ADB

Report and Recommendation of the President to the Board of Directors

Project Number: 47137-006
March 2018

Proposed Policy-Based Grant for Subprogram 2 Lao People's Democratic Republic: Health Sector Governance Program

Asian Development Bank

CURRENCY EQUIVALENTS

(as of 26 March 2018)

Currency unit	–	kip (KN)
KN1.00	=	$0.0001205182
$1.00	=	KN8,297

ABBREVIATIONS

ADB	–	Asian Development Bank
FMNCH	–	free maternal, newborn, and child health care
GDP	–	gross domestic product
GGE	–	general government expenditure
HEF	–	health equity fund
HPMIS	–	health personnel management information system
HSDP	–	Health Sector Development Plan
HSR	–	health sector reform
HSRS	–	Health Sector Reform Strategy
Lao PDR	–	Lao People's Democratic Republic
MNCH	–	maternal, newborn, and child health
MOF	–	Ministry of Finance
MOH	–	Ministry of Health
NHA	–	national health account
NHI	–	National Health Insurance
NHIB	–	National Health Insurance Bureau
NSEDP	–	National Socio-Economic Development Plan
OOP	–	out-of-pocket
P3F	–	post-program partnership framework
SDG	–	Sustainable Development Goal
TA	–	technical assistance
UHC	–	universal health coverage
WHO	–	World Health Organization

NOTES

(i) The fiscal year (FY) of the Government of the Lao People's Democratic Republic ends on 31 December. Prior to FY2016, "FY" before a calendar year denoted the year in which the fiscal year ended, e.g., FY2015 ended on 30 September 2015.

(ii) In this report, "$" refers to United States dollars unless otherwise stated.

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PROGRAM AT A GLANCE

1. Basic Data — **Project Number:** 47137-006

Project Name	Health Sector Governance Program (Subprogram 2)	**Department/Division**	SERD/SEHS
Country	Lao People's Democratic Republic	**Executing Agency**	Ministry of Health
Borrower	Lao People's Democratic Republic		

2. Sector	**Subsector(s)**	**ADB Financing ($ million)**
✓ **Health**	Health sector development and reform	30.00
	Total	**30.00**

3. Strategic Agenda	**Subcomponents**	**Climate Change Information**	
Inclusive economic growth (IEG)	Pillar 2: Access to economic opportunities, including jobs, made more inclusive	Climate Change impact on the Project	Low

4. Drivers of Change	**Components**	**Gender Equity and Mainstreaming**	
Governance and capacity development (GCD)	Institutional development Institutional systems and political economy	Gender equity (GEN)	✓

5. Poverty and SDG Targeting		**Location Impact**	
Geographic Targeting	No	Nation-wide	High
Household Targeting	No		
SDG Targeting	Yes		
SDG Goals	SDG3		

6. Risk Categorization: Low

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

8. Financing

Modality and Sources	Amount ($ million)
ADB	**30.00**
Sovereign Program grant: Asian Development Fund	30.00
Cofinancing	**0.00**
None	0.00
Counterpart	**0.00**
None	0.00
Total	**30.00**

I. THE PROPOSAL

1. I submit for your approval the following report and recommendation on a proposed policy-based grant to the Lao People's Democratic Republic (Lao PDR) for subprogram 2 of the Health Sector Governance Program.[1]

2. The program supports the government's Health Sector Reform Strategy (HSRS),[2] which aims to achieve universal health coverage (UHC) by 2025 and the Sustainable Development Goals (SDGs) by 2030.[3] The HSRS is implemented through health sector development plans (HSDPs). Subprogram 1 supported the 7th HSDP (2011–2015),[4] while subprogram 2 aligns with the 8th HSDP (2016–2020).[5] Policy actions under both subprograms target health sector reform (HSR) processes, health care access for vulnerable groups, quality improvement of health personnel, and sound public financial management.

II. PROGRAM AND RATIONALE

A. Background and Development Constraints

3. **Equitable and inclusive growth**. The 8th Five-Year National Socio-Economic Development Plan (NSEDP) (2016–2020) aims for the Lao PDR to graduate from least-developed country status by 2020, and become an upper middle-income country by 2030.[6] Forecasts for 2017 indicate that the country's gross domestic product (GDP) grew 6.8%, resulting in GDP per capita of $2,579, and its poverty rate fell to 20.0%.[7] Significant development challenges remain, however, including (i) a high fiscal deficit, (ii) accumulated public and publicly guaranteed debt, and (iii) an undiversified resource-based economy. The government recognizes that equitable and inclusive growth requires targeted policy interventions for vulnerable groups, and the NSEDP commits sustained investment to improve access to and the quality of basic social services such as health care, with a view to improving health outcomes, especially for the poor, women, and children. Better health of the workforce results in lower absenteeism, higher labor productivity, and increased wages, all of which contribute to economic growth. Such effects are particularly important in countries where many are engaged in unskilled labor.[8]

4. **Unfulfilled health targets.** The Lao PDR has made good progress in achieving many health targets:[9] (i) life expectancy in 2015 was 68 years, and (ii) the maternal mortality ratio

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1 The design and monitoring framework is in Appendix 1.
2 Government of the Lao PDR, Ministry of Health (MOH). 2013. *Health Sector Reform Strategy, 2013–2025.* Vientiane.
3 UHC is defined by the World Health Organization (WHO) as providing all people and communities with the health services (promotive, preventive, curative, rehabilitative and palliative) they need, which are of sufficient quality to be effective, while ensuring that use of these services does not lead to financial hardship for the user. WHO. What is Universal Coverage?
4 Asian Development Bank (ADB). 2015. *Report and Recommendation of the President to the Board of Directors: Proposed Programmatic Approach, Policy-Based Loan, and Technical Assistance Loan for Subprogram 1 to the Lao People's Democratic Republic for the Health Sector Governance Program*. Manila (accessible from the list of linked documents in Appendix 2).
5 Government of the Lao PDR, MOH. 2011. *The VIIth Five-Year Health Sector Development Plan (2011–2015)*. Vientiane; and Government of the Lao PDR, MOH. 2014. *Directions and Functions of the VIIIth Five-Year Health Sector Development Plan (2016–2020)*. Vientiane.
6 Government of the Lao PDR, Ministry of Planning and Investment. 2016. *8th Five-Year National Socio-Economic Development Plan (2016–2020)*. Vientiane.
7 Country Economic Indicators (accessible from the list of linked documents in Appendix 2).
8 D. Bloom, D. Canning, and J. Sevilla. 2001. The Effect of Health on Economic Growth: Theory and Evidence. *NBER Working Paper Series*. No. 8587. Cambridge: National Bureau of Economic Research.
9 Sector Assessment (Summary): Health (accessible from the list of linked documents in Appendix 2).

decreased from 905 deaths per 100,000 live births in 1995 to 206 deaths in 2015 (the MDG target is 260).[10] Compared with other Asian countries, however, the Lao PDR fares poorly on key health indicators, including those for maternal, newborn, and child health (MNCH), which impedes full achievement of the health-related SDGs.[11] The country's under-5 mortality rate remains the highest in Southeast Asia at 86 deaths per 1,000 live births 2015 (the MDG target is 70), and infant mortality rate in 2016 was 48.9 deaths per 1,000 infants, above the MDG target of 45.[12] Child malnutrition, or underweight children under 5 years of age, dropped to 26.5% in 2011 (more recent data are not available), above the target of 20% (footnote 12). Communicable diseases such as HIV, malaria, and tuberculosis are prevalent.[13] The incidence of noncommunicable diseases, accidents, and injuries remains significant as well; the World Health Organization (WHO) reported that noncommunicable diseases constituted 60% of the burden of disease in 2008, while accidents and injuries accounted for 10%.[14]

5. **Limited utilization of health care services**. Poor health outcomes are closely linked to the limited use of health services. The overall use of public health services is reported to have increased fivefold during 2000–2013 to about 0.6 visits per person per year (footnote 12), but this is still low and gaps in coverage remain between the poor and rich, and rural and non-rural populations, especially for MNCH services, including immunization, antenatal care, skilled birth attendance, and surgery. Children in the poorest quintile are 3.6 times more likely to die before reaching age 5 compared with those in the wealthiest quintile, and children born in Phongsaly province are five times more likely to die before reaching age 5 than those born in Vientiane.[15]

6. The proposed policy-based grant—which is contingent on the achievement of policy actions, including robust policies and strategies for health and finance—can alleviate some of these macroeconomic and health burdens.[16] The program targets four critical areas of reform: improving HSR processes; improving implementation of free health care for the poor, mothers, and children; strengthening human resource management capacity; and strengthening the health sector's financial management system.

7. **Improving health sector reform processes**. Three critical issues impede smooth implementation of HSR. First, no governing body manages and plans HSR, in part because of a lack of competent managers with adequate leadership skills at central, provincial, and district levels and across Ministry of Health (MOH) departments. This affects MOH's ability to advocate for HSR and its related plans at the broader policy level and to respond quickly to new policy challenges. Second, although health sector coordination—across ministries, departments, and development partners—has improved, fragmentation, duplication, and misalignment remain. This is in part because of a lack of direction or planning for key areas, such as health financing and human resources, which can result in limited resources being used inefficiently. Third, progress under the government's decentralization program has been incremental and inconsistent because

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[10] Government of the Lao PDR, MOH. 2016. *National Health Statistics Report, FY 2015–2016*. Vientiane.
[11] ASEAN Secretariat. 2017. *ASEAN Statistical Yearbook 2016/2017*. Jakarta. ASEAN refers to the Association of Southeast Asian Nations.
[12] World Bank. World Development Indicators (accessed 1 December 2017). Infant mortality is defined as deaths between birth and age 1.
[13] In 2016, HIV prevalence among Lao men and women aged 15–49 years old was 0.3% (WHO. 2016. *Country Profiles on HIV: Lao PDR*). In the same year, the Lao PDR had about 27,390 cases of malaria (WHO. 2016. *Malaria Country Profiles: Lao People's Democratic Republic*). The incidence of tuberculosis in the Lao PDR was 175 per 100,000 people in 2016 (WHO. 2017. Tuberculosis Country Profiles: Lao People's Democratic Republic).
[14] WHO. 2015. *Lao People's Democratic Republic: WHO Statistical Profile*.
[15] Government of the Lao PDR, MOH. 2015. *Success Factors for Women's and Children's Health*. Geneva: WHO.
[16] ADB is in ongoing policy dialogue with the International Monetary Fund (IMF), working on broader macroeconomic analysis and fiscal projections.

of the absence of sector coordination and advocacy for needed reform resources.[17] Capacity constraints, limited accountability, and monitoring deficiencies, especially at the provincial level, has further hampered the implementation of key reforms.[18]

8. **Improving implementation of free health care.** Relatively low government spending on health is reflected in high private out-of-pocket (OOP) payments, making health care unaffordable for many. The government is seeking to reduce OOP payments from 45.1% of total health expenditure in FY2016 to 30% by 2025.[19] The government has subsidized specific groups (including the poor, mothers, and children) through programs such as health equity funds (HEFs) and free maternal, newborn, and child health care (FMNCH). The Lao PDR shifted to a national, predominantly prepaid financing mechanism in 2015, however, and introduced National Health Insurance (NHI). NHI drastically increased population coverage, enlarged the risk pool, and reduced fragmentation between different schemes, beginning with the absorption of HEF and FMNCH. The government has also rapidly mobilized resources through an earmarked NHI fund administered by the National Health Insurance Bureau (NHIB).[20] NHI has empowered people through simplified rules to access health benefits and increased predictability of health care financing. Once enrolled and upon payment of a fixed co-payment at a facility, patients are covered for a range of benefits, including all inpatient and outpatient services and medicines. Co-payments are waived for the poor, mothers, and children under 5 upon presentation of qualifying identification at the point of use. The government will continue to expand NHI and introduce implementation improvements, including quality interventions such as performance-based pay for health workers, as the scheme matures. This is expected to increase health service utilization, which will contribute significantly to health outcomes.

9. **Strengthening human resource management**. The Lao PDR has 3.1 health workers per 1,000 people, but this average obscures the poor situation in rural and remote areas and does not indicate what skills are available.[21] Although most health centers have nurses, a medical assistant, and a midwife, specialty staff (e.g., laboratory technicians and pharmacists) are not always available. Health personnel databases for planning staff distribution and skills are still not fully functional. Many health workers have fewer than 3 years of professional training and receive no regular in-service training and supportive supervision. There are also concerns about the commitment of health personnel: many health facilities have difficulty in hiring and retaining good quality staff, and one survey found that 34% of health workers, in particular those from district health centers, had changed jobs within 2 years.[22] These issues stem in part from inadequate and substandard medical education and training. The Lao PDR has not approved standards regarding accreditation of institutions and a national exam to assess qualification and skills. Instead, graduates from medical institutions are given a permit or license to practice, which they can hold indefinitely (there are no regulations for license renewal). The development of provincial workforce plans that reflect staff profiles and requirements and make recommendations on staff incentives, in addition to the creation of a personnel database, will help address these challenges.

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[17] The Sam Sang or "three builds" decentralization directive proposes that villages will serve as the development unit, districts as the integration unit, and provinces as the strategic unit.

[18] Laos-Australia Development Learning Facility. 2015. *Sam Sang in Practice: Early Lessons from Pilot Implementation*. Vientiane.

[19] Government of the Lao PDR, MOH. 2013. *National Health Accounts Report, 2012–2016.* Vientiane; and Government of the Lao PDR, MOH. 2016. *Health Sector Reform: Strategy and Framework Till 2025.* Vientiane.

[20] The amounts allocated to the NHI fund are based on NHIB's calculations of projected budget need.

[21] WHO recommends 4.5 skilled health professionals per 1,000 people, but this is a global target that may not necessarily apply to Lao PDR, which has less-skilled staff than the global average (WHO. Global Health Observatory Data: Health Workforce).

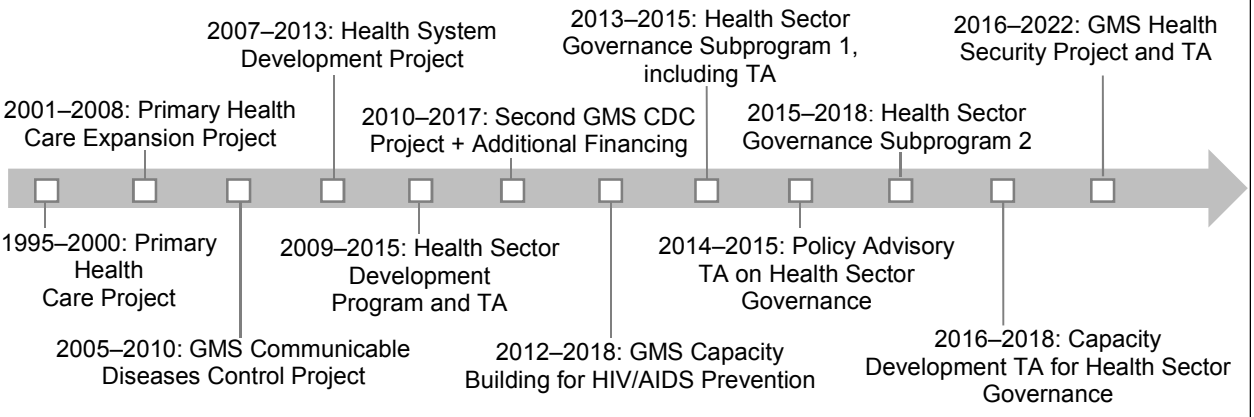
[22] ADB. Summary Report on Human Resources for Health. Consultant's report. Unpublished.

10. **Strengthening the health sector financial management system**. In 2013, the government committed to increase health spending to 9% of general government expenditure (GGE), including external aid and technical revenue.[23] Although domestic government spending on health has doubled during 2009–2013, health expenditure as a share of GGE averages just 5.9%, and the situation is worsened by declining external aid.[24] Health budget allocations vary significantly by province, and formulas to balance these allocations have not yet been introduced.[25] Financial management is not rigorous; with manual bookkeeping and multiple payment sources, leading to fragmented and inaccurate monitoring of expenditures. Moreover, program and finance budget preparation are not in alignment: finance budgets are typically based on preceding allocations and follow the chart of accounts, while program budgets use their own accounting structure often with inaccurate costing, making it difficult to link and sequence resources and track financial progress by program. The Ministry of Finance (MOF) has introduced a 'double entry' accounting system for the health sector to align program and financial budgets, but the situation has been complicated by channeling of non-salary NHI operational expenditures through the NHIB, accompanied by an unclear division of labor between MOH and NHIB.[26]

11. **ADB support.** Asian Development Bank (ADB) engagement with the Lao PDR health sector is long-standing and wide-ranging (Figure). ADB began supporting hospitals and health centers in 1995, starting in two northern provinces and eventually scaling up to eight provinces. Since 2001, ADB has been closely involved in communicable disease control and regional health security. The Health Sector Development Program was ADB's first sector development program for the Lao PDR health sector, and emphasized health systems strengthening for planning and financing, access to MNCH, and human resource quality.[27] Prior to subprogram 1, ADB supported HSR through policy advisory technical assistance (TA) that established a foundation for governance reforms, and draft plans for human resource development and financial management.[28] In addition to a policy-based loan, subprogram 1 provided a TA loan for equipment and training that was implemented in subprogram 2 (footnote 4). An additional grant supports capacity building for key MOH departments carrying out HSR.[29] In public sector management, ADB support has focused on creating medium-term budget frameworks (including for the health sector), improving fiscal transfer from the central government to provincial and district governments, building civil service capacity, strengthening national oversight institutions, and facilitating private sector development.[30]

[23] This is mostly revenue from users at facilities.
[24] *National Health Accounts Report, 2012–2016* (footnote 19, above). The Ministry of Finance Gazette 2017 shows the budget allocation for health was about KN1.28 trillion in FY2015 and KN1.54 trillion in FY2017.
[25] J. Hennicot. 2017. Financial Flows and Budgeting in the Health Sector in Lao PDR. A desk review. WHO.
[26] NHI has yet to agree on formulas and data to be used to allocate funds to the NHI fund.
[27] ADB. Lao People's Democratic Republic: Health Sector Development Program (approved on 10 November 2009).
[28] ADB. 2013. *Technical Assistance to the Lao People's Democratic Republic for Health Sector Governance.* Manila.
[29] ADB. 2016. *Technical Assistance to the Lao People's Democratic Republic for Strengthening Capacity for Health Sector Governance Reforms*. Manila.
[30] ADB. Lao People's Democratic Republic: Governance and Capacity Development in Public Sector Management Program, subprogram 1 and subprogram 2; and Lao People's Democratic Republic: Technical Assistance for Governance and Capacity Development. Manila.

History of ADB Health Sector Support in the Lao People's Democratic Republic



ADB = Asian Development Bank; CDC = communicable disease control; GMS = Greater Mekong Subregion; TA = technical assistance.
Source: Asian Development Bank.

12. **Lessons**. Past programs have been strongly aligned with MOH policies, and therefore highly relevant, but development partners need to go beyond information sharing and better coordinate activities under the government's single reform agenda. To this end, under subprogram 2, partners are engaging through technical working groups to jointly achieve the HSRS pillars. Past interventions reveal constrained provincial managerial capacity and limited coordination between different levels of the health system. Long-term engagement through subprograms 1 and 2 and complementary TA enable improved understanding of the informal and formal rules of the political economy that shape reform processes, and support for building ownership and appropriate leadership skills at the central and provincial levels. Policy reforms by nature take time and require continuous engagement and flexibility to respond rapidly to policy changes. Past projects also show that better cost-sharing mechanisms are needed to make health care more affordable for vulnerable groups. Subprogram 2 specifically targets the poor, women, and children under 5. It also supports NHI, which insures the population from catastrophic expenditures.

B. Policy Reform and ADB's Value Addition

13. **Program alignment with the Health Sector Reform Strategy**. The effect of the reform is improved health service coverage, particularly for the poor, mothers, and children.[31] Both subprograms were designed to support the five pillars under the HSRS: (i) health financing; (ii) human resources for health; (iii) governance, organization, and management; (iv) health service delivery; and (v) information, monitoring, and evaluation. Specific activities are envisioned across four plan periods up to 2030 (subprogram 2 is synchronized with the 8th HSDP). Subprogram 2 advances reforms initiated under subprogram 1, with the government accomplishing 17 policy actions (11 triggers and 6 milestones, Appendix 4). The government introduced NHI between the design and implementation of subprogram 1 (August 2013–July 2015) and the preparation of subprogram 2 (August 2015–March 2018). The HEF and FMNCH programs were subsumed under the NHI program. The government will ensure—through decrees, guidelines, and strategies—that benefits provided to the poor, mothers, and children under 5 under NHI equal or

[31] The program team revised two targets in the design and monitoring framework: the target about population coverage was revised to reflect the policy shift from HEF to NHI, and the target about midwives was revised to avoid repetition.

exceed those provided under HEF and FMNCH, and are provided at no cost.[32] Development partners have harmonized efforts to meet HSR goals. ADB has taken the lead on the first three pillars, and other partners have prioritized pillars 4 and 5. The World Bank disburses funds based on results in service delivery and information monitoring and evaluation. The Japan International Cooperation Agency, the European Union, WHO, Luxembourg Development Agency, and the Swiss Red Cross support financing, human resources, and service delivery.[33]

14. **ADB's value addition.** ADB's comparative advantage and value addition for the program lies in its cross-sector approach that addresses two themes—public finance and governance—that are essential for HSR. ADB's past support to the Lao PDR for public sector and financial management helps it understand the challenges inherent in public sector management reform processes that affect the health sector. As a development bank, ADB can provide significant fiscal and technical support to address the Lao PDR's macroeconomic situation. ADB continues to support domestic policymaking in the health sector and provided critical inputs to the design of HSRS and NHI under both subprograms. ADB is also a strong contributor to development partner forums. Past health projects targeting the supply side and more recent projects on communicable disease control and health security complement the program, and align with ADB's strategic vision on poverty reduction, gender equity, human resource development, and regional cooperation; and its emphasis on governance and long-term support.[34]

15. **Reform area 1: Health sector reform process improved.** Under subprogram 1, the government established the National Commission on Health Sector Reform chaired by the vice-prime minister. The commission oversees reform progress and approves annual reports and plans. MOH drafted road maps to strengthen human resources and financial management for health. To advance these reforms under subprogram 2, the cabinet is fully functional as the secretariat for the national commission. To aid health sector coordination, the secretariat established an HSR coordination unit with 12 staff in August 2017 and HSR committees with focal points to jointly manage HSR and decentralization reforms (footnote 17). MOH has finalized the 2018 annual operational plan for the health sector, which integrates the 2018 HSR plan presented at the annual national commission meeting in December 2017. The Minister of Health has approved road maps on human resource development and financial management, which set clear directions for HSR.

16. **Reform area 2: Implementation of free health care for the poor, mothers, and children improved.** Under subprogram 1, the government expanded the number of HEF and FMNCH beneficiaries.[35] By 2014, HEF covered 43% of poor families and FMNCH services had been initiated in 88 of 146 districts.[36] The government began phasing out HEF and FMNCH during subprogram 2, with resources instead directed to NHI, with implementation guidelines for the schemes harmonized to facilitate a smooth transition to NHI. MOF has created a fund to finance

[32] Summary Assessment of Policy Actions under Subprogram 2 (accessible from the list of linked documents in Appendix 2). The assessment outlines the original indicative policy action, status of accomplishments, and formulation of policy actions for subprogram 2. All actions have been met as of 19 March 2018.

[33] Development Coordination (accessible from the list of linked documents in Appendix 2). Specific disease control programs are spearheaded by The Global Alliance for Vaccines and Immunization and the Global Fund to fight AIDS, Tuberculosis and Malaria.

[34] ADB. 2017. *Country Partnership Strategy: Lao People's Democratic Republic, 2017–2020—More Inclusive and Sustainable Economic Growth*. Manila. The strategy includes health under its strategic priority to enhance human development.

[35] In subprogram 1, the reform area was to improve the implementation of the HEF and FMNCH schemes. Given the change in policy direction toward NHI, this reform area has been reworded.

[36] About 110,000 mothers, 300,000 children under 5, and 620,000 poor people (Government of the Lao PDR, MOH. 2017. *Key Features of the Official Social Health Protection Schemes in Lao PDR*. Vientiane).

NHI to ensure continued provision of free health care for the poor, mothers, and children under 5; as of January 2018, NHI had begun in 141 districts, and will cover 80% of the population (5.65 million) by June 2019.[37] MOH conducted a financial management assessment of NHI in 2017 to revise NHI's implementation guidelines and evaluate reforms under both subprograms.

17. **Reform area 3: Health human resource management capacity strengthened.** Under subprogram 1, the government engaged 4,000 people (many of whom were midwives) to the health workforce in 2014. MOH also implemented a provincial health personnel management information system (HPMIS) to improve human resource management and planning. MOH defined quality standards for medical education institutions and approved competency standards for medical professions, including dentistry, to be included in the training curriculum. Under subprogram 2, MOH has improved the functionality of the HPMIS by developing an import module to transfer data from an online personnel management information system into the HPMIS. Data can now be aggregated by province, district, and health facility for better planning and management. MOH also expanded the HPMIS to capture information on training, gender, and ethnicity. Provincial health office staff have undergone training to use the HPMIS, and 12 provincial health offices have formulated and are beginning to implement provincial workforce development plans to guide the training and deployment of staff in remote and hard-to-reach areas. This is particularly important for continued recruitment of midwives to help improve maternal health; between subprogram 1 and 2, the number of health centers with midwives has more than doubled (from 33% of health centers in 2012–2013 to more than 75.1% in 2016). In addition, MOH has issued decrees defining the licensing and registration process for health professionals and developing quality standards and requirements for the accreditation of medical education institutions. The newly created Health Professionals' Council oversees the implementation of these decrees.

18. **Reform area 4: Health sector financial management system strengthened.** Under subprogram 1, MOH developed staff capacity in preparation for adopting a multiyear health sector budget framework. MOH issued implementation guidelines to regulate the use and accounting of health facility user fees. To better understand resource mobilization and allocations in the health sector, MOH published national health accounts (NHAs) for FY2011 and FY2012. Under subprogram 2, MOH has adopted the widely accepted unitary bookkeeping and reporting system to account for sources and uses of funds in health facilities. MOH has also established a budget expenditure and disbursement monitoring system to document annual and quarterly expenditures and approved budgets. MOH has published NHAs for FY2013–FY2016 and is building capacity to institutionalize NHA production in MOH's Department of Finance. Efforts are underway to better link the finance and program budgets and report expenditures according to the chart of accounts and existing program codes.

19. **Post-program partnership framework.** The post-program partnership framework (P3F) provides a common understanding and proposes possible actions to be supported by ADB and other development partners following subprogram 2 (last column of Appendix 4). Broadly, P3F will sustain the reforms initiated under the program: subprogram 2 supports the beginning of phase 2 of the HSRS (2016–2020), and P3F sets out support for the end of phase 2 and the beginning of phase 3 (2021–2025). Under P3F, MOH will expand access to health facilities and benefits to include more health promotion, prevention, and rehabilitative interventions, with a focus on quality and use of performance-based incentives. The government will continue providing free service delivery for the poor, mothers, and children under 5 under NHI and will

[37] Based on projected total population of 7.06 million by 2019. United Nations Population Division. World Population Prospects 2017.

reduce OOP payments to 30% of total health expenditure by 2025. All health facilities will have the appropriate number and level of skilled health workers who are motivated, trained, and properly incentivized. The HSRS aims to increase domestic health expenditure to 13% of GGE by 2025, with adequate budget allocations for women to ensure universal access to sexual and reproductive health services in accordance with SDG targets 3.7 and 5.6. ADB will provide TA support for NHIB capacity development, including carrying out an expanded NHI evaluation; workforce plan implementation in all provinces; and the further strengthening of the MOF 'double entry' accounting system. ADB's country partnership strategy, 2017–2020 for the Lao PDR fully aligns with subprogram 2 and P3F, with continuing support for HSRS and the attainment of UHC in poor provinces, border areas, and economic corridors (footnote 34).

C. Impacts of the Reform

20. **Economic and financial.** Both the Lao PDR and ADB recognize that improving access to health care without financial hardship cannot be achieved without significant government resources. Quantifying expected benefits accurately is difficult, but reforms especially in financial management, health care financing, and human resources, which are widely perceived to be key bottlenecks for improving quality, efficiency, and equity, are strongly supported and will improve health service coverage and ultimately health outcomes, particularly for vulnerable groups. The program impact assessment estimates that support provided under subprograms 1 and 2 equal 10.2%–13.1% of annual health sector capital requirements during 2016–2020.[38]

D. Development Financing Needs and Budget Support

21. The government has requested a grant not exceeding $30 million from ADB's Special Funds resources (Asian Development Fund) to help finance the program.[39] The size of subprogram 2 reflects the government's financing needs, the strength of and commitment to the reform program, and the development expenditure arising from the reform program. The policy-based grant considers the International Monetary Fund's assessment of the Lao PDR's macroeconomic constraints, including a large current account deficit and high external debt stock.[40] The 8th NSEDP states that the government's capital requirements for development during 2016–2020 equal $5.7 billion–$7.3 billion. Assuming health sector investment is equal to the government budget expenditure on health (5.9%), capital requirements will equal $336 million–$431 million. Figures from FY2014 (footnote 19) show development partners finance around 18% of health expenditure; subprogram 2 will contribute significantly to this total. The grant will be provided in a single tranche and may be withdrawn upon grant effectiveness.

E. Implementation Arrangements

22. The executing agency for the program is MOH, represented by the Department of Planning and Cooperation. As the executing agency, MOH is responsible for program implementation, maintenance of all program records, and communicating with ADB on behalf of

[38] Program Impact Assessment (accessible from the list of linked documents in Appendix 2).

[39] The latest debt sustainability analysis classified the Lao PDR's debt distress as high risk, making the country eligible for an Asian Development Fund grant. However, Lao PDR's per capita gross national income exceeds the international development association threshold, and the country will only be eligible for concessional lending from 2019. International Monetary Fund Assessment Letter (accessible from the list of linked documents in Appendix 2).

[40] The Lao PDR has a current account deficit of –14.1% of GDP in 2016, fiscal deficit of 6.2% of GDP in 2016, and public debt of 68% of GDP in 2017. Country Economic Indicators (accessible from the list of linked documents in Appendix 2); and IMF. 2018. IMF Executive Board Completes the 2017 Article IV Consultation with the Lao People's Democratic Republic. News release. 12 March 2018. https://www.imf.org/en/News/Articles/2017/02/15/PR1750-Lao-IMF-Executive-Board-Concludes-2016-Article-IV-Consultation.

the government. The MOH steering committee is chaired by the health minister and comprises vice-ministers and representatives of MOH departments, including the cabinet, which is responsible for oversight of HSR implementation, and other ministries as requested. It provides guidance on program implementation. The implementation period of subprogram 2 started in August 2015 and will end in March 2018. The grant closing date is 31 December 2018.[41] The proceeds of the policy-based grant will be withdrawn in accordance with ADB's *Loan Disbursement Handbook* (2017, as amended from time to time).

III. DUE DILIGENCE

23. **Environment.** ADB has reviewed subprogram 2's policy actions—which target institutional arrangements, human resources, budget allocation, and financial management—and found no anticipated environmental impacts or requirements for mitigation measures. Consequently, the program is classified category C for the environment. MOH prepared an environmental assessment and review framework for subprogram 1 (minor renovations of existing health centers were originally planned). No physical works were implemented under subprogram 1, however, and none are envisaged under subprogram 2, and an environmental assessment and review framework is thus not required.

24. **Involuntary resettlement**. MOH prepared a resettlement screening and involuntary resettlement framework in preparation for subprogram 1 to address impacts associated with planned refurbishment of health facilities. ADB reviewed policy actions carried out under subprogram 2 and found no new health facility construction or refurbishment activities and no planned land acquisition or involuntary resettlement. A resettlement framework is therefore not required for subprogram 2 and the program is classified category C for involuntary resettlement under ADB's Safeguard Policy Statement (2009).

25. **Ethnic groups**. The program is classified category B for indigenous peoples because of the program's potential positive impacts. MOH prepared an indigenous people's plan, with corresponding mitigation measures, for subprogram 1 and the TA loan to assess the program activities' potential impact on ethnic groups and to ensure that ethnic groups benefited equally from the program activities. MOH updated the indigenous people's plan and subsumed it into the matrix of potential environmental and social impacts and measures for subprogram 2 to reflect key issues, policy actions, potential impacts, and mitigating actions.[42] Further, MOH revised the indigenous people's plan during the midterm review of the TA loan in August 2017 and will continue to implement it during the TA loan term.

26. **Gender**. Both subprograms 1 and 2 are classified *gender equity as a theme* as they promote and contribute to achieving gender equality by enhancing women's access to health services. Subprogram 2 continues to prioritize support for poor provinces with ethnic minority populations that typically have greater maternal health care needs. MOH has initiated policies for increasing access to NHI, including FMNCH services, and the number of health centers with at least one community midwife for safe delivery. The policy matrix in Appendix 4 includes gender-related policy actions. ADB revised the gender action plan, supported by the TA loan, during the midterm review to better reflect the current context (e.g., alignment with new NHI scheme) and to improve its quality by rewording some targets.[43] Gender action plan achievements include the

[41] List of Ineligible Items (accessible from the list of linked documents in Appendix 2).
[42] Indigenous People's Plan and Matrix of Potential Environmental and Social Impacts and Measures (accessible from the list of linked documents in Appendix 2).
[43] Gender Action Plan (accessible from the list of linked documents in Appendix 2).

following: (i) more than 75.1% of 1,017 health centers have at least one midwife;[44] (ii) MOH developed a detailed road map guiding preparation of a national strategy to promote gender equality in the health sector; and (iii) workforce development plans that include action points on gender and equity policies to support women's employment, placement, retention, promotion, and capacity development in the health sector were formulated. The number of female staff undertaking training and fellowships on public health and financial management, and availability of data on utilization and personnel disaggregated by sex and ethnicity, have both increased.

27. **Risks and mitigating measures**. Major risks assessment and mitigating measures are summarized in the table and described in detail in the risk assessment and risk management plan.[45]

Summary of Risks and Mitigating Measures

Risks	Mitigation Measures
Macroeconomic conditions deteriorate, worsening the fiscal deficit.	The government is committed to maintaining macroeconomic stability and reducing vulnerabilities with fiscal reforms, restructuring of weak public banks, and equitization of some state-owned enterprises.
Revenue deficits may pose potential risks for budget allocation to the health sector.	The government is taking administrative measures such as capping expenditure increases by freezing civil servant salaries and limiting intake to improve revenue collection. Subprogram 2 policies will contribute to improving health sector efficiency.

Source: Asian Development Bank.

28. ADB's Anticorruption Policy (1998, as amended to date) was explained to and discussed with the government and MOH.

IV. ASSURANCES

29. The government has 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 grant agreements. No disbursement shall be made unless ADB is satisfied that the government has completed the policy actions specified in the policy matrix relating to the program.

V. RECOMMENDATION

30. I am satisfied that the proposed policy-based grant would comply with the Articles of Agreement of the Asian Development Bank and recommend that the Board approve the grant not exceeding $30,000,000 to the Lao People's Democratic Republic from ADB's Special Funds resources (Asian Development Fund) for subprogram 2 of the Health Sector Governance Program, on terms and conditions that are substantially in accordance with those set forth in the draft grant agreement presented to the Board.

Takehiko Nakao
President

26 March 2018

[44] Government of the Lao PDR, MOH. 2016 Report on Deployment of Human Resource for Health. As of October 2017, 81.4% has been reported but not yet verified through the 2017 report, which is endorsed by the health minister.
[45] Risk Assessment and Risk Management Plan (accessible from the list of linked documents in Appendix 2).

DESIGN AND MONITORING FRAMEWORK

Country's Overarching Development Objectives
Universal health coverage by 2025 (Health Sector Development Plan, 2016–2020)[a]
Achieve Sustainable Development Goals by 2030 (National Socio-Economic Development Plan, 2016–2020)[b]

Results Chain	Performance Indicators with Targets and Baselines	Data Sources and Reporting Mechanisms	Risks
Effect of the Reform Coverage of health services particularly for the poor, mothers, and children improved	By 2019: a. Free facility-based delivery increased to 80.0% (2015 baseline: 25.5%) b. Percentage of population covered by NHI (including free services for the poor, mothers, and children under 5) increased to 80%[c] (2015 baseline: 33%)	a. DHIS2 annual health statistics report b. Annual NHIB report	Macroeconomic conditions deteriorate and worsen the fiscal deficit.
Reform Areas (Subprogram 2)	**Key Policy Actions**		
1. HSR process	By 2018 1.1. FY2018 health sector operational plan to implement HSR approved[d] (2017 baseline: NA) 1.2. Road map for HSR direction and implementation of HR and financial management reforms, including monitoring mechanisms, approved by MOH (2017 baseline: NA)	1.1. Approved 2018 MOH operational plan 1.2. Respective road maps	
2. Implementation of free health care for the poor, mothers, and children	2.1. Funds for NHI (including to provide free services for the poor, mothers, and children under 5) in at least 131 districts increased to KN183 billion (2016 baseline: KN66 billion) 2.2. Assessment and recommendations on NHI financial management, monitoring, and health provider payment mechanisms completed; and recommendations approved for better financial NHI sustainability (2017 baseline: NA)	2.1. Annual DOF report, MOF Gazette or notice, annual NHIB report 2.2 Financial management, monitoring, and health provider payment mechanisms assessment, including approved recommendations	
3. Health human resource management capacity	3.1. Workforce plans, including action points on gender and equity policies, and appropriate staff incentives to determine staff and skill shortages approved in at least 12 PHOs (2016 baseline: 3 PHOs)	3.1. PHO workforce plans	

Results Chain	Performance Indicators with Targets and Baselines	Data Sources and Reporting Mechanisms	Risks
	3.2. Percentage of health centers with at least one community midwife increased to 75% (2015 baseline: 52%)	3.2. Access database, DHIS2 report	
	3.3. Three decrees setting institutional norms and regulations on certification standards, accreditation, and licensing and registration system for health professionals issued (2015 baseline: one decree on certification standards)	3.3. Decrees issued	
4. Health sector financial management system	4.1. Health budget allocation increased to KN1.54 trillion (2015 baseline: KN1.28 trillion)	4.1. MOF Gazette or Notice, annual MOH budget report	Revenue deficits may pose potential risks for budget allocation to the health sector.
	4.2. System to account for sources and uses of funds in health facilities and to enhance monitoring of public finances for health adopted by MOH (2017 baseline: NA)	4.2. Annual DOF report	
	4.3. Expenditure monitoring system documenting expenditure reports of provinces and central health departments, including amounts approved for disbursement, established by MOH (2017 baseline: NA)	4.3. Annual DOF report	
	4.4 Fund flow mechanism to ensure NHI funds reach provinces approved by MOF and MOH (2017 baseline: NA)	4.4. Letter and fund flow diagram from MOF and MOH	
Budget Support			
Asian Development Bank: $30,000,000 (grant)			

DHIS2 = District Health Information System 2, DOF = Department of Finance, FY = fiscal year, HSR = health sector reform, MOF = Ministry of Finance, MOH = Ministry of Health, NA = not applicable, NHI = National Health Insurance, NHIB = National Health Insurance Bureau, PHO = provincial health office.

[a] Government of the Lao People's Democratic Republic, MOH. 2014. *Directions and Functions of the VIIIth Five-Year Health Sector Development Plan (2016–2020)*. Vientiane.

[b] Government of the Lao People's Democratic Republic, Ministry of Planning and Investment. 2016. *8th Five-Year National Socio-Economic Development Plan (2016–2020)*. Vientiane.

[c] NHI will eventually merge all social health protection schemes, starting with health equity funds and free maternal, newborn, and child health.

[d] The government approved the 2018 plan at the end of 2017 and will likely approve the 2019 plan toward the end of 2018.

Source: Asian Development Bank.

LIST OF LINKED DOCUMENTS

http://www.adb.org/Documents/RRPs/?id=47137-006-2

1. Grant Agreement
2. Sector Assessment (Summary): Health
3. Contribution to the ADB Results Framework
4. Development Coordination
5. Country Economic Indicators
6. International Monetary Fund Assessment Letter[1]
7. Summary Poverty Reduction and Social Strategy
8. Risk Assessment and Risk Management Plan
9. List of Ineligible Items
10. Gender Action Plan
11. Indigenous People's Plan
12. Matrix of Potential Environmental and Social Impacts and Measures
13. Approved Report and Recommendation of the President to the Board of Directors: Health Sector Governance Program (Subprogram 1)

Supplementary Documents

14. Program Impact Assessment
15. Summary Assessment of Policy Actions under Subprogram 2

[1] The press release issued on 12 March 2018 is used in lieu of the International Monetary Fund assessment letter. http://www.imf.org/en/News/Articles/2018/03/12/pr1883-lao-peoples-democratic-republic-imf-executive-board-completes-the-2017-article-iv.

DEVELOPMENT POLICY LETTER

LAO PEOPLE'S DEMOCRATIC REPUBLIC
Peace Independence Democracy Unity Prosperity

MINISTRY OF FINANCE

No 0958 /MOF
Vientiane, date 26 MAR 2018

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

Subject: Development Policy Letter – Lao PDR: Health Sector Governance Program, Subprogram 2

Your Excellency,

This letter highlights the Lao PDR Government's 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 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 for 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 governance 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 a $30 million grant to support subprogram 2 policy initiatives which have been implemented since August 2015 and will finish in March 2018. The policy initiatives under both subprogram 1 (August 2013 to July 2015) and subprogram 2 (together the "Program") are described in the attached policy matrix.

The eighth National Socio Economic Development Plan (NSEDP) 2016–2020, aims to achieve sustainable and inclusive economic growth, and achieve the Sustainable Development Goals (SDGs), including poverty reduction. The Lao PDR is starting to prepare for graduation from Least Developed Country status by 2020. Growth in gross domestic product (GDP) reached 6.8% in 2017, resulting in GDP per capita of $2,579 while the poverty rate fell to 20%.In particular, the 8th NSEDP commits sustained investment to improve access to, and quality of, basic social services such as health care, with a view to improving health outcomes especially for the poor, women and children. Generally, a healthier workforce is associated with lower absenteeism from illness, which leads to higher labor productivity, higher wages and economic growth. Such effects are particularly salient in countries like Lao PDR, where many are engaged in manual labor requiring physical strength. 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 meeting the health-related SDGs.

However, the Government recognizes that for equitable and inclusive growth, targeted policy interventions are required. NSEDP recognizes 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 prerequisites to improved service delivery and improved efficiency with which services are provided.

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. Between fiscal years 2014/15 and 2017, the health sector budget from domestic resources increased by 20%, much of which has been due to increases in allocations for provinces through the National Health Insurance Fund. Such increases will significantly benefit the most vulnerable by enhancing health service access to communities.

The Government has been working on the key reform initiatives documented in the policy matrix for subprogram 2 since August 2015. 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 2 to support key reform initiatives, which smoothly follow initiatives under the previous subprogram. The following is a summary of completed actions.

Health sector reform process improved. The Government has begun implementing key governance aspects of the HSRS. Specifically, a National Commission on Health Sector Reform has been established (Prime Minister Decree 29/GOV of January 2014) to implement the HSRS, and is set to have its annual meeting in December 2017 to review HSR progress and approve HSR plans for 2018. This triggered another high-level policy meeting with provincial Governments in January 2018 to roll out HSR activities. The HSR Coordination Unit in Ministry of Health (MOH) has also been established in August 2017. As part of HSRS implementation, the MOH has drafted two road maps on strengthening human resources for health and financial management describing the key medium-term reforms to be implemented, including their sequencing, monitoring and capacity development requirements.

Implementation of free health care for the poor, mothers and children improved. The Government is strongly committed to improved social protection for the vulnerable. Until 2015, the Government targeted specific groups (such as the poor, mothers and children) through programs such as Health Equity Funds (HEF) and Free Maternal, Newborn and Child Health

Care (FMNCH), social welfare schemes such as Community Based Health Insurance (CBHI), and social security based insurance schemes provided by the Social Security Organization (SSO) and the State Authority Social Security (SASS). However, in 2015 the Government decided to shift towards a nationwide, predominantly prepaid financing mechanism, and introduced the National Health Insurance (NHI) scheme for those not enrolled in existing schemes. The NHI is administered by the National Health Insurance Bureau (NHIB) and draws upon an earmarked National Health Insurance Fund. Through NHI and under Decree 470 (2012) and the NHI Strategy, the Government intends to enlarge the risk pool merging all schemes under one umbrella, beginning with the absorption of HEF and FMNCH. Once enrolled into NHI and upon payment of a fixed co-payment at the facility, patients are covered for a range of benefits. Mothers, children under 5 and the poor are exempt from the copayment. NHI is expected to cover the whole country by the end of 2018, with implementation improvements as the scheme matures. The National Assembly is closely monitoring the progress of NHI and is committed to sustain NHI financing as a key strategy towards universal health coverage (UHC).

Health human resources management capacity strengthened. The Government recognizes that the quantity and the quality of human resources in the health sector are critical for effective service delivery. The Government recognizes that there remain very significant skill gaps due to shortages and mismatches between training programs, and health worker skills need to be significantly improved. To address this, the Government has formulated and begun to implement workforce plans in 12 provinces, with a view to achieving the remaining 6 provinces in 2018. The workforce plans also recommend action points for gender, equity policies and appropriate staff incentives to improve the deployment of staff to 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; as of 2017, more than 75% of health centers in the country have a midwife. To support data accuracy and analysis, the 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. To enhance skills and qualification of health care professionals, MOH has issued decrees defining certification standards, licensing and registration system for health professionals, and accreditation of health professionals' education institutions. In 2016, the Health Professional Council was established to oversee all regulations relating to health professionals, including 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 to understand better the available resources and link this information to the planning cycle. To improve budget planning and facilitate its execution, MOH has established an expenditure monitoring system which is aligned with the MOF's paper and excel based 'double entry' accounting system. This is compliant with the Accounting Law of 2014. A manual on accounting for state funds has been published to support implementation, training has been conducted by MOH in all provinces, and the system is now implemented countrywide. This system, linked with budget disbursement procedures, produces financial information required to establish the expenditure monitoring system. This greatly enhances monitoring of public finances for health, and provides a consistent and reliable basis for accounting for sources and uses of funds in health facilities. The MOH has also published

National Health Accounts up to 2016, 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 the NHI system for health service delivery, MOF and MOH have agreed on a fund flow structure.

Conclusion

The Government highly appreciates the Program grant support as part of ADB's sustained health sector support as a long standing and trusted development partner, and would like to assure ADB that it fully commits to support the policy actions contained in the policy matrix and to maintain and monitor such actions thereafter in line with the Government's 8th National Socio Economic Development (2016–2020) Plan and in partnership with other development partners.

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 2 of the Health Sector Governance Program as outlined above, are far from exhaustive. They contribute only in some measure to the larger reform agenda to achieve graduation from Least Developed Country status, UHC and SDGs envisioned by NSEDP and the HSRS. We are nevertheless confident that the reform initiatives supported 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 consideration of this proposed grant and look forward to working together with ADB to improve health outcomes of the Lao PDR.

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

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

Yours Sincerely,

Somdy DOUANGDY
Minister of Finance

POLICY MATRIX

Reform area *(relevant supporting TA in italics)*	**Policy actions (triggers in bold)**		**Post-program partnership framework (2018–2022)**
	Subprogram 1 accomplishments August 2013 to July 2015	*Subprogram 2 August 2015 to March 2018*	*'TAs' refer to corresponding TA 3280 (closing in March 2019), CDTA 9190 (closing in August 2018) and a future TA scheduled for implementation beginning 2019/2020*
1. Health sector reform process improved *(PATA 8576 Health Sector Governance,[a] TA 3280 Health Sector Governance Program,[b] CDTA 9190 Strengthening Capacity for Health Sector Governance Reforms)*[c]	**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.**	**1.1 The National Commission[d] has approved the 2018 HSR implementation plan, as part of MOH's implementation plan.**	The second phase (2016–2020) of the HSR aims to ensure that essential services of reasonably good quality are accessible and utilized by the majority of the population, but especially the poor, mothers and children under 5. After 2020, phase 3 (2021–2025) expects to achieve universal health coverage with an adequate benefit package and appropriate financial protection for the vast majority of the population. This will require strong supply side interventions to encourage demand (and therefore utilization) of health services. Other development partners, especially World Bank and Luxembourg Development Agency are working closely with MOH to enhance service delivery. Similarly, there will need to be an emphasis on cost-effectiveness of health care provided under health insurance to mitigate fiscal deficit risks. The HSR aims to have a strong structure and legal framework; implementation is results-oriented and jointly planned between government and development partners, and regularly monitored. TAs will continue to support capacity development of Cabinet and HSR processes, including roadmap implementation.
	1.2 The government has endorsed the 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.	**1.2 To enhance monitoring of reforms for 2015–2025, MOH has approved the roadmap for reforms in strengthening health human resources and health system financial management.**	
2. Implementation of free health care for the poor,	2.1 By September 2014, the government has rolled out the free MNCH program in 88 districts for maternal care (out	**2.1 The government increased financial resources from 22 billion kip in 2014/5 to 183 billion kip in 2017 to deliver free**	The government will, by 2020, increase coverage of the social health protection schemes to 80% through effective implementation of the national decree on health insurance and government will lower out of pocket expenditures to

Reform area *(relevant supporting TA in italics)*	**Policy actions (triggers in bold)**		**Post-program partnership framework (2018–2022)**
	Subprogram 1 accomplishments August 2013 to July 2015	*Subprogram 2 August 2015 to March 2018*	*'TAs' refer to corresponding TA 3280 (closing in March 2019), CDTA 9190 (closing in August 2018) and a future TA scheduled for implementation beginning 2019/2020*
mothers and children improved[e] *(PATA 8576 Health Sector Governance, TA 3280 Health Sector Governance Program, CDTA 9190 Strengthening Capacity for Health Sector Governance Reforms)*	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).	**of charge health services for the poor, mothers and children under 5 in at least 131 districts, in line with the NHI guidelines.**	35% of total health expenditure. The poor, mothers and children under 5 will continue to receive services free. After 2020, under phase 3 (2021–2025) the government will continue to increase insurance coverage (90%) ensuring gender responsive awareness raising, further decrease out of pocket expenditure and expand the benefits package to include more health promotion, prevention and rehabilitative interventions. Government will consolidate all social health protection schemes into a single pooled fund, and make participation to insurance mandatory. Clear regulations for provider payment mechanisms will be set. (HSRF Priority Area 2: Health Financing) Strong supply side interventions to encourage demand (and therefore utilization) of health services will be needed, with simultaneous emphasis on cost-effectiveness to encourage financial sustainability of health insurance. An assessment of impacts and gaps in access to HEF and FMNCH schemes has been conducted as part of the gender action plan implementation, which provides recommendations to ensure equitable access for women to NHI and will feed into an expanded NHI evaluation (carried out using ADB TA and other development partner resources). The results of the evaluation will determine further capacity development requirements.
	2.2 The MOH has clarified the role of the HIB as administrator of the five existing social health protection schemes.	2.2. MOH continued improving NHI governance arrangements by issuing a NHI decree (outlining benefits, financial management and administrative arrangements) and strengthening capacity of the NHIB and its provincial branches, through training on NHI for staff.	
	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.	**2.3 To ensure sufficient and timely reimbursement to health facilities, MOH assessed financial management, monitoring and health provider payment mechanisms and approved recommendations to improve relevant implementation guidelines.**	
	2.4 To streamline uniformity of HEF and free MNCH schemes, the MOH has harmonized their implementation guidelines for nationwide application.		

Reform area *(relevant supporting TA in italics)*	**Policy actions (triggers in bold)**		**Post-program partnership framework (2018–2022)**
	Subprogram 1 accomplishments August 2013 to July 2015	*Subprogram 2 August 2015 to March 2018*	*'TAs' refer to corresponding TA 3280 (closing in March 2019), CDTA 9190 (closing in August 2018) and a future TA scheduled for implementation beginning 2019/2020*
3. Health human resources management capacity strengthened *(PATA 8576 Health Sector Governance, TA 3280 Health Sector Governance Program, CDTA 9190 Strengthening Capacity for Health Sector Governance Reforms)*	**3.1 The MOH has rolled out the computerized HPMIS in the provinces, to facilitate provision of annually updated information on number, allocation and skills of the health staff.**	3.1 MOH improved the HPMIS to incorporate data on skills, training, sex and ethnicity, and trained provincial health officers to utilize the HPMIS and its data[f] for planning and management purposes.	By 2020, all health centers will have been staffed in accordance with the health coverage plan: (i) Health centers will have at least mid-level health workers, including at least one mid-level midwife (this is one level up from community-level midwives). (ii) District and provincial hospitals will have at least the minimum staffing level and specialist defined in the health coverage plan. The presence of at least one midwife in health centers will help reduce maternal mortality and improve maternal health. After 2020, phase 3 (2021–2025) will have a sufficient and sustainable workforce which is skilled, motivated, supported and equitably, evenly distributed. Performance based payment mechanisms will be introduced and health management capacity will be expanded. Health personnel will be given professional development opportunities, in-service training and continuing medical education supported by relevant institutions. (HSRF Priority Area 1: Human Resources for Health) TA will assist provinces to work towards online access to computerized HPMIS for personnel management. All provincial workforce plans will be completed and implemented in 2018 with TA support, and by 2019 annual operation plans will also include proposed actions. TAs will assist to implement the decrees and carry out relevant capacity development.
	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[g] to 1,020 in 2014.	**3.2 To ensure appropriate staffing level of health facilities with emphasis on deployment of staff in remote and hard to reach areas, at least 12 provincial health offices have approved their workforce plan (including action points on gender and equity policies and appropriate staff incentives).**[h]	
	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.	**3.3. To enhance safe delivery, the MOH gradually increased the deployment of midwives to ensure that 75% of health centers are staffed with at least one community midwife, up from 52% in 2015.**[i]	
		3.4 MOH has issued a decree which states objectives, rights and responsibilities, the organizational structure and assigned personnel	

Reform area *(relevant supporting TA in italics)*	**Policy actions (triggers in bold)**		**Post-program partnership framework (2018–2022)**
	Subprogram 1 accomplishments August 2013 to July 2015	*Subprogram 2 August 2015 to March 2018*	*'TAs' refer to corresponding TA 3280 (closing in March 2019), CDTA 9190 (closing in August 2018) and a future TA scheduled for implementation beginning 2019/2020*
		for the Health Professional Council, which is functional.	
		3.5 To further enhance skills and qualification of health care professionals, MOH approved certification standards, accreditation, licensing, and registration system for health professionals.	
4. Health sector financial management system strengthened *(PATA 8576 Health Sector Governance, TA 3280 Health Sector Governance Program, CDTA 9190 Strengthening Capacity for Health Sector Governance Reforms, TA 9059 Support for Governance and Capacity Development)*[j]	4.1 In 2014, MOH has strengthened staff capacity to adopt multi-year budgeting and budget framework.	**4.1 In FY2017, the Government increased health budget allocation by 20% compared to the FY2014/15 budget allocation.**	By 2020, domestically financed health expenditures are not less than 9% of GGE from 2015 and rise to 13% by 2025. General Government Health Expenditure (including ODA channeled through the government system) is efficiently managed and monitored at all levels. Adequate budget allocation is made with a view of ensuring universal access to sexual and reproductive health services in accordance with the SDGs (SDG 3.7 and SDG 5.6). After 2020, phase 3 (2021–2025) aims for health expenditure from domestic sources to be between 3 and 4% of GDP. The government continues to expand social health protection schemes, and out of pocket payments total less than 30% of total health expenditure. The health insurance system is used as a financing tool for pooling funds and for incentivizing staff working in health facilities.
	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 for health, MOH applied the Accounting Handbook for State Agencies and implemented MOF's 'double entry' system to account for sources and uses of funds in health facilities.**	
	4.3 MOH has issued Implementation Guidelines for the collection, accounting and utilization of the money collected from health service charges.	4.3 MOH started piloting MOF's 'double entry' system to account for sources and application of funds for selected facilities with an initial focus on district and	

Reform area *(relevant supporting TA in italics)*	**Policy actions (triggers in bold)**		**Post-program partnership framework (2018–2022)**
	Subprogram 1 accomplishments August 2013 to July 2015	*Subprogram 2 August 2015 to March 2018*	*'TAs' refer to corresponding TA 3280 (closing in March 2019), CDTA 9190 (closing in August 2018) and a future TA scheduled for implementation beginning 2019/2020*
		provincial level hospitals in at least five provinces.	(HSRF Priority Area 2: Health financing) TAs will continue to monitor and track health budget allocations and assist to operationalize the system to account for sources and uses of funds and encourage other development partners to also align with MOH's system. NHA will be institutionalized and enhanced in terms of policy relevance, and used as a basis of improving sector funding, allocations, performance and coordination. World Bank and ADB, in particular, will continue to provide capacity building support for Public Financial Management, and encourage more timely expenditure reporting. TAs will input into the establishment of a legal framework (health insurance law, law on health care, etc.), institutional arrangements (level of autonomy, structure, governance), and financing arrangements for NHI using the NHI financial assessment and broader NHI evaluation results.
	4.4 To improve health expenditure transparency, MOH has prepared and published NHA for FY2011, and FY2012 detailing health sector funding, its sources, and utilization at national and sub-national levels.	4.4. To improve health expenditure transparency, MOH continued to publish NHA for FY2013–FY2016.	
	4.5 The 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.	**4.5 To improve budget planning and execution, MOH published approved disbursement figures in the Central Budget Units Annual Report for 2015–2016, Central Budget Units 6-month report for 2017, Provincial Health Office Annual Reports for 2015–2016 and Provincial Health Office 6-month reports for 2017.**	
		4.6 MOH adopted a financial management system and accompanying guidelines to align development partner financing with government plans and budget, consistent with Government chart of accounts.	

Reform area *(relevant supporting TA in italics)*	**Policy actions (triggers in bold)**		**Post-program partnership framework (2018–2022)**
	Subprogram 1 accomplishments August 2013 to July 2015	*Subprogram 2 August 2015 to March 2018*	*'TAs' refer to corresponding TA 3280 (closing in March 2019), CDTA 9190 (closing in August 2018) and a future TA scheduled for implementation beginning 2019/2020*
		4.7 To ensure adequate and timely funding for free health services for the poor, mothers and children under 5 and improve financial sustainability of health sector operations, MOH and MOF agreed on a fund flow mechanism.	

ADB = Asian Development Bank, CDTA = capacity development technical assistance, FY = fiscal year, GDP = gross domestic product, GGE = General Government Expenditure, HEF = health equity fund, HIB = Health Insurance Bureau, HPMIS = health personnel management information system, HSRF = Health Sector Reform Framework, MNCH = maternal, new-born and child healthcare MOH = Ministry of Health, MOF = Ministry of Finance, NHA = National Health Accounts, NHI = National Health Insurance, ODA = Official Development Assistance, PATA = policy advisory technical assistance, TA = technical assistance

[a] Implemented between January 2014- September 2015, TA 8576 produced: (i) a situational analysis of human resources for health, health sector financing, and government management and coordination which was endorsed by MOH; (ii) a gender-responsive roadmap for the implementation of health sector reform strategy; and (iii) technical inputs that supported preparation of HSGP which aligns with the TA's target of producing a draft report on gender-sensitive health sector governance assistance. A full review of the existing Free Maternal, Newborn and Child Health scheme, and policy recommendations, is carried out in the health sector financing situational analysis.

[b] Complementary TA to subprogram 1, and continuing after closure of subprogram 2 through to March 2019, supporting reform related activities including equipment and training and implementation of the gender action plan.

[c] CDTA 9190-Lao PDR: Strengthening Capacity of Health Sector Governance Reform implemented between October 2016–August 2018, supporting training and capacity building.

[d] The Vice-President of Lao Women's Union is a member of the National Commission on Health Sector Reform (Decree 029/GOV, Decree for National Commission to implement Health Sector Reform Strategy by 2020).

[e] In subprogram 1, the reform area was 'Implementation of the health equity fund and free maternal, new-born, and child health care schemes improved'. However, given the change in policy direction towards National Health Insurance, this reform area has been reworded.

[f] Including disaggregated data.

[g] midwives were available in approximately 33% of health centers.

[h] Examples of action points include 'provincial health office will deploy 32 community midwives to the following health centers (named) by 2019'; 'provincial health office will aim to deploy additional staff to achieve a minimum of 3 healthcare workers for health centers with < 3 healthcare workers' (health centers identified); 'the provincial health office will aim to deploy additional specialists in the following disciplines' (identified areas); 'the provincial health office will explore the contributing factors to low utilization of services in the following 17 health centers and consider potential solutions' (identified health centers); 'provincial health office in collaboration with department of health personal will provide required training'. In general, provincial workforce development plans reflect the need to increase the number of women working in health facilities, increase the number of women in decision making (management) positions, and increase the number of female care givers so as to ensure a higher incidence of women to women services.

[i] 2015 figures, published in 2016.

[j] TA 9059-Lao PDR: Support for Governance and Capacity Development.