provides details.[17]

E. Implementation Arrangements

24. The executing agency for the program will be the MOH, Department of Planning and International Cooperation, which will be responsible for the overall coordination and disbursement of resources under the programmatic approach. The MOH departments of Finance, Training and Research, and Personnel, and the 18 provincial health departments will be the implementing agencies. As the executing agency, the MOH will be responsible for the overall implementation of subprogram 1 including disbursements, maintenance of all program records, and communicating with ADB on behalf of the government. The MOH steering committee, chaired by the minister of health and comprising vice ministers and representatives of MOH departments including the cabinet (which is responsible for oversight of health sector reform implementation) will provide overall guidance on program implementation.

25. **Tranches, disbursement, and counterpart funds.** The policy-based loan for subprogram 1 will be provided in a single tranche and the proceeds may be withdrawn upon loan effectiveness. The proceeds of the loan will be disbursed in accordance with ADB's simplified disbursement procedures for policy-based loans.[18] The loan proceeds will be used to finance the foreign exchange cost of items produced and procured in ADB member countries, excluding items included in a list of ineligible items, and imports financed by other bilateral and multilateral sources.[19] The implementation period of subprogram 1 is August 2013–July 2015. The loan closing date is 31 March 2016. Local currency generated from the loan will be directed

[15] The FY2015 deficit is estimated at 4.7% of gross domestic product, higher than the FY2014 estimated deficit of 4.2% of gross domestic product.
[16] Actual expenditures of the MOH increased in nominal terms from $64 million in FY2012 to $208 million in FY2014.
[17] Summary Program Impact Assessment (accessible from the list of linked documents in Appendix 2).
[18] ADB. 1998. *Simplification of Disbursement Procedures and Related Requirements for Program Loans*. Manila.
[19] List of Ineligible Items (accessible from the list of linked documents in Appendix 2). Loan proceeds disbursed against imports will require a certificate from the government stipulating that the value of the total imports of the Lao PDR, minus its imports from nonmember countries, ineligible imports, and imports financed under other official development assistance, is greater than the amount of the loan expected to be disbursed in FY2016–FY2018. ADB will have the right to audit the use of the loan proceeds and to verify the accuracy of the government's certification.

to the government's bank account to allow meeting the development financing needs for the FY2016–FY2018 budgets.

III. TECHNICAL ASSISTANCE

26. The government has requested a TA loan in various currencies equivalent to SDR4,307,000 from ADB's Special Funds resources (Asian Development Fund) to be implemented over 3 years to support the initial design and implementation of the reforms identified under subprogram 2.[20] The TA is estimated to cost $6.25 million, of which ADB will finance $6 million equivalent for consulting services, goods, including applicable taxes, duties, and bank charges, as well as project management support expenses. The TA loan will have a 32-year term, including a grace period of 8 years, an interest rate of 1.0% per annum during the grace period and 1.5% per annum thereafter, and such other terms and conditions set forth in the draft TA loan agreement. The government will provide $0.25 million equivalent through in-kind contributions (counterpart staff and various facilities). The TA loan financing plan and investment plan are summarized in Tables 1 and 2.

Table 1: Financing Plan

Source	**Amount** ($ million)	**Share of Total** (%)
Asian Development Bank	6.000	96.0
Government	0.250	4.0
Total	**6.250**	**100.0**

Source: Asian Development Bank estimates.

Table 2: Investment Plan ($'000)

	Item	**Amount**
A.	**Base Cost**[a]	
	1. Health sector reform process improved	155.4
	2. Implementation of the Health Equity Fund and free maternal, neonatal, and child health care schemes improved	767.2
	3. Human resources management capacity strengthened	831.7
	4. Health sector financial management system strengthened	3,955.2
	Subtotal (A)	**5,709.5**
B.	**Contingencies**[c]	**367.4**
C.	**Financial Charges**[d]	**173.1**
	Total (A+B+C)	**6,250.0**

[a] Including taxes and duties of $0.76 million to be financed by the government and the Asian Development Bank.
[b] In May 2015 prices.
[c] Physical contingencies are computed at 3.0% of base costs. Price contingencies are computed at an average of 1.4% on foreign exchange costs and an average of 4.5% on local currency costs.
[d] Interest during implementation for the Asian Development Bank loan is computed at 1% per annum, and will be capitalized in the loan amount.

Source: Asian Development Bank estimates.

27. The TA loan will support the program outputs. Under output 1, the TA loan will assist the cabinet to plan and to monitor the progress and effectiveness of the health sector reform. Under output 2, the TA loan will support the MOH and the PHOs to implement, monitor, and evaluate the HEF and free MNCH schemes. Under output 3, the TA loan will help the PHOs to develop human resources workforce development plans and improve the electronic health personnel management information system. Under output 4, the TA loan will support the MOH Department

[20] ADB will finance taxes and duties for this TA loan as (i) the amount will be within the reasonable threshold identified during the preparation process of the country partnership strategy, (ii) the amount will not represent an excessive share of the investment plan, (iii) the taxes and duties apply only to ADB-financed expenditures, and (iv) the financing of the taxes and duties is material and relevant to the success of the project.

of Finance to enhance the provincial planning and annual budget process, to document the sources and application of funds collected and used by the health facilities, and to develop a new budget and expenditure-reporting process that documents both budgets and expenditures in a standard format for all domestically and development partner-financed projects. The project administration manual (PAM) describes the proposed activities under the TA loan.[21] Goods will be procured in accordance with ADB Procurement Guidelines (2015, as amended from time to time), and consultants will be recruited in accordance with ADB Guidelines on the Use of Consultants (2013, as amended from time to time). The implementation arrangements are summarized in Table 3.

Table 3: Implementation Arrangements

Aspects	**Arrangements**		
Implementation period	October 2015–September 2018		
Estimated completion date	30 September 2018; closing date: 31 March 2019		
Management			
(i) Oversight body	MOH steering committee chaired by the minister of health		
(ii) Executing agency	MOH, Department of Planning and International Cooperation		
(iii) Key implementing agencies	Three MOH departments (DTR, DOF, DOP) and 18 provincial health offices		
(iv) Implementation unit	National Program Coordination Office in MOH		
Procurement	National competitive bidding	4 contracts	$650,000
	Shopping	2 contracts	$150,000
Consulting services	Consultants qualifications selection	2 contracts	$775,000
	Individual consultant selection	225 person-months	$1,302,000
Advance action	Preparation of international, national consultants, and consulting firm recruitment		
Disbursement	The loan proceeds will be disbursed in accordance with ADB's *Loan Disbursement Handbook* (2015, as amended from time to time) and detailed arrangements agreed upon between the government and ADB.		

ADB = Asian Development Bank, DOF = Department of Finance, DOP = Department of Personnel, DTR = Department of Training and Research, MOH = Ministry of Health.
Sources: Government of the Lao People's Democratic Republic and Asian Development Bank.

IV. DUE DILIGENCE

A. Economic and Financial

28. Subprogram 1 will generate economic gains through successful implementation of medium-term policy actions, as described in the Summary Program Impact Assessment (footnote 17). There should be significant gains through improved allocative efficiency, and increased government budget allocations to health that are expected to provide higher rates of socioeconomic return than most other potential uses of budgetary resources. The potential benefits include (i) removal of financial barriers to health service access as a consequence of national implementation of the HEF and MNCH schemes; and (ii) improved quality of services resulting from (a) better distribution of key staff through the health system; and (b) an improved nonsalary budget, which will enable improved outreach and better-quality facilities to support the health services provided. The policy costs to the government are conservatively estimated as a lump sum of $141 million. The costs of the reforms estimated are primarily (i) the short to medium-term costs to the government of administering and enforcing reforms ($12 million); and (ii) the direct fiscal costs of selected reforms, including the costs of service delivery reforms implementation, in concert with governance and public sector management reforms designed to ensure improved service delivery ($129 million).[22]

[21] Project Administration Manual (accessible from the list of linked documents in Appendix 2).
[22] Including the expansion of the workforce by 4,000 ($60 million), additional administrative staff in the provinces ($3 million), implementation of free MNCH and HEF schemes ($33 million), and sustained, improved service quality ($33 million).

B. Governance

29. The overall assessment of fiduciary risk, including for the health sector in the Lao PDR, has been assessed as high to medium, due mainly to (i) insufficient control over revenue collected and expenditures undertaken by provincial governments; (ii) inadequate resources and capacity of state audit organizations, which undermines the independence and effectiveness of oversight institutions; (iii) a weak procurement framework, and lack of regulations for implementation; (iv) corruption (the United Nations Convention Against Corruption is insufficient as a deterrent); and (v) lack of effectiveness of the Inspection Authority. To address these risks, the government has (i) set out the law, implementing decree, framework, and timetable for improving budgetary management; (ii) strengthened the independence and capacity of the state audit organization; (iii) issued a new procurement decree and implementing rules and regulations, a standard procurement manual, and standard bidding documents; and (iv) adopted the Law on Anti-Corruption, Law on State Inspection, and Law on Complaints and State Audit. The TA loan will provide support for the introduction and development of results-based planning, budgeting, financial management systems, reporting, and verification as part of health sector reform at national and subnational levels.

30. The ADB Anticorruption Policy (1998, as amended to date) was explained to and discussed with the government and the MOH, who are familiar with it. The government Anti-Corruption Unit has made some progress but faces challenges with regard to operational effectiveness, carrying out anticorruption activities, and implementing the Anti-Corruption Law systematically. The program will support specific human resource and planning, budgeting, and expenditure-monitoring reforms that will improve information and the transparency of finance and human resource allocations within the health sector. The specific policy requirements and supplementary measures are described in the PAM (footnote 21).

C. Poverty and Social

31. The reforms supported by the program are expected to lower the incidence of poverty, particularly among women and children, by expanding the provision of free health services for the poor and free MNCH services. In addition, financial and human resource management reforms will increase deployment of health staff to remote areas with the greatest needs in support of quality service delivery. The program will support gender and equity policies to (i) ensure access by poor women to the HEF, and (ii) promote recruitment and retention of female and ethnic group staff in remote and disadvantaged rural areas. It is classified as gender equity.

D. Safeguards

32. The program is expected to have no environmental impact and will not include new land acquisition. Therefore, it is classified category C for environment and involuntary resettlement safeguards. A resettlement framework has been prepared to screen program activities that would cause involuntary resettlement impacts, including temporary land acquisition and/or economic displacement of people. Similarly, an environmental assessment and review framework includes a checklist to exclude activities with negative environment impacts. The program includes positive impacts on ethnic groups and is classified category B for indigenous peoples. An indigenous peoples planning framework ensures that (i) ethnic peoples' needs will be analyzed, and (ii) ethnic peoples will fully participate in the project and have equal access to its benefits. A matrix of the potential impacts of each policy action on indigenous people, together with appropriate mitigation measures, has been prepared.

E. Risks and Mitigating Measures

33. The risk for subprogram 1 is assessed as medium. Major risks include macroeconomic imbalances, poor public financial management and accountability mechanisms, limited capacity for public procurement, and corruption. Responsibilities of MOH departments and the PHOs are overlapping and MOH has limited capacity to implement the reforms at all levels. The capacity within the MOF and sector ministries to prepare budgets is not yet fully developed, and the budget–policy linkage is weak. The MOH, and the government more generally, have shown significant commitment to health sector reform through the development of the HSRS and the program. An ADB-funded project supports the MOF and other line ministries in budget planning and in improving the intergovernmental fiscal transfer systems. The program will strengthen key public finance management systems within MOH, including planning and budgeting. The integrated benefits and impacts are expected to outweigh the costs of the program. Major risks and mitigating measures are described in detail in the risk assessment and risk management plan.[23]

V. ASSURANCES

34. The government and the MOH have assured ADB that implementation of the program shall conform to all applicable ADB policies including those concerning anticorruption measures, safeguards, gender, procurement, consulting services, and disbursement as described in detail in the PAM and the loan agreements.

VI. RECOMMENDATION

35. I am satisfied that the proposed programmatic approach and loans would comply with the Articles of Agreement of the Asian Development Bank (ADB) and recommend that the Board approve

(i) the programmatic approach for the Health Sector Governance Program;

(ii) the policy-based loan in various currencies equivalent to SDR12,204,000 to the Lao People's Democratic Republic for subprogram 1 of the Health Sector Governance Program, from ADB's Special Funds resources, with an interest charge at the rate of 1.0% per annum during the grace period and 1.5% per annum thereafter; for a term of 24 years, including a grace period of 8 years; and such other terms and conditions as are substantially in accordance with those set forth in the draft loan agreement presented to the Board; and

(iii) the technical assistance loan in various currencies equivalent to SDR4,307,000 to the Lao People's Democratic Republic for subprogram 1 of the Health Sector Governance Program, from ADB's Special Funds resources, with an interest charge at the rate of 1.0% per annum during the grace period and 1.5% per annum thereafter; for a term of 32 years, including a grace period of 8 years; and such other terms and conditions as are substantially in accordance with those set forth in the draft loan agreement presented to the Board.

Takehiko Nakao
President

25 August 2015

[23] Risk Assessment and Risk Management Plan (accessible from the list of linked documents in Appendix 2).

DESIGN AND MONITORING FRAMEWORK

Impact the Health Sector Governance Program is aligned with:

Universal health coverage achieved by 2025 (Health Sector Reform Strategy)[a]

Results Chain	Performance Indicators with Targets and Baselines	Data Sources and Reporting Mechanisms	Risks
Outcome Health service delivery, particularly for the poor, women, and children, improved	a. By June 2019, 80% of the poor are covered by the HEF scheme (2014 baseline: 43% of the poor covered by the HEF scheme) b. By June 2019, 80% of health centers will have at least one midwife (2013 baseline: 33%)	a. Annual report of the Health Insurance Bureau b. Annual provincial health human resources plans	Macroeconomic imbalances might constrain the planned health budget allocation increase. Patronage and corruption undermine program reforms. The MOH stopped investing in health infrastructure and equipment in rural areas.
Outputs 1. Health sector reform process improved	1a. National Commission on Health Sector Reform approves health sector reform annual implementation plans for FY2017 and FY2018 (baseline: not applicable) 1b. By June 2016, the MOH endorses the road map for implementation of human resource and financial management reforms. (baseline: not applicable)	1a. Minutes of meeting issued by commission's secretariat 1b. MOH decree	Fragmented roles and responsibilities between the MOH, provincial health offices, and provincial authorities Fragmentation of the administrative structure and overlapping responsibilities within the MOH High management staff turnover due to job market pressure
2. Implementation of the HEF and free MNCH schemes improved	2a. By June 2018, at least 131 districts have implemented the HEF program under the national policies and guidelines (2014 baseline: 88 districts) 2b. By June 2018, at least 131 districts apply the free MNCH policy under the national policies and guidelines (2014 baseline: 110 districts) 2c. By June 2018, the MOH has conducted an evaluation of the inclusiveness, efficiency, and impact of the HEF and free MNCH programs (baseline: not applicable)	2a–b. Annual report of the Health Insurance Bureau 2c. Evaluation report produced in June 2018	

Results Chain	Performance Indicators with Targets and Baselines	Data Sources and Reporting Mechanisms	Risks
3. Human resources management capacity strengthened	3a. During FY2018, at least 13 provinces have submitted timely annual updates of their health staff skill database, including data on gender and ethnicity (baseline: not applicable) 3b. By June 2018, at least 13 provinces formulate annual health human resource workforce plans, which include gender and ethnicity dimensions (2013 baseline: 0 provinces) 3c. By June 2018, the MOH has issued a decree for the licensing of health professionals (2017 baseline: no existing decree)	3a. Annual provincial reports 3b. Annual provincial health human resource workforce plans 3c. MOH decree	
4. Health sector financial management system strengthened	4a. System established to account for sources and application of funds, by August 2018 (baseline: system not established) 4b. By June 2018, at least 13 provinces produce quarterly financial reports, according to national guidelines, and integrate all sources of funds (2013 baseline: 0) 4c. NHAs for FY2013 and FY2014 published by June 2018 (baseline: NHAs for FY2011 and FY2012 published)	4a. Published reports by the MOH Finance Department on facility collection of revenues and use of funds 4b. Provincial quarterly financial reports 4c. MOH Department of Finance annual NHA report	

Key Activities with Milestones
(Not applicable; refer to Appendix 4: Policy Matrix)

Inputs
Subprogram 1
Asian Development Bank:
Program ADF Loan: $17 million
Technical Assistance ADF Loan: $6 million

Subprogram 2
Asian Development Bank:
Program ADF loan: estimated at $15.0 million (to be confirmed in 2017)

Government:
$0.25 million in-kind

Assumptions for Partner Financing

Outputs necessary to reach the design and monitoring framework outcome that are not administered by ADB include the World Bank Group's Lao Health Governance and Nutrition Development Project. Components of the World Bank project include (i) MOH information management system improved; (ii) reproductive, MNCH, and nutrition services strengthened; and (iii) nutrition and health-related social and behavior change communication activities implemented.

ADB = Asian Development Bank; ADF = Asian Development Fund; FY = fiscal year; HEF = Health Equity Fund; MNCH = maternal, neonatal, and child health care; MOH = Ministry of Health; NHA = National Health Account.

[a] MOH. 2013. *Health Sector Reform Strategy, 2013–2025*. Vientiane.

Source: Asian Development Bank.

LIST OF LINKED DOCUMENTS

http://www.adb.org/Documents/RRPs/?id=47137-003-3

1. Loan Agreement: Policy-Based Loan
2. Loan Agreement: Technical Assistance Loan
3. Sector Assessment (Summary): Health Sector
4. Project Administration Manual
5. Contribution to the ADB Results Framework
6. Development Coordination
7. Country Economic Indicators
8. International Monetary Fund Assessment Letter
9. Summary Poverty Reduction and Social Strategy
10. Gender Action Plan
11. Environmental Assessment and Review Framework
12. Resettlement Framework
13. Indigenous Peoples Planning Framework
14. Risk Assessment and Risk Management Plan
15. List of Ineligible Items

Supplementary Document

16. Summary Program Impact Assessment

LAO PEOPLE'S DEMOCRATIC REPUBLIC
Peace Independence Democracy Unity Prosperity
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Ministry of Finance

No. 2708 -/MOF
Vientiane, date. 12 AUG 2015

H.E. Mr. Takehiko Nakao
President
Asian Development Bank
Manila, Philippines

Subject: Development Policy Letter – Lao PDR: Health Sector Governance Program

Your Excellency,

This letter highlights the Lao PDR Government's (the Government), continued commitment to governance reform and improvement of health system performance. I would like to thank the Asian Development Bank (ADB) for the sustained support through significant financial resources and technical assistance to the Government's health sector and in its support of our efforts to strengthen health sector governance, particularly financial management and human resource management within the sector. These are critical areas which will enable improved and more cost-effective health services delivery and enhanced protection of the poor, mothers to be and children. The Government has continued to accord high priority to its own resource allocations to the health sector and to ensuring access to quality health services, especially for women, children and ethnic groups. The focus on health sector governance will enable key systems to be enhanced, which in turn, will significantly improve health sector capacity to use increased health resources more efficiently and cost-effectively.

I would like to request financial assistance from ADB in the form of an $17 million loan to support and maintain subprogram 1 policy initiatives which have been implemented from August 2013 to July 2015 and a $6 million technical assistance loan for institutional and capacity development to facilitate implementation health sector reforms, including the detailed design of specific reform actions for subprogram 2. The policy initiatives under subprogram 1 and subprogram 2 (together the "Program") are described in the attached policy matrix. I also acknowledge the close cooperation and coordination between the Government, ADB and the World Bank in the support of the national health sector reform.

The seventh National Socio-Economic Development Plan (NSEDP7) 2011-2015, aims to achieve sustainable economic growth, and achieve the Millennium Development Goals (MDGs), including poverty reduction. While growth faltered through the Asian financial

crisis the economy has grown at an average of 8% per annum during 2011 and 2013 and is expected to grow at 7.4% in 2014 and 7.5 % in 2015, meaning that real GDP per capita has been growing significantly and providing a sound base for improved living standards and reduced poverty levels. As a consequence of this sustained growth, poverty incidence is at 23.2% in 2012-13 significantly down from 46% in 1992-93. Further, industry and services have grown in importance with a gradual shift away from agriculture which accounts for about 30% of GDP compared to 60% in 1990. Nevertheless, agriculture remains the mainstay of livelihoods in the economy for the vast majority (80%) of the population where productivity and income levels remain stubbornly low. Poverty thus remains predominately rural, with high concentrations in the remote and mountainous north-eastern and eastern borders with Viet Nam. This is a critical context for the design of appropriate health programs for our population. The NSEDP7 affirmed the clear link between good governance and broader development effectiveness. The government sees a well functioning health sector one which meets the need of the poor and rural communities as a fundamental pre-requisite of development and improved health service delivery. It also acknowledges that while very significant progress in health outcomes has been made in recent years major challenges remain including in meeting the health related MDGs.

The Seventh Health Sector Development Plan 2011-2015 and the draft Eighth Plan 2016-2020 both recognize that a significant lack of resources and capacity constraints have undermined the effectiveness of public sector management at all levels of the health system. The Health Sector Reform Strategy 2013-2025 (HSRS), endorsed by the National Assembly in December 2012, aims to: (i) improve access to basic health care and financial protection by 2020; and (ii) achieve universal health coverage by 2025 through improved public resources efficiency and expanded health financing. The HSRS identifies five priority areas to improve governance and the transparency of the health system including human resources development; health financing, organization and management, services delivery, with emphasis on maternal and child care, and health information, monitoring and evaluation. The HSRS recognizes the need to develop key government systems particularly in human resources and financial management both of which are prerequisite to improved service delivery and improved efficiency with which services are provided.

In order to achieve these objectives the government has implemented governance reforms (see below) and is committed to allocating additional resources to the sector. The government has significantly increased resources allocated to the health sector over recent years and broadly sustained them during the subprogram 1 period August 2013 to July 2015. Total government expenditure on health as a percentage of total government expenditures has increased from 3.0% in fiscal year (FY) 2012, to 7.5% in FY13 although this did decline to 7.3% and the health budget for FY15 is 7% of planned total government expenditure. However, domestic resources available for health increased almost 4 times from an average of KIP 301,000 million per year over the three year period FY10 to FY12 to an average of KIP 1,190,000 million over the three year period FY13 to FY15. Significantly, major increases were also made for key quality enhancing non salary budgets over this period resources which are key to improved health service delivery and enhanced outreach to those not within easy reach of a health facility.

The establishment of key reform initiatives documented in the policy matrix for subprogram 1 have been completed over the past two years. We are committed to achieving the key reform initiatives for subprogram 2 over the next three years as also identified in the attached policy matrix. These actions will contribute strongly to the larger longer term national governance reform agenda of the Government for the health sector. We therefore request support from the ADB through the Health Sector Governance Program, subprogram 1 to assist the key reform initiatives that we have implemented. As initial steps, we have already completed reform initiatives under subprogram 1 of the Health Sector Governance Program and the following is a brief summary of those completed actions together with an outline of the direction of reforms under subprogram 2.

Health sector reform process improved. The government has begun implementing key aspects of the HSRS and notwithstanding the challenges fully intends to vigorously prosecute implementation of the prioritized reform program outlined in the HSRS and in the "Road Map" (see below). Specifically, a National Commission on Health Sector Reform has been established (Prime Minister Decree 29/GOV of January 2014) to assist the government and the Prime Minister to implement the HSRS. In November 2013, the government has endorsed the Health Sector Reform Framework, which is the guiding document to the implementation of the HSR Strategy with policy matrix and strategic planning matrix. As part of the HSRS implementation the Ministry of Health (MOH), on behalf of the Government, has drafted and initiated for final internal review a draft "road map" describing the key medium-term reforms to be implemented particularly those related to strengthening health human resources and health system financial management including their sequencing, technical assistance and capacity development requirements.

The National Commission will review and approve annual health sector reform implementation plans. MOH will approve the "roadmap" for reforms associated with strengthening health human resources and health system financial management and monitor their implementation

Implementation of the health equity fund (HEF) and free maternal, neonatal, and child health care (MNCH) schemes improved. Government is strongly committed to improved social protection for the vulnerable and improved health care, particularly for mothers and children. As a decisive step towards achieving universal health care, the government through MOH has established: (i) free delivery of maternal, neonatal and child health care (Free MNCH); and (ii) free health services for the poor through Health Equity Funds (HEF) which will be rolled out nationally. The HEF safety net now covers about 46,870 poor families an estimated 43% of the total poor families. Free MNCH was rolled out in 88 districts for maternal care out of a total of 146 districts. Both programs reimburse health facilities for the fees forgone from the provision of the specified health services and pay some key costs for accessing services in specific circumstances thereby significantly reducing the financial barriers for the poor, mothers and children to access health care. The MOH has agreed the role for the Health Insurance Bureau, recently established and located within the MOH Department of Finance, in a pilot in two provinces.

The Government, through MOH, will mobilize the resources required to scale up the provision of Free MNCH and HEF across the country. MOH will continue improving governance arrangements and strengthening management capacity of the Health Insurance Bureau, and undertake a review of implementation experience of the two national programs by September 2018.

Health human resources management capacity strengthened. The Government recognizes that the quantity and the quality of human resources in the health sector are critical to the capacity of the health sector to deliver quality services. In recognition of this the government approved, through the Ministry of Home Affairs, the MOH request for 4,000 additional health staff in 2014 notwithstanding the macroeconomic constraints and wage freeze. This significantly relieved the general understaffing of health facilities. The Government recognizes that there remain very significant skill gaps due to shortages and mismatches between training programs and demand by provincial health services (e.g. midwives and skilled staff with birthing skills) and that health worker skills need to be improved. Further, there is no functioning regulatory system licensing and the registration of health professions. As part of the governance and management reform necessary to redress this situation MOH, has further rolled out a computerized Health Personnel Management Information System in the provinces which provides information on the number, allocation and skills of health staff. Further, in 2013 and 2014, the MOH has further developed the quality standards of health education institutions and improved training curricula for medical professions.

The MOH will improve the accuracy of the Health Personnel Management Information System and provincial health offices will formulate and implement workforce plans to guide the allocation, management and education of health personnel with emphasis on deployment of staff in remote and hard to reach areas. Recognizing the need for skilled staff in primary health care facilities, the MOH is committed to increase the number of midwives in the health centers to ensure that at least 75% of the health centers are staffed with at least one midwife by July 2018. The MOH will operationalize and resource the Health Professional Council and its boards and issue a decree defining the licensing and registration system for health professionals.

Health sector financial management strengthened. The Government recognizes that a significant lack of resources and capacity constraints driven in large part by a lack of fundamental governance/management systems which have undermined the effectiveness of public sector management at all levels of the health system. In particular, the MOH recognizes the need to develop financial management systems within their control as a prerequisite to improved service delivery and improved efficiency with which services are provided. Specifically, existing planning, budget and accounting systems do not fully cover the whole of budget resources made available to the public health system or resources available to health facilities from fee collections the latter which accounts for a large part of resources available to public health facilities. To redress this situation a decree has been issued by the Prime Minister (No 349/Gov) on the management and use of service charges collected at the health facility level. This was supplemented by an implementation decree issued by the Minister of Health designed operationalize decree 349. The MOH has strengthened staff capacity to adopt multi-year budgeting and budget framework. MOH also

produced and published NHA for FY 2010 and FY 2011 to document available knowledge on the sources and the utilization of funds at the national and provincial levels of the health system. To ensure adequate allocation and timely funding support to provincial health offices and MOH relevant departments, the MOF and the MOH have initiated dialogue on establishing efficient and sustainable mechanism for adequate allocation and timely funding support to provincial health offices and MOH key departments for free MNCH, HEF and health service delivery.

For FY 2016 and subsequent years the Government will ensure an increased health budget allocation compared to FY 2015 allocation. MOH will also adopt a new system to account for the sources and application of funds at the health facility level, and establish a quarterly and annual expenditure and disbursement monitoring system for the MOH budget and a set of procedures to align development partner financing with government plans and budgets consistent with the Government Chart of Accounts.

Conclusion

The Government will use the funds generated by the Program loan to support full implementation of the policy actions contained in the policy matrix and to maintain such actions thereafter.

The key reform initiatives undertaken by the Government, through various Departments of the MOH and at the provincial level (where the ultimate impact of the reforms will enable improved service delivery), under subprogram 1 of the Health Sector Governance Program as outlined above, are far from exhaustive. They contribute only in some measure to the larger reform agenda envisioned by the HSRS. We are nevertheless confident that the reform initiatives supported under subprogram 1 and those anticipated under subprogram 2 are focused on strategic areas, and are expected to have long-term impact in strengthening public sector management within MOH. The Government is keen to work with the ADB over the medium term as these reforms take time to succeed. We therefore would appreciate prompt consideration of this proposed loan and look forward to working together with ADB to meet our shared development objectives.

We look forward to continuing partnership with ADB to assist Lao PDR in meeting our development objectives.

Please, Your Excellency, accept the assurances of our highest consideration.

Yours sincerely

Minister Dr.Liane THYKEO
Ministry of Finance

POLICY MATRIX

Outputs	Subprogram 1 Policy Actions (August 2013 to July 2015) (triggers are in bold)	Indicative Policy Actions for Subprogram 2 (August 2015 to July 2018) (triggers are in bold)	Medium-Term Objectives of the Health Sector Reform Framework (phase 2016–2020)
1. Health sector reform process improved	**1.1 The government has established the National Commission on Health Sector Reform (HSR) to steer and to facilitate implementation of the Health Sector Reform Strategy.** **1.2 The government has endorsed the Health Sector Reform Framework (HSRF), describing the reform implementation process for 2013–2025.** 1.3 The government has drafted and initiated internal review of the roadmap describing key reforms in strengthening health human resources and health system financial management, including their sequencing, and technical assistance and capacity development requirements.	**1.1 The National Commission is functioning through periodic meetings and approves annual HSR implementation plan, as part of the Ministry of Health (MOH) implementation plan** **1.2 MOH to approve the roadmap for reforms in strengthening health human resources and health system financial management, and to establish monitoring mechanism of the reforms for the period 2015–2025.**	The phase 2016–2020 of the HSR aims to ensure that essential services of reasonably good quality are accessible and utilized by majority of the population.
2. Implementation of the health equity fund (HEF) and free maternal, neonatal, and child health care (MNCH) schemes improved	2.1 By September 2014, the government has rolled out the free MNCH program in 88 districts for maternal care (out of 146 districts); and has extended the coverage under the HEF safety net program to 46,870 poor families in 110 districts (43% of poor families).[a] 2.2 The MOH has clarified the role of the Health Insurance Bureau (HIB) as administrator of the five existing social health protection schemes.[b] 2.3 MOH has strengthened the capacity of the HIB on financial management, processing and verification of claims, including training of HIB staff on costing; and has established HIB branches in 2 pilot provinces.	**2.1. The government will continue to provide increased financial resources to deliver MNCH services free of charge for users and HEF for the poor in at least 131 districts, within the agreed framework with development partners.** 2.2 MOH to continue improving governance arrangements and strengthening management and financial capacity of the HIB and its provincial branches, including training of staff. **2.3 MOH to assess financial management, monitoring and health provider payment mechanisms of the existing free MNCH and HEF schemes and develop recommendations for improvements of the existing schemes and/or prepare revisions of relevant implementation guidelines.**	The Government will (i) by 2020, increase coverage of the social health protection schemes to 80% through effective implementation of the national decree on health insurance; and (ii) by 2015 ensure that all MNCH services are free of charge to users nationwide. *(HSRF Priority Area 2: Health Financing)* The out of pocket expenditures is 35% of the total health expenditure. *(HSRF Priority Area 2: Health Financing)*

Outputs	Subprogram 1 Policy Actions (August 2013 to July 2015) (triggers are in bold)	Indicative Policy Actions for Subprogram 2 (August 2015 to July 2018) (triggers are in bold)	Medium-Term Objectives of the Health Sector Reform Framework (phase 2016–2020)
	2.4 To streamline uniformity of HEF and free MNCH schemes, the MOH has harmonized their implementation guidelines for nationwide application.		
3. Health human resources management capacity strengthened	**3.1 The MOH has rolled out the computerized health personnel management information system (HPMIS) in the provinces, to facilitate provision of annually updated information on number, allocation and skills of the health staff.** **3.2 The government has increased the quota for health staff by at least 4,000 to ensure availability of adequate health personnel staffing in the provinces, including the increase of community midwives from 747 in 2013 to 1,020 in 2014.** 3.3 The MOH has defined quality standards for medical education institutions and approved competency standards for medical professions (including dentistry) to be included in the training curricula.	3.1 MOH to continue improvement of the HPMIS, including data related to skills, training, gender and ethnicity, and to strengthen capacity of the provincial health offices in utilizing the HPMIS data for planning and management purposes. **3.2 To ensure appropriate staffing level of health facilities with emphasis on deployment of staff in remote and hard to reach areas, each provincial health office to formulate and implement its workforce plan (including, gender and equity policies and appropriate staff incentives).** **3.3 The MOH will gradually increase the deployment of midwives to ensure that 75% of health centers are staffed with at least one community midwife.** 3.4 MOH to ensure allocation and provision of adequate financial and human capital resources, as well as expertise and management, to the Health Professional Council and its boards to enable their delivery of mandated function and responsibilities as stipulated in the Health Law. **3.5 To further enhance skills and qualification of health care professionals, MOH to issue decree defining certification standards, accreditation, licensing, and registration system for health professionals.**	By 2020, all health centers will have been staffed in accordance with the health coverage plan: (i) Health centers will have at least mid-levels health workers, including at least one midwife. (ii) District and provincial hospitals will have at least the minimum staffing level and specialist defined in the health coverage plan. *(HSRF Priority Area 1: Human Resources for Health)*

Outputs	Subprogram 1 Policy Actions (August 2013 to July 2015) (triggers are in bold)	Indicative Policy Actions for Subprogram 2 (August 2015 to July 2018) (triggers are in bold)	Medium-Term Objectives of the Health Sector Reform Framework (phase 2016–2020)
4. Health sector financial management system strengthened	4.1 In 2014, MOH has strengthened staff capacity to adopt multi-year budgeting and budget framework.	**4.1 For FY2016 and subsequent years, the Government will ensure an increased health budget allocation compared to the FY2015 budget allocation.**	Domestically financed health expenditures are not less than 9% of General Government Expenditure (GGE) from 2015 and rise to 13% by 2025
	4.2 To improve transparency and accountability of public finances, the government has approved rules and regulations for the collection, accounting and utilization of the money collected from service charges by publicly owned health facilities.	**4.2 To enhance monitoring of public finances in the health facilities, MOH to adopt and implement a system to account for sources and application of all funds at the health facility level.**	General Government Health Expenditure (including ODA channeled through the government system) is efficiently managed and monitored at all levels. *(HSRF Priority Area 2: Health financing)*
	4.3 MOH has issued Implementation Guidelines for the collection, accounting and utilization of the money collected from health service charges.	4.3 MOH to initiate implementation of the system to account for sources and application of funds for selected facilities with an initial focus on district and provincial level hospitals in at least five provinces.	
	4.4 To improve health expenditures transparency, MOH has prepared and published National Health Accounts (NHA) for FY2011, and FY2012 detailing health sector funding, its sources, and utilization at national and sub-national levels.[c]	4.4 MOH to continue to publish NHA for FY2013 and FY2014.	
		4.5 To improve budget planning and to facilitate its execution, MOH to establish an expenditure monitoring system to document annual and quarterly expenditure reports of provinces and central level health departments together with reports on budget disbursements.	
		4.6 MOH to adopt a new system and set of procedures to align development partner financing with government plans and budget, consistent with Government chart of accounts.[d]	

Outputs	Subprogram 1 Policy Actions (August 2013 to July 2015) (triggers are in bold)	Indicative Policy Actions for Subprogram 2 (August 2015 to July 2018) (triggers are in bold)	Medium-Term Objectives of the Health Sector Reform Framework (phase 2016–2020)
	4.5 The Ministry of Finance (MOF) and MOH has initiated dialogue on establishing efficient and sustainable mechanism for adequate allocation and timely funding support to provincial health offices and MOH relevant departments for free MNCH, HEF and health service delivery.	**4.7 To improve financial sustainability of health sector operations; MOF to adopt a mechanism for adequate allocation and timely funding support to provincial health offices and MOH key departments for free MNCH, HEF and health service delivery.**	

[a] The Health Equity Fund, established in 2007, is a social protection scheme which provides free public health care services for the poor by removing major barriers to health facilities and/or health services access such as transportation and costs of pharmaceuticals and other health care costs paid by those seeking care.

[b] The Prime Minister Decree on Health Insurance (470/GO October 2012) mandates that the Health Insurance Bureau will administer the five existing social health protection schemes [three health insurance schemes: (i) State Authority for Social Security (SASS) for civil servants, (ii) Social Security Organization for private sector employees (SSO), and (iii) Community Based Health Insurance (CBHI) - and two safety nets arrangements (HEF and Free MNCH)].

[c] National health accounts describe expenditure flows both public and private within the health sector. They describe the sources, uses, and channels for all funds utilized in the health sector and are a basic requirement for optimal management of the allocation and mobilization of health sector resources.

[d] In fiscal year 2014, 35% of the total government health expenditure has been financed through investment budget category as either foreign or domestically financed projects. However, the budget and accounting system only monitors budgets and expenditures by aggregate project totals with no breakdown of how the money is spent by inputs or program (as with the rest of the government budget). It is known that many of these projects (development partner- and government-financed) include significant recurrent costs and are not just of a capital nature.

Source: Asian Development Bank.